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NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

ASSESSOR'S GUIDEBOOK FOR NATIONAL QUALITY ASSURANCE STANDARDS IN DISTRICT HOSPITALS

2020

VOLUME - III

Ministry of Health and Family Welfare
Government of India

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Ministry of Health and Family Welfare
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DISCLAIMER

The checklists given in Volume I , II & III have been developed after review Indian Public Health Standards (IPHS), Guidelines of Ministry of Health & Family Welfare, National Health Programmes, Standard Text Books, Journals & Periodicals, etc. The checklists are to be used as tools for the Quality Improvement. While taking patient and clinical care related decisions these checklists may not be used.

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PREFACE

The National Rural Health Mission (NRHM) Strives to Provide Quality Health Care to all citizens of the country in an equitable manner. The 12th Five Year Plan has re-affirmed Government of India's commitment – *"All government and publicly financed private health care facilities would to expected to achieve and maintain Quality Standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements."*

Indian Public Health Standards (IPHS) developed during 11th Five Year Plan describe norms for health facilities at different levels of the Public Health System. However, It has been observed that while implementing these Standards, the focus of the states has been mostly on creating IPHS specified infrastructure and deploying recommended Human Resources. The requirement of national programmes for ensuring quality of the services and more importantly user's perspective are often overlooked.

The need is to create an inbuilt and sustainable quality for Public Health Facilities which not only delivers good quality but is also so perceived by the clients. The guidelines have been prepared with this perspective defining relevant quality standards, a robust system of measuring these standards and institutional framework for its implementation.

These operational guidelines and accompanying compendium of cheklists are intended to support the efforts of states in ensuring a credible quality system at Public Health Facilities. I do hope states would take benefit of this painstaking work.

(Keshav Desiraju)

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FOREWORD

The successful implementation of NRHM since its launch is 2005 is clearly evident by the many fold increase in OPD, IPD and other relevant services being delivered in the Public Health Institutions, however, the quality of services being delivered still remains an issue. The offered services should not only be judged by its technical quality but also from the perspective of service seekers. An ambient and bright environment where the patients are received with dignity and respect along with prompt care are some of the important factors of judging quality from the clients' perspective.

Till now most of the States' approach toward the quality is based on accreditation of Public Health Facilities by external organizations which at times is hard to sustain over a period of time after that support is withdrawn. Quality can only be sustained, if there is an inbuilt system within the institution along with ownership by the providers working in the facility As Aristotle said "Quality is not an act but a habit".

Quality Assurance (QA) is cyclical process which needs to be continuously monitored against defined standards and measurable elements. Regular assessment of health facilities by their own staff and state and 'action-planning' for traversing the observed gaps is the only way in having a viable quality assurance programme in Public Health. Therefore, the Ministry of Health and Family Welfare (MoHFW) has prepared a comprehensive system of the quality assurance which can be operationalized through the institutional mechanism and platforms of NRHM.

I deeply appreciate the initiative taken by Maternal Health Division and NHSRC of this Ministry in preparing these guidelines after a wide range of consultations. It is hoped that States' Mission Directors and Programme Officers will take advantage of these guidelines and initiate quick and time bound actions as per the road map placed in the guidelines.

(Anuradha Gupta)

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FOREWORD

The National Rural Health Mission (NRHM) was launched in the year 2005 with aim to provide affordable and equitable access to public health facilities. Since then Mission has led to considerable expansion of the health services through rapid expansion of infrastructure, increased availability of skilled human resources; greater local level flexibility in operations, increased budgetary allocation and improved financial management. However, improvement in Quality of health services at every location is still not perceived, generally.

Perceptions of poor quality of health care, in fact, dissuade patients from using the available services because health issues are among the most salient of human concerns. Ensuring quality of the services will result in improved patient/client level outcomes at the facility level.

Ministry of Health and Family Welfare, Government of India is committed to support and facilitate a Quality Assurance Programme, which meets the need of Public Health System in the country which is sustainable. The present guidelines on Quality Assurance has been prepared with a focus on both the technical and perception of service delivery by the clients. This would enhance satisfaction level among users of the Government Health Facilities and reposing trust in the Public Health System.

The Operational guidelines along-with standards and checklist are expected to facilitate the states in improving and sustaining quality services beginning with RMNCH-A services at our Health facilities so as to bring about a visible change in the services rendered by them. The guideline is broad based and has a scope for extending the quality assurance in disease control and other national programme. It is believed that states will adopt it comprehensively and extend in phases for bringing all services under its umbrella. Feedback from the patients about our services is single-most important parameter to assess the success of our endeavour.

I acknowledge and appreciate the contribution given by NRHM division and NHSRC to RCH division of this Ministry in preparing and finalizing the guidelines. I especially acknowledge proactive role and initiative taken by Dr. Himanshu Bhushan, Deputy Commissioner and I/C of Maternal Health Division, Dr. S.K. Sikdar Deputy Commissioner and I/C of Family Planning Division and Dr. J.N. Srivastava of NHSRC in framing these guidelines.

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ACKNOWLEDGEMENT

The Operational Guidelines for Quality Assurance have been developed by the Ministry of Health and Family Welfare GoI, under the guidance and support of Shri Keshav Desiraju, Secretary, Health & Family Welfare, GoI. The contribution and insightful inputs given by Ms. Anuradha Gupta, Additional Secretary & Mission Director NRHM helped in firming up the guidelines within a set time period.

I must appreciate the efforts and initiatives of the entire team of Maternal Health, Family Planning & Child health Divisions, especially Dr. Himanshu Bhushan (DC MH I/C), Dr. S.K. Sikdar (DC FP I/C), and Dr. P.K. Prabhakar DC (CH), who have coordinated the process of developing these Operational Guidelines besides making substantial technical contributions in it.

The technical contribution by Dr. J.N. Srivastava, Head of QI Division and their team members Dr. Nikhil Prakash and Dr. Deepika Sharma of NHSRC need a special mention for their robust and sound contribution and collating all available information.

I would like to express my sincere gratitude to Mr. Vikas Kharge, Mission Director & Dr. Satish Pawar, DG (Health), Govt. of Maharashtra for their inputs and continued support. I would also like to place on record the contribution of development partners like WHO, UNICEF, UNFPA particularly Dr. Arvind Mathur, Dr. Malalay, Dr. Ritu Agarwal and Dr. Dinesh Agarwal.

I would like to convey my special thanks to all the experts, particularly Dr. Poonam Shivkumar from MGIMS, Wardha, Dr. Neerja Bhatla from AIIMS, Dr. R. Rajendran, Institute of OBGYN, Chennai, Dr. R.P. Sridhar from MCH Gujart Dr. P. Padmanaban and Mr. Prashanth from NHSRC, MH Division Consultants Dr. Pushkar Kumar, Mr. Nikhil Herur, Dr. Rajeev Agarwal and Dr. Anil Kashyap for putting their best efforts in preparing several drafts and final guidelines. Since it is difficult to acknowledge all those who contributed a list of contributors is attached in the guidelines.

I hope these Operational Guidelines and accompanying compendium of checklists facilitate to build a sound and credible quality system at Public Health facilities at-least in provision of RMNCH-A services to start with.

(Dr. Rakesh Kumar)

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Date: 24th October, 2013

Program Officer's Message

'Quality' is the core and most important aspect of services being rendered at any health facility. The Clinicians at the health facility particularly public health facilities mostly deliver their services based on their clinical knowledge. Mostly client's expectations goes beyond only cure & includes courtesy, behavior of the staff, cleanliness of the facility & delivery of prompt & respectful service. Few of these clinician's also take care of clients perspective however in many cases, it is overlooked. Those who can afford, can go to a private facility but the large mass particularly the poor and those living in rural areas do not have such means neither they have the voices which can be heard.

Government System particularly the policy makers, planners and programme officers have this responsibility to act upon the needs of the people, who cannot raise voice but need equal opportunity, at par with those who can afford. Fulfilling the needs of sick and ailing is the responsibility of public health service provider.

We have several stand alone guidelines from IPHS to Technical aspects of service delivery but there is no standard guidelines defining quality assurance and its different parameters. The present set of guidelines have been prepared comprehensively beginning with areas of concerns, defining its standards, measurable elements and checkpoints both from service provider and service seekers aspect. There is a prudent mix of technical, infrastructural and clients perspective while framing these guidelines.

The programme divisions of RCH, NRHM, NHSRC and other experts along with team from Govt. of Maharashtra, representative from Govt. of Karnataka, Gujarat, Tamil Nadu and Bihar along with institutional experts had extensive deliberations before firming up each and every aspects of these guidelines.

It is an earnest request to all the States and District Programme Officers to utilize these guidelines for placing the services as per the expectations of those who do not have means to afford treatment and services from a private health facility. Protecting the dignity and rendering timely services with competency to the clients is our moral duty but we also need to assess the quality of services sitting on the opposite side of the chair. Implementing these guidelines in letter and spirit will help us in achieving our desired outcomes.

Ensuring standard practices and adherence to the technical protocols, changing behavior and attitude of a staff is not an easy task. It needs rigorous monitoring, continuous support and encouragement by the supervisors and most importantly the ownership of the staff working at the facility for implementation and sustainability of quality efforts. The guidelines are only a tool and its success will depend upon actions envisaged under these guidelines.

(Dr. Himanshu Bhushan)

BACKGROUND

The Assessor's Guidebook for District Hospitals was launched in 2013. Subsequently, 2nd edition was published in 2018. Now, the 3rd edition is an update as per National Quality Assurance Standards 2020, with the primary focus being incorporating the latest National Health Programmes. The revised Assessors' Guidebook serves as a comprehensive tool, to assess the quality of healthcare services in district hospitals aligning with current national health initiatives, scientific knowledge & evidence. Assessors' Guidebook for Quality Assurance for District Hospitals 2018 has two volumes (Volume I & II) while in the revised guidebook, the checklists have been divided into three volumes (Volume I, II, & III).

There is addition of new standards like Standard G10 about clinical governance, Standard E24 about Haemodialysis services and the new National Health Programme like National Viral Hepatitis programme etc. Also, standards about clinical assessment (E2), rational prescribing (E6) & management of Death (E16) are further strengthened.

The revised guidebook reinforces the commitment to continual quality improvement and sustenance of healthcare services nationwide

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PART-A

GUIDELINES FOR ASSESSMENT

I INTRODUCTION TO QUALITY MEASUREMENT SYSTEM

Often, measuring the quality in health facilities has never been easy, more so, in Public Health Facilities. We have quality frame-work and Quality Standards & linked measurement system, globally and as well as in India. The proposed system has incorporated best practices from the contemporary systems, and contextualized them for meeting the needs of Public Health System in the country.

The system draws considerably from various guidelines, Standards and Texts on the Quality in Healthcare and Public health system, which ranges from ISO 9001 based system to healthcare specific standards such as JCI, IPHS, etc. Operational and technical Guidelines for National Health Programmes and schemes have also been consulted.

We do realise that there would always be some kind of 'trade-off', when measuring the quality. One may have short and simple tools, but that may not capture all micro details. Alternatively one may devise all-inclusive detailed tools, encompassing the micro-details, but the system may become highly complex and difficult to apply across Public Health Facilities in the country.

Another issue needs to be addressed having some kind of universal applicability of the quality measurement tools, which are relevant and practical across the states. Therefore, proposed system has flexibility to cater for differential baselines and priorities of the states.

Following are salient features of the proposed quality system:

1. **Comprehensiveness –** The proposed system is all inclusive and captures all aspects of quality of care within the eight areas of concern. The twenty one departmental checklists transposed within seventy five standards, and commensurate measurable elements provide an exhaustive matrix to capture all aspects of quality of care 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, which varies from 'for-profit' sector. For instance, there are standards for providing free drugs, diagnostics, services ensuring availability of clean linen, etc. which may not be relevant for other hospitals.

3. **Contemporary –** Contemporary Quality standards such as NABH, ISO and JCI, and Quality improvement tools such as Six Sigma, Lean and CQI have been consulted and their relevant practices have been incorporated.

4. **User Friendly –** The Public Health System requires a credible Quality system. It has been endeavour of the team to avoid complex language and jargon. So that the system remains user-friendly and enable easy understanding and implementation by the service providers. Checklists have been designed to be user-friendly with guidance for each checkpoint. Scoring system has been made simple with uniform scoring rules and weightage. Additionally, a formula fitted excel sheet tool has been provided for the convenience, and to avoid calculation errors.

5. **Evidence Based –** The Standards have been developed after consulting vast knowledge resource available on the quality. All respective operational and technical guidelines related to RMNCHAN and National Health Programmes have been factored in.

6. **Objectivity –** Ensuring objectivity in measurement of the Quality has always been a challenge. Therefore in the proposed quality system, each Standard is accompanied with measurable elements & Checkpoints to measure compliance to the standards. Checklists have been developed for various departments, which also captures inter- departmental variability for the standards. At the end of assessment, there would be numeric scores, bringing out the quality of care in a snap-shot, 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 some of the departments or group of services in the initial phase for Quality improvement. As baseline differs from state to state, checkpoints may either be made essential or desirable, as per availability of resources. Desirable checkpoints will be counted in arriving at the score, but this may not withhold its certification, if compliance is still not there. In this way the proposed system provides flexibility, as well as 'road-map'.

8. **Balanced –** All three components of Quality – Structure, process & outcome, have been given due weightage.

9. **Transparency –** All efforts have been made to ensure that the measurement system remains transparent, so that assessee and assessors have similar interpretation of each checkpoint.

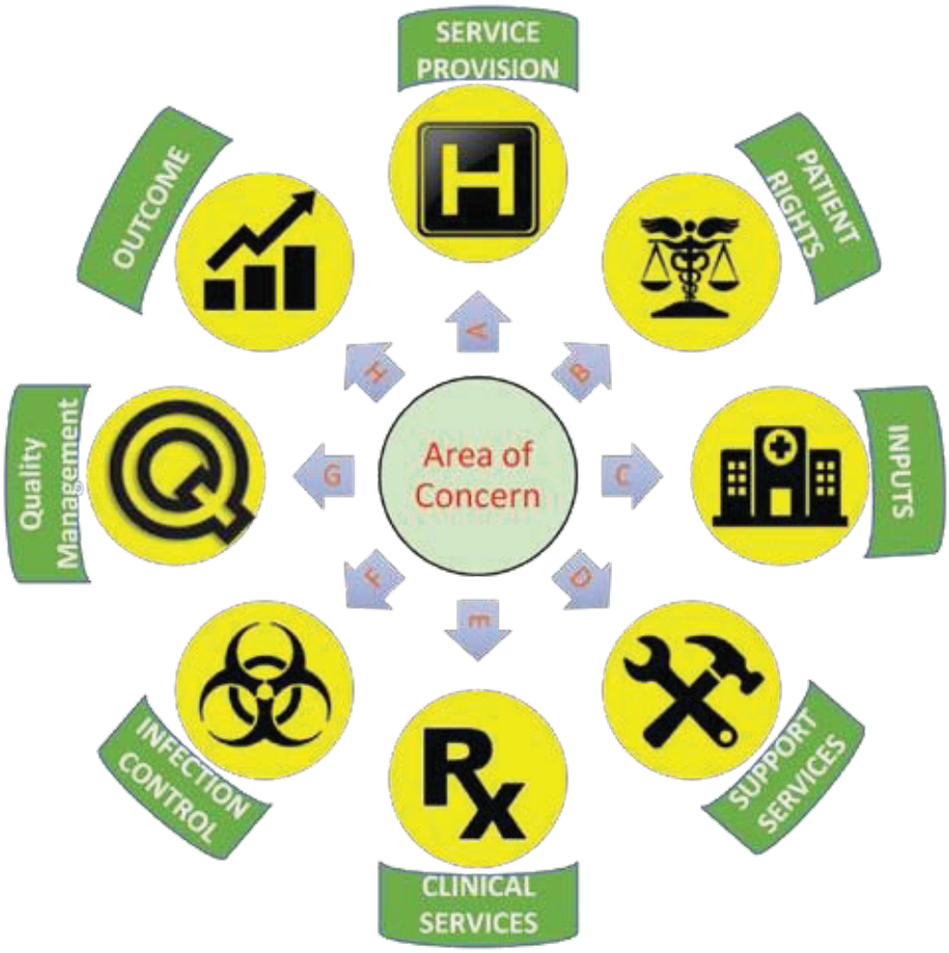
10. **Enabler –** Though standards and checklists are primarily meant for the assessment, it can also be used as a 'road- map' for improvement.

II COMPONENTS OF QUALITY MEASUREMENT SYSTEM AND THEIR INTENT

The main pillars of Quality Measurement Systems are Quality Standards. There are **seventy five standards,** defined under the proposed quality measurement system. The standards have been grouped within the eight **areas of concern**. Each Standard further has specific measurable elements. These standards and measurable elements are checked in each department of a health facility through department specific **checkpoints.** All Checkpoints for a department are collated, and together they form assessment tool called **'Checklist'**. Scored/ filled-in Checklists would generate scorecards.

Following are the area of concern in a health facility:

a. Service Provision
b. Patient Rights
c. Inputs
d. Support Services
e. Clinical Services
f. Infection Control
g. Quality Management
h. Outcome



Categorization of standards within the eight areas of concern is in line with the Quality of Care model - Structure, Process and Outcome.

Currently National Quality Assurance Standards for following level of facilities are available:

1. District Hospital
2. Community Health Centre
3. Primary Health Centre (24x7)
4. Urban Primary Health Centre
5. Health & Welness Centre – Sub Centre

Following is the summary of Standard, Measurable Element, Check Point & Departmental thematic Checklist for various level of Facilities:

MEASUREMENT SYSTEM FOR VARIOUS LEVELS FOR FACILITIES

Component	DH	CHC	PHC	UPHC	HWC-SC
Area of Concern	8	8	8	8	8
Standards	75	65	50	35	50
Measurable Elements	380	297	250	200	129
Checklists	21	12	6	12	1

Intent of Area of Concerns and Standards for District Hospitals is given under Chapter V in Volume I Assessor's Guidebook for Quality Assurance in District Hospital 2020.

Compiled description of Standards and Measurable Elements (facility wise and specific programme wise) is given in Annexure Measurable Elements of this Assessors' Guidebook.

III HOW TO USE ASSESSOR'S GUIDEBOOK

Assessor's Guidebook contains tools for Internal and External Assessment of a District Hospital (and equivalent health facility). This Guidebook has three Volumes, Volume I, II, & III. Details of the departments as per voulmes are given in table below. Soft copy of the assessment tools that is formula fitted MS Excel sheets are given at NHSRC website. To access the assessment tools, QR code is given at the end of the book. State has customized checklists and updated copy of these customized checklists are available in the Gunak App. The following web links may be used to access the Gunak App for iOS and android devices respectively

1. iOS Link: https://apps.apple.com/in/app/gunak/id1354891968
2. Android Link: https://play.google.com/store/apps/details?id=com.facilitiesassessment&pcampaignid

List of checklists given in Assessor's Guidebook is given below:

	Volume I		Volume II		Volume III
1	Accident & Emergency Department	8	Labour Room (LaQshya)	16	Radiology
2	Out Patient Department	9	Maternity Operation Theatre (LaQshya)	17	Pharmacy
3	Operation Theatre	10	Maternity Ward	18	Auxiliary Services
4	Intensive Care Unit (ICU)	11	Paediatric Out Patient Department (MusQan)	19	Mortuary
5	Indoor Patient Department	12	Paediatric Ward (MusQan)	20	Haemodialysis
6	Blood Bank	13	Sick Newborn Care Unit (SNCU) (MusQan)	21	General Administration
7	Laboratory Services	14	Nutritional Rehabilitation Center (NRC) (MusQan)		
		15	Post Partum Unit		

IV INTRODUCTION TO DEPARTMENTAL CHECKLIST - TOOL FOR ASSESSMENT

As we discussed earlier, Checklist are the tools for measuring compliance to the Standards. We may also recall that "standards are statement of requirements that are critical for delivery of quality services".

These are cross sectional themes that may apply to all or some of the departments. Assessing every standard independently in each department may take lot of time and hence not practicable. Therefore for the convenience sake, all the applicable standards and measurable elements for one department have been collated in the checklists. It enables measurement of all aspect of quality of care in a department in one go. After assessing the departments on the checklist, their scores can be calculated to see compliance to different standards in the department.

There are twnety one checklists given District Hospital or equivalent Assessors Guidebooks (Volume I, II & III). Following is a brief description of checklists:

1. **Accident & Emergency Department** – This checklist is applicable to Accident & Emergency department of a hospital. The checklist has been designed to assess all aspects of dedicated emergency department. If emergency department is shared with OPD infrastructure then two checklists should be used independently.

2. **Out Patient Department** – This checklist is applicable to outdoor department of a hospital. It includes all clinics and support areas like immunization room, dressing room, waiting area and laboratory's sample collection centre, located there, except for Family planning Clinic (if co-located in OPD), which has been included in the post partum unit. Similarly dispensary has been included in the Pharmacy check list. This checklist also includes ICTC and ANC clinics. It may be possible that OPD services are dispersed geographically, for example ANC Clinic may not be located in the main OPD complex. Therefore, all such facilities should be visited.

3. **Operation Theatre –** This checklist is applicable for OT complex including General OT, Obstetrics & Gynaecology OT, Orthopaedics OT, Ophthalmic OT and any other facility for undertaking the surgeries (if available). Family planning/ Postpartum OT is excluded from this checklist, which will be assessed through postpartum checklist. This checklist also includes CSSD /TSSU, either co-located within the OT complex or located separately.

4. **Intensive Care Unit –** This checklist is meant for assessing level II ICUs, which are recommended for District Hospitals. The ICU should have ventilators.

5. **Indoor Patient Department –** This is a common checklist for other indoors wards including Medical, Surgical, Orthopaedics, etc. In subsequent years, separate checklist for each ward may be included. However, as of now, this checklist should be used for all such departments.

6. **Blood Bank –** This checklist is applicable to Blood bank available within the premises of the hospital. This checklist covers the blood component services. This checklist is not meant for blood storage unit.

7. **Laboratory** – This checklist is meant for main clinical laboratory of the hospital and also includes the laboratory for testing TB and malaria cases under respective National Health programme. This does not include ICTC lab for HIV testing which is part of OPD checklist

8. **Labour Room (LaQshya)** – This checklist is applicable to the labour room(s) and its auxiliary area like nursing station, waiting area and recovery area. The checklist is focussed on improvement of care during delivery and immediate post-partum. The checklist would be used for LaQshya Assessment as well.

9. **Maternity Operation Theatre (LaQshya) –** This checklist is applicable to the Maternity Operation Theatre of the hospital. It focuses on the management of obstetric emergency services, improvement in Quality of Care during elective C-section. It also gives emphasis on safe anaesthetic and surgical procedures. If the hospital is providing services of general and obstetric cases in same OT, the Maternity Operation Theatre checklist will be applicable separately. It includes management of complications viz APH, PPH, pre-term, pre-eclampsia, eclampsia, obstructed labour etc. The checklist promotes use of safe birth checklist and also respectful maternal care to all pregnant women visiting the health care facilities.

10. **Maternity Ward** – This checklist is meant for assessment of indoor obstetric department including wards for Antenatal care, and Post-partum wards (including C-Section). The auxiliary area for these wards like nursing station, toilets and department sub stores are also included in this check-list. However, general female wards or family planning ward are not covered within the purview of maternity ward.

11. **Pediatric Out patient Department (MusQan)** – This checklist is applicable to dedicated Pediatric Outdoor department. Common childhood ailments' are identified, treated and managed. For specific childhood illness cases alike Opthalmology, ENT, Orthopaedics etc the hospital specific clinics should be visited. The emphasis is given on paediatric ambience, children friendly environment also services in Paediatric OPD should be co-located

12. **Paediatric Ward (MusQan) –** This checklist meant for a dedicated paediatric ward. If, there is no such ward in the hospital and paediatric patients are treated in other wards, then this checklist is not applicable at such health facilities.

13. **Sick Newborn Care Unit (MusQan) –** This checklist is applicable to a functional Level II SNCU, located in the Hospital. It includes auxiliary area like waiting area for relatives, side laboratory and duty rooms for the staff. This checklist is not meant for lower level of facilities like Newborn Stabilization units and Newborn corner.

14. **Nutritional Rehabilitation Centre (MusQan) –** This checklist is applicable to NRC functioning within the health facility. However, it may not be relevant, if management of malnourished patients is done in the paediatric wards.

15. **Post Partum Unit –** This checklist is applicable to Family Planning clinic, separate OT used for Family planning surgeries & abortion cases and separate indoor ward available to admit any such cases. Assessment of Post partum unit would be undertaken through this checklist.

16. **Radiology –** This checklist is applicable on X-ray and Ultrasound departments. This checklist does not cover technical checkpoints for CT Scan and MRI.

17. **Pharmacy –** This checklist is applicable on Drug store, Cold Chain storage and Drug dispensing counter. General store and Drug warehouse are not covered within ambit of this checklist.

18. **Auxiliary Services –** This checklist covers Laundry, Dietary and medical record department. If these departments are outsourced and even located outside the premises, then also this checklist can be used. Washing hospital linen in public water body like river or pond or food supplied by charitable/religious institutions does not constitute having Hospital laundry / kitchen per se.

19. **Mortuary –** This checklist is applicable to Mortuary and post-mortem room located at the hospital

20. **Haemodialysis centre** – This checklist is applicable to the haemodialysis centre. The haemodialysis centre could be a standalone centre with the diagnostic and other support within centre or linkage with the main hospital. This checklist is applicable to dialysis set-up provided by the government, PPP or mixed

21. **General Hospital Administration** – This checklist covers medical superintendent (equivalent) and hospital manager offices and processes related to their functioning. This also covers hospital policy level issues and hospital wide cross cutting processes. This checklist is complimentary to all other checklist. So if a hospital wants to choose only of some of the department for quality assurance initially, then this check list should always be included in the assessment programme.

V ASSESSMENT PROTOCOL

A. General Principles

Assessment of the Quality at Public Health Facilities is based on general principles of integrity, confidentiality, objectivity and replicability:

1. **Integrity -** Assessors and persons managing assessment programmes should:
    - Perform their work with honesty, diligence and responsibility
    - Demonstrate their competence while performing assessment
    - Performance assessment in an impartial manner
    - Remain fair and unbiased in their findings
2. **Fair Presentation -** Assessment findings should represent the assessment activities truthfully and accurately. Any unresolved diverging opinion between assessors and assesses should be reported.
3. **Confidentiality -** Assessors should ensure that information acquired by them during the course of assessment is not shared with any authorised person including media. The information should not be used for personal gain.
4. **Independence -** Assessors should be independent to the activity that they are assessing and should act in a manner that is free from bias and conflict of interest. For internal assessment, the assessor should not assess his or her own department and process. After the assessment, assessor should handhold to guide the service providers for closing the gap and improving the services.
5. **Evidence based approach -** Conclusions should be arrived based on evidences, which are objective, verifiable and reproducible.

B. Planning Assessment Activities

Following assessment activities are undertaken at different level:

1. Internal Assessment at the facility level – A continuous process of assessment within the facility by internal assessors.
2. Assessment by District and State Quality Assurance Units
3. External assessment – Assessment by national assessors for the purpose for certification/ accreditation.

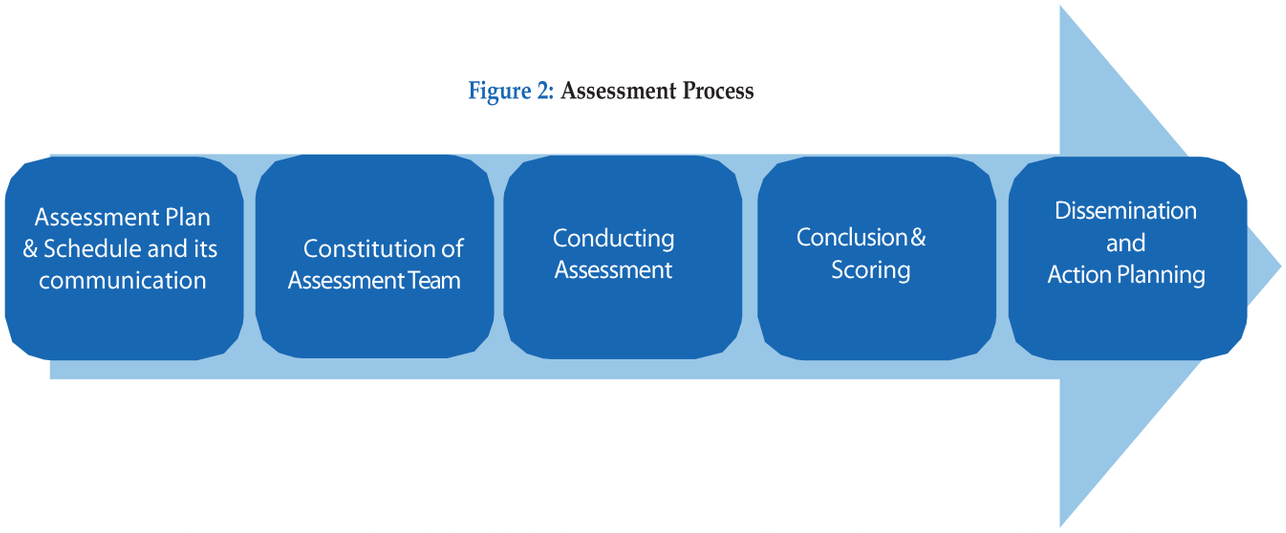
1. **Internal Assessment -** Internal assessment is a continuous process and integral part of facility based Quality assurance program. Assessing all departments in a health facility every month may not be possible. The hospital should prepare a quarterly assessment schedule. It needs to be ensured that every department would be assessed and scored at least once in a quarter. This plan should be prepared in consultation with respective departments. Quality team at the facility can also prioritize certain departments, where quality of services has been a cause of concern.

   For internal assessment, the Hospital Quality Team should appoint a coordinator, preferably the hospital manager or quality manager, whose main responsibilities are given below:

   1. Preparing assessment plan and schedule
   2. Constitute an assessment team for internal assessment
   3. Arrange stationary (forms & formats) for internal assessment
   4. Maintenance of assessment records
   5. Communicating and coordinating with departments
   6. Monitor & review the internal assessment programme
   7. Disseminate the findings of internal assessment
   8. Preparation of action plan in coordination with quality team and respective departments.

2. **Assessment by DQAU/SQAU -** DQAU and SQAU are also responsible for undertaking an independent quality assessment of a health facility. Facilities having poor quality indicators would be at priority in the assessment programme. Visit for the assessment should also be utilized for building facility level capacity of quality assurance and hand holding. Efforts should be made to ensure that all departments of the hospital have been assessed during one visit. Assessment process is shown in Figure 2.

Figure 2: Assessment Process



3. **External Assessment -** When the health facility attains an overall score of 70 percent and above in the State Assessment, it is eligible to apply for the National Quality Assessment by duly filling the application performa (copy of the application format may be referred from the Operational Guidelines for improving quality in Public Health Facilities, 2021, Annexure L, page 130). The External Assessment is conducted by NHSRC through certified External Assessors empanelled with the Ministry of Health and Family Welfare.

C. Constituting Assessment Team

Assessment team should be constituted according to the scope of assessment i.e. departments to be assessed. Team assessing clinical department should have at least one person from clinical domain preferably a doctor, assessing patient care departments. Indoor departments should also have one nursing staff in the team. It would be preferable to have a multidisciplinary team having at least one doctor and one nurse during the external assessment. As DQAU/SQAU may not have their own capacity for arranging all team members internally, a person from another hospital may be nominated to be part of the assessment team. However, it needs to be ensured that person should not assess his/her own department and there is no conflict of interest. For external assessment, the team members should have undergone the assessors' training.

D. Preparing Assessment Schedule

Assessment schedule is a micro-plan for conducting assessment. It constitutes of details regarding departments, date, timing, etc. Assessment schedule should be prepared beforehand and shared with respective departments.

E. Performing Assessment

i. Pre-assessment preparation – Team leader of the assessment team should ensure that assessment schedule has been communicated to respective departments. Team leader should assign the area of responsibility to each team member, according to the schedule and competency of the members.

ii. Opening meeting – A short opening meeting with the assessee's department or hospital should be conducted for introduction, aims & objective of the assessment and role clarity.

iii. Reviewing documents – The available records and documents such as SOPs, BHT, Registers, etc should be reviewed.

