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MD, Ph.D.
VICE CHANCELLOR
प्रो० सोनिया नित्यानंद
एम०डी०, पी०एच०डी०
कुलपति

KING GEORGE'S MEDICAL UNIVERSITY U.P.
LUCKNOW
किंग जार्ज चिकित्सा विश्वविद्यालय, उ०प्र०
लखनऊ

Ref. No.: KGMU/VC/20 /2024 Date: April 26, 2024

ORDER

To ensure the availability of adequate health care facilities as per the standard of National Accreditation Board for Hospitals & Healthcare Providers (NABH) & National Quality Assurance Standards (NQAS) in the Hospitals of King George's Medical University, the following faculty members are being designated for accreditation of NABH & NQAS in the University.

1-	**Prof. D. Himanshu** Department of Medicine	Nodal Officer
2-	**Dr. Nitin Dutt Bhardwaj** Additional Professor & HOD-Hospital Administration	Co-Nodal Officer

All the process for the accreditation of NABH/ NQAS in the University will be done under the supervision of Nodal & Co-Nodal officer.

S. Nityanand

(Prof. Soniya Nityanand)
Vice Chancellor

Distribution:-

1- All CMS/MS/DMS, KGMU, Lko.
2- All HODs, KGMU, Lko.
3- All Dean, KGMU, Lko.
4- Registrar, KGMU, Lko
5- Finance Officer, KGMU, LKo.
6- All Faculty Members, KGMU,Lko.
7- Order Book.

NABH: GAP ASSESSMENT REPORT (HCO)

(King George's Medical University-Lucknow, Uttar Pradesh)

ASTRON HOSPITAL & HEALTHCARE CONSULTANTS PVT. LTD.

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We extend our heartfelt gratitude to the management and leadership of **King George's Medical University (KGMU Hospital), Ambedkar Park Road, Madhuban Nagar, Tiwaripur, Lucknow, Uttar Pradesh**, for granting us the opportunity to be a part of the institution's journey toward national accreditation (NABH). It is a privilege to be associated with such a prestigious organization and contribute to the quality movement spearheaded by its authorities.

We sincerely appreciate the support of the hospital's management in facilitating the Gap Assessment in alignment with NABH Accreditation Standards (6th Edition). We are especially grateful to **Prof. Soniya Nityanand, MD, PhD, Vice Chancellor**, for her unwavering support and leadership from the very beginning. Under her able guidance, we are confident that the goal of achieving quality standards will soon be realized.

Our special thanks go to **Prof. D. Himanshu (Nodal Officer, NABH Cell) Professor Department of Medicine, Prof. Nitin Datt Bharadwaj (Sub Nodal Officer, NABH Cell) Professor, Department of Hospital Administration, Prof. Kirti Srivastava, Professor, Department of Radiotherapy, Prof. Vishwajeet Singh, Professor, Department of Urology, Medical Superintendent, Shatabdi Group of Hospitals, Prof. Wahid Ali, Professor, Department of Pathology, Brig (Dr.) Pradeep Srivastava, Associate Professor, Department of Hospital Administration, Prof. (Jr Grade) Pragya Pandey, Professor Jr Department of Conservative & Endodontics, and their teams** for their exceptional cooperation and invaluable assistance in completing the assessment. Their proactive approach, dedication, and commitment in coordinating and providing the necessary support were truly commendable.

We are also deeply grateful to all **Consultants, Clinicians, Section In-Charges, And Hospital Staff** who took time out of their busy schedules to engage with us, share insights, and provide the essential information required for the assessment. Their dedication and selfless contribution were instrumental in the successful completion of this initiative.

Lastly, we extend our sincere appreciation to everyone who directly or indirectly contributed to the successful completion of this study. Your support and collaboration have been invaluable.

Dr. Yash Paul Bhatia
Managing Director
(Astron Hospital & Healthcare Consultants Pvt. Ltd)

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1. Acronyms

➢ **Accreditation & Standards**
• NABH – **National Accreditation Board for Hospitals & Healthcare Providers**
• AAC – **Access, Assessment & Continuity of Care**
• MOM – **Management of Medications**
• PRE – **Patient Rights & Education**
• ROM – **Responsibilities of Management**
• HRM – **Human Resource Management**
• IPSG – **International Patient Safety Goals**
• COP – **Care of Patients**
• IPC – **Infection Prevention and Control**
• PSQ – **Patient Safety and Quality Improvement**
• FMS – **Facility Management and Safety**
• IMS – **Information Management System**
➢ **Hospital & Patient Care**
• UHID – **Unique Hospital Identification Number**
• ID – **Identity Document**
• OPD – **Outpatient Department**
• IPD – **Inpatient Department**
• MSDS – **Material Safety Data Sheet**
• Dept – **Department**
• LASA – **Look-Alike and Sound-Alike (medications)**
• TAT – **Turnaround Time**
• LAMA – **Leave Against Medical Advice**

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➢ **Emergency & Life Support**
• BLS – **Basic Life Support**
• NALS – **Neonatal Advanced Life Support**
• ACLS – **Advanced Cardiac Life Support**
• CPR – **Cardiopulmonary Resuscitation**
• PALS – **Pediatric Advanced Life Support**
➢ **Operational & Management Terms**
• HR – **Human Resources**
• RCA – **Root Cause Analysis**
• WHO – **World Health Organization**
• SOP – **Standard Operating Procedure**
• IT – **Information Technology**
• HOD – **Head of Department**
• JD – **Job Description**
• TNA – **Training Needs Analysis**
➢ **Medical & Regulatory Bodies**
• **MCI – Medical Council of India**
• **DGCI – Drug Controller General of India**
• **AERB – Atomic Energy Regulatory Board**
• **WHO – World Health Organization**
• **ICD – International Classification of Diseases**

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2. Executive Summary

Quality Assurance (QA) plays a pivotal role in ensuring the smooth delivery of healthcare services. It establishes a framework that assists hospitals in organizing, communicating, monitoring, and continuously improving all aspects of healthcare delivery. Quality Assurance encompasses a set of activities aimed at establishing standards and monitoring the improved performance of healthcare services, ultimately ensuring that patient care is effective and as safe as possible.

In India, the National Accreditation Board for Hospitals and Healthcare (NABH) was established as a visionary initiative to enhance the quality and safety of healthcare services to meet global standards. NABH operates as a constituent board of the Quality Council of India (QCI) and was founded through collaboration between the Government of India and the Indian health industry in the year 2005-06. The primary objective of NABH is to address the needs of consumers, set industry standards, and boost medical tourism by promoting high-quality healthcare services.

NABH Accreditation involves a comprehensive process that includes self-assessment and external peer assessment. Healthcare organizations utilize this process to accurately gauge their performance level in comparison to established standards. The aim is to implement continuous improvement strategies based on the assessment results. A key focus of NABH Accreditation is the reduction of patient harm, reflecting its vital role in enhancing patient safety. Moreover, the accreditation process is designed to encourage the overall development of healthcare organizations, fostering a culture of improvement and excellence.

In summary, Quality Assurance is essential for ensuring the effectiveness and safety of healthcare delivery. NABH Accreditation in India serves as a significant initiative to establish and maintain high standards of healthcare services. By promoting self-assessment, peer evaluation, and continuous improvement, NABH Accreditation contributes to elevating the quality of care provided by healthcare organizations while prioritizing patient safety and organizational development.

Astron Hospital & Healthcare Consultants have been given the responsibility of facilitating the **NABH (National Accreditation Board for Hospitals and Healthcare) accreditation process** for the hospital. As part of their execution plan, the first step taken is to conduct a gap assessment of the hospital's infrastructure, systems, and processes in accordance with the 6th edition of NABH standards. This initial exercise is aimed at identifying any bottlenecks, shortcomings, and gaps that exist in the hospital's infrastructure and operational processes. The goal is to ensure that the hospital's practices align with NABH's established standards and guidelines, and to work on the necessary capacities for improvement.

To carry out this gap assessment effectively, Team Astron has developed a comprehensive toolkit specifically designed for conducting the analysis. We have also devised a robust methodology to gather data from all levels of the hospital. This involves conducting in-depth interviews, engaging in informal discussions, and making on-site observations. By using this approach, team aim to gain a thorough understanding of the existing strengths and weaknesses within the hospital's operations.

Furthermore, in order to gain a deeper insight into the gaps present within the hospital, the survey team has conducted a comprehensive review of various aspects of the hospital. This includes assessing not only clinical departments and laboratory services but also administrative services and even the physical facility itself, including areas like the terrace. The intention is to ensure that all

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facets of the hospital's functioning are evaluated for compliance with NABH standards.

As a result of their assessments, the Gap Assessment Report has been generated. This report highlights the specific issues and concerns that have been identified during the gap assessment process. It provides a detailed overview of the areas that need improvement in order for the hospital to meet NABH accreditation requirements. This initial step serves as a foundation for further interventions and improvements that will ultimately lead to the hospital's successful accreditation by NABH.

The observations made during the gap assessment process have identified several areas where the hospital's current practices do not align with NABH Standards. These observations encompass different aspects of the hospital's operations:

Infrastructure and Facilities: There are discrepancies in certain areas of the hospital's infrastructure, including the Operating Theater (OT), Central Sterile Supply Department (CSSD), Ramp, Kitchen, Laundry, and Central Biomedical Area. These areas, particularly the ones involving the collection and treatment of used and soiled linens, compromise sterility and hinder the organized movement of staff and equipment.