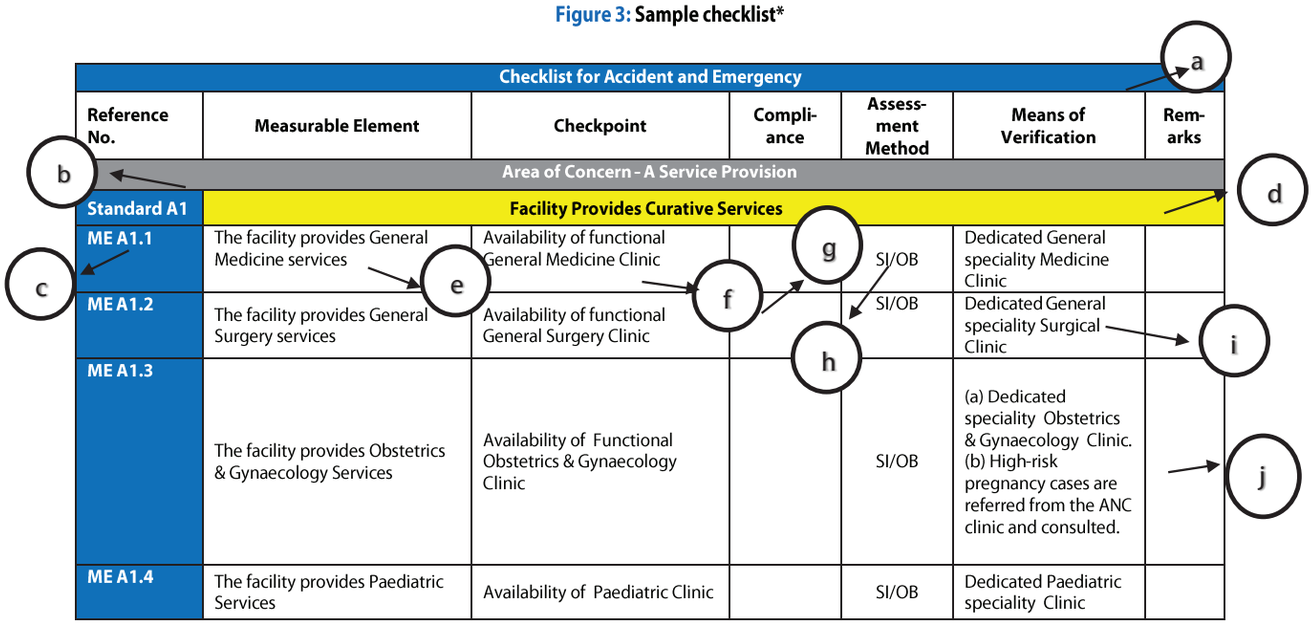
F. Communication During Assessment

Behaviours and communication of the assessors should be polite and empathetic. Assessment should be fact finding exercise and not a fault finding exercise. Conflicts should be avoided.

G. Using Checklists

Checklists are the main tools for the assessment. Hence, familiarity with the tools would be important.

Figure 3: Sample checklist*



Checklist for Accident and Emergency						
Reference No.	**Measurable Element**	**Checkpoint**	**Compli-ance**	**Assess-ment Method**	**Means of Verification**	**Rem-arks**
Area of Concern - A Service Provision						
Standard A1	**Facility Provides Curative Services**					
ME A1.1	The facility provides General Medicine services	Availability of functional General Medicine Clinic		SI/OB	Dedicated General speciality Medicine Clinic	
ME A1.2	The facility provides General Surgery services	Availability of functional General Surgery Clinic		SI/OB	Dedicated General speciality Surgical Clinic	
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Functional Obstetrics & Gynaecology Clinic		SI/OB	(a) Dedicated speciality Obstetrics & Gynaecology Clinic. (b) High-risk pregnancy cases are referred from the ANC clinic and consulted.	
ME A1.4	The facility provides Paediatric Services	Availability of Paediatric Clinic		SI/OB	Dedicated Paediatric speciality Clinic	

* ME denotes measurable elements of a standard, for which details have been provided in the Annexure 'A'.

a) Header of the checklist denotes the name of department for which checklist is intended.

b) The horizontal bar in grey colour contains the name of the Area of concern for which the underlying standards belong.

c) Extreme left column of checklist in blue colour contain the reference no. of Standard and Measurable Elements, which can used for the identification and traceability of the standard. When reporting or quoting, reference no of the standard and measurable element should also be mentioned.

d) Yellow horizontal bar contains the statement of standard which is being measured. There are a total of seventy five standards, but all standards may not be applicable to every department, so only relevant standards are given in yellow bars in the checklists.

e) Second column contains text of the measurable element for the respective standard. Only applicable measurable elements of a standard are shown in the checklists. Therefore, all measurable elements under a standard are not there in the departmental checklists. They have been excluded because they are not relevant to that department.

f) Next right to measurable elements are given the check points to measure the compliance to respective measurable element and the standard. It is the basic unit of measurement, against which compliance is checked and the score is awarded.

g) Right next to Checkpoint is a blank column for noting the findings of assessment, in term of Compliance:

- Full Compliance - 2
- Partial Compliance - 1
- Non Compliance - 0

h) Next to compliance column is the assessment method column. This denotes the 'HOW' to gather the information. Generally, there are four primary methods for assessment:

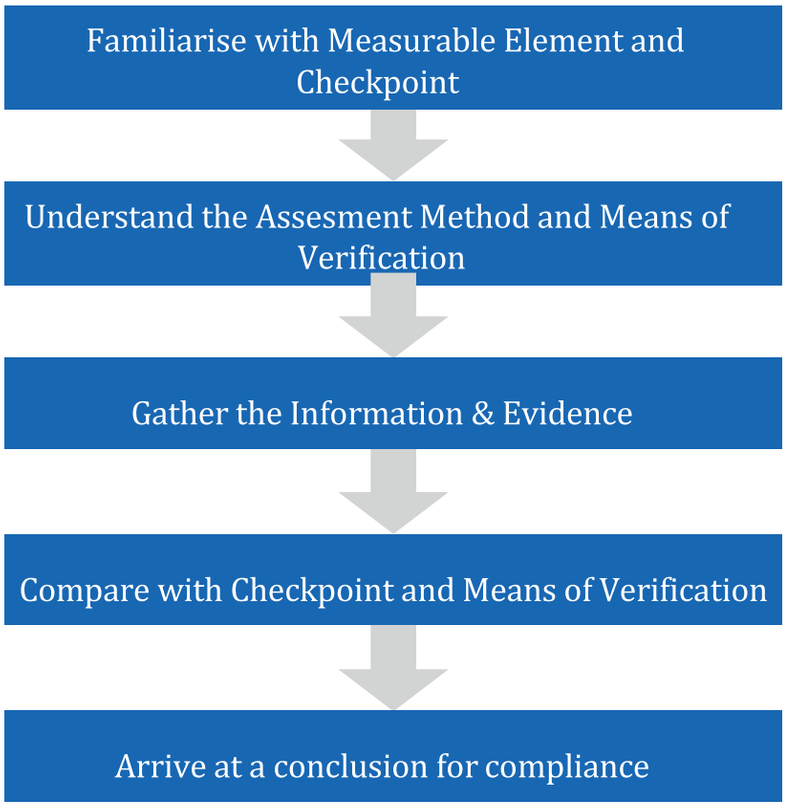
- SI: means Staff Interview
- OB: means Observation
- RR: means Record Review
- PI: means Patient Interview

i) Column next to assessment method contains means of verification. It denotes what to see at a Checkpoint. It may be a

list of equipment or procedures to be observed, or question you have to ask or some benchmark, which could be used for comparison, or reference to some other guideline or legal document. It has been left blank, as the check point is self-explanatory.

j) The last column next to means of verification contains remarks. The assessors can provide their remarks based on their assessment against that particular checkpoint. The remarks could be helpful to understand the compliance given against that checkpoint. Please note, remark coulmn is intentionally not kept in the assessors' guidebook to manage the spacing of the assessors' guidebook

Figure 4: Flow of Information



H. Assessment Methods

1. **Observation (OB):** Compliance against many of the measurable elements can be assessed by directly observing the articles, processes and surrounding environment. Few examples are given below:

   a) Enumeration of articles like equipment, drugs, etc.
   b) Displays of signages, work instructions, important information
   c) Facilities - patient amenities, ramps, complaint-box, etc.
   d) Environment – cleanliness, loose-wires, seepage, overcrowding, temperature control, drains, etc.
   e) Procedures like measuring BP, counseling, segregation of biomedical waste.

2. **Record Review (RR):** It may not be possible to observe all clinical procedures. Records also generate objective evidences, which need to be triangulated with finding of the observation. For example on the day of assessment, drug tray in the labour room may have adequate quantity of Oxytocin, but if review of the drug expenditure register reveals poor consumption pattern of Oxytocin, then more enquiries would be required to ascertain on the adherence to protocols in the labour room. Examples of the record review are:

a) Review of clinical records - delivery note, anaesthesia note, maintenance of treatment chart, operation notes, etc.

b) Review of department registers like admission registers, handover registers, expenditure registers, etc.

c) Review of licenses, formats for legal compliances like Blood bank license and Form 'F' for PNDT

d) Review of SOPs for adequacy and process

e) Review of monitoring records – TPR chart, Input/output chart, culture surveillance report, calibration records, etc.

f) Review of department data and indicators

3. **Staff Interview (SI):** Interaction with the staff helps in assessing the knowledge and skill level, required for performing job functions

Examples include:

a) Competency testing – Quizzing the staff on knowledge related to their job

b) Demonstration – Asking staff to demonstrate certain activities like hand-washing technique, new born resuscitation, etc.

c) Awareness - Asking staff about awareness of patient's right, quality policy, handling of high alerts drugs, etc.

d) Attitude about patient's dignity and gender issues.

e) Feedback about adequacy of supplies, problems in performing work, safety issues, etc.

2. **Patient Interview (PI***):* Interaction with patients/clients may be useful in getting information about quality of services and their experience in the hospital. It gives us users' perspective. It should include:

a) Feedback on quality of services staff behaviour, food quality, waiting times, etc.

b) Out of pocket expenditure incurred during the hospitalization

c) Effective communication like counseling services and self-drug administration

I. Assessment conclusion

After gathering information and evidence for measurable elements, assessors should arrive at a conclusion for extent of compliance - full, partial or non-compliance for each of the checkpoints. If the information and evidence collected gives an impression of not fully meeting the requirements, it could be given 'Partial compliance', provided there some evidences pointing towards the compliance. Non-compliance should be given of none or very few of the requirements are being met.

After arriving on conclusion, assessor should mark '2' for full compliance, '1' for partial compliance and '0' for non-compliance in Compliance column.

VI SCORING SYSTEM

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. Therefore, measuring quality of care forms the path for its improvement. Following the same approach, National Quality Assurance Standards are constituted of the following four parameters:

1. **Area of Concern:** They are broad area/ themes for assessing different aspects for quality like Service provision, Patient Rights, Infection Control etc.
2. **Standards:** They are statements of requirement for particular aspects of quality.
3. **Measurable Element:** These are specific attributes of a standard which should be looked into for assessing the degree of compliance to a particular standard.
4. **Checkpoint:** Tangible measurable checkpoints are those, which can be objectively observed and scored.

Ammalgamation of all these four parameters in a systemic manner constitute a checklist, which may be departmental or thematic.

For Example:

S. No.	Parameter	Example
1	Area of Concern	Area of Concern F: Infection Control
2	Standard	Standard F2: Facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis
3	Measurable Element	ME F2.1: Hand washing facilities are provided at point of use
4	Checkpoint	Facility ensures uninterrupted and adequate supply of antiseptic soap and alcohol hand rub in all departments

After assessing all the measurable elements and checkpoints and marking compliance, scores of the department/facility can be calculated

Rules of Scoring

Measure of Compliance	Marks to be given	Attributes
• Full compliance	2	• All Requirements in Checkpoint are Meeting • All Tracers given in Means of verification are available • Intent of Measurable Element is meeting
• Partial compliance	1	• Some of the requirements in checkpoints are meeting • At Least 50-99% of tracers in Means of verification are available • Intent of Measurable Element is partially meeting
• Non-compliance	0	• Most of the requirements are not meeting • Less than 50% of tracers in Means of verification are available • Intent of Measurable Element is not meeting

All checkpoints have equal weightage to keep scoring simple

Once scores have been assigned to each checkpoint, department wise scores can be calculated for the departments, and also for standards by adding the individual scores for the checkpoints

The final score should be given in percentage, so it can be compared with other groups and department Calculation of percentage is as follows:

$$\frac{\text{Score obtained X 100}}{\text{No. of checkpoint in checklist X 2}}$$

Scores can be calculated manually or scores can be entered into excel sheet given in the accompanying soft copy to get score card. All scores should be in percentages to have uniform unit for inter-departmental and inter-hospital comparison.

The assessment scores can be presented in three ways:

1. **Departmental Scorecard:** This score-card presents the Quality scores of a department. It shows the overall quality score of the department as well as the area of concern wise score in term of percentages. This score card can be generated by two way:

   a. If calculations are done manually departmental score can be calculated by simple formula given above, and filled-in score card format given at the top of checklist

   b. If using excel tool given with this guide book, the scorecard will be generated automatically after filling a score for all checkpoints

   Figure 5 is an example of a filled in score-card after assigning and calculating scores. Score given in the yellow box denotes the overall quality score of the department in percentage.

   Scores given in blue label are area of concern wise scores of the department in percentage.

Figure 5: Sample of filled-in Score card for Outdoor Patient Department

OPD Score Card			
Area of Concern wise Score			OPD Score
A	Service Provision	95%	80%
B	Patient Rights	83%	
C	Inputs	84%	
D	Support Services	73%	
E	Clinical Services	79%	
F	Infection Control	62%	
G	Quality Management	83%	
H	Outcome	82%	

2. **Hospital Quality Scorecard**

   This scorecard depicts departmental and overall quality score of hospital in a snapshot. Another variant depicts area of Concern wise scores of the Hospital.

   Figure 6 is an example of hospital score card generated after calculation of scores for all departments in the hospital. Yellow label depicts the overall score of the hospital in percentage by taking average of departmental scores. Rest of the boxes in blue label shows individual scores of the departments.

Figure 6: Sample Score card of a Hospital with Departmental Score

<table>
<tr><th colspan="8">Hospital Score Card (Department wise)</th></tr>
<tr><td>Accident & Emergency
64%</td><td>OPD
72%</td><td>Labour Room
88%</td><td>Maternity Ward
82%</td><td>Paediateric OPD
88%</td><td colspan="3" rowspan="2">Hospital Score</td></tr>
<tr><td>Paediateric Ward
86%</td><td>SNCU
73%</td><td>NRC
57%</td><td>OT
79%</td><td>M- OT
85%</td><td colspan="3" rowspan="2">76%</td></tr>
<tr><td>PP Unit
77%</td><td>ICU
67%</td><td>IPD
73%</td><td>Blood Bank
74%</td><td>Laboratory
78%</td><td>LaQshya Score</td><td>MusQan Score</td></tr>
<tr><td>Radiology
71%</td><td>Pharmacy
71%</td><td>Auxillary
73%</td><td>Mortuary
72%</td><td>Haemodialysis Centre
78%</td><td rowspan="2">87%</td><td rowspan="2">76%</td></tr>
<tr><td colspan="5">General Administration
80%</td></tr>
</table>

3. **Area of concern wise Scorecard:** Figure 7 gives a sample score card for each of eight areas of concern. These have been calculated by taking average of area of concern score of all departments. Yellow label shows the overall score of Hospital.

Figure 7: Sample Scorecard of a Hospital with Area of Concern Score

<table>
<tr><th colspan="4">HOSPITAL QUALITY SCORE CARD AREA OF CONCERN WISE</th></tr>
<tr><td>Service Provision
72%</td><td>Patient Rights
66%</td><td>Inputs
78%</td><td>Support Services
59%</td></tr>
<tr><td colspan="4">Hospital Score</td></tr>
<tr><td colspan="4">70%</td></tr>
<tr><td>Clinical Services
85%</td><td>Infection Control
75%</td><td>Quality Management
70%</td><td>Outcome
55%</td></tr>
</table>

4. **Standard-wise Scorecard:** Apart from these scorecards, the tool provided in the accompanying QR code for DH Checklist (given at the end of the book) provides flexibility to present scores according to your choice. You can choose some of the area and themes like RMNCHA, Patient Safety, etc, as per requirement.

   There are endless possibilities the way you can represent your quality scores.

Figure 8 depicts a sample scorecard with the Standards under various Area of Concern. Yellow label shows the standards. The calculated score of each standard against NQAS is visible in grey label, while the score against LaQshya is visible in blue label and the score against the MusQan is visible in green label.

Figure 8: Sample Scorecard of a Hospital with Standard-wise Score

Reference No.	Area of Concern & Standards	NQAS Score	LaQshya Score	MusQan Score
Area of Concern A- Service Provision				
Standard A1	Facility Provides Curative Services	100%	100%	100%
Standard A2	Facility provides RMNCHA Services	100%	100%	100%
Standard A3	Facility Provides diagnostic Services	100%	100%	100%
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme	100%	NA	100%
Standard A5	Facility provides support services	100%	NA	100%
Standard A6	Health services provided at the facility are appropriate to community needs.	100%	NA	100%
Area of Concern B- Patient Rights				
Standard B1	Facility provides the information to care seekers, attendants & community about the available services and their modalities	100%	100%	100%
Standard B2	Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.	100%	100%	100%
Standard B3	Facility maintains the privacy, confidentiality & Dignity of patient and related information.	100%	100%	100%
Standard B4	Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.	100%	100%	100%
Standard B5	Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.	100%	100%	100%
Standard B6	Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities	100%	NA	100%

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

PART-B

DEPARTMENTAL CHECKLISTS

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-16

RADIOLOGY

CHECKLIST FOR RADIOLOGY

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.14	Services are available for the time period as mandated	All radiology services are available in routine working hours		SI/RR	
		Emergency radiology services are available for selected procedure 24X7		SI/RR	Check for: 1. Radiological services are available at night 2. Look for number of radiology test performed at night
Standard A2	**Facility provides RMNCHA Services**				
ME A2.2	The facility provides Maternal health Services	Availability of USG services for Pregnant women		SI/OB	
Standard A3	**Facility Provides diagnostic Services**				
ME A3.1	The facility provides Radiology Services	Availability of X ray services		SI/OB	for chest, bones, skull, spine and abdomen.
		Availability of special radio graph services		SI/OB	Barium Swallow, Barium enema, Barium meal, MMR (Miniature mass radiography) Chest, IVP, Mammography, C-arm
		Availability of Dental X ray Services		SI/OB	Radio-vision-Graph (RVG) Digital dental X-ray, OPG services
		Availability of ultrasound services		SI/OB	Pre natal diagnostic procedure: Ultrasonography with colour doppler, Fetoscopy
		Availability of CT scan facility		SI/OB	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages		OB	Numbering, main department and internal sectional signage are displayed

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Display of PNDT Notice at USG		OB	Notice in local language is displayed at entrance of USG department that All persons including the employer, employee or any other person associated with department shall not conduct or associate with or help in carrying out detection or disclosure of sex of foetus in any manner
		Display of cautionary signage outside the X ray department		OB	Radiation hazard sign and caution for pregnant women and children
ME B1.2	The facility displays the services and entitlements available in its departments	List of services available are displayed at the entrance		OB	
		Timing for taking X ray and collection of reports are displayed outside the X ray department		OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges in r/o X ray services are displayed at entrance		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Reports are provided to Patient in proper printed format		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**				
ME B2.1	Services are provided in manner that are sensitive to gender	Female attendant should accompany female patients during radiological procedures		OB/SI	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Check the availability of ramp in OPD/ X ray room		OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	X ray department has provision of privacy while taking X ray.		OB	
		USG department has provision of privacy while taking sonography		OB	provision of screen
ME B3.2	Confidentiality of patients records and clinical information is maintained	Radiology has system to ensure the confidentiality of the reports generated		RR/SI	Radiology staff do not discuss the lab result outside. And reports are kept in secure place
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Form F for USG under PNDT maintained for scan of pregnant woman		RR	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free Diagnostic tests are available as per entitlement		PI/SI	Pregnant women, Infant and Children
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.		PI/SI	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Tests are free of cost for BPL patients		PI/SI	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Cashless investigation by empanelled lab for JSSK beneficiaries for test not available within the facility		PI/SI/RR	
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Room Size of X ray unit is as per AERB safety code		OB	The room housing X -ray equipment have appropriate area to facilitate easy movement of staff & proper patient positioning.
		Availability of adequate waiting area		OB	
ME C1.2	Patient amenities are provide as per patient load	Attached toilet facility available		OB	For USG
		Waiting area with sitting facility		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	Entrance of X ray room is as per AERB layout guidelines		OB	Preferably one entrance with door having hydraulic mechanism to ensure that it is closed during procedure
		Opening for Ventilation and natural light has been provided in X ray room as per AERB layout guidelines		OB	Windows should be above 2m from finished floor level outside the x ray. If no then shielding is provided is provided on the window up to 2 m
		Positioning of chest stand as per AERB layout guidelines		OB	The chest stand should be located opposite to entrance door and control console
		Positioning of control console as per AERB layout guidelines			Control console should be positioned as far away as possible from the X ray tube.

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for movement of trolleys and stretchers		OB	2-3 meters
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	No of X ray machines as per load		OB	Check for the adequacy X-ray machines as per load
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods and services		OB	No cris cross in the movement patient traffic and services flow Should be near emergency department
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	X-ray - does not have temporary connections and loosely hanging wires		OB	Switch Boards other electrical installation are intact
		Adequate electrical socket provided for safe and smooth operation of lab equipment		OB	
		Stabilizer is provided for X-ray machine		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Radiology department are non slippery and even		OB	
		Positioning of mobile protective barrier as AERB layout guidelines		OB	Mobile protective barrier should to positioned in such as manner that the operator is completely shielded during exposure

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Thickness of walls at X room are as AERB layout guidelines		OB/RR	The thickness is appropriate taking into consideration of (1) Distance from centre of patient table (2) type of shielding material (brick, concrete, steel, lead or any other material)
		X ray department should not be located adjacent to patient care area		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Radiology has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	Radiology department has installed fire Extinguisher that is Class A , Class B C type or ABC type		OB	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Radiologist		OB/RR	100-200 -1 200-400- 2 >400 - 3

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Radiographer		SI/RR	100-2, 200-3, 300-5, 400-7, 500-9
ME C4.5	The facility has adequate support / general staff	Availability of housekeeping staff		SI/RR	
		Availability of security staff		SI/RR	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.2	The departments have adequate consumables at point of use	Availability Consumables		OB/RR	X ray films, Developer, Fixer, USG gel, printing paper
		Availability of personal protective equipment		OB/RR	Mobile protective barrier, Lead apron, Rubber hanging flaps, hand glove, lead shields.
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained		OB/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	TLD badges
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of functional X-ray machines		OB	300 MA X ray machine & 100 MA X ray machine
		Availability of functional Dental X-Ray Machine		OB	Radio-Visio-Graph (RVG) – digital dental X-Ray, Orthopantomogram (OPG)
		Availability of functional Ultrasonography		OB	2 one general purpose & one for Obstetric purpose
		Availability of functional Portable X-ray Machine		OB	60 MA X ray machine (Mobile)
		Availability of functional CT-scan machine		OB	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of Accessories for X ray		OB	Cassettes X ray, Intensifying screen X ray, Lead letter (A-Z),Letter figures (0-9) and R & L (Manual). Computer, printer, x -ray holder/ positioner, (Digital)
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of attachment/ accessories		OB	Bucky Stand
		Availability of fixtures at radiology		OB	X-ray View box, Electrical fixture for equipment
		Availability of furniture		OB	rack and cupboard , Chair table
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined			Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Daksha checklist issued by MoHFW can be used for this purpose.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year			Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Training on radiation safety		SI/RR	
		Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
		Patient Safety		SI/RR	
		Basic Life Support		SI/RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Training on Quality Management System		SI/RR	To all category of staff. At the time of induction and once in a year.
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Radiographers are skilled to operating equipment		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipments		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired		OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction		SI/RR	
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator		SI/RR	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated		OB/ RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due		OB/ RR	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions and factor charts are available with the equipments		OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of X ray films, fixer and developers etc.		SI/RR	Stock level are daily updated Indent are timely placed
ME D2.3	The facility ensures proper storage of drugs and consumables	There is separate storage area for undeveloped X ray films and personal monitoring devices		OB/RR	Check the storage area and its condition
		X ray films/ Fixers, developer and consumables are kept away from water and sources of heat, direct sunlight			Storage condition - Kept away from direct sunlight, not in contact with damp wall, water, etc
ME D2.4	The facility ensures management of expiry and near expiry drugs	No expired consumables is found		OB/RR	X ray films, USG jelly, contrast media, plate cleaner (fixer & developer - manual)
		Records for expiry and near expiry are maintained		RR	Check the record of expiry and near expiry drug in drug sub store and are regular update
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculation and maintaining buffer stock		SI/RR	X ray films, USG jelly, contrast media, plate cleaner, print paper roll (fixer & developer - manual)
		Department maintained stock register in X ray & USG		RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procedure for replenishing drug tray /crash cart		SI/RR	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at work station at X ray room		OB	
		Adequate illumination at workstation at USG		OB	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Only one patient is allowed one time at X room		OB	
		Warning light is provided outside X ray room and its been used when unit is functional		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Protective apron and gloves are being provided to relative of the child patient who escort the child for X ray examination/ immobilisation support is provided to children		OB/SI	
		X ray room has been kept closed at the time of radiation exposure		OB	
		Lead apron and other protective equipment's are available with radiation workers and they are using it		OB	Check TLD batch is worn below the lead apron
		TLD badges are available with all staff of X ray department		OB	Records of its regular assessment is done by X ray department
		Temperature control and ventilation in X ray room		SI/RR	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Temperature control and ventilation USG		SI/RR	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the X-ray and USG		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/ rodent/birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in Radiology and USG room		OB/SI	
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**				
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	X ray department has registration from AERB.		RR	
		X ray department has layout approval		RR	
		X ray department has type approval of equipment with QA test report for X ray machine		RR	
		USG department has registration under PCPNDT		RR	
		Duplicate copy of Certificate of registration under Form B is displayed inside the department		OB	
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement	USG is taken by person Qualified as per PCPNDT		RR	
		X ray department has Radiological safety officer (RSO) approved by competent authority		RR	X ray department has certification from AERB for any person discharging duties and functions of RSO.
		Records of submission of Form F to appropriate district authorities		RR	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, technician and support staff adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/Laundry/ Security/Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient		RR	
		Patient demographic details are recorded in radiology/USG records		RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during transfer to X-Ray department/ USG room		SI/RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E3.2	Facility provides appropriate referral linkages to the patients/ Services for transfer to other/higher facilities to assure their continuity of care.	There is procedure for referral of patient for which services can not be provided at the facility		RR/SI	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Radiology/ USG department identify vulnerable patients as per requirement		SI/RR	Check there is any system to give them preference for radiographic procedure
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	Women in reproductive age are asked for pregnancy (LMP)before X-ray		OB/SI/RR	Notice in local language is displayed at entrance of X ray department asking every female to inform radiographer/radiologist whether she is likely to be pregnant
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available		RR/OB	Printed formats for requisition and reporting are available
ME E8.6	Register/records are maintained as per guidelines	Radiology records are labelled and indexed		RR	
		Records are maintained for radiology		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Radiology has adequate facility for storage of records		OB	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
ME E11.5	There is procedure for handling medico legal cases	Procedure for handling of MLC		SI/RR	Requisition and reports are marked with MLC and reports are handed over to authorize person

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Requisition of all X ray examination is done in request form		RR/OB	Request form contain information: Name and identification number of patient, name of authorized requester, examination requested, type of X ray, date and time of X ray taken and date and time of receipt of X ray from X ray department
		X ray has system to identify radiographer from who has taken X ray		RR/SI	
		X ray department has system in place to label X ray films		RR/SI	
		X ray department has system to trace back the recorded X ray film from requisition form		RR/SI	
		Records of type of X ray prescribed is made at the time of reception		RR/SI	
		Requisition of all USG examination is done in request form		RR/OB	
		USG department has system in place to label the USGs		RR/SI	
		Preparation of the patient is done as per requirement		RR/SI	
		Instructions to be followed by patient for USG are displayed in local language at reception		RR/SI	
ME E12.2	There are established procedures for testing Activities	X ray taking and processing procedure are readily available at work station and staff is aware of it		OB/RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Necessary Instruction for taking X ray and its processing are displayed at work station in language understood by staff		OB/RR	
		X ray department has system in place to take X ray of patients in case of Emergency.		RR/SI	
		Radiographer is aware of operation of X ray machine		RR/SI	
		Necessary Instruction for USG Examination are displayed at work station in language understood by staff		OB/RR	
		USG of the patient is taken as per consultant requirement		OB/RR	
		USG department has system in place to take sonograph of patients in case of Emergency.		RR/SI	
ME E12.3	There are established procedures for Post-testing Activities	X ray department has format for reporting of results		RR/OB	
		X ray department has system to provide the reports within defined time intervals		RR/SI	
		USG department has format for reporting of results		RR/OB	
		USG report is signed by Radiologist/ Sonologist		RR/OB	
		USG department has system to provide the reports within defined time intervals		RR/SI	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxoid etc
		Periodic medical check-ups of the staff		SI/RR	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin near the point of use along with availability of elbow operated tap
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipment's as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Masks		OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves and Masks.		OB/SI	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard F4	**Facility has standard Procedures for processing of equipment's and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces		SI/OB	Ask staff about how they decontaminate the procedure surface stretcher/ Trolleys etc. (Wiping with 0.5% Chlorine solution
		Staff know how to make chlorine solution		SI/OB	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipment's like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1 Facility Ensures segregation of Bio Medical Waste as per guidelines		Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of different category of waste as per guidelines		OB/SI	
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste			
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disposal of Fixer and Developer		SI/OB/RR	
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Radiology		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	There is system to take feed back from clinician about quality of services		RR	
		Patient satisfaction survey done on monthly basis		RR	
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	Internal quality Assurance program is established in Radiology		SI/RR	
		Periodic QA of equipment by AERB authorized agencies		SI/RR	QA to be carried out at least once in 2 yrs. and also after any repairs having radiation safety implications

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work Instructions are displayed for radiation safety		OB	Factor chart, radiation safety, development for x-ray films
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for process of taking and handling X ray		RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Department has documented procedure for acceptance and rejection of X ray taken		RR	
		Department has documented procedure for receipt, labelling , Processing and reporting of X ray		RR	
		Department has documented procedure for taking X ray in emergency conditions		RR	
		Department has documented procedure for quality control system to verify the quality of results		RR	
		Radiology has documented system for repeat X ray.		RR	
		Department has documented procedure for storage, retaining and retrieval of department records, and reports of results.		RR	
		Department has documented procedure preventive and break down maintenance		RR	
		Department has documented procedure for purchase of External services and supplies		RR	
		Department has documented procedure for inventory management		RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Department has documented procedure for upkeep management of department		RR	
		Department has documented procedure for radiation safety of staff , patients and visitors		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria	Check if periodic assessment of Physical and electrical safety risk is done using the risk assessment checklist		SI/RR	Verify with the assessment records. Comprehensive of physical and electrical safety should be done at least once in three month

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	X ray done per 1000 OPD patient		RR	
		X ray done per 1000 IPD patient		RR	
		Ultrasound done per 1000 OPD patient		RR	
		Proportion of X ray done at night		RR	
		No. of dental X ray per 1000 dental OPD		RR	
		Proportion of BPL Patients screened		RR	X-ray, USG
		Percentage of re-dos in imaging		RR	X-ray, USG (reason of image repeating is related to errors, mistakes or image quality)
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime for critical equipment		RR	
		Turn around time for X-Ray film development		RR	
		Proportion of waste of films		RR	

Reference no.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Proportion of X ray rejected/repeated		RR	
		X ray done per radiographer		RR	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Proportion of X rays for which report is signed by radiologist		RR	
		Proportion of scans for which F form is filled out of pregnant women scanned		RR	
		Examination Demography		RR	Proportion of General, Chest examination and specialised examination
		Report correlation rate		RR	Proportion of radiology report co related with clinical examination/laboratory reports out of Total X ray reported
		No of adverse events per thousand patients		RR	
		No of events of over limit of radiation exposure		RR	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Average waiting time at radiology		RR	
		Average waiting time at USG		RR	
		Number of stock out incidences of x ray films		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

RADIOLOGY SCORE CARD	
Area of Concern wise score	**Radiology Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-17

PHARMACY

CHECKLIST FOR PHARMACY

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.14	Services are available for the time period as mandated	Dispensary services are available in OPD hours		SI/RR	
		Facility ensure access to medicine store after OPD hours		SI/RR	
		Generic medicine store is operational 24X7		SI/RR	Check availability and functionality of Janaushadhi Kendras in the premises
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of medicines under NVBDCP		SI/OB	Chloroquine, Primaquine, ACT (Artemisinin Combination Therapy)
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Availability of medicines under NTEP		SI/OB	
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of medicines under NLEP		SI/OB	Rifampicin, Clofazimine, Dapsone
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Availability of ARV medicines under NACP		SI/OB	Zidovudine, Stavudine, Lamivudine, Nevirapine in combination as per NACO
		Availability of medicines for Paediatric HIV management		SI/OB	Paediatric Dosages FDC 6, FDC 10, Efavirenz, Cotrimoxazole
Standard A5	**Facility provides support services**				
ME A5.6	The facility provides pharmacy services	Dispensing of Medicines and consumables for OPD Patients		SI/OB	Functional dispensary
		Generic medicine Store		SI/OB	Functional jan ayushdhalya in premises or equivalent