Signage and Standardization: A lack of proper signage has been observed throughout the hospital. This absence disrupts the uniformity of design, symbols, and directional signs. Additionally, the lack of glow strips on passages and staircases poses an increased risk of falls and trips for both staff and patients.

Staff Awareness and Training: Staff members show a lack of awareness regarding key processes such as Triaging, Initial Assessment, Medication Errors, Medication Rights, Standard Hand Washing Procedures, Biomedical Waste Management, General Housekeeping Procedures, Equipment Cleaning, Infection Control Surveillance Audits, Emergency Procedures like- Codes, etc. and Clinical Performance Indicators. This suggests a need for comprehensive training and education.

Biomedical Engineering and Maintenance department of the hospital is a critical component in ensuring the proper functioning, safety, and reliability of medical equipment. The observations from the gap assessment have identified a need for improvement to meet NABH standards. Here are the key points related to this aspect:

- **Structured Documentation:** The hospital needs to establish a comprehensive system of structured documentation for all medical equipment. The documentation need to include records of equipment specifications, maintenance schedules, calibration history, repair logs, and any relevant manufacturer guidelines. Proper documentation enables effective tracking, monitoring, and management of equipment performance.

- **In-house Equipment Calibration:** The hospital need to establish an in-house calibration program for medical equipment. Calibration involves adjusting and verifying the accuracy of equipment measurements to ensure they meet predefined standards. Implementing an in-house calibration process helps maintain equipment accuracy and reduces reliance on external services. Trained personnel within the hospital can carry out routine calibration procedures as part of the maintenance plan.

- **Preventive Maintenance:** Preventive maintenance involves routine checks, inspections, and

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servicing of equipment to prevent potential breakdowns and ensure optimal functionality. Regular and planned maintenance activities, such as cleaning, inspection, calibration, and performance checks, can significantly extend the lifespan of equipment and reduce the likelihood of unexpected failures that could impact patient care.

- **Annual Maintenance:** Annual maintenance is a mandatory practice for all hospital equipment. It involves a comprehensive review, assessment, and servicing of equipment to ensure it continues to function optimally. Regular annual maintenance minimizes the risk of equipment breakdowns and disruptions in patient care.

- **Calibration Priority:** Calibration of medical equipment holds paramount importance due to its specialized nature. Calibration ensures that measurements taken by medical devices are accurate and consistent, which is essential for correct diagnosis and treatment.

By focusing on these aspects within the Biomedical Engineering and Maintenance department, the hospital can enhance the quality, safety, and efficiency of its medical equipment. Proper Documentation, Calibration, Preventive Maintenance, and Annual Maintenance practices contribute to meeting NABH standards and ensuring that the medical equipment is in optimal working condition, thereby positively impacting patient care and safety.

The above mention observations collectively highlight the significant areas where interventions are necessary to meet NABH Accreditation requirements. While this summary provides an overview of the key concerns, more detailed information. Addressing these issues will be crucial in ensuring the hospital's alignment with NABH Standards and in fostering a culture of continuous improvement, ultimately leading to improved quality and safety of healthcare delivery.

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Accreditation Profile

……..*NABH 06th Edition*

National Accreditation Board for Hospitals & Healthcare Providers
(Constituent Board of Quality Council of India)

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1. Accreditation Profile

"NABH: National Accreditation Board for Hospitals & Healthcare Providers"

Accreditation standards have been designed to ensure the high- quality standards in patient care, safety and overall operations of healthcare services. The board was created as a constituent part of the **(QCI) Quality Council of India in 2006**, with the primary goal of establishing and operating an accreditation program for healthcare organizations. NABH aims to address the needs of consumers while setting benchmarks for the progress of the health industry.

Since its inception, NABH has been continuously upgrading and expanding its standards. The Sixth edition of NABH hospital accreditation standards came into effect in **January 2025**.

These Standards are categorized into two sections:

- Patient-Centered Standards
- Organization-Centered Standards

Section I: Patient-Centered Standards

1. **Access, Assessment, and Continuity of Care (AAC)**
2. **Care of Patients (COP)**
3. **Management of Medications (MOM)**
4. **Patient Rights and Education (PRE)**
5. **Infection Prevention and Control (IPC)**

Section II: Organization-Centered Standards

6. **Patient Safety and Quality Improvement (PSQ)**
7. **Responsibilities of Management (ROM)**
8. **Facility Management and Safety (FMS)**
9. **Human Resource Management (HRM)**
10. **Information Management System (IMS)**

The Sixth edition of NABH standards comprises **10 Chapters, 100 standards and 639 Objective Elements**, addressing various facets of patient-centered care and organization-centered management. These standards are structured to ensure comprehensive quality and safety across healthcare services, aiming for continuous improvement and excellence in patient care.

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Outline of Chapters:

Section I: Patient-Centered Standards:
This section focuses on standards related to patient care and is divided into five chapters:

1. **Access, Assessment and Continuity of Care (AAC):** This chapter emphasizes that patients must be well-informed about the services offered by the organization, and only those patients who can be appropriately cared for should be admitted to the hospital. The standards cover aspects such as admission, discharge, transfer, referral, initial assessment, periodic reassessment, and the formulation of care plans. It also addresses the planning for laboratory and imaging services.

2. **Care of Patients (COP):** This chapter focuses on uniform care for all patients in various care settings. It covers processes related to emergency and ambulance services, cardio-pulmonary resuscitation, nursing care, blood products, and specialized care for different patient groups such as vulnerable patients, high-risk obstetrical patients, pediatric patients, and those undergoing sedation, anesthesia, surgical procedures, pain management, nutritional therapy, and end-of-life care.

3. **Management of Medications (MOM):** This chapter deals with the establishment of a process for medication availability, safe storage, prescription, dispensing, and administration. It highlights patient and family education, safe medication practices, and food-drug interactions.

4. **Patient Rights & Education (PRE):** The chapter focuses on patient and family rights, including protection and education. It addresses patient education on diseases, treatment outcomes, mechanisms for addressing grievances, and the importance of informed consent.

5. **Infection Prevention and Control (IPC):** This chapter guides the implementation of an effective infection control program within the organization. It emphasizes the need for facilities, resources, and strategies to reduce the risk of Healthcare Associated Infections (HAIs), control infection outbreaks, and manage biomedical waste efficiently.

Section II: Organization-Centered Standards:
The second section of the NABH standards book contains all standards related to the patient & their care and divided into another five chapters.

6. **Patient Safety and Quality Improvement (PSQ):** This chapter encourages an environment of patient safety and continuous quality improvement. It emphasizes that the patient safety and quality program should be documented and involve all areas of the organization and its staff members.

7. **Responsibilities of Management (ROM):** This chapter defines the responsibilities of management and emphasizes ethical governance, including legal and statutory requirements. The standards address patient safety, risk management, and related issues.

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8. **Facility Safety and Safety (FMS):** This chapter guides the provision of a safe and secure environment for patients, their families, staff, and visitors. It addresses emergency management, the management of utilities, and the maintenance of clinical and support service equipment.

9. **Human Resource Management (HRM):** This chapter underscores the importance of effective human resource management, including planning, acquisition, training and development, credentialing, privileging, and performance appraisal to motivate employees.

10. **Information Management System (IMS):** The final chapter focuses on the identification of information needs, management of information, and its utilization for improving clinical outcomes and overall organizational performance.

These outlined chapters and standards represent a comprehensive framework that healthcare organizations can adopt to ensure the provision of high-quality care, patient safety, and continuous improvement in their services.

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……The road traversed

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Strategic Approach

Purpose of Gap Assessment Exercise:

KGMU stands as a prominent private medical college and comprehensive healthcare provider. Operating around the clock, the institution offers a wide array of services, including Emergency Care, Critical Care, Ambulance Services, Trauma Care, Accident Care, Imaging, and Laboratory Services.

Driven by the pursuit of quality enhancement through standardized processes, continuous improvement, risk reduction, and the implementation of best practices, KING GEORGE'S MEDICAL UNIVERSITY (KGMU HOSPITAL), aspired to elevate patient safety measures to meet national benchmarks. In pursuit of these goals, the hospital's management made the strategic decision to pursue NABH accreditation.

Recognizing the value of expert guidance, **Astron Hospital & Healthcare Consultants**, leveraging their prior experience with NABH Accreditation, was entrusted with the responsibility of facilitating the NABH accreditation process for the hospital.

Scope of Work:

In preparation for achieving NABH Accreditation, it is a prudent approach to conduct a comprehensive gap assessment of the hospital. This assessment aims to thoroughly examine the current state of hospital operations and identify areas that require improvement. The purpose of this report is to provide a summarized overview of the findings from the gap assessment and to establish a framework that outlines the path forward toward NABH Accreditation.

The Key objectives of the gap assessment were as follows:

Identifying Existing Gaps: The assessment aimed to identify any gaps that currently exist in terms of infrastructure, human resources, and equipment within the hospital. This involved evaluating whether the hospital's resources and facilities align with the requirements set by NABH standards.

Understanding Current Systems and Processes: An essential aspect of the assessment was to gain a thorough understanding of the existing systems and processes in place within the hospital. This involved evaluating how various departments and functions operate and whether they adhere to established standards.

Statutory Compliance Evaluation: The assessment sought to observe and evaluate the hospital's adherence to statutory regulations and legal requirements. This ensures that the hospital operates within the framework of relevant laws and regulations.

Assessment of Systems & Processes for Quality Patient Care: The gap assessment focused on evaluating the compliance of systems and processes that contribute to the delivery of quality patient care. This included examining protocols, procedures, and practices that directly impact patient well-being and safety.

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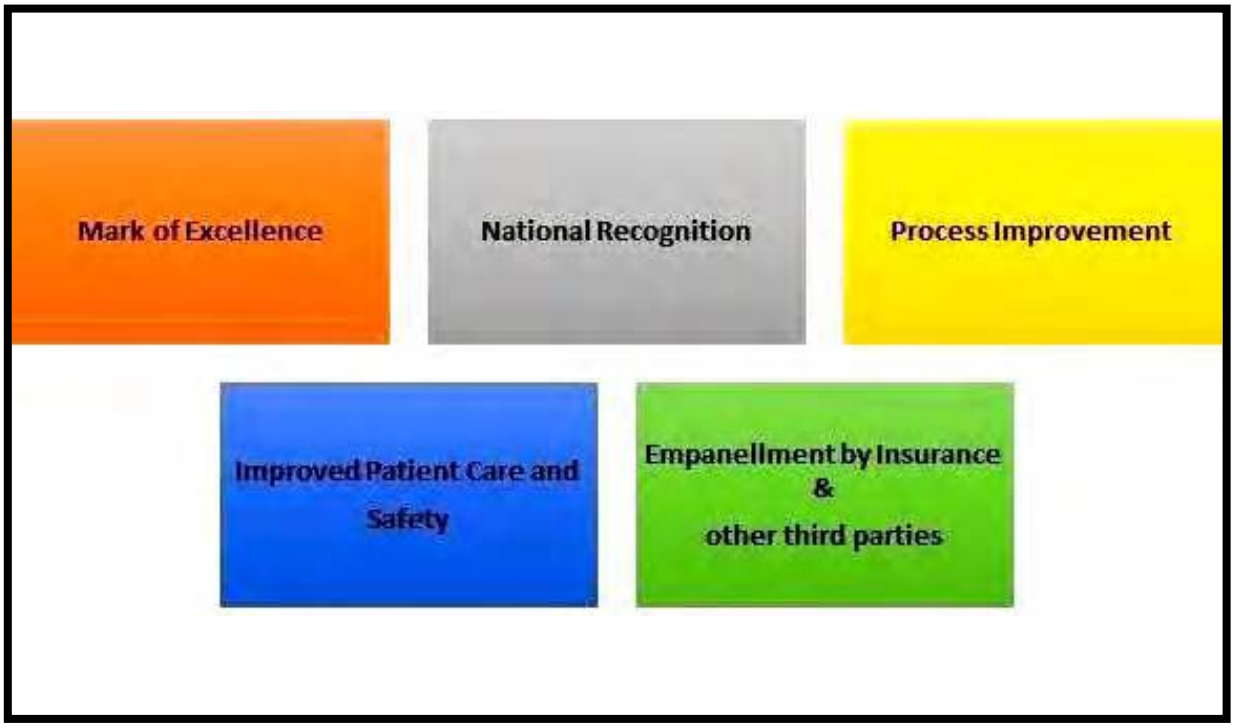
Assessment of Training Needs: Another important objective was to assess the training needs of healthcare providers. This involved identifying areas where additional training and education are required to enhance the skills and knowledge of the hospital staff.

By conducting this comprehensive gap assessment, the hospital aims to gain a clear understanding of its current strengths and areas for improvement. The assessment provides a foundation for developing a strategic roadmap that outlines the necessary steps to achieve NABH Accreditation. This process underscores the hospital's commitment to enhancing its quality of care, aligning with best practices, and ensuring the highest standards of patient safety and well-being.

WHY NABH??? **WHY NABH????**



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Assessment Methodology:

The assessment methodology employed a comprehensive, multi-phased approach to initiate the accreditation process, ensuring a thorough evaluation of the hospital's services and patient care. A three-day gap assessment was conducted at each level of service delivery, involving a team of experts. This approach focused on multi-stakeholder involvement, critical infrastructure review, in-depth analysis of systems and processes, and their alignment with NABH standards for compliance.

The study design utilized a triangular approach, combining both qualitative and quantitative data collection methods. The integration of findings from both methods contributed to drawing comprehensive conclusions.

Phase1:

To establish of a multi-disciplinary Gap Assessment Team of experts in guiding, executing, and analyzing the assessment process.

The team comprised of a Principal Consultant, Project Coordinator and Team leader supported by three Associate Consultants.

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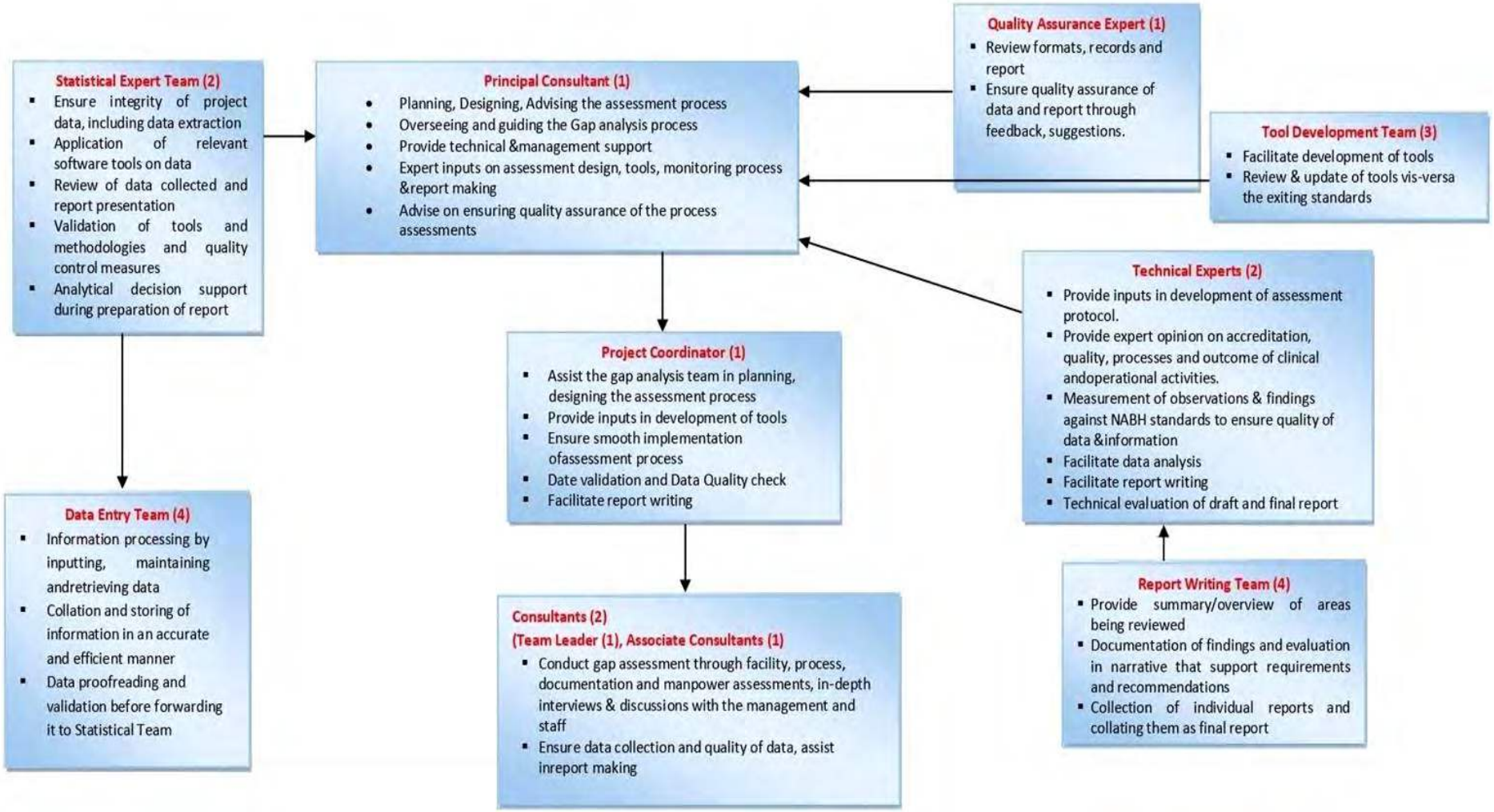
Team Structure



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Phase2
Unveiling Assessment Process to the Client

Before initiating the assessment, a briefing of the same was given by the Team Leader to theTeam of **King George's Medical University (KGMU Hospital),** to orient them about the process of the gap assessment.The key elements discussed were:

- Assessment Process
- Schedule of assessment
- Facility visit and interaction with staff
- Documents required for assessment

The briefing meeting was attended by the Hospital Quality & Administrator and the Empanelments from **KING GEORGE'S MEDICAL UNIVERSITY (KGMU HOSPITAL)**. These key representatives were present to receive essential information about the gap assessment process and its various aspects. Their participation ensured that the hospital's administration and empanelment functions were well-informed and prepared to collaborate effectively with the assessment team.

Phase3
Assessment on Ground

The assessment process was undertaken in the following phases:

1. Pre-Assessment planning & preparation
2. Onsite assessment preparation
    - Facility visits
    - Assessment Planning
    - Scheduling of tracks
3. OnSite Assessment
4. Report Preparation

1. Pre-Assessment Planning & Preparation:

Tool Development: At the initial stage, the team was briefed about the background of KING GEORGE'S MEDICAL UNIVERSITY (KGMU HOSPITAL), its scope of operations and departments.