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Storage of medicines		SI/OB	
		Cold chain management services		SI/OB	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages are displayed for easy access to Pharmacy/ Generic medicine store		OB	Numbering, main department and internal sectional signage are displayed
ME B1.2	The facility displays the services and entitlements available in its departments	List of medicines available displayed at Pharmacy		OB	
		Status of availability of medicines is updated daily		OB	
		Timing for dispensing counter of pharmacy are displayed		OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges in r/o services are displayed at entrance of generic medicine store		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of separate Queue for Male and female at dispensing counter		OB	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Pharmacy has easy access for moment of goods		OB	Check for availability of ramp and goods trolley/ cart

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Method of Administration /taking of the medicines is informed to patient/ their relative by pharmacist as per doctors prescription in OPD Pharmacy		OB/SI	
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re addressal and whom to contact is displayed		OB	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free medicines and consumables for all		PI/SI	JSSK, RBSK & PMJAY beneficiaries
ME B5.2	The facility ensures that medicines prescribed are available at Pharmacy and wards	Pharmacy provides generic medicine list to all hospital department		SI/OB	
		Check that patient party has not incurred expenditure on purchasing medicines or consumables from outside.		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Free medicines for BPL patients		PI/SI/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Local purchase of stock out medicines/ Reimbursement of expenditure to the beneficiaries		PI/SI/RR	
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Hospital has allocated space for Pharmacy in OPD		OB	Minimum space required is 250sq F or 5% of average OPD X 0.8 sq m.
		Dispensary has adequate waiting space as per load		OB	
ME C1.2	Patient amenities are provide as per patient load	Pharmacy has patients sitting arrangement as per requirement		OB	
		Dispensary counter has provision of shade		OB	If it is outside the hospital building
ME C1.3	Departments have layout and demarcated areas as per functions	Dedicated area for keeping medical gases		OB	
		Dedicated area for keeping inflammables		OB	Storage of sprit etc.
		Demarcated are of keeping near expiry medicines		OB	
		Demarcated are of keeping expired medicines		OB	
		Demarcated area for keeping instruments and consumables		OB	
		Dedicated area for cold chain management		OB	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff , medicines and carts		OB	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C1.6	Service counters are available as per patient load	Adeqauate No of medicine dispensing counter as per load		OB	
ME C1.7	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods in the Pharmacy .		OB	Receipt and Inspection area at one side and issue area on the other side
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	Pharmacy does not have temporary connections and loosely hanging wires		OB	
		Stabilizer is provided for cold chain room		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Windows of medicine store have grills and wire meshwork		OB	
		Floors of the Pharmacy department are non slippery and even		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Pharmacy has plan for safe storage and handling of potentially flammable materials.		OB/SI	
		Department has sufficient fire exit to permit safe escape to its occupant at time of fire		OB	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C3.2	The facility has adequate fire fighting Equipment	Pharmacy has installed fire Extinguisher that is Class A , Class B C type or ABC type		OB/RR	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.4	The facility has adequate technicians/ paramedics as per requirement	Availability of Pharmacist		SI/RR	
ME C4.5	The facility has adequate support / general staff	Availability of security staff		SI/RR	
Standard C5	**Facility provides medicines and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate medicines at point of use	Non-opioid Analgesic, Anti-Pyretic and Nonsteroidal Anti-Inflammatory Medicines		OB/RR	As per State's EML
		Anti-infective medicines - Antibiotics, Antifungal, Antiamoebic		OB/RR	As per State's EML
		Antiseptic Liquid/ Cream/lotion		OB/RR	As per State's EML
		Solution Correcting Water, Electrolyte Disturbances and Acid-Base Disturbances and plasma expenders		OB/RR	As per State's EML

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Anti-Allergic and Medicines used in Anaphylaxis		OB/RR	As per State's EML
		Medicines acting on Digestive system - Anti Diarrhoeal, Anti-Ulcer, Anti - Emetic, Anti Constipation, Anti-Inflammatory		OB/RR	As per State's EML
		Antidote and other Substances used in Poisoning		OB/RR	As per State's EML
		Immunosuppressive Medicines		OB/RR	As per State's EML
		Pain and Palliative Care Medicines		OB/RR	As per State's EML
		Opioid Analgesic Medicines		OB/RR	As per State's EML
		Medicines Affecting Blood		OB/RR	As per State's EML
		Dermatological medicines (Topical)		OB/RR	As per State's EML
		Ear, Nose and Throat (ENT) Medicines		OB/RR	As per State's EML
		Dental Restorative Materials and Medicines		OB/RR	As per State's EML
		Ophthalmological Medicines		OB/RR	As per State's EML
		Availability of psychotherapeutic medicines		OB/RR	As per State's EML
		Medicines acting on Cardiovascular system		OB/RR	As per State's EML
		Medicines acting on Central/Peripheral Nervous system		OB/RR	As per State's EML
		Medicines acting on Respiratory system		OB/RR	As per State's EML
		Medicines acting on Urogenital system		OB/RR	As per State's EML
		Medicines used on Obstetrics and Gynaecology		OB/RR	As per State's EML

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Hormonal preparation and other Endocrine Medicines		OB/RR	As per State's EML
		Immunological/ Vaccine medicine and logistics		OB/RR	As per State's EML
		Surgical accessories for Eye		OB/RR	As per State's EML
		Vitamins, Mineral and nutritional supplement		OB/RR	As per State's EML
		Dialysis Solution		OB/RR	As per State's EML
		Prophylactic Iron, folic acid and deworming			As per State's EML
ME C5.2	The departments have adequate consumables at point of use	Availability of Consumables		OB/RR	As per State's EML
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.5	Availability of Equipment for Storage	Availability of Equipment for maintenance of Cold chain		OB	ILR, Deep Freezers, Insulated carrier boxes with ice packs, refrigerator
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Storage furniture for medicine store		OB	Racks ,Cupboards, Sectional Drawer cabinet/ Shelves, Work table
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined			Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year			Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Inventory management		SI/RR	
		Cold chain management of ILR and deep freezer		SI/RR	
		Rational use of medicines		SI/RR	
		Prescription Audit		SI/RR	
		Patient Safety		SI/RR	
		Basic Life Support		SI/RR	
		Training on Quality Management System		SI/RR	To all category of staff. At the time of induction and once in a year.
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for estimation of the requirement and proper storage of the medicines		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for maintaining pharmacy records and bin cards		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system of timely corrective break down maintenance of the equipments		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated		OB/ RR	Calibration of thermometers at cold chain room
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions for ILR/ Deep Freezers are available at cold chain room		OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting medicines and consumables	Medicine store has process to consolidate and calculate the consumption of all medicines and consumables		RR/SI	
		Forecasting of medicines and consumables is done		RR/SI	Scientifically based on consumption pattern, disease prevelence, seasonality
		Staff is trained for forecast the requirement using scientific system		RR/SI	
ME D2.2	The facility has establish procedure for procurement of medicines	Facility has a established procedures for local purchase of medicines in emergency conditions		RR/SI	10% of total budget
		Hospital has system for placing requisition to district medicine store		RR/SI	
ME D2.3	The facility ensures proper storage of medicines and consumables	There is allocated place to store medicines in Pharmacy and medicine store		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		All the shelves/ racks containing medicines are labelled in pharmacy and medicine store		OB	Stock is arranged neatly in alphabetic order/ Therapeutic category with name facing the front and expiry date
		Medicines of similar name and multiple strength are stored separately		OB	E.g. Montelukast 5mg, Montelukast 10mg
		Heavy items are stored at lower shelves/racks		OB	Syrup cartons, reagents cartons are kept at the lower shelves
		Fragile items are not stored at the edges of the shelves.		OB	Syrup bottles, glass ampoules, vials are not stored at the edge of the rack
		Look Alike and Sound alike medicines are stored separately in patient care area and pharmacy		OB	LASA medicines kept away from their identical one in look or sound. Tall Man lettering method used for identification/labelling of LASA
		High alert medicines are stored separately in patient care area and pharmacy		OB	High alert medicines are stored separately and labelled
		There is separate shelf /rack/area for storage near expiry, expired, NSQ medicines in the drug store		OB	
		Pharmacy has system of inventory Management		OB/SI	DVDMS, E-Aushadhi, etc.
		Medicines and consumables are stored away from water and sources of heat, direct sunlight, etc.		OB/RR	Medicines that are considered light-sensitive are stored in closed drawers.
		Medicines are not stored at floor and adjacent to wall		OB	Pallets are provided if required to store at floor
ME D2.4	The facility ensures management of expiry and near expiry medicines	Dispensing counter has system to check the expiry of medicines		RR/SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Medicine store has system to check the expiry of medicines		RR/SI	DVDMS, E-Aushadhi, etc.
		Medicine store has system to inform the patient care areas about near expiry/ expired medicines		RR/SI	
		There is a system of periodic random quality testing of medicines		RR/SI	
ME D2.5	The facility has established procedure for inventory management techniques	Physical verification of inventory is done periodically		RR/SI	Stock audit sheet
		Facility uses bin card system		RR/OB	Bin cards are used for each medicines and are updated regularly
		First Expiry First Out (FEFO) System is established for medicines		OB	Storage - Near expiry medicines are stored in front and long expiry medicines are kept in back.
		Stores has defined minimum stock for each category of medicine as per there consumption pattern		RR/OB	Minimum quantity/stock level of each category of drug is defined. E.g. Paracetamol 500mg 100 strips, etc.
		Reorder level is defined for each category of medicines		RR	
		Medicine store has supply chain software for the management of innventory		OB/RR	DVDMS, E-Aushadhi, etc.
		Medicines are categorized and stored		OB/RR	Medicines are stored and categorized in the store's shelves as per their consumption (Vital, Essential and Desirable, Fast Moving, slow moving)/ Alphabetically/Therapeutic category, etc.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D2.6	There is a procedure for periodically replenishing the medicines in patient care areas	Hospital has established system to take medicines from store in case of emergency or if required urgently		RR/SI	
ME D2.7	There is process for storage of vaccines and other medicines, requiring controlled temperature	Check vaccines are kept in sequence		OB	(Top to bottom) : Hep B, DPT, DT, TT, BCG, Measles, OPV
		Work instruction for storage of vaccines are displayed at point of use		OB	
		ILR and deep freezer have functional temperature monitoring devices		OB	
		There is system in place to maintain temperature chart of ILR		OB	Temp. of ILR: Min +2°C to 8°c in case of power failure min temp. +10°C . Twice a day temperature log are maintained
		There is system in place to maintain temperature chart of deep freezers		OB	Temp. of Deep freezer cabinet is maintained between -15°C to -25°C. Twice a day temperature log are maintained
		Check thermometer in ILR is in hanging position		OB	
		ILR and deep freezer has functional alarm system		SI/RR	
		Staff is aware of Hold over time of cold storage equipments		SI/RR	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic medicines	Narcotic medicines are kept separetly in double lock		OB	As per Narcotic Drugs and Psycotropic Substances (NDPS) Act and Rules, Narcotic medicines are kept in double lock.
		Empty ampoules/ strips are returned along with narcotic administration detail sheet		OB/RR	Consumption of Narcotic drugs & psychotropic substances (NDPS) drugs by the wards and return back to the pharmacy

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Hospital has system to discard the expired narcotic medicines		RR/SI	Discarded narcotic medicines are documented with witness.
		Facility maintains the list of narcotic and psychotropic medicines available at facility		RR	List of NDPS drugs are maintained
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at medicine store		OB	
		Adequate Illumination at dispensing counter		OB	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in pharmacy		SI/RR	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at pharmacy		OB	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/ Junk material in the Pharmacy and medicine store		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/ rodent/birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in Pharmacy		OB/SI	
		Availability of power back for cold chain		OB/SI	
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**				
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	License for storing spirit		RR	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Pharmacist adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E6	**Facility ensures rationale prescribing and use of medicines**				
ME E6.1	Facility ensured that medicines are prescribed in generic name only	Medicines are purchased in generic name only		RR/SI	
		Facility has essential medicine list as per State guideline		OB	
		Facility provide list of medicines available to different departments as per essential medicine list		RR/SI	
		Facility has enabling order from state for writing medicines in generic name only		RR/SI	
		There is system of conducting periodic prescription audit to ensure that only generic medicines are prescribed		RR/SI	
ME E6.2	There is procedure of rational use of medicines	Hospital has its own medicine formulary based on EML		RR/SI	
		medicine formulary is available with doctors and nurses/ clinical table		RR/SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Hospital has system to review the medicine formulary as per EML at defined intervals		RR/SI	
		Hospital has system to review the prescription as per medicine formulary and STG		RR/SI	
Standard E7	**Facility has defined procedures for safe medicine administration**				
ME E7.1	There is process for identifying and cautious administration of high alert medicines	Pharmacy has list of high risk medicines are available		RR/SI	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available		RR/OB	Bin cards, indent forms etc
ME E8.6	Register/records are maintained as per guidelines	Pharmacy records are labeled and indexed		RR	
		Records are maintained for Pharmacy		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Pharmacy has adequate facility for storage of records		OB	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxid etc
		Periodic medical checkups of the staff		SI/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F1.6	Facility has defined and established antibiotic policy	Check for Pharmacist are aware of Hospital Antibiotic Policy		SI/RR	
		Pharmacist check the antibiotic consumption periodically		SI/RR	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of expired or discarded medicines in Yellow Bin			Pharmaceutical waste like antibiotics, cytotoxic medicines including all items contaminated with cytotoxic medicines along with glass or plastic ampoules, vials etc.
		There is no mixing of infectious and general waste		OB	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disposal of expired medicines as per state guidelines		SI/OB	Either sent back to manufacturer or disposed by incineration
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Pharmacy		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	Patient satisfaction survey done on monthly basis		RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	Physical verification of the inventory by Pharmacist/hospital manager at periodic intervals		SI/RR	
ME G3.2	Facility has established external assurance programs at relevant departments	Periodic and random sampling of the medicines for Quality Assurance		SI/RR	By medicine controller/State medicine quality Assurance
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Work instruction/ clinical protocols are displayed		OB	Work instruction for storing medicines, Cold chain management
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for indent the medicines and items from district medicine warehouse		RR	
		Department has documented procedure for local purchase of medicines/ generic medicine stores		RR	
		Department has documented procedure for reception and storage of medicines and items		RR	
		Department has documented procedure for maintaining near expiry medicines at store and pharmacy and disposal of expired medicines		RR	
		Department has documented procedure for dispensing of medicines at Pharmacy		RR	
		Department has documented procedure of indenting the medicines to patient care area		RR	
		Department has documented procedure for issue of the medicines in emergency condition		RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Department has documented procedure for maintenance of temperature of ILR/Deep freezer / refrigerators		RR	
		Department has documented procedure for storage of narcotic and psychotropic medicines		RR	
		Department has documented system for periodic random check and quality testing of medicines		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analyzed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	Percentage of medicines available against essential medicine list for OPD		RR	
		Percentage of medicines available against essential medicine list for IPD		RR	
		Expenditure on medicines procured throughlocal purchase for BPL patient		RR	
		Percentage of medicines procured locally		RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Number of stock out situations in Vital category medicines		RR	
		% of medicines expired during the months		RR	
		Number of stock out medicines against EML		RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Proportion of prescription found prescribing non generic medicines		RR	
		No of advere medicine reaction per thosuand patients		RR	
		Antibiotic rate		RR	No. of antibiotic prescribed /No. of patient admiited or consulted
		Percentage of irrational use of medicines/ overprescription		RR	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Turn Around time for dispensing medicine at Pharmacy		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

PHARMACY SCORE CARD	
Area of Concern wise score	**Pharmacy Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-18

AUXILIARY SERVICES

CHECKLIST FOR AUXILLARY SERVICES

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A5	**Facility provides support services**				
ME A5.1	The facility provides dietary services	Availability of operational Kitchen		SI/OB	Functional Kitchen within the premise of the hospital
ME A5.2	The facility provides laundry services	Availability of functional laundry		SI/OB	Arrangement of laundry services inhouse or outsourced
ME A5.3	The facility provides security services	Availability of functional security services 24 X7		SI/OB	
ME A5.4	The facility provides housekeeping services	Availability of Housekeeping services 24X7		SI/OB	
ME A5.5		Availability of waste disposal services		SI/OB	Arrangement for disposal of Bio medical and general waste Inhouse or outsouced
ME A5.6	The facility ensures maintenance services	Availability of maintenance services 24X7		SI/OB	Includes Physical infrastructure maintenance and equipment maintenance
ME A5.8	The facility has services of medical record department	Availability of Medical record department		SI/OB	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental and directional signage for support service department		OB	Internal sectional signage are displayed
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Medical records are provided to patient/ Next to kin on request		RR/OB	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.2	Confidentiality of patients records and clinical information is maintained	MRD has system to maintain Confidentiality of patient records		SI/RR	Patient records are not shared except the patient until it is authorized by law
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Availability of free diet		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Free diet for BPL patients		PI/SI	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**				
ME B6.5	There is an established procedure for sharing of hospital/ patient data with individuals and external agencies including non governmental organization	Check hospital administration has defined protocols for data sharing		RR/SI	Check list of agencies with which data shared has routinely shred has been prepared. For any other agency a formal permission is sought from competent authorities before sharing the data including international agencies, press and NGOs.
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research	Check hospital ensures that informed consent is taken from patient participating in any clinical or public Health research		RR/PI/SI	Check for policy or practice

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B6.9	There is an established procedure to issue of medical certificates and other certificates	Check hospital has documented policy for issuing medical certificates		RR/SI	Check for policy defines List of certificates can be issued by hospital Who can issue certificates Formats shall used for different certificates Record keeping of issued certificate procedures for issuing duplicate certificates
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Dietary Department has adequate space as per requirement		OB	15-20 sq ft/bed space requirement for 100 and more than 100 bed hospital.
		Laundry Department has adequate space as per requirement		OB	Minimum space requirement 10sq ft/bed
		Medical record Department has adequate space as per requirement		OB	Minimum space requirement is 2.5 to 3,5 sq ft per bed
ME C1.3	Departments have layout and demarcated areas as per functions	Check Dietary department has demarcated and dedicated area for various activities		OB	Layout as per functional flow that is receipt, storage, daily storage, preparation, Cooking area ,Service area, dish washing area, Garbage collection area and administrative area.
		Check laundry department has demarcated and dedicated area for its various activities		OB	Layout as per functional flow that is from dirty end (receipt) to clean end (Issue). That is receipt, sorting, sluicing, washing, drying, ironing and issue
		Availability of complaint box and display of process for grievance redressal and whom to contact is displayed		OB	Layout as per functional flow that is receipt, checking of completion of records, indexing and filling of records, storage.

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff , goods and food trolley in dietary department		OB	
		Availability of adequate circulation area for easy moment of staff, equipments and carts in laundry		OB	
		Availability of adequate circulation area in MRD		OB	
ME C1.5	The facility has infrastructure for intramural and extramural communication	All support services department are connected with intercom		OB	
ME C1.6	Service counters are available as per patient load	Unidirectional flow of goods and services in dietary services		OB	
		Unidirectional flow of goods and services in laundry services		OB	
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	Support services departments does not have temporary connections and loosely hanging wires		OB	
		Equipments in wet areas like Laundry and Kitchen are equipped with ground fault protection and designed for wet conditions		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Support services are non slippery and even		OB	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Building has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	dietary department laundry and Medical record department
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	dietary department laundry and Medical record department
		Dietary Department has plan for safe storage and handling of potentially flammable materials.		OB	Dietary Department
ME C3.2	The facility has adequate fire fighting Equipment	Support services has installed fire Extinguisher that is Class A , Class B C type or ABC type are installed in adeqaute number at every strategic points		OB/RR	dietary department and Medical record department
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	dietary department and Medical record department
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Dietician		SI/RR	
		Availability of MRD technician		SI/RR	
ME C4.5	The facility has adequate support / general staff	Availability of washer man		SI/RR	In-house/Out-sourced
		Availability of Cook		SI/RR	In-house/Out-sourced
		Availability of Data Entry operator for MRD		SI/RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.2	The departments have adequate consumables at point of use	Availability of consumables at dietary department		OB/RR	Cap, gowns, gloves, Detergent for cleaning of utensil and Soap for hand washing
		Availability of consumables at laundry department		OB/RR	Detergent and disinfectant, Heavy utility gloves, apron.
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.6	Availability of functional equipment and instruments for support services	Availability of Equipments & utensils for Dietary department		OB	Refrigerator, LPG, food trolley and cooking utensils
		Availability of Equipments for Laundry		OB	Washing machine, drier, Iron, Separate trolley for clean and dirty linen
		Availability of Equipments for Medical record department		OB	Computer with scanner
		Availability of equipments for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of furniture and fixtures for Dietary department		OB	Exhaust fan, Storage containers, Work bench/ slab, Utensil stand
		Availability of furniture and fixtures for laundry department		OB	Stand/ Hanger for drying of linen, Iron table, Cupboard
		Availability of furniture and fixtures for Medical record department		OB	Racks and cupboard, table, Sectional Drawer cabinet/ Shelves,
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
		Training on Medical record Management		SI/RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	MRD Staff is skilled for indexing and storage of Medical records		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Laundry staff is skilled for segregating and processing of soiled and infectious linen		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipments		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.		OB/SI	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at Kitchen		OB	
		Adequate Illumination at Laundry		OB	
		Adequate Illumination at Medical record department		OB	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D3.2	The facility has provision of restriction of visitors in patient areas	Hospital ensures unauthorised entry into dietary department is not permitted		OB/SI	
		Hospital ensures unauthorised entry into Laundry department is not permitted		OB/SI	
		Hospital ensures unauthorised entry into Medical record department is not permitted		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in dietary department		SI/RR	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
		Temperature control and ventilation in Laundry		SI/RR	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
		Temperature control and ventilation in Medical record Department		SI/RR	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	Dietary department, laundry and medical record department
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	Dietary department, laundry and medical record department
		Window panes , doors and other fixtures are intact		OB	Dietary department, laundry and medical record department
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the Diet department		OB	Dietary department, laundry and medical record department
		No condemned/ Junk material in the Laundry		OB	
		No condemned/Junk material in the MRD		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/ rodent/birds/pests		OB	Dietary department, laundry and medical record department
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	Dietary and laundry department
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up		OB/SI	For Laundry, Diet and MRD department
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**				
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Hospital has defined diet schedule for the patients.		RR/SI	
		Hospital has Special diet schedule for the critical ill patients suffering from Heart Disease, Hypertension, Diabetes, Pregnant Women, diarrhoea and renal patients		RR/SI	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	Dietary department has system to calculate the number of diets to be prepared		RR/SI	
		Dietary department has procedure for procurement of perishable and non perishable items		OB/SI/RR	Time interval for procurement of Perishable and non perishable items is fixed
		Perishable items are stored in the cold room or refrigerators.		OB	Like milk, cheese, butter, egg, vegetables, and fruits
		Non perishable items are kept in racks/ storage container, in ventilated and rodent proof room		OB	All the food items are stored above floor level.
		Food is prepared by trained staff, ensuring standards practices		OB/SI	
		There is a procedure for the distribution of the diet		SI/RR	Ensure diet is supplied at defined duration.
		Distribution of the food is done in covered food trolleys		OB	
		Dietary department has system to check the quality of food provided to patient		RR/SI	There is designated person preferably nurse in Ward to check the Quality of food
		Dietary department has procedure to collect and dispose of kitchen garbage at defined interval and place		OB/SI	
		There is practice of calculating and maintaining buffer stock in Kitchen		SI/RR	
		Department maintained stock and expenditure register in Kitchen		RR/SI	
		There is system to replenish raw food material		RR/SI	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate sets of linen	Hospital has sufficient set of linen available per bed		RR/SI	at least 5 sets for each functional bed
		Hospital/ department has inventory of total linen available with category wise distribution in every area		RR/SI	Patient, staff and bed linen
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	Linen department has system for Periodic physical verification of linen inventory		RR/SI	To check the theft and pilferage
		Linen department has separate trolley for distribution of clean linen and collection of dirty linen		OB	
		Linen are transported into closed leak proof containers /bags		OB	
		Infectious and non infectious linen are transported into separate containers / bags		OB/RR	
		Linen department has system of sorting of different category of linen before putting in to washing machine		OB/RR	Soiled, infected fouled type of linen
		Linen department has procedure for sluicing of soiled, infected and fouled linen		OB/RR	
		Linen department has procedure to keep record of daily load received from each department		RR	
		Hospital has system/ designated person to check quality of washed linen		RR/SI	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is a fix time for collection for dirty linen and supply of clean linen		RR/SI	
		There is a system for verifying the quantity of linen received		RR/SI	
		There is procedure for condemnation of linen		RR/SI	
		There is system to check pilferage of linen from ward		RR/SI	Security guards keep vigil
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for Laundry department		RR/SI	
		There is designated in charge for Dietary department		RR/SI	
		There is designated in charge for MRD department		RR/SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Staff is adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.6	Register/records are maintained as per guidelines	All register/records are identified and numbered		RR	
		Diet Registers are maintained at Kitchen		RR	
		Laundry registers are maintained at laundry		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Hospital has procedure for collection, Compilation and maintenance of patient's records after discharge		RR	Manual/e-records
		Medical record department has system to check for completion of records		RR	Checking the records as per checklist for completion
		Medical record department has system for ICD coding /indexing the records		RR	As per ICD coding / indexing name, disease, diagnosis, physician and surgical procedure carried out
		Medical record department has system to generate statistics for clinical use		RR	Submitting the reports to required health authorities (Birth death notification, notification of communicable diseases etc)
		Medical record department has system to generate statistics for administrative use		RR	Hospital information system
		Medical record department has system for filling and safe storage of records		RR	Give full compliance if system is in place for manual record management OR If the facility has e-records in place, check for 1. Password/finger print protected computer 2. Any restriction/firewall to protect the individual's information from misuse

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Medical record department has procedure for retention/ Preservation of records		RR	Retention is as per state guideline
		Medical record department has procedure for destruction of old records		RR	
		Medical records department has system for retrieval of records		RR/SI	Give full compliance if system is in place for manual record management OR If the facility has e-records in place, check for 1. System is in place to define who all are authorized to access the patient e-records
		Medical record department has procedure for production of records in Courts of law when summoned		RR/SI	In case of MLC
		Medical records are issued to authorized personnel only		RR/SI	To patient/next kin to patient
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxid etc
		Periodic medical checkups of the staff		SI/RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility in kitchen		OB	Preferably in preparation and cooking area along with elbow operated tap
		Availability of Running Water (Hot and cold)		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of soap with soap dish/ liquid antiseptic with dispenser		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available for distribution of food		OB/SI	
		Availability of apron		OB/SI	
		Availability of caps		OB/SI	
		Availability of Heavy duty gloves for laundry		OB/SI	
		Availability of gum boats for laundry		OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, caps and aprons.		OB/SI	
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Cleaning and decontamination of food preparation surfaces like cutting board		SI/OB	Ask the cleanliness and ask staff how frequent they clean it
		Cleaning of utensils and food trolleys		SI/OB	Check the cleanliness and how frequent they clean it

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Decontamination of heavily soiled linen		SI/OB	
		Cleaning of washing equipments		SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Proper cleaning of items used for preparation and cooking of food		SI/OB	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of routes for clean and dirty items in kitchen		OB	
		Facility layout ensures separation of routes for clean and dirty items in laundry		OB	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipments like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Surface & fixtures are visibly clean with no dust or debris		OB	
		Staff is trained for spill management		SI/RR	
		Floors are clean		OB	
		No stray animals in the facility/ Patient Care areas		OB	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of different category of waste as per guidelines		OB/SI	
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste		OB	
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of post exposure prophylaxis		OB/SI	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disinfection of liquid waste before disposal		SI/OB	
		Daily disposal of food waste with general waste		SI/OB	
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Auxillary		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	Hospital has system to take feed back regarding quality of diet		RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Hospital has system to take feed back regarding cleanliness of linen provided		RR	
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	Check for entries in Round Register
ME G3.2	Facility has established external assurance programs at relevant departments	Kitchen is has system of regular external inspection by Municipal/ FDA authorities		SI/RR	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for Dietary **and Laundry** department has been prepared and approved		RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Current version of SOP are available with process owner		OB/RR	
		Standard operating procedure for Medical record Department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work instruction/ clinical protocols are displayed in Dietary and Laundry Department		OB	
		Work instruction/ clinical protocols are displayed in Medical Record Department		OB	
		Work instructions are displayed for hospital cleaniness		OB	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Record Department has documented procedure for indexing, receiving, compiling, maintaining, issuing and retention of the records		RR	
		Record department has documented procedure for pest and rodent control		RR	
		Diet department has documented procedure for diet schedule, calculation of diet required in wards, procurement of food items		RR	
		Diet department has documented procedure for preparation, distribution and disposal of remaining food		RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Diet department has documented procedure to check the quality of food provided to the patient		RR	
		Diet department has documented procedure for cleaning of kitchen and utensils		RR	
		Diet department has documented procedure for checkups of kitchen workers at defined intervals		RR	
		Linen department has documented procedure for collection, sorting, cleaning, sluicing of the blood/bidy fluid stained linen and distribution of linen		RR	
		Linen department has documented procedure for physical verification of the linen for cleanliness or torn out and condemnation of linen		RR	
		Linen department has documented procedure corrective and preventive maintenance of laundry equipments		RR	
		Security department has documented procedure for duty hours, control of incoming and outgoing items		RR	
		Security department has documented procedure for visiting hours in patient care area		RR	

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Security department has documented procedure for fire safety in hospital		RR	
		Security department has documented procedure for electrical safety		RR	
		Security department has documented procedure for training and drills of security staff		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status

Reference no	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	No of cases for which medical audit done		RR	
		No of cases for which death audit is done		RR	
		Linen Index		RR	No. of bed sheet washed in a month/Patient bed days in month
		Diet Index		RR	No. of meals provided in the month/no. of times meal served in a day * bed days
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Proportion of maternal deaths audited		RR	
		Proportion of newborn deaths audited		RR	
		Cycle for laundry services		RR	Time elapsed between collection of used linen and receiving clean linen
		Proportion of special diets		RR	No. of special diets (diabetic, hypertensive, semi solid or other diet) in the month*100/tital no. of diets provided in the month
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Medical Audit Score		RR	
		Death Audit Score		RR	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Waiting time for getting handicap certificate		RR	
		Waiting time for getting death certificate		RR	
		Patient feedback on cleanliness of linen		RR	
		Patient feedback on quality of food		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

AUXILIARY SERVICES SCORE CARD	
Area of Concern wise score	Auxiliary Services Score
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-19

MORTUARY

CHECKLIST FOR MORTUARY

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**The facility provides Curative Services**				
ME A1.14	Services are available for the time period as mandated	Availability of services 24X7		SI/RR	
Standard A5	**The facility provides support services**				
ME A5.8	The facility provides mortuary services	Dead bodies are kept till the relatives take over the bodies		SI/RR	
		Dead bodies are brought to hospital for medico legal post mortem work		SI/RR	
		Unclaimed bodies are kept until disposal is arranged		SI/RR	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages		OB	Numbering, main department and internal sectional signage are displayed
		Restricted area signage are displayed		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's are available in local language and pictorial		OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Post mortem records of deceased are issued to police/next kin of deceased as per state guideline		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**				
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services	Religious and cultural preferences of deceased and relatives are taken in to consideration while handling over the body		OB/SI	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of ramp/level ground for easy access of stretcher to mortuary/ post mortem room		OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	There are arrangements that Post mortem room is not in direct line of sight of general public/ visitors		OB	Provision of curtain, screen or buffer area or any other in post mortem room
ME B3.2	Confidentiality of patients records and clinical information is maintained	Confidentiality of PM records are maintained for all MLC cases		RR/SI	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous to deceased relative		PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV and suicidal cases		RR/SI	
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Adequate space to conduct the Post mortem and accommodate dead bodies		OB	
ME C1.2	Patient amenities are provide as per patient load	Availability of adequate seating arrangement in waiting area		OB	
		Availability of Drinking water		OB	
		Availability of functional toilets			

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME C1.3	Departments have layout and demarcated areas as per functions	Mortuary has reception and waiting area as per requirement		OB	Waiting area has space of 17.5 sq m along with toilet and drinking water facility
		Mortuary has morgue freezer for preservation of bodies as per requirement		OB	
		Mortuary has post mortem room as per requirement		OB	Post mortem room has area of 17.5 sq m for 101-300 beds and 21 sq m for 301-500 beds
		Mortuary and post mortem has Ancillary area as per requirement		OB	Ancillary area consist of Consultant room, mortuary supervisor room and stores
		Cold room and autopsy room are interconnected		OB	Cold room should lead to entrance area into autopsy room
		Access way connected from hospital to mortuary is covered		OB	As protection in wet weather and as screen from adjoining area
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors of Mortuary area are wide enough to allow passage of trolleys		OB	Not less than 8 ft
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	Availability of deep freezer for storage as per load		OB	
ME C1.7	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	Mortuary has functional linkage with hospital Emergency, OT and IPD etc.		OB	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	Mortuary building does not have temporary connections and loosely hanging wires		OB	
		Adequate electrical socket provided for safe and smooth operation of morgue freezer		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Mortuary are thick, durable and can be easily cleaned		OB	
		Window have wire meshwork and intact window panes		OB	
		Floors of the Mortuary are non slippery and even		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.2	The facility has adequate fire fighting Equipment	Fire Extinguisher that is Class A , Class C type or ABC type are installed in mortuary		OB	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of specialist/ MO to conduct autopsy as per state norms		OB/RR	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of post mortem technician/assistant as per state guideline		SI/RR	
ME C4.5	The facility has adequate support / general staff	Availability of sweeper in Mortuary		SI/RR	
		Availability of security staff in mortuary		SI/RR	
Standard C5	**The facility provides drugs and consumables required for assured services.**				
ME C5.2	The departments have adequate consumables at point of use	Repairing Material		OB/RR	Thread, needle, cotton wool, wool waste, clothes, malleable wire, polythene bag, gloves, mask and apron
		Plastic bins		OB/RR	for fixing specimens
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	Weighting Mechanise. Platform scale Weighting Whole body, Balance to weight 100gm to 10 Kg, Balance to weight 0.2 gm to 10gm
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of Cutting Instruments trays		OB	Skull Cutter, Organ Knife blade, cartilage Knife, Caltin solid, Rib cutter, Brain knife, resection knife, Scissor (of varying sizes), forceps (of varying sizes)
ME C6.5	Availability of Equipment for Storage	Availability of Cabinets for storage of dead bodies		OB	Refrigerated body storage room, Instrument trolley
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of Post mortem table		OB	
		Availability of Fixtures		OB	Electrical fixture for storage cabinet
		Availability of furniture		OB	cupboard, counter for delivery of reports, table for preparation of reports chair.

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for preservation of dead bodies in the mortuary		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for maintaining post mortem records		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipments		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the monitoring equipments are calibrated		OB/ RR	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions for critical equipments are available		OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.5	The facility has established procedure for inventory management techniques	Department maintained stock register		RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a daily and are maintained		OB/RR	Check for refrigerator temperature charts. Charts are maintained and updated twice a day
		Staff is aware of Hold over time of cold storage equipments		SI/RR	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at post mortem table		OB	
		Adequate illumination at morgue		OB	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Hospital ensures unauthorised entry into mortuary is not permitted		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in Mortuary		OB/RR	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement
ME D3.4	The facility has security system in place at patient care areas	Hospital has sound security system to manage overcrowding in Mortuary		OB	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
		Post-mortem table is intact and with out rust		OB	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material stored in the mortuary		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/ birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	Availability of water in sinks, washbasin and post mortem table should be fitted with water hose
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in mortuary		OB/SI	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor and support staff adhere to their respective dress code		OB	
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Department has process for storage and retrieval of Medico-legal record		RR/SI	MLC case reports etc.
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**				
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives		SI/RR	
ME E16.2	The facility has standard procedures for handling the death in the hospital	The body of deceased is handled with respect and dignity		SI/RR/OB	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
		Socio-cultural beliefs of patient 's family are identified and respected		SI/RR/OB	
		Unclaimed bodies are handled/ handed over, buried or cremated as per applicable laws and regulation		SI/RR	All the unclaimed bodies are handled with respect and dignity
ME E16.3	The facility has standard procedures for conducting post-mortem, its recording and meeting its obligation under the law	Mortuary has system for categorize the dead bodies before preservation.		SI/RR	Main categorization in Non medico legal and medico legal which is further divided into Identified and Unknown
		Mortuary technician to maintain full records of body brought to mortuary			Check Mortuary register which contain details: Identification number, Name, Sex, age of deceased, date and time of death, identification mark of deceased and finger impression, details of near relative, weather autopsy is done or not, if done then date and time of autopsy, name of autopsy surgeon, date and time when body is placed in cold storage, length of body and breadth across should, list of valuables which have been removed from body, signature of technician, date and time of when body is removed & Name of relative/police collecting body.
		Mortuary has system to provide identification tag/ wrist band for each stored dead body		RR/OB	Identification tag should be of plastic water proof type and carry information on full name,address,age,sex, registration number, date and time of death and when body kept for storage

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
		Mortuary has system for preparation of body before cold storage		RR/SI	
		Each cold storage door has holder for identification ticket		RR/OB	Check identification ticket is available on storage cabin containing dead body
		Name of deceased is written on board on wall of the room which list each cold storage compartment		RR/OB	
		Cold storage room has system to maintain temperature of cabinets		RR/OB/SI	Temperature should not be allowed to fall below 0oC for short duration preservation while to preserve the body for long time it must be deep frozen so -20oC temp must be kept for one compartment
		Hospital has system to intimate mortuary staff before sending body to mortuary		SI/RR	
		All bodies sent to mortuary is accompanied with copy of death certificate issued by hospital		SI/RR	
		Death Certificate and label is marked MLC in bold if medico legal cases		RR/OB	Check death certificate / dead body.
		Mortuary/Hospital has standard label fixed to winding cloth over upper part of body		RR/OB	The upper part of the body is taken out of mortuary cold storage room i.e. head for identification
		Mortuary has system for storage of unclaimed body for fixed duration as per state guideline		SI/RR	
		Mortuary has system for disposal of unclaimed bodies as per state guideline		SI/RR	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxic etc
		Periodic medical checkups of the staff		SI/RR	
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin and elbow operated tap near the point of use
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
Standard F3	**The facility ensures standard practices and materials for Personal protection**				
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Masks		OB/SI	
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
		Compliance to correct method of wearing and removing the PPE		SI	Gloves, Masks, Caps and Aprons
Standard F4	**The facility has standard procedures for processing of equipment and instruments**				
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of mortuary table		SI/OB	Ask stff about how they decontaminate the mortuary table (Wiping with 0.5% Chlorine solution)
		Decontamination of instrument after use		SI/OB	Ask staff how they decontaminate the instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable
		Contact time for decontamination is adequate		SI/OB	10 minutes
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Staff know how to make chlorine solution		SI/OB	
		Sterilization of mortuary equipment		SI/OB	
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	High level disinfection by boiling or chemical done as per protocol at mortuary		SI/OB	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic		OB	
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Gluteraldehye, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipments like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of Anatomical and solied waste in Yellow Bin		OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids,dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vaccutainers with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste			
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters		OB	See if it has been used or just lying idle.
		Seggregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers		OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI/OB	
		Disinfection of liquid waste before disposal		SI/OB	
		Transportation of bio medical waste is done in close container/trolley			
		Staff is aware of mercury spill management		SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to lacate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Mortuary		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**				
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system daily round by Hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	Check for entries in Round Register
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work instructions are displayed		OB	Work Instruction for Dead body storage, receiving and issue of dead body

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for death in ward and emergency		RR	
		Department has documented procedure for receiving, storage and tagging of the body in mortuary		RR	
		Department has documented procedure for temperature maintenance and its corrective & preventive maintenance in cold store		RR	
		Department has documented procedure for maintenance of records		RR	
		Department has documented procedure sending the bodies for autopsy		RR	
		Department has documented procedure for hand over the body to deceased relatives		RR	
		Department has documented procedure for issuing the records to police and patient relatives		RR	
		Department has documented procedure for storage and send the viscera/tissue for further investigation		RR	
		Department has documented procedure for cleaning and upkeep of mortuary and post mortem room		RR	
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	The facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	The facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	The facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	The facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk asesement of all processes should be done using pre define critera at least once in three month.
AREA OF CONCERN - H OUTCOMES					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	Proportion of non MLC cases		RR	
		Occupancy rate of cold storage for dead bodies		RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Mean storage time for dead body in cold storage		RR	
		Down time Cold storage equipments		RR	

Reference No.	Measurable Element	Checkpoints	Compli-ance	Assessment method	Audit Support
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Waiting time for carrying out post mortem		RR	
		Waiting time for getting post mortem report in MLC cases		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

MORTUARY SCORE CARD	
Area of Concern wise score	**Mortuary Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-20

HAEMODIALYSIS

CHECKLIST FOR HAEMODIALYSIS

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**The facility Provides Curative Services**				
MEA1.14	Services are available for the time period as mandated	Dialysis services are available as per time mandate		RR/OB/SI	Check for timing of Dialysis centre as per MOU/As per State mandate
ME A1.19	The facility provides Dialysis services	Availability of haemodialysis services		RR/OB/SI	
		Availability of services to manage complications during dialysis process		RR/OB/SI	1. Hypotension 2. Dialyzer reactions (both anaphylactic reaction and non-specific reaction) 3. Haemolysis 4. Air embolism 5. Seizures 6. Chest pain, MI 7. Arrhythmias 8. Sudden cardiac arrest 9. Nausea, Vomiting 10. Chills, Rigors, Fevers
		Availability of Nutritional Counselling Services		RR/OB/SI	Counselling may be provided by dietician/ nephrologist/MO
Standard A3	**The facility Provides diagnostic Services**				
ME A3.1	The facility provides Radiology Services	Availability of Portable X ray Services		OB/SI	Within centre or linkage with the main hospital
		Availability of USG services		OB/SI	Within centre or linkage with the main hospital
ME A3.2	The facility Provides Laboratory Services	Availability of lab services		OB/SI	Within centre or linkage with the main hospital for: Heamogram, Iron study, LFT, KFT, Hb1Ac, Viral Marker, Vit D
		Availability of Point of care diagnostic devices			Hb, Blood Sugar, Blood Group, HIV, HbsAg(HBV)
ME A3.3	The facility provides other diagnostic services, as mandated	Functional ECG Services are available		OB/SI	Within centre and staff should be trained to operate ECG machine

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard A4	**2**				
ME A4.13	The facility provide services as per Pradhan Mantri National Dialysis Programme	Availability of Haemodialysis services free of cost for BPL & Economically Weaker Section(EWS) patients		RR/PI/SI	Economically weaker Section(EWS) certifcate issued by appropriate authority(District Magistrate/Revenue Ofificer not below the rank of Tahsildar/Sub Divisional Officer)
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental and directional signages		OB	Numbering, main department and internal sectional signages
		Signage for restricted area and safety hazard are displayed			1.Restricted signages at the entry & restricted area within the dialysis centre 2. Safety Hazard and Caution signs, for e.g. hazards from electrical shock, inflammables etc. shall be displayed at appropriate places
ME B1.2	The facility displays the services and entitlements available in its departments	Services available and not available in the dialysis centre are displayed		OB	e.g. Display of Haemodialysis for HIV or Hepatitis B/C patients
		Name of the Nephrologist/in charge with registration number are displayed		OB	Contact details & days of visits of Nephrologist/ in charge, Quality Managers are displayed
		Important numbers are displayed		OB	Blood Banks, Fire Department, Police, Ambulance Services, ICU and OT
ME B1.4	User charges are displayed and communicated to patients effectively	User Charges for dialysis services are displayed		OB	User charges(if any) are displayed at prominent places including display of free dialysis services for BPL/EWS patients

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC materials are displayed in waiting area		OB	IEC to prevent infection for patient with catheters & patient with fistulas or grafts, dietary advice are displayed IEC for care givers to manage day to day management
		Relevant IEC are displayed inside dialysis unit		OB	Check for IEC related to fluid intake, Know about dry weight, Patient guide for access care are displayed inside the unit
ME B1.6	Information is available in local language and easy to understand	Signages and information are available in local language		OB	At least in two languages with one being local
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Dialysis card/Logbook is provided to all patient		RR/SI/OB	Check dialysis card/ Logbook is provided to the patient and records are updated after each session
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female attendant/female staff, if a male staff examine, treat or manage a female patient		OB/SI	Ask the staff about the adopted procedure
ME B2.3	Access to facility is provided without any physical barrier & friendly to specially able people	Availability of Wheel chair and stretcher for easy Access to the Dialysis unit		OB	Check availability of both wheel chair and stretcher for the dialysis patients
		Availability of ramp with appropriate gradient			A gradient of 1:8
		Availability of disabled friendly toilets		OB/SI	At least one disabled-friendly toilet readily accessible to the Dialysis unit
ME B2.4	There is no discrimination on basis of social & economic status of patients.	There is no discrimination on the basis of social and economic status of the patients		OB/PI	Look for any discrepancies from the previous patient records receiving the services

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen/ curtains		OB	Check for screen/ curtains between the beds
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/ visitors		OB/SI	Confidentiality, security and integrity of records shall be ensured at all times
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV cases		OB/SI	HIV status of the patient is coded and not displayed publicly Internal policy to be checked(for maintenance of record)
Standard B4	**The facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent are obtained from the patient/ next of kin/ legal guardian as and when required		RR/SI	The consent includes general condition of the patient, treatment options, adverse reactions, consequence of missing dialysis, risk and complications Frequency of consent: before every session / every procedure
ME B4.2	Patient is informed about his/her rights and responsibilities.	Patients' rights and responsibilities are displayed		PI/OB	Patients are aware of their rights and responsibilities
ME B4.3	Staff are aware of Patients' rights and responsibilities	Staff is aware of patients' rights and responsibilities		SI	Randomly choose any staff
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Dialysis Unit has a system in place to communicate with patient/ their family member regarding the nature and seriousness of the illness		PI/SI	Ask the family members whether they have been communicated and involved in the treatment plan and progress

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME B4.4	The facility has defined and established grievance redressal system in place	Check availability of complaint box		OB/RR/SI	Check when it was last open, check for complaint received and action taken
		Availability of display of process for grievance re addressal and whom to contact is displayed		OB/SI	Check for display regarding mechanism of grievance redressal
Standard B5	**The facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	All Drugs and consumables as per MoU with the private partner/ hospital EML are free for BPL/EWS and other notified patients		PI/RR	Notified patients are the other poor patients validated by the facility in charge of the hospital
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that BPL/EWS and other notified patient has not incurred expenditure on diagnostics from outside		PI/RR	For APL Patients cost of diagnostics is included in the package rate
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Dialysis services are free for BPL and other notified patients		PI/RR/SI	
		APL Patients are charged as per the MoU rates		PI/RR/SI	The rates are inclusive of drugs, consumables and diagnostics (Give full compliance if it is free for all, or not applicable for the centre)
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme.	Dialysis sessions of BPL families registered under PMJAY/Equivalent schemes are funded by respective scheme up to its maximum coverage		RR/SI	Check for any duplication of payments received under Pradhan Mantri National Dialysis programme and PMJAY/ equivalent schemes
Standard B6	**The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**				
ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.	Ethical norms for Medical officers, Staff nurses and technician are defined and staff are aware about it		SI/RR	Ask staff about the ethical norms

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME B6.3	The facility has an established procedure for entertaining representatives of drug companies and suppliers	No medical representatives are allowed in the dialysis unit		OB/RR/SI	Check that no promotional posters/ activities are encouraged for drugs and diagnostics. Ask staff about the current practice
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization.	Check dialysis unit has defined protocols for data sharing		RR/SI	Check list of agencies with whom the data is to be routinely shared. For any other agency a formal permission is sought from competent authority before sharing the data including press
ME B6.6	There is an established procedure for 'end-of-life' care	Patients relatives are informed clearly about the deterioration in health condition of Patients		SI/RR/PI	
		There is established procedure for transfer of patients to other facilities in end stage of life		SI/RR/PI	Check the records for transfer of the patients to Specialist Hospital/ Tertiary Hospital / Palliative Care Centres
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific treatment	Declaration is taken from the patient seeking early termination of dialysis and the consequences are explained		RR/SI	Check for filled declaration form
ME B 6.9	There is an established procedure to issue of medical certificates and other certificates.	Check hospital has documented policy for issuing medical certificates		RR/SI	Check for policy defines List of certificates can be issued by the dialysis centre, Who can issue certificates, Formats shall used for different certificates, Record keeping of issued certificate, Procedures for issuing duplicate certificates

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dillemas' in a time-bound manner through ethical committee	Check facility has defined its ethical issues management framework		SI/RR	(a) Check the adequacy of the framework. It address the ethical issues and decision making in clinical care (b) Check facility's ethical management framework address issues like admission, discharge, transfer, disclosure of information or any professional conflict which may not be in patient's best interest
		Check facility has ethical committee or person designated to address the ethical issues confronted by medical professionals while delivering the services		SI/RR	Facility's supporting human subject research activities/ publishing the scientific papers/ supporting medical students in thesis writing/ running any course where patient data is collected and used for above mentioned actvities - an ethical committee is constitituted and approval are taken before publication.
					or Facility may collaborate with the institutions where there are ethical committee is present and appropriate approvals, guided by applicable laws and regulations is taken. or the facilties where they are not involved in research actvities, to address the ethical dielamma's a person or group is appointed to address the dilemmas effectively within legal parameter

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Check the list of ethical issues is available and regularly updated		RR/SI	Check when the list was last updated. Engage with the available medical professionals to check what type of ethical dilemmas they are facing while performing their job & how they are dealing with dielmma's.
		Check the facility has defined mechanism identification and reporting of the ethical issues/ dilemmas confronted during services delivery		SI/RR	Check staff is aware of reporting mechanism
		Check regular review of identified and reported ethical issue is done by appointed personnel / group/ committee		RR/SI	Check the timely resolution of the identified and reported ethical issues is done
		Check all the decisions related to ethical dilemma's are communicated to all concerned		SI	Check information regarding ethical dilemma's & its handling is also given to new joinee's
AREA OF CONCERN C: INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.**				
ME C1.1	Departments have adequate space as per patient or work load.	Availability of adequate space for Dialysis room/ area/Machine area		OB	At least 120 square feet per machine
		Availability of dedicated Consultation room		OB	
		Availability of dedicated Water treatment area		OB/RR	The area have booster pumps, particle filters, water softener, carbon filter and RO system
		Water treatment area have sufficient space for soft curving of tubings to prevent right angle bends		OB	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Availability of Dual water treatment system		OB	Each water treatment system includes reverse osmosis membrane
		Availability of administrative area		OB	This area includes registration, medical records and billing / insurance
		Availability of dedicated Dialyzer Reprocessing room/area		OB	Check the followings: 1. A work bench with sink having side board & drainage. 2.The work bench is supplied with treated as well as untreated water which are separately marked. 3.Two sinks for the work bench 4.Sufficient space for at least two persons working simultaneously.
		Availability of dedicated Storage area (both dry & wet)		OB	1.Check the dry storage area is capable of storing 3months supply of dialyzers, tubings, hemodialysis concentrate solutions, IV fluids. It should also have space for stationery, linen etc. 2.Reprocessed dialyzers & tubings are being stored in the wet storage
ME C1.2	Patient amenities are provided as per patient load.	Availability of seating arrangement in Waiting area and Drinking water		OB	The centre shall have waiting area with sufficient seating arrangement for patients and visitors
		Availability of functional Toilets separate for male & female		OB	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME C1.3	Departments have layout and demarcated areas as per functions.	Demarcated stretcher & trolley bay		OB	Check the corridor is wide enough for easy movement of stretcher/ trolley
		Dedicated nursing station		OB	Location of nursing station should be such that the patients are under direct and easy observation
		Demarcated changing area for staffs with adequate privacy		OB	Separate male & female changing room
		Demarcated area for Infectious patients (HBV,HCV,HIV etc)		OB	
		Demarcated dirty utility room/area		OB	For cleaning and storage of housekeeping consumables
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law.	Corridors at Dialysis unit are broad enough for easy moment of stretcher and trolley		OB	Corridors are around 3 meter wide
ME C1.5	The facility has infrastructure for intramural and extramural communication.	Availability of functional telephone/ Intercom Services /CUG		OB/RR	Please ask the staff about the availability of intra/extramural communication
ME C1.6	Service counters are available as per patient load.	Availability of adequate no. of machines		OB/RR	Waiting time for scheduling session is not more than 24hrs. At least one machine is dedicated for infectious patients
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital).	Unidirectional flow of services.		OB	Check the directional flow as follows: 1. entry 2. reception & registration 3. Admission, and Discharge 4. Procedure 5. Ancillary area (water treatment, dialyzer reprocessing, toilets and stores)

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Functional linkage and access to critical departments		OB	Dialysis has functional linkage with ICU , laboratories, Blood Bank, Emergency dept, OT
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.2	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/board	Measures are being taken for safety of lifts		OB/RR	If the dialysis centre is at ground floor or accessible through ramp, give full compliance
ME C2.3	The facility ensures safety of electrical establishment.	Dialysis room does not have temporary connections and loosely hanging wires		OB	Check there is no multi plug system mechanism for periodical check/test of all electrical installation by competent electrical Engineer
		Each dialysis machine has in-built UPS or supplied with a UPS		OB/RR	
ME C2.4	Physical condition of buildings are safe for providing patient care.	Floors of the Dialysis room are non slippery and even		OB	Easily cleanable and acid, alkaline proof
		Windows have grills and wire meshwork		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster.**				
ME C3.1	The facility has plan for prevention of fire.	Dialysis Centre has sufficient fire exit to permit safe escape to its occupant at time of fire		OB	Check the fire exits are clearly visible and routes to reach exit are clearly marked
ME C3.2	The facility has adequate fire fighting equipment	Fire Extinguisher ABC type are installed		OB	Expiry date and due date for next refilling is clearly mentioned
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation.	Check for staff competencies for operating fire extinguisher and what to do in case of fire		OB/SI	Randomly ask one of the staff to operate fire extinguisher

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.**				
ME C4.1	The facility has adequate specialist doctors as per service provision.	Availability of Nephrologist or equivalent		OB/RR	Qualified Nephrologist / MD Medicine with one year dialysis training from recognized centre performing one visit every fortnight and clinical review for all patients
ME C4.2	The facility has adequate general duty doctors as per service provision and work load.	Availability of duty medical officer		OB/RR	Medical Officers (on duty) – One doctor (MBBS) per shift
ME C4.3	The facility has adequate nursing staff as per service provision and work load.	Availability of Nursing staff / dialysis technician		OB/RR/SI	1. One dedicated staff nurse/technician for 3 patients 2. One dedicated staff nurse/technician for each infectious patient 3. One of the staff nurse/ technician trained in CPR is available in each shift
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Dialysis Unit Manager/in-charge for day to day management		OB/RR	With management/ medicine/quality background
ME C4.5	The facility has adequate support/general staff.	Availability of housekeeping staff and other support staff		OB/SI/RR	At least one housekeeping staff and one hospital attendant per shift
		Availability of dedicated security guard		OB/RR	At least one security guard per shift
Standard C5	**The facility provides drugs and consumables required for assured services.**				
ME C5.1	The departments have availability of adequate drugs at point of use.	All the drugs and consumables are available at point of use		OB/RR	As per MoU with the private partner/hospital EML
		Availability of adequate quantity of dialysate as per requirement		OB/RR/SI	Dialysate prepared either commercially or on-site on daily basis meeting standards or regulatory requirements (ISO 23500:2014, ISO 13958:2014, ISO 11663:2014)
		Availability of medical gases		OB/RR	Oxygen cylinders and suction machine or through piped supply

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME C5.2	The departments have adequate consumables at point of use.	Availability of consumables, connectors, Tubing		OB/RR	Adequate quantity of disposable consumables like Blood tubing set, Fistula needle(16 G), Sodium Bicarbonate powder, IV sets, Dialyser starting kit, , Double lumen catheter set 12F(curved), etc. are available
		Availability of adequate quantity of functional dialyser as per requirement		OB/RR/SI	Every patient is provided with either a new dialyser or a reprocessed dialyser of the same patient. All reprocessed dialysers must meet the standard norms for test of performance
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed.	Emergency Drug Tray/ Crash Cart is maintained at dialysis unit		OB/RR	Inj. Adrenaline, Atropine, Hydrocortisone, Dexamethasone, Warfarin, Erythropoietin, ET Tube, Ambu Bag with Mask, Laryngoscope, etc.
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients.	Availability of functional Equipment &Instruments for examination & Monitoring		OB	BP Apparatus, Stethoscope, Weighing Scale, Thermometer, Torch, X-ray view box, Multipara monitor
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility.	Availability of instruments for dialysis procedure		OB	Dialysis starting kit, Equipment for dressing/bandaging/ suturing, Stand-by heamodialysis machine, Equipment for water treatment and dialyser reprocessing, etc.
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility.	Availability of Point of care diagnostic devices		OB	Glucometer, ECG and HIV rapid diagnostic kit, Blood group testing,HbsAg(HBV)

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients.	Availability of functional Instruments for Resuscitation.		OB	1.Laryngoscope 2.Endotracheal tubes 3.Suction equipment 4.Xylocaine spray 5.Oropharyngeal and Nasopharyngeal airways 6.Ambu Bag- Adult & Paediatric
ME C6.5	Availability of Equipment for Storage.	Availability of equipment for storage for drugs		OB	Refrigerator, Crash cart/ Emergency Drug tray, instrument trolley/tray, dressing trolley/tray
ME C6.6	Availability of functional equipment and instruments for support services.	Availability of equipments for cleaning		OB	Buckets for mopping, mops, duster, waste bins, cleaning brushes
		Availability of equipment for sterilization and disinfection		OB	Autoclave
ME C6.7	Departments have patient furniture and fixtures as per load and service provision.	Availability of patient bed with accessories		OB	1. Hospital graded Mattress 2. IV stand 3. Bed rails 4. Stool 5. Footstep, 6. Bedside locker
Standard C7	**The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Criteria for Competence assessment are defined for doctor, nurse, technician.		SI/RR	Criteria may include skill, proficiency, knowledge and competencies required to carry out day to day procedures and manage complications. Competence assessment is done at least once in a year.
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year	Performance based appraisal is done once in a year for all staff		SI/RR	Appraisal is done on the basis of objective assessments and linked with renumeration

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME C7.9	The Staff is provided training as per defined core competencies and training plan.	All staff are trained in skills required for general management of the dialysis unit		SI/RR	Risk Management, Infection Control Practices, Bio-medical Waste Management, Patient and Fire Safety, Quality Management Comprehensive training programme for all staffs including PPP service providers
		Doctors are trained in skills required for clinical management of dialysis unit		SI/RR	Evaluation, Initiation, Monitoring and Termination of Dialysis session including prevention and management of complication
		Doctors, Nurses/ Technicians are trained in general counselling of patients		SI/RR	Self-care, do's and don'ts, diet and psychological counselling
		All staff are trained for life-saving skills		SI/RR	Basic life support (BLS)/ Advance life support (ALS) Doctors, nurses/technicians are trained for life saving skills
		Periodic refresher training are provided for all staff		SI/RR	As mentioned in above checkpoints for different categories of staff
AREA OF CONCERN D: SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment.	All equipment are covered under AMC including preventive maintenance.		SI/RR	Haemodialysis (HD) machine & all the assessories including alarms
		AMC/CMC of Water treatment system with reverse osmosis		SI/RR	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		There is system of timely corrective break down maintenance of the equipment		SI/RR	1. Maintenance for all the major equipmemts including process of periodic inspection 2. Cleaning and maintenance 3.The unit may have AMC/CMC for individuals machines or collectively enrolled under BMEMP
		Staff of dialysis unit is skilled for routine trouble shooting of minor equipment failure		SI/RR	
		Maintenance of different components of water treatment system are recorded		OB/SI	The log book is adequately maintained
ME D1.2	The facility has established procedure for internal and external calibration of measuring equipment.	All the measuring equipment/ instruments are calibrated		OB/RR	Dialysis machine (Blood pump, Heparin pump, Pressure monitor, Conductivity meter), Weighing scale, Thermometer, BP Apparatus
ME D1.3	Operating and maintenance instructions are available with the users of equipment.	Operating instructions for critical equipment are available		OB/SI	Operating Dialysis Machine, Water Treatment System, Dialyzer Reprocessing, Preparation of Dialysate
		Lay-out and flow diagram of the water treatment system is displayed in the water treatment room		OB	The flow-diagram is self-explanatory and easy to comprehend
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables.	There is established system of timely indenting of consumables and drugs		SI/RR	Forecasting or demand generation manually/IT
ME D2.2	The facility has established procedure for procurement of drugs.	There is an established procedure for placing requisition		SI/RR	Requisition are timely placed

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME D2.4	The facility ensures management of expiry and near expiry drugs.	Expiry and near expiry dates are maintained at emergency drug tray		OB/SI	Please check for records for expiry and near expiry drugs are maintained for drug stored in the department
		No expired drugs or consumables found		OB/SI	Check expiry date of dialysate packaging
ME D2.5	The facility has established procedure for inventory management techniques.	Department maintained stock and expenditure register of drugs and consumables including buffer stock		SI/RR	There is practice of calculating and maintaining buffer stock
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas.	There is no stock out of drugs & consumables		SI/RR	
ME D2.7	There is a process for storage of vaccines and other drugs, requiring controlled temperature.	Temperature of refrigerators are kept as per storage requirement and records are maintained		OB/SI/RR	Check for temperature charts are maintained and updated periodically (Erythropoietin)
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors**				
ME D3.1	The facility provides adequate illumination at patient care areas.	There is adequate illumination at the procedure area		OB	Provision of at least 300 lux.
		There is adequate illumination at the water treatment area		OB	Provision of at least 300 lux.
ME D3.2	The facility has provision of restriction of visitors in patient areas.	Entry of visitors into the dialysis unit are restricted		OB/SI	Visiting hours are defined, displayed & adhered with
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers.	The Dialysis unit shall be provided with effective and suitable ventilation to maintain comfortable room temperature.		OB/SI	Fans/ Air conditionings are available as per environment condition and requirement
		Water treatment area should have measures for noise attenuation		OB	
		There is adequate ventilation to prevent over-heating		OB	In dialysis unit and water treatment area

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility.**				
ME D4.1	Exterior and interior of the facility building is maintained properly	Hospital infrastructure is adequately maintained along with interior of patient care areas are plastered & painted		OB/RR	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, sinks patient care and circulation areas are clean		OB	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/junk material in the dialysis centre		OB/SI/RR	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/ birds		OB/SI/RR	
Standard D5	**The facility ensures 24 × 7 water and power backup as per requirement of service delivery, and support services norms.**				
ME D5.1	The facility has adequate arrangement for storage and supply of potable water in all functional areas.	The unit shall have 24 hour provision of potable water for RO system		OB	Check the availability of functional water points for RO system
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load.	Availability of genset		OB	To meet the requirements of all machine
		Availability of UPS		OB	Check the backup of UPS is at least up to 15 minutes in case of power failure/all dialysis machines are connected to a central servo controlled stabiliser of adequate capacity
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply.	Availability of Centralized /local piped oxygen and vacuum supply		OB/RR	if oxygen cylinder/ oxygen concentrator is available, then full compliance will be given
ME D5.4	The facility has adequate arrangement for uninterrupted supply of RO water for dialysis unit	The dialysis unit have sufficient supply of RO water		OB	480 Litres of water needed per machine (Note: This does not include the water requirement of other activities of the unit such as hand washing)/ Water is available on 24*7 basis at all points of usages

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		The dialysis unit has adequate arrangements for preventing back flow of water		OB	1. Back-flow preventer 2. Temperature blending valve 3. Booster pump and raw water tank 4. ±acid feed pump etc.
		The RO plant has adequate arrangements for pre-treatment of water		OB/RR	Pre-treatment should consist of: 1. Filtration for suspended particles. 2.Activated carbon filtration 3.Softener or deionizers
		The RO plant has standardized pipes and valves for water distribution		OB/RR	Check for: 1.All pipelines after reverse osmosis system are of stainless steel (grade 316) or medical grade PVC. 2.All valves joints & connectors are of the same material. 3. Bends & blind loops must be avoided
		The RO plant has adequate arrangements for post-treatment of water		OB/RR	Microbial and UV filters or/and deionization
		There is adequate arrangements for safe storage of water		OB/RR	Please check for: 1. Storage tank is made up of stainless steel or medical grade PVC with an air tight lid 2.The tank has de-aeration valve & drain facility at the bottom
		The facility has adequate arrangements for management of drainage System		SI/RR	The drains are provided with adequate gradients and adequate no. of floor traps are available to drain excess water
Standard D6	**Dietary services are available as per service provision and nutritional requirement of the patients**				
ME D6.1	The facility has provision of nutritional assessment of the patients.	Availability of nutritional assessment and counselling facility		OB/PI	Ideally by a dietician else by the doctor(Arrangements could be made for videography lecture)