The assessment team was also briefed on the assessment requirements of the client hospital. Comprehensive Gap Analysis Tools were developed in coordination with the technical experts. And the Scoring tools were also developed to rate the observations and findings made during the assessment. The tool assigns scores or ratings to various aspects or criteria based on the assessment team's observations. The scoring system could help quantify the extent of gaps or areas of improvement.

The tools were then organized into the following sections:

1. Determining readiness of hospital to NABH Assessment.
2. Identifying priorities for Infrastructural changes.
3. Quantitative assessment of various standards of NABH as per their criteria of scoring.

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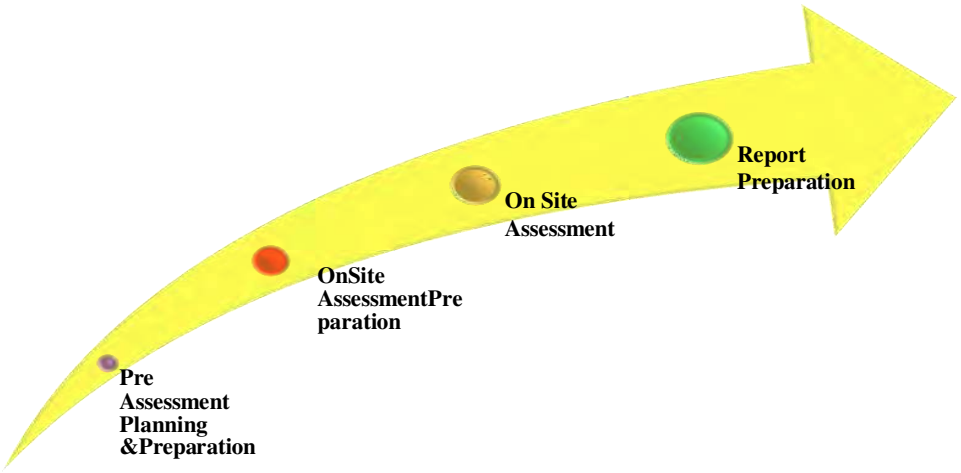

2. On Site Pre-Assessment Preparation:

Facility Visit: A facility to uncovering the entire length & breadth of the hospital starting from the terrace to the ground floor and associated facilities was undertaken by a team-member of Astron for an orientation of the hospital before conducting the assessment.

Assessment Planning:

- After having an understanding about the facility, The Team Astron worked on a detailed assessment schedule with a space focus on the following:
- Flow of assessment
- Departments to be covered
- Time to be devoted in each department
- Type of Employees & staff to be interviewed
- Records to be furnished for the assessment
- Special issues to be addressed during assessment. Consequently, an Assessment Schedule was prepared.

Scheduling for Tracks: Based on the list of specialties and services provided by the hospital, the assessment team developed tracks for visits to various sections of the hospital. These tracks were then compiled to craft a detailed department-wise gap analysis plan. The plan also reflected the timelines and team members involved in the exercise. The plan was finalized in consensus with the concerned officials of the hospital.

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3. OnSite Assessment

The Assessment Team then initiated the gap analysis survey and went to all departments as per schedule, which included the following:

Primary Data Collection:			
S.No.	**Mode of Assessment**	**Applicability / Target Population**	**Outcome of Instrument**
1.	Gap Analysis of Structure, Process and Manpower	Hospital wide	▪ Study of current processes in the hospital incomparison to NABH standards. ▪ Determining the process gaps. ▪ Identification of gaps in infrastructure, Processes and Manpower.
2.	In-depth interviews and informal Discussions	Hospital Management, doctors, nurses, employees & staff	▪ Collection of high-quality & unbiased Qualitative data. ▪ Probing and uncovering greater insights of processes and systems.
3.	Direct & in-Direct observations	Processes,staff, patients, physical settings, behaviour, reports & records	▪ Support in collection of qualitative data. ▪ Understanding staff knowledge and behaviour through overt & covert observations.
Secondary Data Collection:			
4.	Document Review	▪ Statutory compliance ▪ Hospital Policies, ▪ Standard Operating Protocols ▪ Job Descriptions ▪ Patient Medical Records	▪ Understanding the status of availability of applicable licenses, policies, SOPs, Job Description, etc. ▪ Status of completeness of the patient medical records as per the NABH Standards.

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Scoring Guidelines:

The scoring guidelines set by NABH were followed:
For NABH Accreditation, each Objective Element (OE) of a standard is evaluated and scored as one of the following:

i. **No Compliance** – No systems in place to meet the requirements.
ii. **Poor Compliance** – Basic systems exist, but implementation is limited, with minimal evidence of progress.
iii. **Partial Compliance** – Systems are partially established, and there is evidence of progress; a significant portion (41-60%) of samples meet the requirements.
iv. **Good Compliance** – Systems are in place with clear evidence of implementation; the majority of samples (61-80%) meet the objective element requirements.
v. **Full Compliance** – Systems are well-established and consistently implemented across the organization; the majority of samples (81-100%) meet the requirements.

Report Preparation:

Upon completing the three-day Gap Assessment, the team collated a preliminary summary of findings. These observations were then compiled into a comprehensive report, which included the hospital profile, identified infrastructural gaps, and a department-wise classification of requirements based on **Vitals, Essentials, and Desirables (VED)**. Additionally, the report prioritized these requirements for accreditation preparedness and incorporated the NABH toolkit along with photographic evidence of the identified gaps.

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OVERVIEW OF KING GEORGE'S MEDICAL UNIVERSITY

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5. Overview of King George's Medical University- Lucknow, Uttar Pradesh Hospital Profile:

S.NO.	PARTICULARS	DETAILS
1.	**Name of Hospital:**	King George's Medical University- Lucknow, Uttar Pradesh (Shatabdi Phase 01 & 02)
2.	**Ownership Type:**	Government Hospial
3.	**Address:** **For Communication** **For locating Hospital**	 Medical Superitendent Shatabdi phase 01& 02 KGMU Hospital
4.	**Contact person:** **(For correspondence and liaison)**	Prof. Vishwajeet Singh
5.	**Contact numbers: (landline with area code and mobile)**	7607683654; 9839350170
6.	**E-mail**	msshatabdi@kgmuindia.edu
7.	**Date of establishment of hospital:**	Phase 01 - 2010 Phase 02 - 2016
8.	**Vision statement:**	• To be a world-class university that provides high-quality medical education • To be a leader in advancing human healthcare • To promote sustainable higher education • To stimulate and extend the frontiers of knowledge
9.	**Mission statement:**	• To provide compassionate, patient-centered care. • To promote multi-disciplinary scientific biomedical research. • To nurture professionalism and behavioral skills in medical professionals. • To incorporate medical ethics, moral values, team spirit, responsibilities, and sense of integrity in medical faculty and students.
10.	**Any Quality Certification or Accreditation received by the facility in past**	_

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11	Clinical Services offered by the hospital Speciality(s):		
	Broad Specialties	**Numberof Specialist (fulltime)**	**Numberof Specialist (Visiting/ Honorary)**
	Nuclear Medicine	1	_
	Radiotherapy	10	_
	Transfusion Medicine	3	_
	Pulmonary Critical Care medicine	3	_
	Surgical Oncology	5	_
	Pediatric Orthopedic	3	_
	Clinical Hematology	2	_
	Neurosurgery	12	_
	Medical Gastroenterology	05	_
	Endocrine surgery	03	_
	Sports Medicine	_	_
	Medical Oncology	01	_
	Trauma Surgery	06	03
	Emergency Medicine	02	_
	Hospital Administration	02	_
	Nephrology and Dialysis	04	_
	Interventional Radiotherapy	11	_
	Surgical Gastroenterology	08	_
	Human Organ Transplant	01	_
	Others, if any-		

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HOSPITAL FACILITY

FACILITY DETAILS:

S.No.	Particulars	Details
1.	Plot Area	Approx. 24.200sqmt.
2.	Total build-up area	Phase 01: 15,406sqmt. & phase 02: 45,265sqmt.
3.	Number of buildings	02
4.	Number of floors	Phase 01: 04 floors; Phase 02: 11 floors
5.	Number of lifts	Phase 01: 05 lifts; Phase 02: 08 lifts
6.	Number of Ramps/ Stairs	01 in phase 01 connecting floors 01-04; 01 in phase 02 connecting floors 01-08

BED DISTRIBUTION:

S. No.	Categories of Beds	Numberof Beds
1	Single Rooms	69
2	Suite	00
3	Deluxe	43
4	Twin Rooms	25
5	Multi- Bed Rooms	193
6	ICU	41
7	SICU / MICU	00
8	CCU	00
9	NICU	00
10	HDU	22
11	Isolation Room	00
12	Dialysis	22
13	Emergency	00

OPERATING SUITES:

S.No.	Designation of Operation Theatre (Major and Minor)	Number
1	Operation Theatre	16
2	Procedure Room (Dressing Room)	11
3	Labor Room	00
4	Minor OT	02
5	Cath Lab	00

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HOSPITAL HUMAN RESOURCE:

Staffing Pattern:

S.No.	StaffCategory	On hospital payroll	Contractual
1.	**Nursing Staff (category wise)**		
A	Nursing Superintendent	24	_
B	Infection Control Nurse	03	_
C	Sister In Charge- IPD, Emergency & Day Care Services	17	_
D	SisterIn Charge- OT	08	_
E	Staff Nurse	251	200
2.	**Paramedical Staff (category wise)**		
A	Laboratory Technicians	00	03
B	OT Technicians	05	22
C	X-Ray Technicians	00	00
D	Dialysis Technicians	00	00
E	ECG Technicians	00	00
F	Cath Lab Technicians	00	00
G	Pharmacist	01	04
3.	**Medical Administration (category wise)**		
A	Senior Administrative Staff	06	02
B	Honorary Consultants	-	-
4.	**General Administration (category wise)**		
A.	SeniorAdministrative staff	-	-
B.	Maintenance Staff	01	-
5.	**Housekeeping & Security staff (category wise)**		
A	Ward Boy	34	110
B	Ward Lady	06	41
C	Sweepers	10	46
D	Security (Contract)	05	11

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DETAILS OF DIAGNOSTIC SERVICES:

1.	LaboratoryMedicine	Available/ NotAvailable
a	Bio-Chemistry	Available
b	Pathology	Available
c	Haematology	Available
d	Micro-Biology&Serology	Available
e	Histopathology	Available
f	Cytopathology	Available
2.	**Diagnosis**	**Available / Not Available**
a	X-Ray	Available
b	Ultra-Sound	Available
c	CT-Scan	Available
d	ECG	Available
e	MRI	Available
f	Mammography	Available
g	C-Arm	Available

SUPPORT SERVICES:

S.No.	ServiceCategory	Available/NotAvailable
1	Pharmacy	Available
2	Medical Record Room	Available
3	CSSD	Available
4	Piped medical gas system	Available
5	Dietetics	Available
6	Food&Beverages	Available
7	Security	Available
8	Housekeeping &Laundry	Available
9	Clinical Laboratory	Available
10	Blood Bank	Available

ADMINISTRATIVE DEPARTMENTS

S.No.	Service Category	Available/ Not Available
1	Accounts / Finance (including IP Billing)	Available
2	Human Resource Department	Available
3	Stores & Purchases	Available
4	IT Services	Available
5	OPD, Reception & Enquiries	Available
6	Medical Records Department	Available
7	Quality Assurance Department	Not Available
8	Nursing Services	Available
9	Medical Administration	Available
10	Bio-Medical Department	Available
11	Engineering and Maintenance Department	Available

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	• **ETP & STP**	Not Available
	• **DG Set**	Phase 01: 04 AHU & 21 CSU Phase 02: 03 AHU
	• **Fire Tank**	Phase 01: 02 Phase 02: 01
	• **Manifold**	Available
	• **RO Filter - water**	Available
	• **Number of AHU**	Phase- 01: 32 & Phase 2: 68
	• **Number of AC**	Centralised AC

OUTSOURCED SERVICES:

S.No.	Service Category	Available/ Not available
1	**Security**	Available
2	**Housekeeping**	Available
3	**Kitchen**	Available
4	**Laundry**	Available

WORK LOAD DETAILS (as per last Six months):

S.No.	Particulars	Details
A	**IPD Indices**	
1	Bed Occupancy rate	_
2	Average Length of Stay (ALOS)	_
3	Average Daily Surgeries	_
4	Average Daily Admissions	_
5	Average Daily Discharges	_
B	**OPD indices**	
1	Average Daily OPD Attendance	1450 approx.
2	Average Daily New Patients' Registration	620 approx.
3	Average Daily Follow-up Patients	730 approx.
4	Average Daily Daycare Patients	260 approx.
C	**Emergency indices**	
1	Average Daily Emergency Attendance	_
2	Average Monthly Emergency Surgeries	_
D	**Diagnostics**	
1	Average Number of Laboratory Tests per Day	_
2	Average Number of Radiological Tests per Day	_

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HOSPITAL REGULATORY COMPLIANCE:

S.NO.	REGULATORY NAME	Available/ Not available
1.	Building permit (from the municipality)	Not Available
2.	Registration under CE Act	Not Available
3.	Approval for Electrical Instrallations	From KGMU (Electrical dept.)
4.	No objection certificate from the chief fire officer	Not Available
5.	License under Bio- medical management an dhandling rules, Rules 1998 + MOU	Available (approved from KGMU EC)
6.	No objecton certificate under Pollution Control Act	Not Available
7.	Income Tax Pan (related documents)	Not Available
8.	Permit / License to operate life under the lift and escalators act	Not Available
9.	Narcotics and Psychotropic substances act (related documents)	Not Available
10.	Sales Tax Registration Certificate	Not Available
11.	Vehicle registration certificates	Not Available but registered from KGMU
12.	Retail drug lisence	Not Available
13.	Air (prevention and control pf pollution) Act, 1981 (copy of act & related documents)	Not Available
14.	Biomedical waste management handling rules 2016	from KGMU
15.	ESI Act, 1948	from KGMU
16.	Pharmacy Licence	from KGMU
17.	Registration of pharmacist	from KGMU
18.	Lift lisence	from KGMU
19.	Authoriation under Hazardour Waste (Management & Handling) Rules, 1989	from KGMU
20.	MTP	from KGMU
21.	Building Occupancy	Not Available
22.	PC- PNDT Act Registration (USG, CT, ECHO)	Available
23.	AERB for Foxed X-RAY	Available
24.	AERB consent for Mobile X-RAY	Available
25.	AERB consent for C-Arm	Available
26.	AERB for C-Arm	Available
27.	AERB consent forInterventional Radiology (Cath lab)	Available
28.	Drugs – Buk licence	Not Available
29.	Drugs – Wholesale license	Not Available
30.	License for Possession and Use of Methylated Spirit, Denatured spirit and Methyl Alcohol	Not Available
31.	Registration with local authority, e.g, City corporation, Muncipality, Village Panchayat	Not Available
32.	FSSAI for Pharmacy	Not Available
33.	FSSAI for Kitchen	Not Available
	OTHER LICENCES RELATED TO ERP	
34.	Operating system licence – Windows XP/8	Not Available
35.	MS- Office License	Not Available
36.	DB License from IBM	Not Available
37.	Domain Server	Common facility in IT CELL
38.	Proxy Server	Common facility in IT CELL

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VED Analysis

....an Overview

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1. Physical Infrastructure

This section elaborates on the infrastructural issues that need a focused attention to smoothen the process of Quality Assurance Management and Accreditation.

<u>Apart from these structural deficiencies, certain facility requirements are essential to ensure a safe and secure environment. (V - Vital, E - Essential, D - Desirable) (Priority: P1 - High Priority, P2 - To be incorporated into the hospital maintenance plan, P3 - To be addressed in planned renovations later).</u>
The findings have been presented department-wise and prioritized based on operational necessity. They serve as an indicative tool for the hospital to prioritize tasks and plan improvements in alignment with resource availability and needs.

S. NO.	OBSERVATIONS	NABH STANDARD	VITAL-ESSENTIAL-DESIRABLE (VED)	PRIORITY WISE (P1, P2, P3)	RECOMMENDATION
Emergency & Ambulance Services					
1.	The ambulance parking was not well defined & demarcated. The hospital ambulances were observed being parked among the other vehicles in the parking area of the hospital.	**AAC**	**V**	**P1**	"Ambulance Parking" should be clearly marked and sign-posted. The external signage system shall direct ambulances and vehicles carrying emergency cases to the emergency department. These signs shall be clearly visible at the entrance to the hospital.
2.	Lack of display signage for ambulance parking was evidenced.	**COP** **FMS**	**V**	**P1**	Signs directed to emergency shall be permanent lit during the night. In order to avoid confusion, the signage system shall be designed in such away that ambulanty (OPD/walkin) patients, includingambulanty access to an emergency unit is not to be directed to the ambulance parking or emergency department.

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3.	The assembly area under the emergency response plan (fire/ incident) for evacuation was not demarcated as well.	**COP**	**V**	**P1**	Assembly area and ambulance parking area should be separate.The following are the recommendations for locating an assembly area:- • The area shall be familiarand readily accessible to the building vacuees. • It shall be able to accommodate the full occupant load (or evacuees) of the hospital building. • It shall be far enough to avoid falling debris, collapsing structures and/or spread of the fire/incident. • A distance more than one and a half the height of the building is recommended for locating the assembly area, or alternately, it can be in a protected area shielded from the burning building by a fire barrier or fire wall, or it maybe in an adjacent building if it offers sufficient protection a disable to accommodate the evacuees.) The assembly area shall not interfere with the fire fighting / response operations and/ or its responding forces.
4.	There was no designated & demarcated space for parking the stretchers. Some of the wheel chairs/ stretchers were evidenced with out safety belts.	**FMS**	**E**	**P1**	Wheel chair/ trolley bay should be demarcated at the entrance of the department to ensure easy movement of patients during emergency situations. Safety belts should be made available on every wheelchair and patient's stretchers ensuring safety.
5.	Though the waiting area of emergency was defined. However, lack of display of signage was also observed for the same.	**FMS**	**E**	**P1**	The emergency waiting area should be well identified. The waiting area should provide sufficient space for waiting patients as well as relatives/ escorts. The area should be open and easily visible from the Triage and Reception areas. Seating should be comfortable and adequate. Space should be allowed for wheelchairs, prams, walking aids and patients being assisted Signage for waiting area should be displayed prominently.