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard D7	**The facility ensures clean linen to the patients.**				
ME D7.2	The facility has established procedures for changing of linen in patient care areas	A fresh set of linen is provided to each patient and is changed in case of any major spill		OB/SI/RR/PI	On a daily basis
ME D7.3	The facility has standard procedures for handling, collection, transportation and washing of linen.	There is an established procedures for handling dirty, soiled and clean linens		OB/SI/RR	Dirty, soiled and clean linens are collected, transported and stored separately
Standard D9	**Hospital has defined and established procedures for Financial Management.**				
ME D9.1	The facility ensures proper utilization of the fund provided to it.	There is no delay in payments to the service provider		SI/RR	Payments to the providers are made as per the MoU. If not applicable, give full compliance
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines.	Staff is aware of their role and responsibilities		OB/SI/RR	Job descriptions/TOR are available with the facility
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments.	There is procedure to ensure that staff is available on duty as per duty roster and there is designated in charge for the department		OB/SI/RR	
ME D11.3	The facility ensures adherence to dress code as mandated by the administration.	Doctor, nursing staff and support staff adhere to their respective dress code		OB	All the categories of staffs are in proper dress code as assigned by the hospital management/ administration
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system of contract management for the out sourced services.	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		RR/SI	There is a valid MoU with outsourcing agencies (If not applicable, give full compliance)
ME D12.2	There is a system of periodic review of quality of out-sourced services.	Regular monitoring of quality of services		SI/RR	The quality of services are monitored periodically using objective criteria, process of black listing and provision of penalties for non-conformance(check MoU)

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Every patient is provided with individual dialysis card/booklet with Unique identification number during registration		RR	The same card/ booklet may be used for multiple sessions
		There is provision of prior appointment for new & old patients		RR/PI	Check the process for appointment & also advanced communication is given to the patient in case of any cancellation/ delay
		Patient details are recorded in Dialysis Card/ Booklet		RR	Check for that patient details like Name, age, Gender, Blood group, Nephrologist details, Dialysis start date, HBV/ HCV status, etc.
ME E1.3	There is established procedure for admission of patients	There is an established criteria for initiation of dialysis session		SI/RR	Criteria based on Nephrologist's recommendations, Dry weight/weight gain, Vital sign, KFT results and Physical finding
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all patients on dialysis is done as per standard protocols		RR/SI	Initial Assessment will include weight, seated blood pressure, pulse rate, temperature, respiratory rate
		Dialysis history is taken and recorded		RR	Check whether the patient has come for first session or a follow-up session
		Physical Examination is done and recorded		RR	Look for signs of Mobility, Pain, Skin changes, Oedema, Signs of bruising & bleeding, Signs & symptoms of infection

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of stable and non-infective patients		RR/OB	Every hour and look for safety checks as Air detector/Line clamp, Dialysate Flow Rate, Dialysate temp, Conductivity, Status of heparin pump, "A" and "B" concentrate, Concentrate Na+, Alarm limit is set, if any
		There is fixed schedule for reassessment of unstable and infective patients		RR/OB	Every half hour and look for safety checks as Air detector/Line clamp, Dialysate Flow Rate, Dialysate temp, Conductivity, Status of heparin pump, "A" and "B" concentrate, Concentrate Na+, Alarm limit is set, if any
		There is system in place to identify and manage the changes in Patient's health status		RR/SI	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating
		Check the treatment or care plan is modified as per re assessment results		RR/SI	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process		RR/SI	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Check treatment/care plan is prepared as per patient's need		RR/SI	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.
		Check treatment / care plan is documented		RR/SI	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc
		Check care is delivered by competent multidisciplinary team		RR/SI	Check care plan is prepared and delivered as per direction of qualified physician
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer and referrals	There is an established procedure for patient transferred from dialysis unit to ICU /OT/ Emergency and vice versa		SI/RR	Check how hand over is given when patient is transferred from dialysis unit to ICU /OT/ Emergency and vice versa
		There is an established procedure for referral of patients to higher facility		RR/SI	All patients are provided with referral card with details of patient, details of the facility where referred, treatment given, reasons for referral, etc.
		Necessary support is provided for referral		RR/SI	Advance communication is done with higher centre, Referral vehicle is arranged
ME E3.3	A person is identified for care during all steps of care	Doctor and nurse/ technician is designated for each patient		RR/SI	At least one doctor is available for each shift and one nurse/ technician for each patient

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Detailed hand over is given between change of the shifts		RR/SI	Patient condition is reviewed during hand over between resident doctors as well as nurses/technicians
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification of the patient before each dialysis session		OB/SI	Patient id band/ verbal confirmation/Bed no. etc. Any two identifiers may be used
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Dialysis chart is maintained		RR	Check for Patient name, Age, Sex, Id no, Date, Dialysis no, Weight (Pre/Post), BP (Pre/Post), Starting and closing time of dialysis session, Any symptoms or medication given, etc.
ME E4.4	Nursing records are maintained	General records of haemodialysis are adequately maintained		RR/SI	Look for Id on dialyzer, Dialyzer type, Dialyzer reuse no, Machine no, Bed no, Dialysis duration, start and termination time, Dialysis no
		Pre-dialysis records are adequately maintained		RR/SI	Look for Machine rinse with RO water, Dialyzer sterilant active, pre dialysis weight, dry weight of the patient, interdialytic wt. gain, UF target, pulse, BP, Temp, Anticoagulation bolus and maintenance dose with signature of nurse/ technician commencing Haemodialysis session
		Post-dialysis records are adequately maintained		RR/SI	Look for UF reading, post dialysis weight, weight loss/ gain, achieved Kt/V, BP, Temp, Pulse, Inj. EPO/ Iron/Carnitine, if any

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Records of the safety checks are adequately maintained		RR/SI	All general, pre-dialysis and post-dialysis records are duly signed by nurse/technician
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority		OB/SI	Hepatitis B/C, HIV positive patients, Grossly dearranged KFT, Immuno-compromised patients and patients with pre-existing illnesses e.g. Heart Failure, IHD, LVF, HTM, COPD, etc.
Standard E7	**Facility has defined procedures for safe drug administration**				
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs and chemicals available in department are identified		SI/OB	Dialysate A & B, Electrolytes like Potassium chloride, Anti thrombolytic agent, insulin, warfarin, Heparin, etc.
		Maximum dose of high alert drugs are defined and communicated		SI/RR	Value for maximum doses are available with the technician and doctor in the dialysis unit
		There is process to ensure that right doses of high alert drugs are only given		SI/RR	A system of independent double check before administration, Error prone medical abbreviations are not used
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date, time and signature in comprehendible hand-writing		RR	Check for Date, Time, name of the doctor, reg no, no of medicines, dosage form, strength, time-duration, dosage route, signature of doctor, instructions for patient, etc.
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs and chemicals are checked for expiry and other inconsistency before administration		OB/SI	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Check single dose vial are not used for more than one dose		OB	Check for any open single dose vial with left over content indented to be used later on
		Any adverse drug reaction is recorded and reported		RR/SI	
ME E7.4	There is a system to ensure right medicine is given to right patient	Administration of medicines done after ensuring right patient, right drug, right dose, right time, right route, right reason and right documentation		SI/OB	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Dialysis process is recorded as per defined assessment schedule		RR	Pre, Post and Intra Dialysis processes and investigations are recorded
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Each Dialysis session is planned and documented on dialysis card		RR	Before initiation of dialysis session
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available		RR/OB	Check for the availability of Dialysis card, Dialysis chart, Dialysis record, Referral slip, Consent form, Lab requisition form, etc.
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records		OB	
Standard E9	**The facility has defined and established procedures for discharge of patient.**				
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Dialysis card is updated at the end of each dialysis session		RR/PI	Look for date of next session
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge		PI/SI	Patient is counselled for do's and don'ts, care of access site, diet, water intake, dry weight, etc.

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.2	Emergency protocols are defined and implemented	Protocols of dialysis for emergency cases are defined and implemented		SI/RR	Acute renal failure/ septicaemia in IPD/ICU patients
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
ME E12.2	There are established procedures for testing Activities	Facility for point of care diagnostic tests are available		OB/SI	Blood Sugar, Blood group, HbsAg(HBV) etc.
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**				
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion		RR	
		Patient's identification is verified before transfusion		SI/OB	
		Blood is kept on optimum temperature before transfusion		RR	
		Blood transfusion is monitored and regulated by qualified person		SI/RR	
		Blood transfusion note is written in patient records		RR	
ME E13.10	There is an established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person		RR	
Standard E24	**The facility has defined and established procedure for Haemodialysis Services**				
ME 24.1	The facility has defined and established procedure for Pre Haemodialysis assessment	Patient washes hand and relevant limb (with AVF/GF) with soap and water before entering the dialysis unit		OB/RR/SI	Encourage the patients to wash their hands themselves
		All the patients are weighed before entering the dialysis unit		OB/RR/SI	Encourage the patients to weigh themselves

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Pre-dialysis observations are performed and pre-recorded		OB/RR/SI	Seated blood pressure, pulse, temp, respiratory rate are recorded
		Complete assessment of the patient is done before commencement of the dialysis		OB/RR/SI	Look for any changes since last session in mobility, pain, skin state, oedema, bruising/ bleeding or any sign or symptom of infection
		Information of the previous dialysis session is reviewed		OB/RR/SI	Note pre and post dialysis observation of the previous dialysis session and any dialysis variances
		Baseline information is reviewed		OB/RR/SI	Weight gain (ideally less than 5%), urine output, blood glucose level
		Dialysis plan is documented based on observation and patient assessments		OB/RR/SI	Plan should have details of Ultra filtration goal (amount of fluid to be removed), Ultra-filtration rate, dialysis duration, any expected complications
		Review and prepare for pre-dialysis testing		OB/RR/SI	HbSAg, HCV, HBV, HIV, MRSA
		Blood sample is taken for pre-dialysis testing		OB/RR/SI	Hb, KFT, LFT
ME 24.2	The facility has defined and established procedure for care during Haemodialysis	Prepare the access sites		OB/RR/SI	Cleaning and disinfection with antiseptic solution
		Safety checks for Blood tubing are ensured		OB/RR/SI	Check that Inserted canula is secured, check for air bubble via Air detector/ Line clamps, and patency of the circuit
		Safety checks for Dialysis machine are ensured		OB/RR/SI	Check that Dialysis machine is disinfected and rinsed with RO water. Conductivity is maintained. Alarm limit and dialysate flow rate is set

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Safety checks for dialyzer and dialysate are ensured		OB/RR/SI	Check that Dialyzer reuse no is written, Check for Dialysate temp and A and B concentrate
		Periodic and regular monitoring of the patient is done		OB/RR/SI	All the observations are recorded including BP, Pulse, Respiratory Rate, Machine parameters
		Patient with any comorbidity are monitored and parameters are recorded periodically		OB/RR/SI	Blood sugar monitoring of diabetic patient and INR of patients on Warfarin
		Routine medications are administered to patients as scheduled		SI/RR	
		Intervention/Medication during the session are monitored and recorded		OB/RR/SI	Change in machine settings Iron/Erythropoietin
		Strict monitoring of the dialysis related errors is done		OB/RR/SI	Needle dislodgement and clotted circuit
ME 24.3	The facility has defined and established procedure for care after completion of Haemodialysis	Keep equipment ready to terminate the session and disconnect the patient from the machine		OB/SI	Swab, Tape, Bandage
		Take post-dialysis sample		OB/RR/SI	For KFT or any other investigations
		Disconnect the access as per the protocols		OB/RR/SI	Sequence and timing of removing the cannulas and tubing's
		Post-dialysis observations are recorded		OB/RR/SI	BP, Pulse, Temp, Respiratory Rate, Blood Sugar, UF reading, weight, Inj. Iron/ Erythropoietin
		Patient is counselled for self-care		OB/RR/SI	Water intake, Protein intake, Care of the access site, do's and don't, alarming signs and when & whom to contact in case of emergencies

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
AREA OF CONCERN - F: INFECTION CONTROL					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection.**				
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas.	Dedicated person is in-charge for infection control in the dialysis unit		SI/RR	Doctor/Nurse/ Technician may be designated Person responsible for quality can also handle
		Surface and environment samples are taken for microbiological surveillance		SI/RR	Swab are taken from infection prone surfaces at least once in month like machine, machine control panel, dialyz-er(in case of reuse), bed railing, working bench,machine,dial-ysate, RO,connectors used /supply to ma-chine etc.
		Water samples are taken for microbial culture and microelements in RO water		SI/RR	Analysis of water used for haemodialysis for bacteria required to be done at least monthly and analysis for chemicals required to be done at least every six months
ME F1.3	The facility measures hospital associated infection rates.	There is procedure to report cases of infection with blood borne infections		SI/RR	The facility should develop methods to monitor, review and evaluate all blood borne infections
ME F1.4	There is provision of Periodic Medical Check-up and immunization of staff.	There is procedure for immunization of the staff		SI/RR	Hepatitis B and Tetanus Toxoid etc.
		Periodic medical check-ups of the staff		SI/RR	At least once in a year including housekeeping and support staff
ME F1.5	The facility has established procedures for regular monitoring of infection control practices.	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard F2	**The facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use.	Availability of hand washing facility as per norms		OB	One hand wash basin to be provided for every 2-3 dialysis stations in the main dialysis area
		Availability of running water		OB/SI	Ask Staff if water supply is regular
		Availability of antiseptic liquid soap with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	One alcohol hand rub for every dialysis machine. Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
		Availability of elbow operated taps		OB	
		Hand washing sink is wide and deep enough to prevent splashing and retention of water		OB	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask for demonstration
		Staff aware of when to wash hand		SI	Ask 5 moments for hand washing
ME F2.3	The facility ensures standard practices and materials for antisepsis.	Availability of Antiseptic Solutions		OB	Providine iodine, Isopropyl alcohol, etc.
		Proper cleaning of vascular access site with antiseptics		OB/SI	Before preparing the access for cannulation/ blood tubing, before giving IM/IV injection and drawing blood (If not applicable, give full compliance)

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard F3	**The facility ensures standard practices and materials for Personal protection.**				
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements.	Clean gloves are available at point of use		OB/SI	
		Availability of Mask		OB/SI	
		Availability of gown/ Apron		OB/SI	Staff and visitors
		Availability of shoe cover		OB/SI	Staff and visitors
		Availability of Caps		OB/SI	Staff and visitors
		Personal protective kit for infectious patients		OB/SI	
ME F3.2	The facility staff adheres to standard personal protection practices.	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the gloves		SI	
Standard F4	**The facility has standard procedures for processing of equipment and instruments.**				
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and equipments	Cleaning & Decontamination of dialysis machine and patient care area		SI/OB	Surfaces like dialysis bed or chair, countertops, external surfaces of dialysis machine & control panel etc. by wiping with .5% hypochlorite solution followed by removing chlorine residues from metallic surfaces with water
		Proper Decontamination of instruments after use		SI/OB	Ask staff how they decontaminate the instruments like scissors, haemostats, clamps (Soaking in 0.5% Chlorine Solution), blood pressure cuffs, stethoscopes, etc. (Wiping with 0.5% Chlorine Solution or 70% Alcohol)
		Contact time for decontamination is adequate		SI/OB	10 minutes

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Proper handling of Soiled and infected linen		SI/OB	Sorting, Rinsing or sluicing of soiled/ infected linen is done outside the dialysis unit/ Patient care area
		Staff know how to make chlorine solution		SI/OB	Prepared chlorine solution has 500-600ppm free chlorine (e.g., 1:100 dilution of a 5.25-6.15% sodium hypochlorite provides 525-615 ppm available chlorine)
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Dialysis machines are disinfected after each session taking in to account level of biofilm and endotoxin removal		OB/SI	Using Citric acid in the hydraulic circuit of haemodialysis machines
		Bottles containing unused dialysate are disinfected after session		OB/SI	
		Opened bottles containing unused fluid should be discarded after 24 hours		OB/SI	
		Unfinished bottles used for infected patients must be discarded immediately		OB/SI	
		Cleaning and disinfection of Hemodialysers is done as per protocols		OB/SI/RR	Blood compartment is rinsed with water till the effluent is clear while hydrogen peroxide should be instilled in dialysate compartment followed by rinsed out of cleaning agents from dialysate compartment with water

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Backwashing or Reverse Ultrafiltration is done as per protocols		OB/SI/RR	Backwashing is carried out for at least 15 minutes with periodic 1-2 minute rinsing of the blood compartment. The direction of flow should be reversed at 5 minute intervals.
		Only dialysers clearing the 'Test of performance' are reused		OB/SI/RR	The 'Test of Performance' includes testing for total cell volume (TCV should be more than <80%), membrane integrity (should pass leak test) and perform residual disinfection (shall be checked using 'Potency Test Strip'). Dialyser failing 'Test of Performance' are discarded
		Labelling and storage of Dialyzer is done appropriately		OB/SI/RR	Dialyzer should be kept in a sealed polythene bag/leakproof box with the patients name, TCV, reuse number and date marked with indelible ink over it. If stored for more than 7 days prior to the subsequent use, it should be refilled with disinfectant before use
		Cleaning/Disinfection of the pipes of water management system		OB/SI/RR	Distribution loop of water treatment system should be cleaned preferably, once in 6 months
		Autoclaved dressing material is used		OB/SI	Ensure the traceability of sterilized packs is maintained during storage

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.1	Functional area of the department are arranged to ensure infection control practices	Facility layout ensures separation of general patient from infectious patients		OB	Separate bed/area for HBV, HCV and HIV cases
		Facility layout ensures separation of routes for clean and dirty items		OB	
		Floors and wall surfaces are easily cleanable		OB	Look for non-slippery floor (or epoxy grout in tiles), surfaces should be smooth & washable, seamless and impervious with sealed or welded joints
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Sodium Hypochlorite solution, Citric acid, Glutaraldehyde
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	Blood spill management
		Cleaning of patient care area with detergent solution		SI/RR	chair, armrests, bedside table top/ counter, and drawer/ cupboard handles) and high touch surfaces (the exterior surfaces of the HD machine, computer screens, and keyboards
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipment like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
		Use of three bucket system for mopping		OB/SI	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		External foot wares are restricted		OB	
ME F5.4	The facility ensures segregation infectious patients.	Isolation and barrier nursing procedure are followed for septic cases		OB/SI	
		Separate staff for infected patients		OB/PI	Staff caring for HBV, HCV, HIV patients
ME F5.5	The facility ensures air quality of high risk area.	Negative pressure is maintained in Isolation		OB/SI	
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste carried out as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of Anatomical and soiled waste in Yellow Bin		OB/SI	Human Anatomical waste, Dialysers after treatment, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, dialysers filters, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste		OB	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional hub cutters		OB	See if it has been used or just lying idle.
		Segregation of sharps waste including Metals in white (translucent) puncture proof, leak proof, tamper proof containers		OB	See availability near the point of generation. Needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Look for facilities for post-exposure prophylaxis
		Contaminated and broken glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI/OB	
		Disinfection of liquid waste before disposal		SI/OB	Dialysate A and B, Discarded disinfectant
		Transportation of bio medical waste is done in close container/trolley		SI/OB	
AREA OF CONCERN - G : QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement.**				
ME G1.1	The facility has a quality team in place.	A Quality Circle is formed and functional with a designated nodal officer for quality.		RR/SI	Quality circle may have nephrologist/ equivalent, Technician, nurses and housekeeping staff.

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME G1.2	The facility reviews quality of its services at periodic intervals.	Quality Circle meets once in a month and review quality of services.		RR/SI	Quality circle meets at least once in a month and minutes are recorded.
Standard G2	**The facility has established system for patient and employee satisfaction.**				
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals.	Patient satisfaction survey done on monthly basis		RR/SI	
ME G2.2	The facility analyses the patient feedback, and root-cause analysis.	Analysis of low performing attributes of patient feedback is done		RR/SI	
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients.	Action plan is prepared to address the areas of low satisfaction		RR/SI	
		Action plan is implemented to improve the patient satisfaction		RR/SI	
Standard G3	**The facility has established internal and external quality assurance Programmes wherever it is critical to quality.**				
ME G3.1	The facility has established internal quality assurance programme in key departments.	There is system of daily round by Dialysis Unit in charge for monitoring of services		SI/RR	Unit In charge should visit on daily basis and the findings/instructions during the visits are recorded
ME G3.3	The facility has established system for use of check lists in different departments and services.	Internal assessment is done at periodic interval		RR/SI	NQAS assessment toolkit is used to conduct internal assessment
		Departmental checklist is used for monitoring and quality improvement		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded			Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		SI/RR	Randomly check the details of action, responsibility, time line and feedback mechanism

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME G3.5	Planned actions are implemented through Quality Improvemnet Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available.	Standard operating procedure for department has been prepared and available		RR	
		Current version of SOP are available with process owner		RR	Check current version of SOP is available with the staff of Dialysis Unit.
ME G4.2	Standard Operating Procedures adequately describes process and procedures.	Department has documented procedure for ensuring patients rights including consent, privacy, confidentiality & entitlement		RR	Processes pertaining to ensuring privacy, confidentiality, respectful maternity care and consent
		Department has documented procedure for safety & risk management		RR	Processes related to physical safety, patient safety and risk assessment
		Department has documented procedure for support services & facility management.		RR	Process description of support services such as equipment maintenance , calibration, housekeeping, security, storage and inventory management
		Department has documented procedure for general patient care processes		RR	Processes of triage, assessment, admission, identification of high risk patients, Referral , Medication management and maintenance of clinical records
		Department has documented procedure of pre-dialysis care.		RR	Processes of physical assessment, information related to previous dialysis session and dialysis plan

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Department has documented procedure of care during dialysis session.		RR	Monitoring of the patient, frequency of observation as per their clinical status, safety measures e.g. needle dislodgement, clotted circuit, adverse drug reaction, etc.
		Department has documented procedure of post-dialysis care.		RR	Protocols for post-dialysis investigations, disconnecting access, dressing, post-dialysis advice and counselling
		Department has documented procedure for infection control & bio medical waste management		RR	Process of Hand Hygiene, personal protection, environmental cleaning, instrument sterilization, asepsis, Bio Medical Waste management , surveillance and monitoring of infection control practices.
		Department has documented procedure for quality management & improvement		RR	Process of internal quality assessment & gap analysis, Root cause analysis, Change ideas to address the gap, implementing & monitoring the change ideas (PDCA)
		Department has documented procedure for data collection, analysis & using the information for improvement		RR	Process related to collection of data & quality indicators , their analysis and use for quality improvement
ME G4.3	Staff is trained and aware of the procedures written in SOPs.	Check Staff is aware of relevant part of SOPs		SI/RR	Interview dialysis Unit staff for their awareness about content of SOPs
ME G4.4	The facility ensures the documented policies and procedures are appropriately approved and controlled	Standard operating procedure for department is duly approved by the competent authority		RR	

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Work instructions are duly approved		OB	
		Work instructions are displayed		OB	How to calculate dry weight, information on maintaining fluid balance before, during and after dialysis session, bio-medical waste management, hand wash instructions (when and how), diet counselling, etc.
		SOP is controlled by providing unique identification number		RR	
		Standard operating procedure for department is reviewed periodically by quality circle		RR	At least once in a year
		Revision history of the SOP is documented		RR	Date of revision, revision no, changes suggested by, changes made, reason of change, etc.
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	The facility maps its critical processes.	Process mapping of critical processes done		SI/RR	Critical processes are the ones where there are some problem-delays, errors, cost, time, etc. and improvement will make our process effective and efficient.
ME G5.2	The facility identifies non value adding activities/ waste/redundant activities.	Non value adding activities are identified		SI/RR	Non value adding activities are wastes. In these steps resources are expanded, delays occur, and no value is added to the service.
ME G5.3	The facility takes corrective action to improve the processes.	Processes are improved & implemented		SI/RR	Look for the improvements made in the critical process in measurable terms.

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard G6	**The facility has defined Mission, Values, Quality policy and Objectives, and prepares a strategic plan to achieve them.**				
ME G6.1	Facility has defined mission statement	Check if mission statement has been defined adequately		RR/SI	Mission statement should be defined by the implementing agency (In-house/ PPP) with purpose, target users and long term goal of dialysis unit. Mission should be aligned with the stated mission of Pradhan Mantri National Dialysis Program
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		RR/SI	Check quality policy has been defined in consultation with dialysis unit staff and duly approved by appropriate authority.
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		RR/SI	Check if the Quality objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check if staff is aware of Mission , Values, Quality Policy and objectives		RR/SI	Interview with staff for their awareness. Check if Mission Statement and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		RR/SI	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with staff.
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		RR/SI	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used
Standard G8	**Facility has defined, approved and communicated Risk Management framework for existing and potential risks.**				
ME G8.1	Risk Management framework has been defined including context, scope, objectives and criteria	There is a well defined and documented Risk Management Framework		SI/RR	The risk management framework should include incident reporting related to 1. Patient: Identification, Assessment, Diagnosis, Patient fall 2. Device related: Dialyzer identification, Efficacy of dialyzer, Alarm failure, Clotted circuit, Short-circuit 3. Process related: Haematoma, Air, Embolism, Fluid Imbalance, Dialysis plan, Monitoring errors, Infection control and prevention, Needle dislodgement and Safety checks and mitigation measures
ME G8.3	Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders	Check if process of reporting risks and hazards have been defined and implemented		SI/RR	Responsibility of identifying the existing and potential risks is defined amongst staff and all the staff are aware of how to identify the risks, how to report them and mitigate them
ME G8.5	Modality for staff training on risk management is defined	Check training on risk management has been provided to all staff members		SI/RR	Verify with the training records . Training on risk management at least should be provided to person/ staff responsible in haemodialysis unit for indemnifying and managing risks

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
ME G8.6	Risk Management Framework is reviewed periodically	Check risk management framework is reviewed at least once in a year		SI/RR	Check with the records that quality circle reviews the framework at least once in a year
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
G9.3	Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders	Check if risk assessment checklist is available with stakeholders		SI/RR	Check if facility has prepared assessment checklist for identifying risk on routine basis. This checklist has been disseminate to the staff members responsible for identifying and reporting risks
G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria	Check if periodic assessment of Physical, Fire and electrical safety risk is done using the risk assessment checklist		SI/RR	Verify with the assessment records. Comprehensive of physical, Fire and electrical safety should be done at least once in three month
G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	Check if Periodic assessment of violence risks is done		SI/RR	Verify with records. At least once in year and whenever a major incident has occurred.
G9.8	Risks identified are analysed, evaluated and rated for severity	Check if various risks identified during the risk assessment proceeds are evaluated		SI/RR	Risk identified should be listed and evaluated for their severity, frequency for occurrence and consequences.
G9.9	Identified risks are treated based on severity and resources available	Risks are prioritized and action plan is made to eliminate/mitigate the risks		SI/RR	Verify with the records that a risk priority number (RPN) is given to each identified risk. Risks are prioritized based on their RPN and action plan is prepared and implemented to eliminate/mitigate the occurrence of risks

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
Standard G10	**The facility has established clinical governance framework to improve the quality and safety of clinical care processes**				
ME G10.3	Clinical care effectiveness criteria has been defined and communicated	Criteria for effectiveness of dialysis sessions are defined and communicated		SI/RR	For e.g. URR (Urea Reduction Ratio), and Kt/V (amount of fluid that is cleared of urea during each dialysis session/volume of water a person's body contains), Symptomatic improvement
		The facility has established process to review the clinical care		RR/SI	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.
		Check regular ward rounds are taken to review case progress		RR/SI	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-
		Check the patient /family participate in the care evaluation		RR/SI	Feedback is taken from patient/family on health status of individual under treatment
		Check the care planning and co- ordination is reviewed		RR/SI	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical	Periodic dialysis unit audits are conducted.		SI/RR	Look for records. Should be conducted at least quarterly.

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		There is procedure to conduct medical audits		RR/SI	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission
		There is procedure to conduct death audits		RR/SI	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		There is procedure to conduct prescription audits		RR/SI	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings
		All non compliance are enumerated recorded for medical audits		RR/SI	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated recorded for death audits		RR/SI	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated recorded for prescription audits		RR/SI	Check the non compliances are presented & discussed during clinical Governance meetings
ME G10.5	Clinical care audit data is analysed, and actions are taken to close the gaps identified during the audit process	Non Compliance are enumerated and recorded, Action plan prepared, Corrective and preventive action taken		SI/RR	Look for completeness of audit report with non-compliances identified, action plan with designated responsibilities, corrective and preventive plan is implemented with measurable improvements
		Check action plans are prepared and implemented as per medical audit record findings		RR/OB	Randomly check the actual compliance with the actions taken reports of last 3 months

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Check action plans are prepared and implemented as per death audit record's findings		RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per prescription audit record findings		RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check the data of audit findings are collated		RR	Check collected data is analysed & areas for improvement is identified & prioritised
		Check PDCA or revalent quality method is used to address critical problems		RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement
ME G10.6	Governing body/ top management of healthcare facilities ensures accountability for clinical care provided	Top management review the audit reports and PSS periodically		SI/RR	Members of the top management meet at least quarterly, audits and PSS analysis reports are reviewed, minutes of the meeting are recorded, the minutes show that data relating to audit reports and grievances are discussed, decisions to improve quality are made and progress is followed.
ME G10.7	Facility ensures easy access and use of standard treatment guidelines and implementation tools at point of care	Standard norms, guidelines and other implementation tools are accessible to Dialysis unit's staff		SI/RR	Ask staff how they adhere with norms, guidelines and implementation tools during the provision of care at Haemodialysis Unit
		Check standard treatment guidelines / protocols are available at point of use		SI/RR	Staff is aware of Standard treatment protocols/ guidelines
		Check treatment plan is prepared as per Standard treatment guidelines		SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Check the drugs are prescribed as per Standards treatment guidelines		RR	Check the drugs are as per EML or formulary
AREA OF CONCERN - H: OUTCOMES					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National Benchmarks.**				
ME H1.1	The facility measures productivity Indicators on monthly basis	Average dialysis session conducted per day		RR	Total no of dialysis sessions done in a month/ total no of days in a month
		Percentage of dialysis session conducted free of cost for entitled patients		RR	No of dialysis session done free*100/ total no of dialysis sessions conducted
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark.**				
ME H2.1	The facility measures efficiency Indicators on monthly basis	Average dialysis sessions performed per machine		RR	Total no of dialysis sessions performed/ total no of functioning dialysis machine
		Downtime critical equipments/unit		RR	
		Percentage of patients shortening their dialysis sessions		RR	No of patients leaving dialysis session before completion of dialysis session*100/ total no of dialysis sessions conducted
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	The facility measures Clinical Care & Safety Indicators on monthly basis	Dialysis complication rate (Percentage of incidence of complication occurring while dialysis session)		RR	Total no of complications occurring during dialysis session e.g. Haematoma, Needle dislodgement, Dialyzer mismatch, Air embolism, Clotted circuit/ Total no of dialysis sessions
		No of adverse events per thousand patients		RR	
		Average Urea Reduction Ratio		RR	Average of (pre dialysis urea-post dialysis urea) of all the patients underwent dialysis session

Standard	Measurable Element	Checkpoints	Compli-ances	Assessment	Mean of verification
		Average Kt/V		RR	Average of Kt/V (1.2) (amount of fluid that is cleared of urea during each dialysis session/ volume of water a person's body contains) of all the patients underwent dialysis session
		Dialyser reuse rate		RR	Total no of dialysis sessions performed/ Total no of dialyzer used
		Culture Surveillance sterility rate		RR	% of environmental swab culture reported positive
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	The facility measures Service Quality Indicators on monthly basis	Average days in availing follow up sessions		RR	
		Patient Satisfaction Score		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

HAEMODIALYSIS SCORE CARD	
Area of Concern wise score	**Haemodialysis Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-21

GENERAL ADMINISTRATION

CHECKLIST FOR GENERAL ADMINISTRATION

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.16.	The facility provides Accident & Emergency Services	Availability of functional A& E department		SI/OB	
		Availability of functional disaster management unit		SI/OB	
ME A1.17.	The facility provides Intensive care Services	Availability of functional Intensive care unit		SI/OB	
ME A1.18.	The facility provides Blood bank & transfusion services	Availability of functional Blood Bank		SI/OB	
Standard A2	**Facility provides RMNCHA Services**				
ME A 2.1.	The facility provides Reproductive health Services	Availability of Post Partum unit at the facility		SI/OB	
ME A2.3.	The facility provides Newborn health Services	Availability of functional SNCU		SI/OB	
ME A2.4.	The facility provides Child health Services	Availability of Functional NRC		SI/OB	
		Availability of dedicated paediatric ward		SI/OB	
		Availability District Early Intervention Centre (DEIC)		SI/OB	
Standard A3	**Facility Provides diagnostic Services**				
ME A3.1.	The facility provides Radiology Services	Availability of X-Ray Unit		SI/OB	Availability of in-house services. Partial Compliance if it is outsourced
		Availability of Ultrasound services		SI/OB	Availability of in-house services. Partial Compliance if it is outsourced
		Availability of CT scan		SI/OB	
ME A3.2	The facility Provides Laboratory Services	Availability of In-house/ outsourced lab		SI/OB	
ME A 3.3	The facility provides other diagnostic services, as mandated	Availability of ECG Services		SI/OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Formation of District Apex Group		SI/RR	Headed by Dermatologist/ Physician along with specialists of Orthopaedics/ General Surgery, Ophthalmology, assisted by Physiotherapist and laboratory Technician
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Availability Functional ICTC is available		SI/OB	
		Availability Functional ART centre is available		SI/OB	
ME A4.7.	The facility provides services under National Programme for the health care of the elderly as per guidelines	Availability of geriatric ward/ Clinic		SI/OB	
ME A4.8.	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability of CCU		SI/OB	
ME A4.9	The facility Provides services under Integrated Disease Surveillance Programme as per Guidelines	Hospital has System for immediate reporting of any disease out break authorities		SI/RR	
		A Nodal person is designated for collecting and reporting data to IDSP cell		SI/RR	
		Hospital disseminate the list of conditions to be reported to all clinical department		SI/RR	
Standard A5	**Facility provides support services**				
ME A5.1.	The facility provides dietary services	Availability of dietary service		SI/OB	
ME A5.2.	The facility provides laundry services	Availability of laundry services		SI/OB	
ME A5.3.	The facility provides security services	Availability of security services		SI/OB	
ME A5.4.	The facility provides housekeeping services	Availability of Housekeeping services		SI/OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME A5.5.	The facility ensures maintenance services	Availability of maintenance services		SI/OB	
ME A5.6.	The facility provides pharmacy services	Availability of drug storage and dispensing services		SI/OB	
ME A5.7.	The facility has services of medical record department	Availability of Medical record services		SI/OB	
ME A5.8	The facility provides mortuary services	Availability of mortuary services		SI/OB	
Standard A6	**Health services provided at the facility are appropriate to community needs.**				
ME A 6.1.	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of 300 indoor functional beds per ten lakh population		SI/RR	
ME A 6.2.	There is process for consulting community/ or their representatives when planning or revising scope of services of the facility	Community representative are consulted while revising or expanding the scope of service		SI/RR	
		User charges if any are decided in consultation with user groups /RKS		SI/RR	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1.	The facility has uniform and user-friendly signage system	Name of the facility prominently displayed at front of hospital building		OB	
		Hospital lay out with location and name of the departments are displayed at the entrance.		OB	
		Hospital has established directional signage		OB	
		List of departments are displayed		OB	
		All signages are in uniform colour scheme		OB	
		Signages are user friendly and pictorial		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B1.2	The facility displays the services and entitlements available in its departments	Services not available are displayed		OB	
		Availability of administrative services like handicap certificate, death certificate services are displayed.		OB	
		Processing time for issuing documents and Medical records are displayed		OB	
		Mandatory information under RTI is displayed		OB	
ME B1.3. .	The facility has established citizen charter, which is followed at all levels	Citizen charter is established in the facility		OB	
		Citizen Charter includes Mission statement and Quality Policy of the facility			
		Citizen charter includes the services available at the facility		OB	
		Citizen Charter includes the days and timings of different services available		OB	
		Citizen Charter Includes Rights of Patient		OB	
		Citizen Charter includes Responsibilities of Patients and Visitors		OB	
		Citizen Charters includes Beds available		OB	Check for display of number for General beds, critical care beds
		Citizen Charters Includes Complaints and Grievances Mechanism		OB	
		Citizen Charter mention about paid services, if applicable		OB	
		Citizen Charter includes Grievance Redressal's Help Desk		OB	Check for Toll free number, name, contact number and email id of designated officer for assistance

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Citizen Charter include details of visitor policy			Check for visiting time (Morning & Evening), details of visiting pass system
ME B1.4	User charges are displayed and communicated to patients effectively	Facility prepares a comprehensive list of user charges and display at strategic point in the hospital		OB	
ME B1.6.	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.7.	The facility provides information to patients and visitor through an exclusive set-up.	A dedicated facilitation counter/Rogi sahayata Kendra available		OB	Important contact no. are available at the counter/Rogi sahayata kendra
		Information regarding services available at the counter		OB	
		A dedicated facilitation counter for PM-JAY		OB	Contact details of the PM-JAY assisting officer is available at the counter
		Availability of ASHA help desk		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**				
ME B2.1	Services are provided in manner that are sensitive to gender	Hospital has defined policy for non discrimination according to gender		SI/PI	
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services	Environment of the health facility should be inclusive of all religious faiths		OB	
		Staff is respectful to patients religious and cultural beliefs		PI/SI	
		Hospital has defined policy to ensure the religious and cultural preferences of the patient		RR/SI	
ME B2.3.	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Approach road to hospital is accessible without congestion or encroachment		OB	
		Internal Pathways and corridors of the facility are without any obstruction / Protruding Object		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There are no open manholes/ Potholes at access road and internal pathways		OB	
		Hospital has defined policy to provide barrier free services to patient		OB	
		Ramps are conducive for use		OB	At least 120 cm width, gradient not steeper than 1:12, ramp has slip resistance surface
		Warning blocks have been provide at beginning and end of the ramp and Stairs		OB	To aid people with visual impairment
		Hand rails are provided with stairs		OB	
		Facility conducts periodic Access Audits		OB	
		Hospital has defined policy for providing specially able facility		OB	
		Parking area is earmarked for People with disabilities		OB	
		Symbol of Access is displayed at the facilities available for people with disabilities		OB	Ramps, Wheel Chair Bay, Lifts, Toilets
ME B2.4	There is no discrimination on basis of social and economic status of the patients	There is no discrimination on basis of social and economic status of the patients		PI/SI	
		Hospital has defined policy for ensuring non discrimination on basis of social and economic status of the patient		RR/SI	
ME B2.5	There is affirmative actions to ensure that vulnerable sections can access services	There are arrangement and Linkages for care of terminally ill patients		RR/SI	Linkage for Palliative Care , Hospice
		There are Linkages for care , Counselling and Protection of Victims of Violence including domestic violence		RR/SI	Linkages with NGOS, Police Mediation Cell
		There are arrangements for adequate care and post discharge support of Orphan patients including homeless children		RR/SI	Linkages with NGOS , Orphan , old age home, Children home

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	Hospital has defined policy for maintenance of privacy of patients		RR/SI	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Hospital has defined policy for maintenance of patient records and clinical information		RR/SI	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Hospital defines and communicate policy regarding decent communication and courteous behaviour towards the patient and visitors		RR/SI	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Hospital defines the policy for privacy and confidentiality of the patient and condition related with social stigma and vulnerable groups		RR/SI	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Hospital define policy for taking consent.		RR/SI	
ME B4.2	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.		OB	
ME B4.3	Staff are aware of Patients rights responsibilities	Staff is aware of patients rights responsibilities		SI	
		Staff is regularly sensitize about rights and responsibilities of the patient		SI/RR	
ME B4.5.	The facility has defined and established grievance redressal system in place	Availability of complaint box at administrative office and display of process for grievance re Redressal and whom to contact is displayed		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Hospital defines policy for grievance redressal mechanism		RR/SI	
		There is defined frequency of collecting complaints from complaint box		RR/SI	
		Records of patient complaints suggestion are maintained		RR	
		There is system of periodic review of patient complaints		RR/SI	Check for: 1. There is evidence of action taken on complaints 2. Action taken are informed to the complainant
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Hospital establish policy for providing free services for GoI and state scheme		RR/SI	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Hospital has established policy for providing all drugs in the EDL free of cost		RR/SI	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Hospital has established policy for providing all diagnostics free of cost		RR/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Methods for verification of documents of patient is user friendly		PI/SI	
		Hospital has established policy to provide free of cost treatment to BPL patients		RR/SI	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Hospital has establish policy for timely Reimbursement and payment to beneficiaries		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme	Availability of dedicated PMJAY help desk		OB	Availability of a help desk/ kiosk/Arogya Mitra Sahayta Kendra near the reception area run by Pradhan Mantri Aarogya Mitra (PMAM)
		Finger print verification is done through a finger print scanner		OB/PI/RR	Availability of 'Beneficiary Identification System' for creation of Golden card Give full compliance incase the beneficiary already holds e-card (Golden record)
		All tests and drugs are covered underPMJAY		OB/SI/PI	Treatment is free of cost for hospitalised cases
		Services and entitlements available under PMJAY are prominently displayed		RR/SI	The doctors have a standard template for pre-authorization form and a list of packages
		Manual process is in place in case smart card is not working		OB/PI	The beneficiary is informed of the amount of charges for diagnosis availing consultation only
		Availability of functional Transaction Management System		SI/PI	
		Pre-authorisation request is approved timely		PI/SI/RR	Maximum time of 6 hrs, in case approval is required from ISA/trust or should be approved automatically, if no prior approval required from ISA (implementation support agency)
		Medicines and diagnostic services are free of cost for 15 days post-discharge		PI/RR	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**				
ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.	Check that hospital administration has defined code of conduct for various cadre of staff		RR/SI	Check for any circular, policy, notice, government order issued that explains the code of conduct for staff such as doctor and nurses.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B6.2	The Facility staff is aware of code of conduct established	Check if staff is aware of code of conduct		RR/SI	Interview doctors and nursing / paramedical staff on sample basis.
ME B6.3	The Facility has an established procedure for entertaining representatives of drug companies and suppliers	Check hospital has implemented a policy of not entertaining representative of pharma companies within hospital premises		RR/SI	Ask medical superintendent / manager regarding any such circular / instructions issued to the doctors. Check on sample basis if doctors are aware of this policy and do not entertain medical representatives in hospital premises
ME B6.4	The Facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions	Check hospital administration has aware of protocols for examination and treatment t of individuals brought police		RR/SI	As per state law and supreme court direction
ME B6.5	There is an established procedure for sharing of hospital/ patient data with individuals and external agencies including non governmental organization	Check hospital administration has defined protocols for data sharing		RR/SI	Check list of agencies with which data shared has routinely shred has been prepared . For any other agency a formal permission is sought from competent authorities before sharing the data including international agencies, press and NGOs.
ME B6.6	There is an established procedure for 'end-of-life' care	Facility has established has established policy of end of life care		SI/RR	
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research	Check hospital ensures that informed consent is taken from patient participating in any clinical or public Health research		SI/RR	Check for policy or practice

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B6.9	There is an established procedure to issue of medical certificates and other certificates	Check hospital has documented policy for issuing medical certificates		SI/RR	Check for policy defines List of certificates can be issued by hospital Who can issue certificates Formats shall used for different certificates Record keeping of issued certificate procedures for issuing duplicate certificates
ME B6.10	There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services	Hospital has laid strategy to resume the basic emergency and patient care services during strikes		SI/RR	Check hospital administration has made Buffer stock and alternate source pf supplies for consumables Strategy and coordination with local disruption to maintain hospital functions
ME B6.11	An updated copy of code of ethics under Indian Medical council act is available with the facility	Check code of conduct copies are available at the hospital		SI/RR	Check for availability of printed copies of code of conduct distributed to staff
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dilemmas' in a time-bound manner through ethical committee	Check facility has defined its ethical issues management framework		RR/SI	(a) Check the adequacy of the framework. It address the ethical issues and decision making in clinical care (b) Check facility's ethical management framework address issues like admission, discharge, transfer, disclosure of information or any professional conflict which may not be in patient's best interest

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check facility has ethical committee or person designated to address the ethical issues confronted by medical professionals while delivering the services		RR/SI	Facility's supporting human subject research activities/ publishing the scientific papers/ supporting medical students in thesis writing/ running any course where patient data is collected and used for above mentioned activities - an ethical committee is constituted and approval are taken before publication. or Facility may collaborate with the institutions where there are ethical committee is present and appropriate approvals, guided by applicable laws and regulations is taken. or the facilities where they are not involved in research activities, to address the ethical dilemma's a person or group is appointed to address the dilemmas effectively within legal parameter
		Check the list of ethical issues is available and regularly updated		RR/SI	Check when the list was last updated. Engage with the available medical professionals to check what type of ethical dilemmas they are facing while performing their job & how they are dealing with dilemma's.
		Check the facility has defined mechanism identification and reporting of the ethical issues/ dilemmas confronted during services delivery		RR/SI	Check staff is aware of reporting mechanism

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check regular review of identified and reported ethical issue is done by appointed personnel /group/ committee		RR/SI	Check the timely resolution of the identified and reported ethical issues is done
		Check all the decisions related to ethical dilemma's are communicated to all concerned		RR/SI	Check information regarding ethical dilemma's & its handling is also given to new joinee's
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1.	Departments have adequate space as per patient or work load	Residential quarters for clinical and support staff		OB/RR	
		Hospital has adequate space as per bed strength		OB/RR	80 to 85 sqm per bed .
ME C1.2.	Patient amenities are provide as per patient load	Availability of public toilet for visitors		OB	
		Availability of dharmshala/ stay facility for attendants		OB	
		Adequate number of Staff toilets available in proximity to duty area		OB/SI	
		Adequate number of Staff change room available in proximity to duty area		OB/SI	
		Separate cafeteria for patient and their relatives		OB	
		Cafeteria/ Recreation room for staff		OB/SI	
		Availability of Staff amenities at nursing station and duty room		OB/SI	
ME C1.3.	Departments have layout and demarcated areas as per functions	Hospital has independent entry for emergency, OPD and support services/staff		OB	
		Corridors shall be at Wide to accommodate the daily traffic.		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		The general traffic should not pass through the indoor/ critical patient care area		OB	
		Ambulatory services are located in outermost zone		OB	OPD, Emergency and Administrative offices are situated in near the entry/ exit of the hospital with direct access from approach road
		Clinical support Services are located in proximity to outer zone		OB	Lab , Radiology and Pharmacy
		Procedure and Intensive Care areas are located in Middle zone of the Hospital		OB	Operation Theatre, ICU, SNCU, Labour Room
		Indoor area are located in Inner zone of the Hospital		OB	Wards and Nursing Units are located in inner most area
ME C1.4.	The facility has adequate circulation area and open spaces according to need and local law	Corridors shall be at Wide to accommodate the daily traffic.		OB	
		Facility maintains open area as per floor area ratio mandated by authorities		OB	
ME C1.5.	The facility has infrastructure for intramural and extramural communication	Hospital has 24X7 functional telephone connection		OB	
		There is designated person to answer the telephone enquiries		OB/SI/RR	
		Hospital has broadband internet connectivity		OB	
		There is establish system for managing postal communication		OB/RR	Records are maintained for received and dispatched communication
		There is established system for internal movement of documents and communication		OB/RR	System for communicating circulars, notices and orders etc.
		There is assigned person for managing internal and external movement of documents and communications		OB/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		General notices and information are displayed at notice boards at relevant points		OB/RR	
		There is system of removal of old notices and updating the notice board		OB/RR	
ME C1.6	Service counters are available as per patient load	Availability of admission counter as per load		OB/RR	
ME C1.7.	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	There is no crises cross between General and Patient Traffic		OB	
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1.	The facility ensures the seismic safety of the infrastructure	Facility has been surveyed by Structural engineer for seismic vulnerability		OB/RR	Ask for records of survey
		Structural Components been made earthquake proof		OB/RR	Check for records of in correction has been done to strengthen structural components like columns, beams, slabs, walls etc.
		Foundation of buildings are adequate		OB/RR	Check for any information available about the depth of foundation. Its should not be less the 1.5 meters
		There is no irregularity in height of different stories		OB/RR	In multi story building height of the story should be of same height (Difference should not be more than 5%.
ME C2.2.	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/ board	Lifts are installed with Automatic Rescue device.		OB/RR	
		Every lift has Emergency Alarm System		OB/RR	
		Periodic Maintenance of lift		OB/RR	
		Licence for lift operation		OB/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C2.3.	The facility ensures safety of electrical establishment	Facility has mechanism for periodical check / test of all electrical installation by competent electrical Engineer		OB/RR	
		Facility has system for power audit of unit at defined intervals		OB/RR	
		Danger sign is displayed at High voltage electrical installation		OB	
		All electrical panels are covered and has restricted access		OB	
		Personal protective equipment are available with electrician		OB/SI	
ME C2.4.	Physical condition of buildings are safe for providing patient care	Windows have grills and wire meshwork		OB	
		Terrace, roof, balconies and stair case have protective railing		OB	
		Hospital premises has intact boundary wall		OB	
		Hospital has functional gate with provision of cattle trap		OB	
		There is system of periodic inspection of patient care areas of safety related issues		OB	
		Hospital building including walls, roofs, floor, windows , balconies and terraces are maintained		OB	
		Access to roof and terraces are restricted		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1.	The facility has plan for prevention of fire	Check the fire exits provide egress to exterior of the building or to exterior open space		OB	
		Check the fire exits are free from obstruction		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Facility has conducted fire safety audit by competent authority		OB/RR	
		Evacuation plan is displayed at critical areas		OB	
		Facility has defined and implemented evacuation plan in case of fire		OB/RR	
		No smoking sign displayed inside and outside the working area		OB/RR	
ME C3.2.	The facility has adequate fire fighting Equipment	Facility has fire safety alarm		OB	
		There is system to track the expiry dates and periodic refilling of the extinguishers		OB/RR	
ME C3.3.	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Periodic Training is provided for using fire extinguishers		OB/RR	
		Periodic mock drills are conducted		OB/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1.	The facility has adequate specialist doctors as per service provision	Availability of General Surgeon		OB/RR/SI	As per patient load
		Availability of Obstetric & Gynae Specialist		OB/RR/SI	As per patient load
		Availability of General Medicine specialist		OB/RR/SI	
		Availability of Paediatrician		OB/RR/SI	As per patient load
		Availability of Anaesthetics		OB/RR/SI	As per patient load
		Availability of Ophthalmologist		OB/RR/SI	As per patient load
		Availability of Orthopaedic Surgeon		OB/RR/SI	As per patient load
		Availability of Radiologist		OB/RR/SI	As per patient load
		Availability of Pathologist		OB/RR/SI	As per patient load
		Availability of ENT specialist		OB/RR/SI	As per patient load
		Availability of Dentist		OB/RR/SI	As per patient load
		Availability of Dermatologist		OB/RR/SI	As per patient load
		Availability of Psychiatrist		OB/RR/SI	As per patient load
		Availability of Microbiologist		OB/RR/SI	As per patient load

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of AYUSH Doctors		OB/RR/SI	As per patient load
ME C4.2.	The facility has adequate general duty doctors as per service provision and work load	Availability of general duty doctors		OB/RR/SI	As per patient load
ME C4.3.	The facility has adequate nursing staff as per service provision and work load	Availability of nursing staff		OB/RR/SI	As per patient load
ME C4.4.	The facility has adequate technicians/ paramedics as per requirement	Availability Lab Tech		OB/RR/SI	As per patient load
		Availability Pharmacist		SI/RR	As per patient load
		Availability Radiographer		SI/RR	As per patient load
		Availability ECG Tech/Eco		SI/RR	As per patient load
		Availability Audiometrician		SI/RR	As per patient load
		Availability Optha. Technician/Referactionist		SI/RR	As per patient load
		Availability Dietician		SI/RR	As per patient load
		Availability Physiotherapist		SI/RR	As per patient load
		Availability O.T. technician		SI/RR	As per patient load
		Counsellor		SI/RR	As per patient load
		Dental Technician		SI/RR	As per patient load
		Rehabilitation Therapist		SI/RR	As per patient load
		Biomedical Engineer		SI/RR	As per patient load
ME C4.5.	The facility has adequate support / general staff	Availability of storekeeper		SI/RR	
		Availability of Housekeeping supervisor/In charge		SI/RR	
		Availability of security In charge		SI/RR	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate drugs at point of use	Hospital has policy to ensure drugs at all point of use as per state EML		SI/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for Facility management		OB	Equipment's for horticulture, electrical repair, plumbing material etc
		Availability of equipment for processing of Bio medical waste		OB	Autoclave and mutilator

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of fixture for administrative office		OB	
		Availability of furniture for administrative office		OB	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.3	Criteria for performance evaluation clinical and Para clinical staff are defined	Check performance criteria for clinical staff has been defined		RR	Check if performance appraisal critical clinical staff has been defines as per state service rules/ NHM Guidelines and job description of staff
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year	Check if annual performance appraisal for clinical staff is practiced		RR	Verify with records that performance appraisal has been done at least once in a year for all Doctor, Nurses and paramedic staff .l. Check that predefined criteria has been used for the appraisal only.
ME C7.5	Criteria for performance evaluation of support and administrative staff are defined	Check performance criteria for support staff has been defined		RR	Check if performance appraisal critical for both support/ administrative staff has been defines as per state service rules/ NHM Guidelines and job description of staff

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C7.6	Performance evaluation of support and administration staff is done on predefined criteria at least once in a year	Check if annual performance appraisal for support & administration staff is practiced		RR	Verify with records that performance appraisal has been done at least once in a year for all administrative and support staff either appointed at hospital . Check that predefined criteria has been used for the appraisal only.
ME C7.7	Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff	Check staff if competence assessment and performance appraisal program includes staff is inclusive contractual staff.		RR	Verify with records that staff on contract under NHM or any other program, staff working through outsource agencies such as housekeeping and security are also go through the competence assessment along with regular staff. Also their performance appraisal is done at least once in year by their respective employer.
ME C7.8	Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan	Check if hospital administration has a system for identifying the training needs and plan to address them		RR	Check that hospital administration has listed the gaps found during competence assessment and performance appraisal exercise . These gaps in performance and competence are factored in while developing training plan for staff. This includes both clinical as well as non clinical staff.
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Facility conduct training need assessment periodically for all cadre of staff		SI/RR	
		Facility has program for continuous medical education for doctors and nursing staff		SI/RR	
		Facility prepares training calendar as per training need assessment		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Training feed back is taking and records are maintained for training		SI/RR	
		Details and Records of training provided are available with unit		SI/RR	
		Training on Disaster Management		SI/RR	
		Training on Cardio Pulmonary resuscitation		SI/RR	
		Training on staff Safety		SI/RR	
		Training on Measuring Hospital Performance Indicators		SI/RR	
		Training on facility level Quality Assurance		SI/RR	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Hospital has policy for regular competence testing as per job description.		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
ME C7.11	Feedback is provided to the staff on their competence assessment and performance evaluation	Check if feedback is given after each round of competence assessment and performance appraisal		RR	Verify with records of performance appraisal for feedback has been written on appraisal form and shared with staff. Interview staff for verification for feedback has been shared
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1.	The facility has established system for maintenance of critical Equipment	Facility has contract agency for maintenance for equipment		SI/RR	
		Contact details of the agencies responsible for maintenance are communicated to the staff		SI/RR	
		Asset list of all equipment are maintained		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system to maintain records of down time of equipment		SI/RR	
		Indexing of all equipment is done		SI/RR	
		All equipment are covered under AMC including preventive maintenance for computers and other IT equipment		SI/RR	
		There has system to label Defective/Out of order equipment and stored appropriately until it has been repaired		OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction		SI/RR	
		There is system of timely corrective break down maintenance of the for computers and other IT equipment		SI/RR	
ME D1.2.	The facility has established procedure for internal and external calibration of measuring Equipment	Facility has contracted agency for calibration of equipment.		SI/RR	
		Records of the calibrated equipment are maintained		RR	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.4	The facility ensures management of expiry and near expiry drugs	Hospital has system to ensure that short expiry drugs are not procured		SI/RR	Check record of stock receipt from warehouse and Local purchase purchase receipt
		Hospital has process for proper disposal and prevention of unintended use of expired drugs		SI/RR	Check policy for disposal of expired drugs and consumables
ME D2.5	The facility has established procedure for inventory management techniques	Hospital implements scientific inventory management system according to their needs		OB/RR/SI	Previous consumption pattern, disease burden, local disease prevalence, seasonality, ABC, VED, FSN

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	Hospital has policy that there is no stock out of the drugs and consumables at patient care area		RR/SI	Check policy for no stock out situation, stock replenishment
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Hospital has a policy for ensuring proper management and restriction of unintended use of narcotic substance and psychotropic drugs as per prevalent law		RR/SI	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1.	The facility provides adequate illumination level at patient care areas	Adequate illumination in open area at night		OB	
		Adequate illumination in circulation area		OB	Stairs, corridor and waiting area
		Adequate illumination in toilets		OB	
		Hospital periodically measure illumination at different area of the hospitals		OB	
		Adequate illumination at approach roads to hospital		OB	
ME D3.2.	The facility has provision of restriction of visitors in patient areas	There is restriction on entry of vendors and hawkers inside the premise of the hospital		OB	
		Hospital has visitor policy in place		OB/RR	
		Hospital has policy for restriction of media person in side the hospital		OB/RR	
		Hospital implement visitor pass area for indoor areas		OB/RR	
ME D3.4.	The facility has security system in place at patient care areas	Hospital has in-house/ outsourced security system in place		RR/SI	
		Duty roaster is available for security staff		RR/SI	
		Training and Drills of security staff is done		RR/SI	
		Security staff is aware of patient right, visitor policy and disaster Management		RR/SI	
		There is system for supervision of security staff		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Facility has a security plan for deputation of guard at different location		RR/SI	
		Responsibility and timing of opening and closing different department is fixed and documented		RR/SI	
		There is established procedure for safe custody of keys		RR/SI/OB	
		There is procedure for handing over the keys at the time of shift change		RR/SI	
		Hospital has system to manage violence /mass situation		RR/SI	
ME D3.5.	The facility has established measure for safety and security of female staff	No female staff is posted alone at night		SI	
		Where ever there are male employees/patients female staff are posted in pairs		SI/RR	
		Timing of the shift is arranged keeping in mind the safety of female staff		SI/RR	
		Committee against sexual harassment is constituted at the facility		RR/SI	
		Staff has been provided awareness training on Gender issues		RR/SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1.	Exterior of the facility building is maintained appropriately	Boundary Walls of building is plastered and whitewashed.		OB	
		No unwanted/outdated posters on hospital boundary and building walls		OB	
		Hospital Buildings are in uniform colour scheme		OB	
		Hospital has system to whitewash the building periodically		OB/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D4.2.	Patient care areas are clean and hygienic	General waste from hospital is removed daily by municipal/outsourced agency		OB/RR	
		Every department has Schedule of cleaning		SI/RR	Every department has schedule for inspection of cleaning work
ME D4.3.	Hospital infrastructure is adequately maintained	Hospital has system for periodic maintenance of infrastructure at defined interval		OB/RR	
		There is no clogged/over flowing drain in facility		OB	
		Hospital sewage is linked with municipal drainage system		OB/SI/RR	
		Facility has a closed drainage system		OB	
		Intramural roads are in good condition without potholes/ ditches		OB	
		Facility has a annual maintenance plan for its infrastructure		RR/SI	
ME D4.4.	Hospital maintains the open area and landscaping of them	Availability of parking space as per requirement		OB	
		Dedicated parking space for ambulances		OB	
		No water logging in side the premises of the hospital		OB	
		There is no abandoned / dilapidated building in the premises		OB	
		Proper landscaping and maintenance of trees, garden		OB	
		There shall be no encroachment in and around the hospital		OB	
		Hospital has rain water harvesting facility		OB	
		Hospital has Herbal garden		OB	
ME D4.5.	The facility has policy of removal of condemned junk material	Hospital has condemnation policy in place		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Periodic removal of junk material done		OB/RR	
		Hospital has designated covered place to keep junk/ condemned material		OB	
		No junk/condemned articles in open spaces		OB	
ME D4.6.	The facility has established procedures for pest, rodent and animal control	Pest control measures are evident at facility		RR/SI	
		Anti Termite treatment of the wooden furniture		RR/SI	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1.	The facility has adequate arrangement storage and supply for portable water in all functional areas	Hospital has adequate water storage facility as per requirements		OB/RR/SI	450-500 Litres per bed per day
		Hospital has adequate water supply from municipal /under ground source		OB/SI	
		All water tanks are kept tightly closed		OB	
		Periodic cleaning of water tanks carried out		OB/RR	Records of cleaning is maintained
		Hospitals periodically tests the quality of water from the source (municipal supply, bore well etc) for bacterial and chemical content		RR	
		Chlorination of water is done as per requirement		RR	
		RO/ Filters are available for potable drinking water		OB	
		Hospital ensures that the distribution pipelines are not running in close vicinity of the sewage system.		RR/SI	
ME D5.2.	The facility ensures adequate power backup in all patient care areas as per load	Availability of noiseless generators for power back up		OB/SI	
		Estimation of power consumption of different department of hospitals is done		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Generator has adequate capacity to provide 24x7 power back at least critical areas		RR/SI	
		Hospital has dedicated sub station for electrical supply		OB/RR/SI	
		Hospital has adequate power supply connection		RR/SI	3Kw to 5Kw per bed
		Use of energy efficient bulbs/ solar panel for light		SI	
ME D5.3.	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Manifold room is located on ground floor		OB	
		Manifold room has adequate stock of Oxygen and Nitrogen Cylinders		OB/SI	At least for three days
		Cylinders banks are in duplicate		OB/RR/SI	Check for there two dedicated banks - Running and reserve fitted with automatic changeover device
		Colour of gas pipeline and Gas Cylinder are as per standards		OB/RR	
		Alarm system has been provided to indicate any abnormal pressure change		RR/SI	
		LMO storage tank has a Petroleum and Explosive Safety Organisation (PESO) license		RR/SI	Also check for availability of Medical Gas Pipeline System (MGPS) network in the hospital
		LMO tank is located away from the indoor environment or not located near drain or pits		OB	
		Availability of vacant space within a radius of 5 meters around the tank			Check that 1. flammables and combustibles are not stored in near vicinity 2. Postage of 'No Smoking" and 'No Open Flames' signages
		There is procedure for prompt replacement of empty cylinders with filled cylinders		SI/RR/OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is a procedure for periodic checking of all terminal units for malfunctioning		SI/RR	
		Entry to Manifold room/LMO plant is prohibited		OB/SI	
		Instruction for operating different equipment clearly displayed		OB	
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Hospital has policy to change linen		RR/SI	
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**				
ME D8.1.	The facility has established procedures for management of activities of Rogi Kalyan Samitis	Hospital Management Society/RKS is registered under societies registration act		RR	
		Availability of Income tax exemption certificate for donations		RR	
		RKS meeting are held at prescribed interval		RR	
		Minutes of meeting are recorded		RR	
		Participation of community representatives/NGO is ensured		RR	
		RKS reviews the patient complaint/ feedback and action taken		RR	
		RKS generates its own resources from donation/ leasing of space		RR/SI	
ME D8.2.	The facility has established procedures for community based monitoring of its services	Community based monitoring/social audits are done at periodic intervals		RR/SI	
		Facility communicate updated information on Quality of services		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Facility participates in Jan Sunawais and Jan Samvads at regular intervals		RR/SI	
Standard D9	**Hospital has defined and established procedures for Financial Management**				
ME D9.1.	The facility ensures the proper utilization of fund provided to it	There is system to track and ensure that funds are received on time		RR/SI	
		Funds/Grants provided are utilized in specific time limit		RR	
		There is no backlog in payment to beneficiaries as per their entitlement under different schemes		RR/PI	E.g.; Payment for JSY ,Family planning & ASHA
		Salaries and compensation are provided to contractual staff on time		RR/SI	
		Facility provides utilization certificate for funds on time		RR	
ME D9.2.	The facility ensures proper planning and requisition of resources based on its need	Facility prioritize the resource available		RR/SI	
		Requirement for funds are sent to state on time		RR/SI	
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**				
ME D10.1.	The facility has requisite licences and certificates for operation of hospital and different activities	Availability of valid No objection Certificate from fire safety authority		RR	
		Availability of Biomedical Waste Management Authorisation for generating BMW as per prevalent norms/ regulations		RR	
		Availability of certificate of inspection of electrical installation		RR	
		Availability of licence for operating lift		RR	
ME D10.2.	Updated copies of relevant laws, regulations and government orders are available at the facility	Availability of copy of Bio medical waste management rules 2016 and it's subsequent amendments		RR	
		Drug and cosmetic Act 2005		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Safety code for Medical diagnostic X ray equipment and installation		RR	AERB safety code no. AERB/SC/MED-2(Rev 1)
		Narcotics and Psychotropic substances act 1985		RR	
		Code of Medical ethics 2002		RR	
		Nursing Council Act		RR	
		Medical Termination of Pregnancy 1971 & amendments		RR	
		Person with disability Act 1995		RR	
		Pre conception pre natal diagnostic test 1996		RR	
		Right to information act 2005		RR	
		Indian Tobacco control Act 2003		RR	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1.	The facility has established job description as per govt guidelines	Job description of Specialist Doctor is defined and communicated		RR	Regular + contractual
		Job description of General duty Doctor is defined and communicated		RR	Regular + contractual
		Job description of nursing staff is defined and communicated		RR	Regular + contractual
		Job description of paramedic staff is defined and communicated		RR	Regular + contractual. Lab technician, X ray technician, OT technician, MRD technician etc.
		Job description of counsellor is defined and communicated		RR	Regular + contractual
		Job description of ward boy is defined and communicated		RR	Regular + contractual
		Job description of security staff is defined and communicated		RR	Regular + contractual
		Job description of cleaning staff is defined and communicated		RR	Regular + contractual