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6.	The emergency department has not designated the triage beds. The existing triage beds were not designated in an appropriate sequence according to the recommended colour coding for the prioritization of patients. The Triaging of patient was not being done accordingly.	**COP**	**V**	**P1**	The department should have designated and well defined triage beds in the emergency department in Shatabdi Buidling based on a good clinical practice. The triage should be a part of routine day-to- day functioning of the department and not only disaster point of view. To strengthened the triaging of patients.
7.	Unlabeled sodium hypochlorite solution was observed being kept at various places of the department.	**FMS**	**V**	**P1**	Safe storage for hazardous chemicals includes the following: Safe and secured area needs to be designated for chemical storages as to reduce the risks of breakage and spills. It is recommended that the storage area should be ventilated, locked, and fire-resistant. Display of signs/ labels for hazardous chemical storage to ensured so as to assure proper identification. All chemicals should be stored in the containers designed for chemical storage and appropriate for each type of chemical; ensure that lids are tight. Storage of all chemicals should be ensured at or below eye level. Store chemicals by chemical group (chemical class/ reactive group) to keep incompatible chemicals away from each other.Appropriate measures may include separation by shelving, and or the use of secondary containment such as clean tubs, buckets, and trays. Hazard vulnerability assessment should be included in the emergency management program.
8.	Inadequacy of floor plans & fire exit signage's were observed throughout the department.	**FMS**	**V**	**P1**	Floor plans depicting the evacuation and escape routes during fire to be displayed at prominent locations. Self-illuminated directional & fire exit signages should bedisplayed to ensure timely & safe exit of staff patients and visitors in the event offire.

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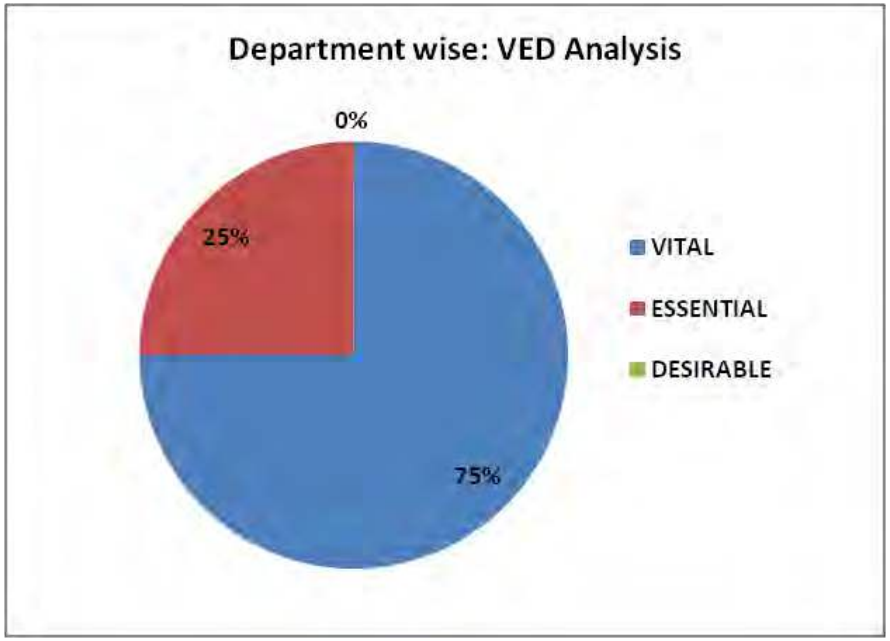
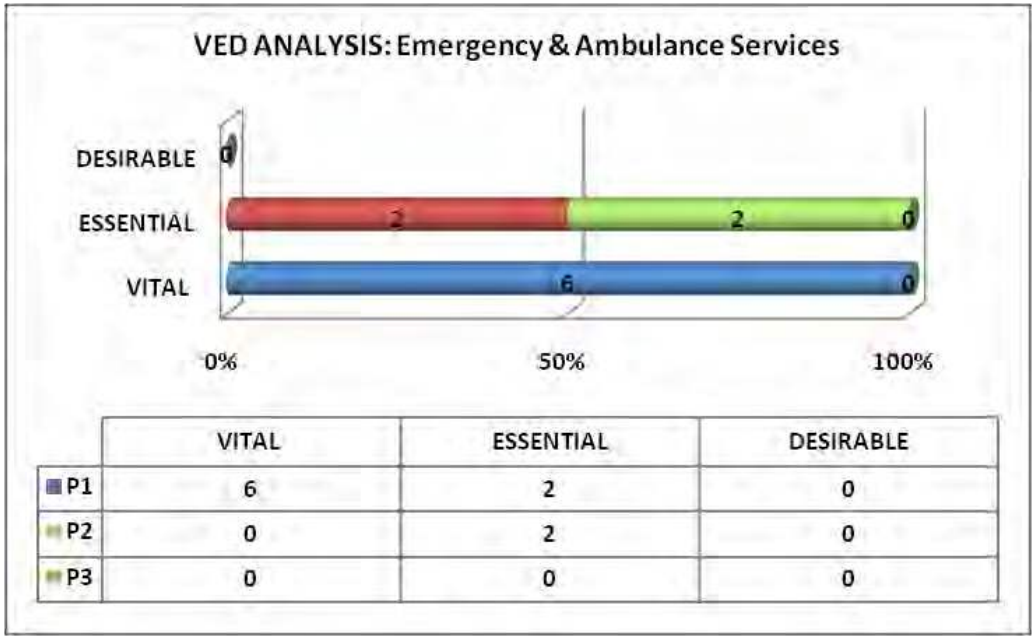
9.	The placement of wall mounted curtain was not available uniformly in the emergency triage area was not available compromising patient confidential and privacy.	**PRE**	**E**	**P2**	Curtains in the triage rooms should be hanged at a distance of at least 1.5 ft from the treatment couch to enable easy and free movement for the doctor, staff, and trolleys.
10.	There were no grab bars in the toilets. Panic alarms were not installed in the toilet.	**FMS**	**E**	**P2**	The washrooms should include the following w.r.t to patient & staff safety aspects- ▪ GarbBars ▪ Door width to include provisions for wheelchair access ▪ Panic Alarms Outward door opening of toilet facilities are recommended for emergency access to the toilet users.





	VITAL	ESSENTIAL	DESIRABLE
P1	6	2	0
P2	0	2	0
P3	0	0	0

Summary: There are a total of 10 observations compiled for infrastructural assessment of Departments. Out of these observations, 06 observations are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 02 of the observations are under the Essential category. While none of the observation is under 02 Desirable categories.

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S. NO.	OBSERVATIONS	NABH STANDARD	VITAL-ESSENTIAL-DESIRABLE (VED)	PRIORITY WISE (P1,P2,P3)	RECOMMENDATIONS
Operation Theatre Complex					
1.	A lack of proper zoning was observed in the OT complex. The movement of sterilized and unsterilized items, including linen, biomedical waste, instrument trolleys, and patients, was overlapping, compromising infection control practices.	**IPC** **FMS**	**V**	**P1**	The OTshouldbeplannedonthe concept of fourfollowingzones- ▪ Disposalzone, ▪ Protectivezone, ▪ Cleanzone ▪ Sterilezone. The design and zoning should be based on the typeof activities, pattern of circulation and degree ofsterilitytobemaintained. Containerized mechanism to be implemented for transportation of dirty and clean linen, BMW and instrument trolley.
2.	Monitoring of pressure differential levels in the OT complex, relative to adjoining areas, was not evidenced, compromising infection control practices.	**IPC**	**V**	**P1**	Differential pressure meter should be installed for each OT room.The same should be recorded aswell.
3.	Scrub stations were being used for instrument washin, Hand washing and mop washing.	**IPC** **FMS**	**V**	**P1**	The Scrub stations should be used for only handwashing and required separate area for instrument washing station. Also the mops washing should not be done in scrub stations.
4.	The oxygen cylinder in the OT was not secured with a chain, posing a risk of accidental falls. Additionally, a rubber mat was not evident in the scrub area.	**FMS**	**V**	**P1**	Oxygen cylinders should be stored properly with chain. To avoid the risk of fall Rubber mat, need to be placed in scrub area.
5.	Inadequate floor plans and fire exit signage were observed in both the labor room and OT complex.	**FMS**	**V**	**P1**	Floor plans depicting the evacuation and escape routes during a fire should be displayed at prominent locations. Self-illuminated directional and fire exit signage should be installed to ensure the timely and safe evacuation of staff, patients, and visitors in the event of a fire.