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Job description of Administrative staff is defined and communicated		RR	Regular + Contractual MS, Hospital Manager, supervisor, Matron, Ward Master. Pharmacist etc.
ME D11.2.	The facility has a established procedure for duty roster and deputation to different departments	Duty roster of doctors is prepared, updated and communicated		RR/SI	
		Duty roster of Nurses is prepared, updated and communicated		RR/SI	
		Duty roster of Paramedics is prepared, updated and communicated		RR/SI	
		Duty roster of Cleaning staff is prepared, updated and communicated		RR/SI	
		Duty roster of security staff is prepared, updated and communicated		RR/SI	
		There is provision of Rotatory posting of staff		RR/SI	
		Facility has established line of reporting for clinical and administrative staff		RR/SI	
ME D11.3.	The facility ensures the adherence to dress code as mandated by its administration / the health department	Facility has policy for dress code for different cadre of hospital.		RR/SI	
		I Cards have been provided to staff		OB	
		Name plate have been provided to staff		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1.	There is established system for contract management for out sourced services	Valid contract for disposal for Bio Medical waste with common treatment facility		RR	
		Selection of outsourced agencies done through competitive tendering system		RR	
		Eligibility criteria is explicitly defined as per term of reference		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system to make payment as per adequacy and quality of services provided by the vendor		RR	Check for that Contract document has provision for dedication of payment if quality of services is not good
		Payment to the outsourced services are made on time		RR	
ME D12.2.	There is a system of periodic review of quality of out sourced services	Facility as defined criteria for assessment of quality of outsourced services		RR	
		Regular monitoring and evaluation of staff is done according against defined criteria		RR	
		Actions are taken against non compliance / deviation from contractual obligations		RR/SI	
		Records of blacklisted vendors are available with facility		RR	
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.3	There is established procedure for admission of patients	Facility ensures that there is process for admission of patients after routine working hours		RR/SI	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Facility updates daily availability of vacant patient beds in different in door units		RR/SI/PI	
		Facility has established plan for accommodating high patient load due to situation like disaster/ mass casualty or disease outbreak		RR/SI	
		Facility has policy for internal adjustment of the patient within cold wards for accommodating patient as extra temporary measure		RR/SI	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1.	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established policy for co ordination and handover during interdepartmental transfer		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is a policy for consultation of the patient to other specialist with in the hospital		RR/SI	
ME E3.2.	Facility provides appropriate referral linkages to the patients/ Services for transfer to other/higher facilities to assure their continuity of care.	There is policy for referral of patient for which services can not be provided at the facility		RR/SI	
		Facility maintain list of higher centres where patient can be managed.		RR/SI	
		Facility ensures the referral patient to public healthcare facilities		RR/SI	
		Facility defines and communicate referral criteria for different departments		RR/SI	
		There is system to check that patient are not unduly referred for the services those can be available at the facility		RR/OB	
ME E3.4	Facility is connected to medical colleges through telemedicine services	There is functional telemedicine centre		OB	
		Telemedicine services are utilized for continual medical education		RR/SI	
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.1	Procedure for identification of patients is established at the facility	There is policy for identification of patient before any clinical procedure		RR/SI	
ME E4.2.	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	There is a policy for ensuring accuracy of verbal/telephonic orders		RR/SI	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Hospital has policy for patient hand over during shift change		RR/SI	
ME E4.4	Nursing records are maintained	Hospital has policy for maintaining nursing records		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E4.5	There is procedure for periodic monitoring of patients	There is policy for periodic monitoring of patient		RR/SI	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Hospital identify and communicate the category of patient considered as vulnerable		OB/SI	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	Hospital identify and communicate the category of patient considered as high risk		OB/SI	
Standard E6	**Facility follows standard treatment guidelines defined by state/Central government for prescribing the generic drugs & their rational use.**				
ME E6.1.	Facility ensured that drugs are prescribed in generic name only	Facility has policy and enabling order for prescribing drugs in generic drug only		RR	
ME E6.2	There is procedure of rational use of drugs	Facility provides adequate copies of STG to respective department		SI/RR	
		Facility maintains a list of updated version of STG		RR	
		Facility provides training on use of STG		SI/RR	
Standard E7	**Facility has defined procedures for safe drug administration**				
ME E7.3	There is a procedure to check drug before administration/ dispensing	Facility has policy for reporting of adverse drug reaction		RR/SI	Adverse drug event trigger tool is used to report the events
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Hospital has policy for retention period for different kinds of records		RR	
		Hospital has policy for safe disposal of records		RR	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3.	The facility has disaster management plan in place	Hospital has prepared disaster plan		RR	
		Disaster management committee has been constituted		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**				
ME E16.1.	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives		SI/RR	
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**				
ME E20.1	The facility provides immunization services as per guidelines	Facility has established produce for reporting and follow up of AEFI		SI/RR	
		Staff is trained for detecting , managing and reporting of AEFIs		SI/RR	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.1.	Facility has functional infection control committee	Infection control committee constitute at the facility		SI/RR	
		ICC is approved by appropriate authority		SI/RR	
		Roles and responsibilities are defined and communicated to its members		SI/RR	
		ICC meet at periodic time interval		SI/RR	
		Records of Infection control activities are maintained		SI/RR	
ME F1.2.	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Facility has in-house/ linkage with microbiology lab for culture surveillance		SI/RR	
		There is defined format for requisition and reporting of culture surveillance		SI/RR	
		Reports of culture surveillance are collated and analysed		SI/RR	
		Feedback is given to the respective departments		SI/RR	
ME F1.3	Facility measures hospital associated infection rates	Sample are taken for culture to detect HAI in suspected cases.		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is defined criteria and format for reporting HAI based on clinical observation		SI/RR	
		Reports from different department are collated and analysed		SI/RR	
		Feedback is given to the respective departments		SI/RR	
ME F1.4.	There is Provision of Periodic Medical Check-ups and immunization of staff	Records of immunization available		SI/RR	
		Records of Medical Check-ups are available		SI/RR	
ME F1.5.	Facility has established procedures for regular monitoring of infection control practices	There is designated person for Co coordinating infection control activities		SI/RR	Infection control nurse
		There is defined format/ checklist for monitoring of hand washing and infection control practices		SI/RR	
ME F1.6.	Facility has defined and established antibiotic policy	Facility has antibiotic policy in place		SI/RR	
		There is system for reporting Anti Microbial Resistance with in the facility		SI/RR	
		Antibiotic policy includes plan for identifying, transferring , discharging and readmitting patients with specific antimicrobial resistant pathogen		SI/RR	
		Policy Includes Rational Use of Antibiotics		SI/RR	
		Standard treatment guidelines are followed while developing Antibiotic Policy		SI/RR	
		There is procedure for periodic Laboratory Surveillance for Antibiotic Resistance		SI/RR	
		Facility Measures the Antibiotic Consumption Rates		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Facility ensures uninterrupted and adequate supply of antiseptic soap and alcohol hand rub in all departments		SI/RR	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Check for the records that training have been provided		SI/RR	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Facility ensures uninterrupted and adequate supply of antiseptics		SI/RR	
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Availability of Heavy duty gloves for cleaning staff		OB/SI	
		Availability of gum boats for cleaning staff		OB/SI	
		Availability of mask for cleaning staff		OB/SI	
		Availability of apron for cleaning staff		OB/SI	
		Facility ensure adequate and regular supply of personal protective equipment		SI/RR	
ME F3.2	Staff is adhere to standard personal protection practices	There is policy for judicious use of personal protective equipment specially sterile gloves		SI/RR	
Standard F4	**Facility has standard Procedures for processing of equipment and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Facility ensure adequate supply of disinfectant at the point of use		SI/RR	Disinfectant like hypochlorite, bleaching powder etc.
		Staff is trained for preparation of disinfectant solution		SI/RR	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Facility ensure the availability of good quality disinfectant and cleaning material		SI/RR	
ME F5.4	Facility ensures segregation infectious patients	Hospital has policy for identification and segregation of infectious patient		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Facility ensures adequate and regular supply of non chlorinated colour coded liners		SI/RR	
		Separate bins for Recyclable and biodegradable waste is available			Check adequacy in patient care and administrative areas. Also check there is no mixing of waste
		There is established procedure for daily monitoring of proper segregation of Bio medical waste by a designated person		SI/RR	
		Bar code system for the bags or containers containing BMW			
ME F6.2	Facility ensures management of sharps as per guidelines	Facility ensures supply of puncture proof containers and needle cutters		SI/RR	Containers are puncture proof, leak proof and temper proof
		Facility ensures availability of post exposure prophylaxis drugs		SI/RR	
		There is system for reporting of needle stick injuries		SI/RR	
ME F6.3.	Facility ensures transportation and disposal of waste as per guidelines	Facility has secured designated place for storage of Bio Medical waste before disposal		SI/OB	
		BMW is stored in lock and key		SI/OB	Check there is no scope for unauthorized entry
		Log book /Record of waste generated is maintained on day to day basis		RR	Check records are being displayed monthly on its web site
		No signs of burning within the premises.		OB	
		Check infectious liquid waste is not directly drained in to municipal sewerage system		OB	
		Display of Bio Hazard sign at the point of use		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Infectious Waste is not stored for more than 48 hours		RR	
		Disposal of anatomical waste as per BMW rule		OB/SI/RR	Preferably by CTWF/in-house deep burial pits/ In house incinerator with prior approval
		Disposal of solid waste as per BMW rule		OB/SI/RR	Preferably by CTWF/ Deep burial/ in absence of above autoclaving or micro waving/ hydroclaving followed by shredding or mutilation or combination of sterlization and shredding.
		Disposal of sharp waste as per BMW rule		OB/SI/RR	Preferably by CTWF/ autoclaving or dry heat sterlization followed by shredding or mutilation or encapsulation in metal contained or cement concrete
		Disposal of contaminated waste (recyclable) as per BMW rule		OB/SI/RR	Preferably by CTWF/ Autoclaving or microwaving/ hydroclaving followed by shredding or mutilation or combination of sterlization and shredding
		Disposal of Glass ware and metallic body implants (Blue)			Preferably By CTWF/ disinfection (by soaking the washed glass waste after cleaning with detergent and Sodium Hypochlorite treatment) or through autoclaving or microwaving or hydroclaving
		Annual report to the pollution control board is submitted		RR	
		Biomedical waste transported in authorized vehicle		OB/SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	District Quality Team for district hospitals are Constituted		SI/RR	Check for Office order by designated authority
		There is designated person for co coordinating with the quality circles and overall quality assurance program at the facility		SI/RR	Hospital Manager
		There is designated head of the quality team		SI/RR	MS
		Team members are aware for of there respective responsibilities		SI/RR	
ME G1.2.	The facility reviews quality of its services at periodic intervals	Quality team meets monthly and review the quality activities		SI/RR	
		Minutes of meeting are recorded		RR	
		Results for internal /External assessment are discussed in the meeting		SI/RR	Check the meeting records
		Hospital performance and indicators are reviewed in meeting		SI/RR	Check the meeting records
		Progress on time bound action plan is reviewed		SI/RR	Check the meeting records
		Follow up actions from previous meetings are reviewed		SI/RR	Check the meeting records
		Resource requirement and support from higher level are discussed		SI/RR	Check the meeting records
		Quality team review that all the services mentioned in RMNCHA are delivered as per guideline		SI/RR	
		Quality team review that all the services mentioned in National Health Program are delivered as per guideline		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Resolution of the meeting are effectively communicated to hospital staff		SI/RR	Check how resolution are communicated to staff
		Quality team report regularly to DQAC about Key Performance Indicators		SI/RR	
		Quality Team DQAC about internal assessment results and action taken		SI/RR	
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1.	Patient Satisfaction surveys are conducted at periodic intervals	There is person designated to co ordinate satisfaction survey		SI/RR	
		Patient feedback form are available in local language		RR	
		Adequate sample size is taken to conduct patient satisfaction		RR	
		There is procedure to conduct employee satisfaction survey at periodic intervals		RR	
ME G2.2.	Facility analyses the patient feed back and do root cause analysis	There is procedure for compilation of patient feedback forms		RR	
		Patient feedback is analysed on monthly basis		RR	Overall department wise/attribute wise score are calculated
		Root cause analysis is done for low performing attributes		RR	
		Results of Patient satisfaction survey are recorded and disseminated to concerned staff		RR/SI	
		There is procedure for analysis of Employee satisfaction survey		RR	
		There is procedure for root cause analysis of Employee satisfaction survey		RR	
ME G2.3.	Facility prepares the action plans for the areas of low satisfaction	There is procedure for preparing Action plan for improving patient satisfaction		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is procedure to take corrective and preventive action		RR/SI	
		There is procedure for preparing action plan for improving employee satisfaction		RR/SI	
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1.	Facility has established internal quality assurance program at relevant departments	Daily round schedule is defined and practiced		SI/RR	Check for entries in Round Register
ME G3.2.	Facility has established external assurance programs at relevant departments	External Quality assurance is done on defined interval by DQAC		SI/RR	
		External Quality assurance is done on defined interval by SQAC		SI/RR	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1.	Departmental standard operating procedures are available	Hospital has documented Quality system manual		RR	
		Hospital has Records of distribution of Standard operating procedure		RR	
		Hospital has system for periodic review of the standard procedures as and when required		RR	
ME G4.2.	Standard Operating Procedures adequately describes process and procedures	Hospital has documented system for Internal audits at defined intervals		RR	
		Hospital has documented procedure for control of documents and records		RR	
		Hospital has documented procedure for defining Quality objectives		RR	
		Hospital has documented procedure for action planning		RR	
		Hospital has documented procedure for training and CMEs of hospital staff at defined intervals		RR	
		Hospital has documented procedure for monthly review meeting		RR	
ME G4.3.	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is trained for relevant part of SOPs		SI/RR	Check for the training records
ME G4.4	The facility ensures documented policies and procedures are appropriately approved and controlled	Hospital has established procedure for drafting, reviewing, approving the Quality Management systems documents		RR	(a) Check availability of requisition forms & formats for developing the required documents. A system in place to draft, review the QMS documents and approval to use the documents is given by appropriate authority. (b) Check the detailed procedure is mentioned in Quality Improvement manual and followed

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Hospital has established procedure for controlling & updating the QMS documents		RR	(a) Check all the QMS documents and records (both internal & external origin) are controlled. (b) Check the documents are updated as and when required
		Hospitals has established system to provide identification number to the QMS documents and records		RR	(a) Check system in place to retention and retrieval the all QMS documents (b) Check all documents have title, effective date, reference number etc and signed by competent authority (C) Check the system is meticulously followed in all departments
		Master list of the documents and records is available		RR	(a) Check master list of documents and records is maintained. (b) Check the list is updated.
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1.	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2.	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3.	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.1	Facility has defined mission statement	Check if mission statement has been defined adequately		SI/RR	Mission state meant should define the purpose , target users and long term goal of facility. Mission should be defined in consultation with stakeholders and duly approved by head of facility. Mission should be in coherence with the stated mission of state health department and National Health Mission

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.2	Facility has defined core values of the organization	Check if core values of the facilities have been defined		SI/RR	Check if core values of organization such as non discrimination, transparency, ethical clinical practices, competence etc have been defined
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1.	Facility uses method for quality improvement in services	PDCA		SI/RR	
		5S		SI/OB	
		Mistake proofing		SI/OB	
		Six Sigma		SI/RR	
ME G7.2.	Facility uses tools for quality improvement in services	Basic tools of Quality		SI/RR	
		Prateo/Priorization		SI/RR	
		Gantt Chart/Project Management		SI/RR	
Standard G8	**Facility has de defined, approved and communicated Risk Management framework for existing and potential risks.**				
ME G8.1	Risk Management framework has been defined including context, scope, objectives and criteria	Check for adequacy of Risk Management Framework		SI/RR	Review the risk management framework document. Check scope and objectives of the framework is contextual to the facility and criterion for identifying risk has been explicitly laid out.
ME G8.2	Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions	Check if responsibilities for identifying and managing risk has been defined and communicated		SI/RR	Review risk management framework delineation of responsibilities amongst staff for identifying the risk in their work area and their management. Verify with the staff members if they are aware of their responsibilities

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G8.3	Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders	Check if process of reporting risks and hazards have been defined		SI/RR	Review risk management framework for process of reporting incidents including near miss and potential risks
ME G8.4	A compressive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared	Check if list of existing and potential risk have been prepared		SI/RR	Review risk management framework includes list of identified current and potential risks. These may included safety, strategic, financial, statutory, operational and environmental risks.
ME G8.5	Modality for staff training on risk management is defined	Check training on risk management has been provided to key staff members		SI/RR	Verify with the training records . Training on risk management at least should be provided to person responsible for indemnifying and managing risks
ME G8.6	Risk Management Framework is reviewed periodically	Check risk management framework is reviewed at least once in a year		SI/RR	Check with the records that quality team/ risk management committee reviews the framework at least once in a year
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.1	Risk management plan has been prepared and approved by the designated authority and there is a system of its updating at least once in a year	Check if a valid risk management plan is available at the facility		SI/RR	Review the risk management plan document. Check it has been updated at lest once in a month and duly approved by the head of facility.
ME G9.2	Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders	Check if risk management plan has been communicated to all stake holders		SI/RR	ask staff if they are aware of key actionable points of risk management plan of their concerned areas. Check what measures hospital administration has taken for effective dissemination of risk management plan amongst staff members, outsource agencies and as well as concerned officials in district and state health administration

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G9.3	Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders	Check if risk assessment checklist is available with stakeholders		SI/RR	Check if facility has prepared assessment checklist for identifying risk on routine basis. This checklist has been disseminate to the staff members responsible for identifying and reporting risks
ME G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria	Check if periodic assessment of Physical and electrical safety risk is done using the risk assessment checklist		SI/RR	Verify with the assessment records. Comprehensive of physical and electrical safety should be done at least once in three month
ME G9.5	Periodic assessment for potential disasters including re is done as per de defined criteria	Check periodic assessment pf potential disaster is done periodically		SI/RR	Check comprehensive assessment of both manmade and natural potential disaster is done at least once in year
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define d criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	Check if Periodic assessment of violence risks is done		SI/RR	Verify with records. At least once in year and whenever a major incident has occurred.
ME G9.8	Risks identified are analysed evaluated and rated for severity	Check if various risks identified during the risk assessment proceeds are formally evaluated		SI/RR	Risk identified should be listed and evaluated for their security and frequency for occurrence. A risk severity score / grade should be give to each risk identified and according gaps should be rated. Verify with the records

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G9.9	Identified risks are treated based on severity and resources available	Check if risk have high severe are prioritised.		SI/RR	Check risks are prioritized base on their severity rating. Verify with the records
ME G9.10	A risk register is maintained and updated regularly to risk records identify ed risks, there severity and action to be taken	Check if a risk register is maintained		SI/RR	Check hospital administration/ responsible committee maintains a risk register which risk identified, their severity, action to be taken to mitigate risk and follow up action. Check if risk register share been updated timely.
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**				
ME G10.1	The facility has defined clinical governance framework	Facility has defined framework for clinical Governance		RR/SI	(a) Framework reflects facility's commitment & accountability for Continuous quality improvement in their Clinical services . (b) Framework define the responsibilities of clinical Governance board (c) Framework defines the approaches used to implement clinical Governance in healthcare facility i.e. audits, risk management, clinical effectiveness, patient & public involvement, education and training, information management etc
		Facility has clinical Governance Board at place		RR/SI	(a) Check Clinical Governance Board/ Apex Committee has representation from all the clinical departments. (b) Department Heads/ Inchages/ Representatives are identified or appointed (c) Members of Apex Committee is aware about their roles & responsibilities

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Clinical Governance Board/ Apex committee prepared & approve the facility's plan for improving clinical quality and safety of patients		RR/SI	All the Clinical committee viz Infection control committee, medical, death and prescription audit committee etc. are functioning under guidance of Clinical Governance board
		Clinical Governance Board/ Apex committee regularly receive reports on the quality and patient safety activities		RR/SI	Board review the reports & monitor the compliance to action taken reports. Also, provide support for the compliance .
		Clinical Governance board meet at regular intervals		RR/SI	At least once in month
		Check clinical care outcomes & indicators are reviewed		RR/SI	Aggregate patient data is collected and reviewed: (a) Clinical Outcomes (b) Clinical indicators (c) Adverse/sentile events that occurred
		Decision taken in clinical Governance meeting are communicated to all concerned staff		RR/SI	Check the system in place to communicate the decisions of clinical governance meetings to all medical professionals
		There is system in place to conduct grand rounds regularly		RR/SI	(1) To promote collegiality, communication, collaboration, and learning among healthcare professionals (2) Check how frequently the grand rounds are conducted
ME G10.2	Clinical Governance framework has been effectively communicated to all staff	Check staff is aware of Clinical Governance framework		SI	Staff is aware of role of clinical Governance in improving quality of care
ME G10.6	Governing body of healthcare facilities ensures accountability for clinical care provided	Hospitals has defined accountability & responsibility for day to day operations		RR	Check hospital has defined & documented organogram
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1.	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate		RR	
		No. of total admissions per thousand population		RR	
		IPD per thousand population		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		OPD consultation per Thousand Population		RR	
		Number of beds per 10 thousand		RR	
		Maternal mortality per 1000 deliveries		RR	
		Neonatal mortality per 1000 live births		RR	
		Nurse to bed ratio		RR	
		No. of meeting held under RKS		RR	
		Proportion of BPL patient in hospital		RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Overall Referral Rate		RR	
		Overall discharge rate		RR	
		Proportion of obstetric cases out of total IPD		RR	
		Proportion of fund/ grant utilized		RR	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average Length of Stay		RR	
		Crude mortality rate		RR	
		Maternal mortality per 1000 deliveries		RR	
		Neonatal mortality per 1000 live births		RR	
		Hospital acquired infection rate		RR	Surgical Site, Device related hospital acquired infection rate
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Overall LAMA Rate		RR	
		Patient satisfaction Score IPD		RR	
		Staff Satisfaction Score		RR	
		Turn over rate of contractual staff		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

GENERAL ADMINISTRATION SCORE CARD	
Area of Concern wise score	**General Administration Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

AREA OF CONCERN A- SERVICE PROVISION	
Standard A1	**Facility Provides Curative Services**
ME A1.1	The facility provides General Medicine services
ME A1.2	The facility provides General Surgery services
ME A1.3	The facility provides Obstetrics & Gynaecology Services
ME A1.4	The facility provides paediateric services
ME A1.5	The facility provides Ophthalmology Services
ME A1.6	The facility provides ENT Services
ME A1.7	The facility provides Orthopaedics Services
ME A1.8	The facility provides Skin & VD Services
ME A1.9	The facility provides Psychiatry Services
ME A1.10	The facility provides Dental Treatment Services
ME A1.11	The facility provides AYUSH Services
ME A1.12	The facility provides Physiotherapy Services
ME A1.13	The facility provides services for OPD procedures
ME A1.14	Services are available for the time period as mandated
ME A1.15	The facility provides services for Super specialties, as mandated
ME A1.16	The facility provides Accident & Emergency Services
ME A1.17	The facility provides Intensive care Services
ME A1.18	The facility provides Blood bank & transfusion services
ME A1.19	The facility provides the dialysis services
Standard A2	**Facility provides RMNCHA Services**
ME A2.1	The facility provides Reproductive health Services
ME A2.2	The facility provides Maternal health Services
ME A2.3	The facility provides Newborn health Services
ME A2.4	The facility provides Child health Services
ME A2.5	The facility provides Adolescent health Services
Standard A3	**Facility Provides diagnostic Services**
ME A3.1	The facility provides Radiology Services
ME A3.2	The facility Provides Laboratory Services
ME A3.3.	The facility provides other diagnostic services, as mandated
Standard A4	**Facility provides services as mandated in National Health Programmes/ State Scheme**
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines
ME A4.5	The facility provides services under National Programme for Prevention and control of Blindness as per guidelines
ME A4.6	The facility provides services under Mental Health Programme as per guidelines
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines
ME A4.9	The facility Provides services under Integrated Disease Surveillance Programme as per Guidelines

ME A4.10	The facility provide services under National health Programme for deafness
ME A4.11	The facility provides services as per State specific health programmes
ME A 4.12	The facility provided services as per Rashtriya bal swasthya Karykram
ME A4.13	The facility provides services as PMNDP
ME A4.14	The facility provides services as per National Viral Hepatitis Program
ME A4.15	The facility provide services under National Programme for pallative care
Standard A5	**Facility provides support services**
ME A5.1	The facility provides dietary services
ME A5.2	The facility provides laundry services
ME A5.3.	The facility provides security services
ME A5.4	The facility provides housekeeping services
ME A5.5	The facility ensures maintenance services
ME A5.6	The facility provides pharmacy services
ME A5.7	The facility has services of medical record department
ME A5.8	The facility provides mortuary services
Standard A6	**Health services provided at the facility are appropriate to community needs.**
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.
ME A6.2	There is process for consulting community/ or their representatives when planning or revising scope of services of the facility
AREA OF CONCERN B- PATIENT RIGHTS	
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**
ME B1.1	The facility has uniform and user-friendly signage system
ME B1.2	The facility displays the services and entitlements available in its departments
ME B1.3	The facility has established citizen charter, which is followed at all levels
ME B1.4	User charges are displayed and communicated to patients effectively
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches
ME B1.6	Information is available in local language and easy to understand
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**
ME B2.1	Services are provided in manner that are sensitive to gender
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities
ME B2.4	There is no discrimination on basis of social and economic status of the patients
ME B2.5	There is affirmative actions to ensure that vulnerable sections can access services
Standard B3	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**
ME B3.1	Adequate visual privacy is provided at every point of care
ME B3.2	Confidentiality of patients records and clinical information is maintained
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups

Standard B4	Facility has defined and established procedures for informing patients about the medical condition,and involving them in treatment planning, and facilitate informed decision making patient.
ME B4.1	There is established procedures for taking informed consent before treatment and procedures
ME B4.2	Patient is informed about his/her rights and responsibilities
ME B4.3	Staff are aware of Patients rights responsibilities
ME B4.4	Information about the treatment is shared with patients or attendants, regularly
ME B4.5	The facility has defined and established grievance redressal system in place
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**
ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.
ME B6.2	The Facility staff is aware of code of conduct established
ME B6.3	The Facility has an established procedure for entertaining representatives of drug companies and suppliers
ME B6.4	The Facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization
ME B6.6	There is an established procedure for 'end-of-life' care
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research
ME B6.9	There is an established procedure to issue of medical certificates and other certificates
ME B6.10	There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services
ME B6.11	An updated copy of code of ethics under Indian Medical council act is available with the facility
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dilemmas' in a time-bound manner through ethical committee
AREA OF CONCERN C - INPUTS	
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**
ME C1.1	Departments have adequate space as per patient or work load
ME C1.2	Patient amenities are provide as per patient load
ME C1.3	Departments have layout and demarcated areas as per functions
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law
ME C1.5	The facility has infrastructure for intramural and extramural communication
ME C1.6	Service counters are available as per patient load

ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)
Standard C2	**The facility ensures the physical safety of the infrastructure.**
ME C2.1	The facility ensures the seismic safety of the infrastructure
ME C2.2	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/ board
ME C2.3	The facility ensures safety of electrical establishment
ME C2.4	Physical condition of buildings are safe for providing patient care
Standard C3	**The facility has established Programme for fire safety and other disaster**
ME C3.1	The facility has plan for prevention of fire
ME C3.2	The facility has adequate fire fighting Equipment
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**
ME C4.1	The facility has adequate specialist doctors as per service provision
ME C4.2	The facility has adequate general duty doctors as per service provision and work load
ME C4.3	The facility has adequate nursing staff as per service provision and work load
ME C4.4	The facility has adequate technicians/paramedics as per requirement
ME C4.5	The facility has adequate support / general staff
Standard C5	**Facility provides drugs and consumables required for assured list of services.**
ME C5.1	The departments have availability of adequate drugs at point of use
ME C5.2	The departments have adequate consumables at point of use
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed
Standard C6	**The facility has equipment & instruments required for assured list of services.**
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients
ME C6.5	Availability of Equipment for Storage
ME C6.6	Availability of functional equipment and instruments for support services
ME C6.7	Departments have patient furniture and fixtures as per load and service provision
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year
ME C7.3	Criteria for performance evaluation clinical and Para clinical staff are defined
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year
ME C7.5	Criteria for performance evaluation of support and administrative staff are defined
ME C7.6	Performance evaluation of support and administration staff is done on predefined criteria at least once in a year
ME C7.7	Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff
ME C7.8	Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan

ME C7.9	The Staff is provided training as per defined core competencies and training plan
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision
ME C7.11	Feedback is provided to the staff on their competence assessment and performance evaluation
AREA OF CONCERN D - SUPPORT SERVICES	
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**
ME D1.1	The facility has established system for maintenance of critical Equipment
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment
ME D1.3	Operating and maintenance instructions are available with the users of equipment
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas**
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables
ME D2.2	The facility has establish procedure for procurement of drugs
ME D2.3	The facility ensures proper storage of drugs and consumables
ME D2.4.	The facility ensures management of expiry and near expiry drugs
ME D2.5	The facility has established procedure for inventory management techniques
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**
ME D3.1	The facility provides adequate illumination level at patient care areas
ME D3.2	The facility has provision of restriction of visitors in patient areas
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers
ME D3.4	The facility has security system in place at patient care areas
ME D3.5	The facility has established measure for safety and security of female staff
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**
ME D4.1	Exterior of the facility building is maintained appropriately
ME D4.2	Patient care areas are clean and hygienic
ME D4.3	Hospital infrastructure is adequately maintained
ME D4.4	Hospital maintains the open area and landscaping of them
ME D4.5	The facility has policy of removal of condemned junk material
ME D4.6	The facility has established procedures for pest, rodent and animal control
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply
ME D5.4	The facility has adeqaute arrangement for uninterrupted supply of RO water for dialysis unit
Standard D6	**Dietary services are available as per service provision and nutritional requirement of the patients.**
ME D6.1	The facility has provision of nutritional assessment of the patients
ME D6.2	The facility provides diets according to nutritional requirements of the patients
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients

Standard D7	**The facility ensures clean linen to the patients**
ME D7.1	The facility has adequate availability of linen for meting its need.
ME D7.2	The facility has established procedures for changing of linen in patient care areas
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**
ME D8.1	The facility has established procures for management of activities of Rogi Kalyan Samitis
ME D8.2	The facility has established procedures for community based monitoring of its services
Standard D9	**Hospital has defined and established procedures for Financial Management**
ME D9.1	The facility ensures the proper utilization of fund provided to it
ME D9.2	The facility ensures proper planning and requisition of resources based on its need
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities
ME D10.2	Updated copies of relevant laws, regulations and government orders are available at the facility
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**
ME D11.1	The facility has established job description as per govt guidelines
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**
ME D12.1	There is established system for contract management for out sourced services
ME D12.2	There is a system of periodic review of quality of out sourced services
AREA OF CONCERN E - CLINICAL SERVICES	
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**
ME E1.1	The facility has established procedure for registration of patients
ME E1.2	The facility has a established procedure for OPD consultation
ME E1.3	There is established procedure for admission of patients
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and preparation of the treatment plan.**
ME E2.1	There is established procedure for initial assessment of patients
ME E2.2	There is established procedure for follow-up/ reassessment of Patients
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.
ME E3.3	A person is identified for care during all steps of care
ME E3.4	Facility is connected to medical colleges through telemedicine services

Standard E4	The facility has defined and established procedures for nursing care
ME E4.1	Procedure for identification of patients is established at the facility
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens
ME E4.4	Nursing records are maintained
ME E4.5	There is procedure for periodic monitoring of patients
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**
ME E5.1	The facility identifies vulnerable patients and ensure their safe care
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need
Standard E6	**Facility ensures rationale prescribing and use of medicines**
ME E6.1	Facility ensured that drugs are prescribed in generic name only
ME E6.2	There is procedure of rational use of drugs
ME E6.3	There are procedures defined for medication review and optimization
Standard E7	**Facility has defined procedures for safe drug administration**
ME E7.1	There is process for identifying and cautious administration of high alert drugs
ME E7.2	Medication orders are written legibly and adequately
ME E7.3	There is a procedure to check drug before administration/ dispensing
ME E7.4	There is a system to ensure right medicine is given to right patient
ME E7.5	Patient is counselled for self drug administration
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.
ME E8.3	Care provided to each patient is recorded in the patient records
ME E8.4	Procedures performed are written on patients records
ME E8.5	Adequate form and formats are available at point of use
ME E8.6	Register/records are maintained as per guidelines
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records
Standard E9	**The facility has defined and established procedures for discharge of patient.**
ME E9.1	Discharge is done after assessing patient readiness
ME E9.2	Case summary and follow-up instructions are provided at the discharge
ME E9.3	Counselling services are provided as during discharges wherever required
Standard E10	**The facility has defined and established procedures for intensive care.**
ME E10.1	The facility has established procedure for shifting the patient to step-down/ward based on explicit assessment criteria
ME E10.2	The facility has defined and established procedure for intensive care
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubation, and care of patients on ventilation and subsequently on its removal
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**
ME E11.1	There is procedure for Receiving and triage of patients
ME E11.2	Emergency protocols are defined and implemented
ME E11.3	The facility has disaster management plan in place
ME E11.4	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement
ME E11.5	There is procedure for handling medico legal cases
Standard E12	**The facility has defined and established procedures of diagnostic services**
ME E12.1	There are established procedures for Pre-testing Activities

ME E12.2	There are established procedures for testing Activities
ME E12.3	There are established procedures for Post-testing Activities
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**
ME E13.1	Blood bank has defined and implemented donor selection criteria
ME E13.2	There is established procedure for the collection of blood
ME E13.3	There is established procedure for the testing of blood
ME E13.4	There is established procedure for preparation of blood component
ME E13.5	There is establish procedure for labelling and identification of blood and its product
ME E13.6	There is established procedure for storage of blood
ME E13.7	There is established the compatibility testing
ME E13.8	There is established procedure for issuing blood
ME E13.9	There is established procedure for transfusion of blood
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication
Standard E14	**Facility has established procedures for Anaesthetic Services**
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up and medical records
ME E14.2	Facility has established procedures for monitoring during anaesthesia and maintenance of records
ME E14.3	Facility has established procedures for Post Anaesthesia care
Standard E15	**Facility has defined and established procedures of Operation theatre services**
ME E15.1.	Facility has established procedures OT Scheduling
ME E15.2	Facility has established procedures for Preoperative care
ME E15.3	Facility has established procedures for Surgical Safety
ME E15.4	Facility has established procedures for Post operative care
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**
ME E16.1	Death of admitted patient is adequately recorded and communicated
ME E16.2	The facility has standard procedures for handling the death in the hospital
ME E16.3	The facility has standard procedures for conducting post-mortem, its recording and meeting its obligation under the law
Standard E17	**Facility has established procedures for Antenatal care as per guidelines**
ME E17.1	There is an established procedure for Registration and follow up of pregnant women.
ME E17.2	There is an established procedure for History taking, Physical examination, and counselling for each antenatal visit.
ME E17.3	Facility ensures availability of diagnostic and drugs during antenatal care of pregnant women
ME E17.4	There is an established procedure for identification of High risk pregnancy and appropriate treatment/referral as per scope of services.
ME E17.5	There is an established procedure for identification and management of moderate and severe anaemia
ME E17.6	Counselling of pregnant women is done as per standard protocol and gestational age
Standard E18	**Facility has established procedures for Intranatal care as per guidelines**
ME E18.1	Facility staff adheres to standard procedures for management of second stage of labour.
ME E18.2	Facility staff adheres to standard procedure for active management of third stage of labour
ME E18.3	Facility staff adheres to standard procedures for routine care of new-born immediately after birth
ME E18.4	There is an established procedure for assisted and C-section deliveries per scope of services.
ME E18.5	Facility staff adheres to standard protocols for identification and management of Pre Eclampsia / Eclampsia
ME E18.6	Facility staff adheres to standard protocols for identification and management of PPH.

ME E18.7	Facility staff adheres to standard protocols for Management of HIV in Pregnant Woman & Newborn
ME E18.8	Facility staff adheres to standard protocol for identification and management of preterm delivery.
ME E18.9	Staff identifies and manages infection in pregnant woman
ME E18.10	There is Established protocol for newborn resuscitation is followed at the facility.
ME E18.11	Facility ensures Physical and emotional support to the pregnant women means of birth companion of her choice
Standard E19	**Facility has established procedures for postnatal care as per guidelines**
ME E19.1	Facility staff adheres to protocol for assessment of condition of mother and baby and providing adequate postpartum care
ME E19.2	Facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding
ME E19.3	Facility staff adheres to protocol for ensuring care of newborns with small size at birth
ME E 19.4	The facility has established procedures for stabilization/treatment/referral of post natal complications
ME E19.5	The facility ensure adequate stay of mother and new born in a safe environoment as per standard protocols
ME E19.6	There is established procedure for discharge and follow up of mother and newborn.
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**
ME E20.1	The facility provides immunization services as per guidelines
ME E20.2	Triage, Assessment & Management of newborns having emergency signs are done as per guidelines
ME E20.3	Management of Low birth weight newborns is done as per guidelines
ME E20.4	Management of neonatal asphyxia is done as per guidelines
ME E20.5	Management of neonatal sepsis is done as per guidelines
ME E20.6	Management of children with Jaundice is done as per guidelines
ME E20.7	Management of children presenting with fever, cough/ breathlessness is done as per guidelines
ME E20.8	Management of children with severe acutue malnutrition is done as per guideline
ME E20.9	Management of children presenting diarrhoea is done per guidelines
ME 20.10	The facility ensures optimal breast feedingpractices for new born & infants as per guidelines
ME E20.11	The facility provide services under Rashtriya Bal Swasthya Karyakram (RBSK)
Standard E21	**Facility has established procedures for abortion and family planning as per government guidelines and law**
ME E21.1	Family planning counselling services provided as per guidelines
ME E21.2	Facility provides spacing method of family planning as per guideline
ME E21.3	Facility provides limiting method of family planning as per guideline
ME E21.4	Facility provide counselling services for abortion as per guideline
ME E21.5	Facility provide abortion services for 1st trimester as per guideline
ME E21.6	Facility provide abortion services for 2nd trimester as per guideline
Standard E22	**Facility provides Adolescent Reproductive and Sexual Health services as per guidelines**
ME E22.1	Facility provides Promotive ARSH Services
ME E22.2	Facility provides Preventive ARSH Services
ME E22.3	Facility Provides Curative ARSH Services
ME E22.4	Facility Provides Referral Services for ARSH
Standard E23	**Facility provides National health program as per operational/Clinical Guidelines**
ME E23.1	Facility provides service under National Vector Borne Disease Control Program as per guidelines

ME E23.2	Facility provides service under National TB Elmination Program as per guidelines
ME E23.3	Facility provides service under National Leprosy Eradication Program as per guidelines
ME E23.4	Facility provides service under National AIDS Control program as per guidelines
ME E23.5	Facility provides service under National program for control of Blindness as per guidelines
ME E23.6	Facility provides service under Mental Health Program as per guidelines
ME E23.7	Facility provides service under National programme for the health care of the elderly as per guidelines
ME E23.8	Facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines
ME E23.9	Facility provide service for Integrated disease surveillance program
ME E23.10	Facility provide services under National program for prevention and control of deafness
ME E 23.11	The facility provide services under National viral Hepatitis Control Programme
ME E23.12	Facility provide services under National program for pallative care
Standard E24	**The facility has defined and established procedure for Haemodialysis Services**
ME E 24.1	The facility has defined and establised procedure for Pre Haemodialysis assessment
ME E 24.2	The facility has defined and establised procedure for care during Haemodialysis
ME E 24.3	The facility has defined and established procedure for care after completion of Haemodialysis
AREA OF CONCERN F - INFECTION CONTROL	
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**
ME F1.1	Facility has functional infection control committee
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas
ME F1.3	Facility measures hospital associated infection rates
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff
ME F1.5	Facility has established procedures for regular monitoring of infection control practices
ME F1.6	Facility has defined and established antibiotic policy
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**
ME F2.1	Hand washing facilities are provided at point of use
ME F2.2	Staff is trained and adhere to standard hand washing practices
ME F2.3	Facility ensures standard practices and materials for antisepsis
Standard F3	**Facility ensures standard practices and materials for Personal protection**
ME F3.1	Facility ensures adequate personal protection equipments as per requirements
ME F3.2	Staff is adhere to standard personal protection practices
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**
ME F5.1	Layout of the department is conducive for the infection control practices
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas
ME F5.4	Facility ensures segregation infectious patients
ME F5.5	Facility ensures air quality of high risk area

Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines and on-site management of waste is carried out as per guidelines
ME F6.2	Facility ensures management of sharps as per guidelines
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines
AREA OF CONCERN G - QUALITY CONTROL	
Standard G1	**The facility has established organizational framework for quality improvement**
ME G1.1	The facility has a quality team in place
ME G1.2	The facility reviews quality of its services at periodic intervals
Standard G2	**Facility has established system for patient and employee satisfaction**
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals
ME G2.2	Facility analyses the patient feed back and do root cause analysis
ME G2.3	Facility prepares the action plans for the areas, contributing to low satisfaction of patients
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**
ME G3.1	Facility has established internal quality assurance program at relevant departments
ME G3.2	Facility has established external assurance programs at relevant departments
ME G3.3	Facility has established system for use of check lists in different departments and services
ME G3.4	Actions are planned to address gaps observed during quality assurance process
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**
ME G4.1	Departmental standard operating procedures are available
ME G4.2	Standard Operating Procedures adequately describes process and procedures
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs
ME G4.4	The facility ensures documented policies and procedures are appropriately approved and controlled
Standard G5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**
ME G5.1	Facility maps its critical processes
ME G5.2	Facility identifies non value adding activities / waste / redundant activities
ME G5.3	Facility takes corrective action to improve the processes
Standard G6	**The facility has defined Mission, values, Quality policy and objectives, and prepares a strategic plan to achieve them**
ME G6.1	Facility has defined mission statement
ME G6.2	Facility has defined core values of the organization
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**
ME G7.	Facility uses method for quality improvement in services
ME G7.2	Facility uses tools for quality improvement in services

Standard G8	**Facility has de defined, approved and communicated Risk Management framework for existing and potential risks.**
ME G8.1	Risk Management framework has been defined including context, scope, objectives and criteria
ME G8.2	Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions
ME G8.3	Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders
ME G8.4	A compressive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared
ME G8.5	Modality for staff training on risk management is defined
ME G8.6	Risk Management Framework is reviewed periodically
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**
ME G9.1	Risk management plan has been prepared and approved by the designated authority and there is a system of its updating at least once in a year
ME G9.2	Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders
ME G9.3	Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders
ME G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria
ME G9.5	Periodic assessment for potential disasters including re is done as per de defined criteria
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria
ME G9.8	Risks identified are analyzed evaluated and rated for severity
ME G9.9	Identifed risks are treated based on severity and resources available
ME G9.10	A risk register is maintained and updated regularly to risk records identify ed risks, there severity and action to be taken
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**
ME G10.1	The facility has defined clinical governance framework
ME G10.2	Clinical Governance framework has been effectively communicated to all staff
ME G10.3	Clinical care assessment criteria have been defined and communicated
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process
ME G10.6	Governing body of healthcare facilities ensures accountability for clinical care provided
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care
AREA OF CONCERN H - OUTCOME	
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**
ME H1.1	Facility measures productivity Indicators on monthly basis
ME H1.2	Facility endavours to improve its productivity indicators to meet benchmarks
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**
ME H2.1	Facility measures efficiency Indicators on monthly basis
ME H2.2	Facility endavours to improve its efficiency indicators to meet benchmarks

Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis
ME H3.2	Facility endavours to improve its clincal & safety indicators to meet benchmarks
Standard H4	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**
ME H4.1	Facility measures Service Quality Indicators on monthly basis
ME H4.2	Facility endavours to improve its service Quality indicators to meet benchmarks

KEY CHANGES IN NATIONAL QUALITY ASSURANCE STANDARDS, 2020

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
Broad Changes	8 Area of Concerns 74 Standards 362 Measurable Elements 19 Checklists	8 Areas of Concern 75 Standards 380 Measurable Elements 21 Checklist
Standards Added	**STANDARD B6:** The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities. **STANDARD C7:** The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff. **STANDARD G9:** The facility has defined, approved and communicated Risk Management framework for existing and potential risks. **STANDARD G10:** The facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan.	**Standard E24:** The facility has established a procedure for haemodialysis services. **Standard G10 :** The facility has established clinical governance framework to improve the quality and safety of clinical care processes.
Measurable Elements Added	**UNDER STANDARD A4:** **ME A4.12:** The facility provides services as per Rashtriya Bal Swasthya Karyakram. **UNDER STANDARD B6:** **ME B6.1:** Ethical norms and code of conduct for medical and paramedical staff have been established. **ME B6.2:** The facility staff is aware of code of conduct established. **ME B6.3:** The facility has an established procedure for entertaining representatives of drug companies and suppliers. **ME B6.4:** The facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions. **ME B6.5:** There is an established procedure for sharing of hospital/patient data withindividuals and external agencies including non-governmental organization. **ME B6.6:** There is an established procedure for 'end-of-life' care. **ME B6.7:** There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific treatment. **ME B6.8:** There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research. **ME B6.9:** There is an established procedure to issue medical certificates and other certificates.	**Under Standard A1:** **ME A1.19** : The facility provides Dialysis Services. **Under Standard A4:** **ME A4.13:** The facility provides services as per Pradhan Mantri National Dialysis Programme **ME A4.14:** The facility provides services as per National Viral Hepatitis Program **ME A4.15:** The facility provides services as per National Program for palliative care. **Under Standard D5:** **ME D5.4:** The facility has adequate arrangements for an uninterrupted supply of RO water for the dialysis unit. **Under Standard E23:** **ME E23.11:** The facility provides services under the National Viral Hepatitis Control Programme **ME 23.12:** The facility provides services under the National Program for palliative care. **Under Standard E24:** The facility has defined and established a procedure for Pre-Haemodialysis assessment.

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME B6.10: There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services. **ME B6.11:** An updated copy of code of ethics under Indian Medical Council Act is available with the facility. **UNDER STANDARD C7:** **ME C7.1:** Criteria for competence assessment are defined for Clinical and Para clinical staff. **ME C7.2:** Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year. **ME C7.3:** Criteria for performance evaluation of Clinical and Para clinical staff are defined. **ME C7.4:** Performance evaluation of Clinical and Para clinical staff is done on predefined criteria at least once in a year. **ME C7.5:** Criteria for performance evaluation of support and administrative staff are defined. **ME C7.6:** Performance evaluation of support and administration staff is done on predefined criteria at least once in a year. **ME C7.7:** Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff. **ME C7.8**: Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan. **ME C7.9:** The staff is provided training as per defined core competencies and training plan. **ME C7.10:** There is established procedure for utilization of skills gained through trainings by on-job supportive supervision. **ME C7.11:** Feedback is provided to the staff on their competence assessment and performance evaluation. **UNDER STANDARD E18:** **ME E18.1:** The facility staff adheres to standard procedures for management of second stage of labor. **ME E18.2:** The facility staff adheres to standard procedure for active management of third stage of labor. **ME E18.3:** The facility staff adheres to standard procedures for routine care of newborn immediately after birth. **ME E18.5:** The facility staff adheres to standard protocols for identification and management of Pre Eclampsia/Ecalmpsia	The facility has defined and established procedure for care during haemodialysis. The facility has defined and established procedures for care after the completion of haemodialysis

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME E18.6: The facility staff adheres to standard protocols for identification and management of PPH **ME E18.7:** The facility staff adheres to standard protocols for Management of HIV in pregnant woman & newborn **ME E18.8:** The facility staff adheres to standard protocol for identification and management of preterm delivery. **ME E18.9:** Staff identifies and manages infection in pregnant woman. **ME E18.11:** The facility ensures physical and emotional support to the pregnant women by means of birth companion of her choice. **UNDER STANDARD E19:** **ME E19.3:** The facility staff adheres to protocol for ensuring care of newborns with small size at birth. **UNDER STANDARD E20:** **ME E20.5:** Management of neonatal sepsis is done as per guidelines. **ME E20.6:** Management of children with Severe Acute Malnutrition is done as per guidelines. **ME E20.10:** The facility ensures optimal breast feeding practices for new born & infants, as per guidelines. **UNDER STANDARD G9:** **ME G9.1:** Risk Management framework has been defined including context, scope, objectives and criteria. **ME G9.2:** Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions. **ME G9.3:** Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders. **ME G9.4:** A comprehensive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared. **ME G9.5:** Modality for staff training on risk management is defined. **ME G9.6:** Risk Management Framework is reviewed periodically. **UNDER STANDARD G10:** **ME G10.1:** Risk management plan has been prepared and approved by the designated authority and there is a system of its updation at least once in a year. **ME G10.2:** Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders. **ME G10.3:** Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders. **ME G10.4:** Periodic assessment for physical and electrical risks is done as per defined criteria.	

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME G10.5: Periodic assessment for potential disasters including fire is done as per defined criteria. **ME G10.6:** Periodic assessment for medication and patient care safety risks is done, as per defined criteria. **ME G10.7:** Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria. **ME G10.8:** Risks identified are analyzed, evaluated and rated for severity. **ME G10.9:** Identified risks are treated based on severity and resources available. **ME G10.10:** A risk register is maintained and updated regularly to identify risks, their severity and action to be taken. **UNDER STANDARD E19:** **ME E19.3:** The facility staff adheres to protocol for ensuring care of newborns with small size at birth. **UNDER STANDARD E20:** **ME E20.5:** Management of neonatal sepsis is done as per guidelines. **ME E20.6:** Management of children with Severe Acute Malnutrition is done as per guidelines. **ME E20.10:** The facility ensures optimal breast feeding practices for new born & infants, as per guidelines. **UNDER STANDARD G9:** **ME G9.1:** Risk Management framework has been defined including context, scope, objectives and criteria. **ME G9.2:** Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions. **ME G9.3:** Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders. **ME G9.4:** A comprehensive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared. **ME G9.5:** Modality for staff training on risk management is defined. **ME G9.6:** Risk Management Framework is reviewed periodically. **UNDER STANDARD G10:** **ME G10.1:** Risk management plan has been prepared and approved by the designated authority and there is a system of its updation at least once in a year. **ME G10.2:** Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders.	

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME G10.3: Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders. **ME G10.4:** Periodic assessment for physical and electrical risks is done as per defined criteria. **ME G10.5:** Periodic assessment for potential disasters including fire is done as per defined criteria. **ME G10.6:** Periodic assessment for medication and patient care safety risks is done, as per defined criteria. **ME G10.7:** Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria. **ME G10.8:** Risks identified are analyzed, evaluated and rated for severity. **ME G10.9:** Identified risks are treated based on severity and resources available. **ME G10.10:** A risk register is maintained and updated regularly to identify risks, their severity and action to be taken.	
Measurable Elements Deleted/ Shifted	Shifted under ME C7.9 Shifted under ME C7.8, C7.9, C7.10 & C7.11 Shifted under ME B6.7 Shifted under ME B6.6 Shifted under ME E18.1, E18.2 & E18.3 Shifted under ME E18.5, E18.6 & E18.7	**ME G6.1:** The facility conducts periodic internal assessment – Shifted as a checkpoint in ME G3.3 **ME G6.2** The facility conducts the periodic prescription/medical/death audits". – Shifted as ME G10.4 **ME G6.3:** The facility ensures non compliances are enumerated and recorded adequately" – Shifted as a checkpoint in ME G10.4 **ME G6.4:** Action plan is made on the gaps found in the assessment/audit process" – Shifted as ME G3.4 **ME G6.5:** Planned action are implemented through Quality Improvement Cycle (PDCA)". – Shifted as ME G3.5
Standards Rephrased	**ME E18.10:** There is an established protocol for newborn resuscitation and it is followed at the facility. **ME E19.1:** The facility staff adheres to protocol for assessments of condition of mother and baby and provide adequate postpartum care. **ME E19.2:** The facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding. **ME E20.4:** Management of neonatal asphyxia is done as per guidelines **ME G6.5:** Planned actions are implemented through Quality improvement cycle (PDCA). **ME G7.1:** The facility has defined mission statement. **ME G7.2:** The facility has defined core values of the organization.	**Standard E2 :** The facility has defined and established procedure for clinical assessment, reassessment and treatment plan preparation". **Standard E6 :** The facility ensures rationale prescribing and use of medicines". **Standard E16:** The facility has defined and established procedures for the management of death & bodies of deceased patients

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME G7.3: The facility has defined Quality policy, which is in congruency with the mission of facility. **ME G7.4:** The facility has defined Quality objectives to achieve mission and Quality policy. **ME G7.5:** Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services. **ME G7.6:** The facility prepares strategic plan to achieve mission, Quality policy and objectives. **ME G7.7:** The facility periodically reviews the progress of strategic plan towards mission, policy and objectives. **ME H1.2:** The facility endeavours to improve its Productivity Indicators to meet benchmarks. **ME H2.2:** The facility endeavours to improve its Efficiency Indicators to meet benchmarks. **ME H3.2:** The facility endeavours to improve its Clinical & Safety Indicators to meet benchmarks. **ME H4.2:** The facility endeavours to improve its Service Quality Indicators to meet benchmarks.	
Standard Deleted		**Standard G6:** The facility has established system for periodic review as internal assessment, medical & death audit and prescription audit.
		Apart from above changes National Health Programmes are updated as per latest guidelines.

LIST OF ABBREVIATIONS

5S	Sort, Set In Order, Shine, Standardize, Sustain
A& E	Accident & Emergency
ABC	Airway, Breathing and Circulation
ABPMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
ACD	Anti Convulsant Drug
AEFI	Adverse Events Following Immunization
AERB	Atomic Energy Regulatory Board
AES	Acute Encephalitis Syndrome
AFHC	Adolescent Friendly Health Centre
AIDS	Acquired Immuno Deficiency Syndrome
ALS	Advanced Life Support
AMC	Annual Maintenance Contract
AMSTL	Active Management of the Third Stage of Labour
ANC	Anti Natal Check-up
ANM	Auxiliary Nurse Midwife
APH	Ante Partum Haemorrhage
APL	Above Poverty Line
ARF	Acute Renal Failure
ARI	Acute Respiratory Infection
ART	Anti Retroviral Therapy
ARV	Anti Rabies Vaccine
ASHA	Accredited Social Health Activist
ASV	Anti Snake Venom
ATD	Anti Tubercular Medicines
AYUSH	Ayurveda, Yoga, Unani, Sidhha & Homoeopathy
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guerin
BHT	Bed Head Ticket
BLS	Basic Life Support
BMEMP	Biomedical Equipment Management & Maintenance Program
BMW	Biomedical Waste
BP	Blood Pressure
BPL	Below Poverty Line
BT	Bleeding Time
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
CBMWTF	Common Bio medical Waste Treatment Facility
CCU	Cardiac Care Unit
CDR	Child Death Review
CHC	Community Health Centre
CHW	Community Healthcare Worker
CLMC	Comprehensive Lactation Management Centre
CLW	Contused Lacerated Wound
CME	Continuous Medical Education

COPD	Chronic Obstructive Pulmonary Disorder
CPC	Clinical Pathological Case
CPR	Cardiopulmonary Resuscitation
CRT	Cardiac Resynchronization Therapy
CSSD	Centralized Sterile Supply Department
CT	Clotting Time
CVA	Cerebral Vascular Accident
CVS	Cardio-Vascular System
D&C SET	Dilatation & Curettage Set
D&E	Dilation & Evacuation
DEIC	District Early Intervention Centre
DGO	Diploma in Obstetrics & Gynaecology
DLC	Differential Leukocyte Count
DMC	Designated Microscopy Centre
DNI	Do Not Intubate
DNR	Do Not Resuscitate
DOTS	Directly Observed Treatment (Short Course)
DPT	Diphtheria, Pertussis and Tetanus
DQAC	District C}uality Assurance Committee
DRTB	Drug Resistance Tuberculosis
DT	Diphtheria & Tetnus
DVDMS	Drugs and Vaccine Distribution Management System
ECG	Electrocardiography
ECP	Emergency Contraceptive Pills
EDD	Expected Date of Delivery
EDL	Essential Drug List
ELISA	Enzyme-Linked Immunosorbent Assay
EML	Essential Medicine List
ENT	Ear Nose Throat
ETAT	Emergency Triage Assessment and Treatment
ET TUBE	Endotracheal Tube
EVA Tray	Electric Vacuum Aspiration
FBNC	Facility Based Newborn Care
FHR	Foetal Heart Rate
FIFO	First In First Out
FIMNCI	Facility Based Integrated Management of Neonatal and Childhood Illnesses
FMP	Falciparum Malaria Parasite
FP	Family Planning
FSN	Fast Moving, Slow Moving , Non Moving
FT4	Free Thyroxine
GOB	General Order Book
GoI	Government of India
HAI	Hospital Acquired Infection
HB	Haemoglobin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDU	High Dependency Unit
HIE	Hypoxic- Ischaemic Encephalophaty
HLD	High-Level Disinfection

HWC	Health & Wellness Centre
I&D	Incision & Drainage
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Program
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IFA	Iron Folic Acid
IHD	Ischaemic Heart Disease
IM/IV	Intra Muscular/Intra Venous
IMNCI	Integrated Management of Newborn Childhood Illnesses
IMS	Infant Medical Substitute
IO Chart	Input-output Chart
IOL	Intra Ocular Lens
IPD	In Patient Department
IQAS/EQAS	Internal Quality Assessment Services/External Quality Assessment Services
IUCD	Intra Uterine Contraceptive Device
IUGR	Intra Uterine Growth Retardation
IYCF	Infant and Yong Child Feeding
JSSK	Janani —Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
JVP	Jugular Venous Pressure
KFT	Kidney Function Test
KMC	Kangaroo Mother Care
LAMA	Leave Against Medical Advice
LDR	Labour-Delivery-Recovery
LFT	Liver Function Test
LMA	Laryngeal Mask Airway
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarean section
LVF	Left Ventricular Failure
MAS	Meconium Aspiration Syndrome
MCP	Mother Child Protection Card
MDR-TB	Multi-Drug Resistance Tuberculosis
ME	Measureable Element
MGPS	Medical Gas Pipeline System
MI	Myocardial Infarction
MLC	Medico Legal Case
MMR	Miniature Mass Radiography
MNCU	Mother Newborn Care Unit
MNT	Medical Nutrition Therapy
MO	Medical Officer
MRD	Medical Record Department
MRO	Medical Record Officer
MRSA	Methicillin-resistant Staphylococcus aureus
MSBOS	Maximum Surgical Blood Order Schedule
MTP	Medical Termination of Pregnancy
MUAC	Mid-Upper Arm Circumference
MVA	Manual Vaccum Aspiration
NACO	National AIDS Control Organisation

NACP	National AIDS Control Programme
NBCC	New Born Care Corner
NCO	Non Communicable Diseases
NHP	National Health Programme
NHSRC	National Health Systems Resource Centre
NICU	Newborn Intensive Care Unit
NOTTO	National Organ & Tissue Transplant Organization
NRC	Nutritional Rehabilitation centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Surkasha Karyakram
NSV	No-ScalpelVasectomy
NTEP	National TB Elimination Programme
NVBDCP	National Vector Borne Disease Control Programme
NVHCP	National Viral Hepatitis Control Program
OB	Observation
OBG	Obstetrics and Gynaecology
OCP	Oral Contraceptive Pills
OGTT	Oral Glucose Tolerance Test
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OT	Operation Theatre
PAC	Pre Anaesthesia Check-up
PASS	Pull, Aim, Squeeze & Sweep
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PDCA	Plan Do Check Act
PEM	Protein Energy Malnutrition
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Centre
PI	Patient Interview
PIB	Police Information Book
PICU	Paediatric Intensive Care Unit
PIH	Pregnancy Induced Hypertension
PLHA	People Living with HIV/AIDS
PMJAY	Pradhan Mantri Jab Arogya Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PPBS	Post Prandial Blood Sugar Test
PPE	Personal Protective Equipment
PPH	Postpartum Haemorrhage
PPIUCD	Postpartum Intra Uterine Contraceptive Device
PPROM	Preterm Premature Rupture of Membranes
PPTCT	Prevention of Parent to Child Transmission
PRC	Packed Red Cells
PV SET	Per Vaginal Set
PVC	Polyvinyl chloride
QA	Quality Assurance
RA Factor	Rheumatoid Arthristis Factor
RACE	Rescue, Alarm, Confine & Extinguish
RBRC	Random Blinded Re Checking

RCS	Re Constructive Surgery
RDK	Rapid Diagnostic Kit
RDS	Respiratory Distress Syndrome
RFT	Renal Function Tests
RKS	Rogi Kalyan Samiti
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH	Reproductive, Maternal, Newborn and Child Health
RMNCHA	Reproductive Maternal Neonatal Child Health and Adolescent
RR	Respiratory Rate/ Record Review
RSBY	Rashtriya Swasthya Bima Yojana
RSO	Radiological Safety Officer
RTA	Road Traffic Accident
RTI/STI	Reproductive Tract Infections / Sexually Transmitted Infections
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SGA	Small for Gestational Age
SI	Staff Interview
SMART	Specific, Measurable, Attainable Relevant, Time Based
SNCU	Sick Newborn Care Unit
SOP	Standard Operating Procedure
SQAC	State Quality Assurance Committee
STG	Standard Treatment Guideline
SWD	Short Wave Diathermy
TB	Tuberculosis
TLC	Total Leukocyte Count
TLD	Thermoluminescent Dosimeter
TMT	Tread Mill Test
TPHA	Treponema pallidum Hemaglutination Assay
TPR	Temperature, Pulse, Respiration
TSB	Total Serum Bilirubin
TSH	Thyroid stimulating Hormone
TSSU	Theatre Sterile Supply Unit
TT	Tetanus Toxoid
TTI	Transfusion Transmitted Infection
TTNB	Transient tachypnoea of new-born
UID	Unique Identification
UPS	Uninterrupted Power Supply
USG	Ultra Sonography
VAP	Ventilator Associated Pneumonia
VD	Venereal Diseases
VDRL	Venereal Disease Research Laboratory
VED	Vital, Essential and Desirable
V-PEP (PAP)	Variable Positive Air Pressure
VVM	Vaccine Vial Monitor
WHO	World Health Organization

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4	Adolescent health	Standard E22
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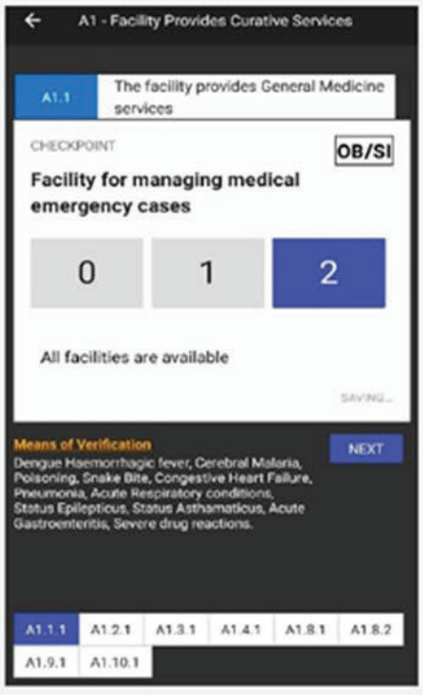
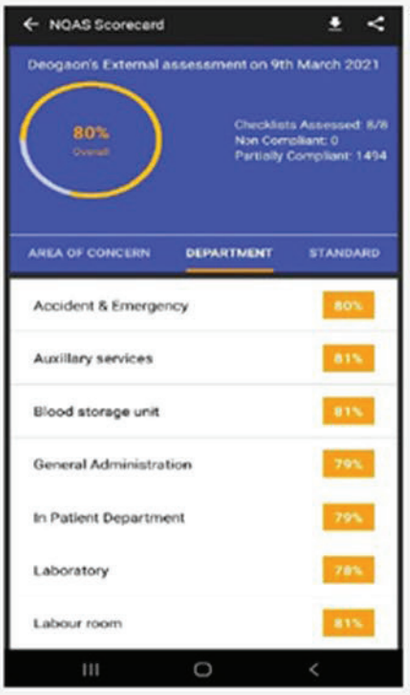
180	Triage	ME E11.1
181	Utilization	Standard H1
182	Vulnerable	ME B2.5 for Affirmative action for Vulnerable sections ME E5.1 for Care of Vulnerable Patients
183	Waiting Time	ME H4.1
184	Water Supply	ME D5.1
185	Work Environment	Standard D3
186	Work Instructions	ME G4.4

APP FOR QUALITY & KAYAKALP ASSESSMENT

Gunak – Guide for NQAS and Kayakalp





- Digital version of NQAS (National Quality Assurance Standards), Kayakalp, LaQshya and MusQan assessments.
- Availability of State/UTs wise customized checklists.
- User-friendly assessment interface with single-hand navigation.
- Automated scorecard generation that can be shared as an excel sheet or image file.
- Real-time reporting of scores to State/UTs & District Quality Assurance teams.

Available on the App Store

GET IT ON Google Play

Go to- or search on Play store/Apple store – NHSRC or NQAS or Kayakalp or Gunak

https:// play.google.com/ store/apps/details? id=co. Facilities assessment

https://apps.apple.com/in/app/gunak /id1354891968

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