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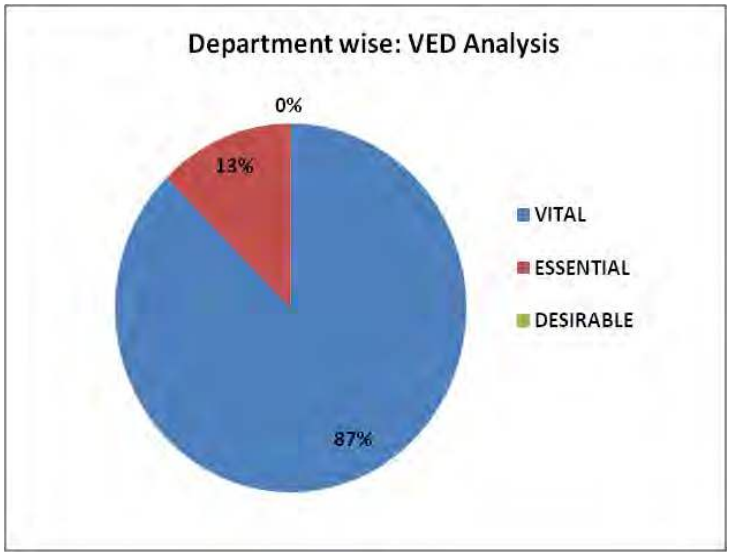
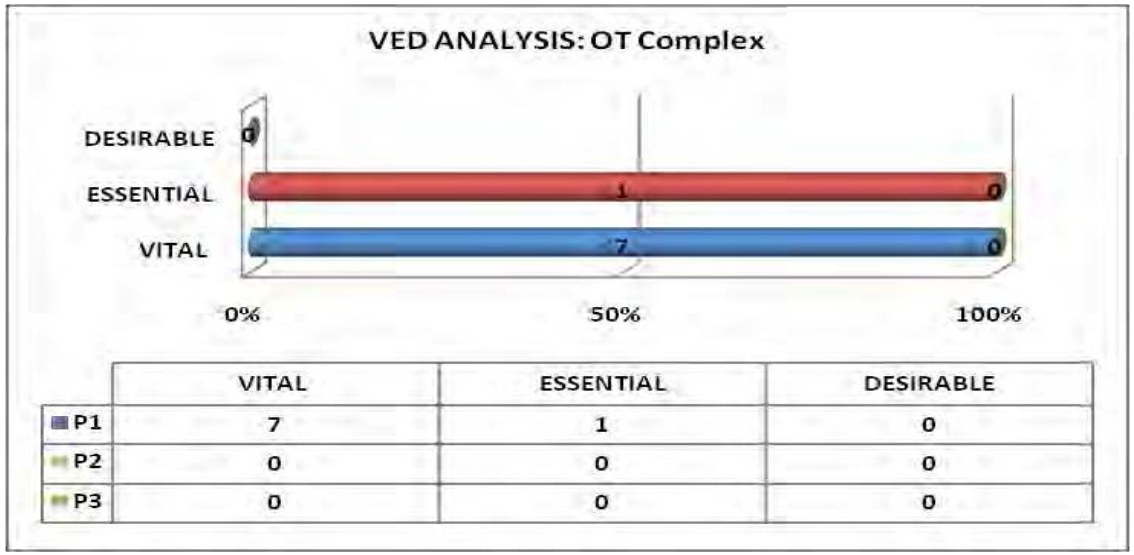
6.	Tempreture, Humidity and Diffrential Pressure monitoring not being monitored for OT.	**MOM**	**E**	**P1**	A temperature monitoring device should be installed for the medicine refrigerator, and the temperature should be recorded accordingly.
7.	Labelling on the hazardous material and display of MSDSclose to the hazardous material could not be evidenced in the department.	**FMS**	**V**	**P1**	Labelling of storage areas along with display of MSDS to beensured.
8.	No dedicated dirty utility and clean utility areas, along with an equipment holding area, were observed in the OT. The designated area for dirty utility was not properly demarcated.	**IPC**	**V**	**P1**	A dedicated zoning system should be established in the OT by clearly demarcating areas for dirty utility, clean utility, and equipment holding to prevent cross-contamination. Proper signage must be installed to distinguish sterile and non-sterile zones, ensuring adherence to infection control protocols. Additionally, optimizing workflow will help minimize the overlap of sterile and unsterile items. Regular monitoring and audits should be conducted to maintain compliance with zoning guidelines and infection control standards.





	VITAL	ESSENTIAL	DESIRABLE
P1	7	1	0
P2	0	0	0
P3	0	0	0

Summary: There are a total of 08 observations compiled for infrastructural assessment of Departments. Out of these observations, 07 observations are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 01 of the observations is under the Essential category. While none of the observation is under 0 the Desirable category.

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S. NO.	OBSERVATIONS	NABH STANDARD	VITAL-ESSENTIAL-DESIRABLE (VED)	PRIORITY WISE (P1,P2,P3)	RECOMMENDATIONS
Inpatient Areas-Intensive CareUnit (ICU's) and Wards					
1.	The department did not have a separate isolationroom available to deal with the infectious orimmune-suppressed patients who require airbornedroplet nuclei isolation (this includes pathogenssuch as measles, varicella zoster (chicken pox), legionella, tuberculosis).	**FMS** **IPC**	**E**	**P2**	Negative pressure in isolation rooms is essential for patients requiring airborne droplet nuclei isolation, including those with infections such as measles, varicella zoster (chickenpox), Legionella, and tuberculosis. The primary objective of placing patients in a negative pressure room is to reduce the risk of airborne transmission to other individuals. Requirements for a Negative Pressure Isolation Room: • A dedicated exhaust system must be installed for the negative pressure isolation room. • The pressure inside the isolation room should be lower than that of adjoining rooms or corridors, with a pressure differential of no less than 10–15 Pa between the isolation room and adjacent ambient air. • The room should have 100% outside air ventilation, meaning there should be no return air for infection control purposes. • A self-closing door must be provided. The door between the anteroom and isolation room should also be self-closing. If the door swings inward, it indicates a positive pressure room, whereas an outward-swinging door indicates a negative pressure room. • The supply air ducts must be independent of the building's main air supply system. • For immunosuppressed and infectious patients, a HEPA filtration system should be installed in the supply air ducting to protect the patient from unfiltered air. • The exhaust air must be HEPA-filtered to ensure effective containment of airborne pathogens.

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2.	Inadequate inter-bed distance and insufficient bed-to-head distance were observed.	**IPC FMS PRE**	**E**	**P1**	The inter-bed space should be sufficient to allow medical procedures to be performed from either side of the bed while ensuring adequate circulation for emergency teams and equipment access. Additionally, there should be ample space for: • Movable furniture • Biomedical waste bins • Unobstructed wheelchair and patient trolley access • Accommodation for patient attendants
3.	There was no space identified for the storage ofchemical hazards. Hazardous material (spirit, sodiumhypochlorite) was stored at various places of thewards, ICU's and OT's. Storage norms for the hazardous chemicals werenot as per HIRA (Hazard Identification and RiskAnalysis). They have not been labeled &individualized throughoutthedepartment.	**FMS**	**V**	**P1**	Safe Storage for Hazardous Chemicals:- • A safe and secure area should be designated for chemical storage to reduce the risks of breakage and spills. • The storage area should be ventilated, locked, and fire-resistant. • Signs and labels should be displayed at hazardous chemical storage areas to ensure proper identification. • All chemicals should be stored in appropriate containers designed for chemical storage, with tight-fitting lids. • Chemicals should be stored at or below eye level to ensure safe handling. • Store chemicals by chemical group (chemical class/reactive group) to keep incompatible substances separate. • Separation measures may include shelving or secondary containment such as clean tubs, buckets, and trays. • Hazard Vulnerability Assessment (HVA) should be included in the Emergency Management Program.
4.	Nurse call bell could not be evidenced at patient bedsideinanyoftheward.	**FMS**	**E**	**P1**	The installation of nurse call bells on each bed panel is advised to ensure patient safety and avoid sentinel and adverse events.
5.	There was no designated & demarcated space forparkingthe wheelchairs,stretchers &Portable X-ray. Trolleys were kept in corridor insomeward.	**FMS**	**V**	**P1**	The wheelchair/trolley bay should be demarcated at the entrance of the department to ensure easy movement of patients during emergency situations.

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6.	Grab bars were not installed in most of the toilets, and there was no panic alarm installed in any of the toilets.	**FMS**	**E**	**P1**	The washrooms should include the following safety features that be implemented in all toilets to ensure the safety and accessibility of patients and staff: • Grab bars should be installed to provide support and enhance safety. • Door widths should be adjusted to include provisions for wheelchair access, ensuring that individuals with mobility impairments can easily use the facilities. • Panic alarms should be installed in each toilet to enable a quick response in case of emergencies. • Toilet floors should be leveled to prevent tripping hazards and ensure ease of movement. • Outward-opening doors should be installed for emergency access, allowing quick evacuation and use of the facilities in urgent situations.
7.	Inadequacy of floor plans & fire exit signage's wasobserved	**FMS**	**V**	**P1**	Floor plans depicting the evacuation and escape routes during a fire should be displayed at prominent locations. Self-illuminated directional & fire exit signages should be displayed to ensure timely & safe exit of staff, patients and visitors in an event of fire.
8.	Designated Dirty utility and clean utility rooms are not evidenced	**IPC**	**E**	**P1**	Dirty utility and clean utility rooms should be designated for the storage.
9.	Bed side rails were not evidences in the ICU's and wards.	**FMS**	**V**	**P1**	Bed side rail should be available for all the beds it's compromising patient safety and increase the chances of patient fall.

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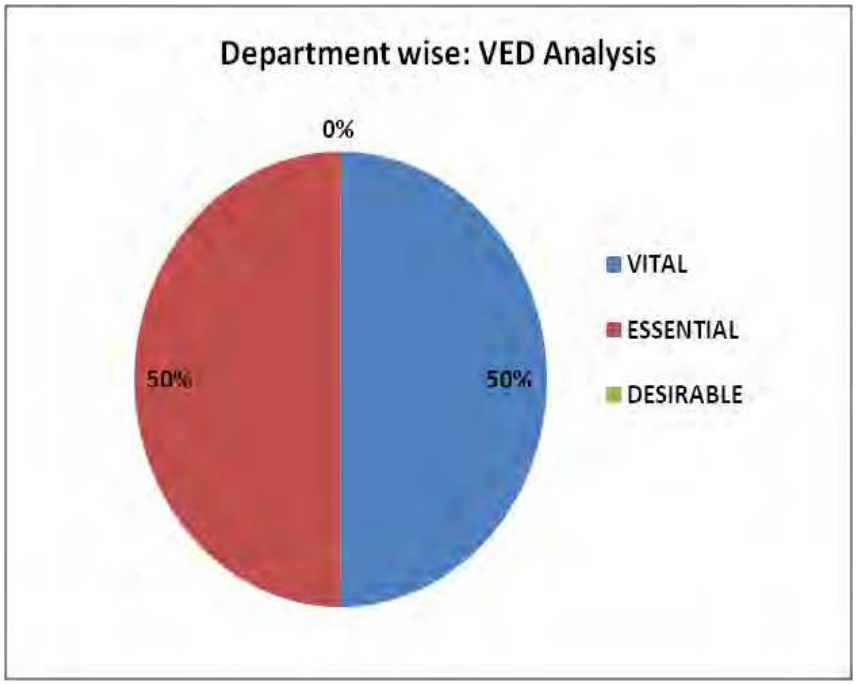

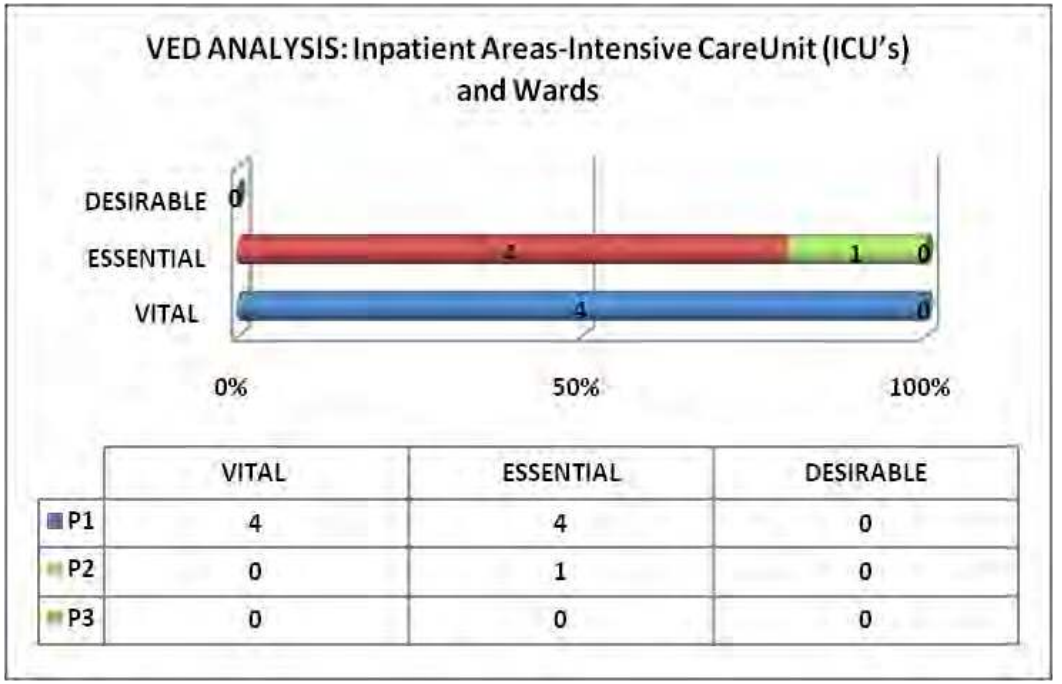

	VITAL	ESSENTIAL	DESIRABLE
P1	4	4	0
P2	0	1	0
P3	0	0	0

Summary: There are a total of 09 observations compiled for infrastructural assessment of Departments. Out of these observations, 04 observations are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 05 of the observations are under the Essential category. While none of the observation is under 0 the Desirable category.

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S. NO	OBSERVATIONS	NABH STANDARD	VITAL-ESSENTIAL-DESIRABLE (VED)	PRIORITY WISE (P1,P2,P3)	RECOMMENDATIONS
Dialysis					
1.	Dialysis was situated with the emergency ICU which compromising infection control practices. Also, there is no designated area for the washing and storage.	**IPC FMS**	**V**	**P1**	A designated area should be provided for dialysis, including dedicated washing and storage areas for dialyzers.
2.	Inadequacy of floor plans & fire exit signage'swasobserved.	**FMS**	**V**	**P1**	Floor plans depicting evacuation and escape routes during a fire should be prominently displayed. Self-illuminated directional and fire exit signage should be installed to ensure the timely and safe evacuation of staff, patients, and visitors in case of a fire.
3.	Labelling on the hazardous materialand display of MSDS close to thehazardous material could not be evidenced in the department.	**FMS**	**V**	**P1**	Storage areas should be clearly labeled, and Material Safety Data Sheets (MSDS) should be displayed as per safety guidelines.
4.	The absence of curtains around the dialysis beds compromised patient privacy.	**FMS PRE**	**E**	**P1**	Wall-mounted curtains should be installed at all patient beds to ensure privacy.
5.	There was no separate dedicated area for infected patients.	**IPC**	**V**	**P1**	A separate designated room should be allocated for infected patients in the dialysis department.

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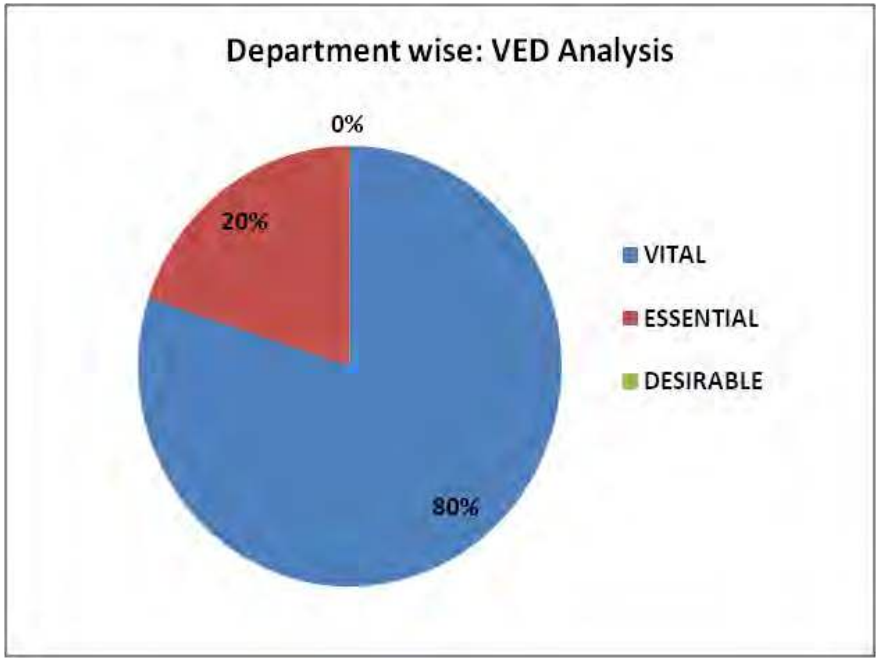

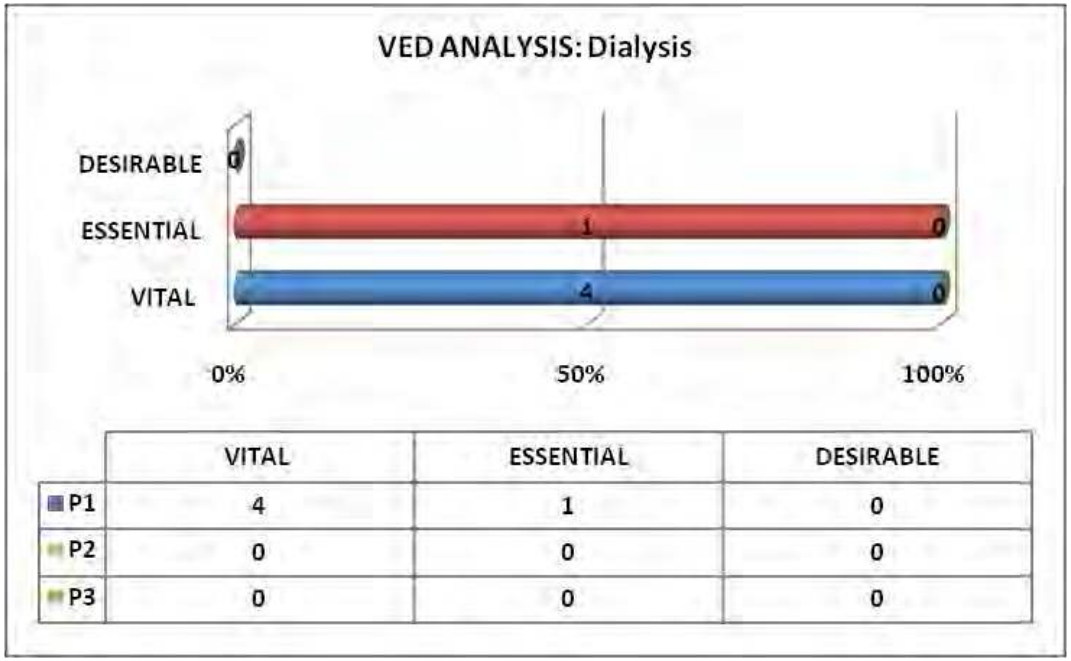

	VITAL	ESSENTIAL	DESIRABLE
P1	4	1	0
P2	0	0	0
P3	0	0	0

Summary: There are a total of 05 observations compiled for infrastructural assessment of Departments. Out of these observations, 04 observations are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 01 of the observations is under the Essential category. While none of the observation is under 0 the Desirable category.

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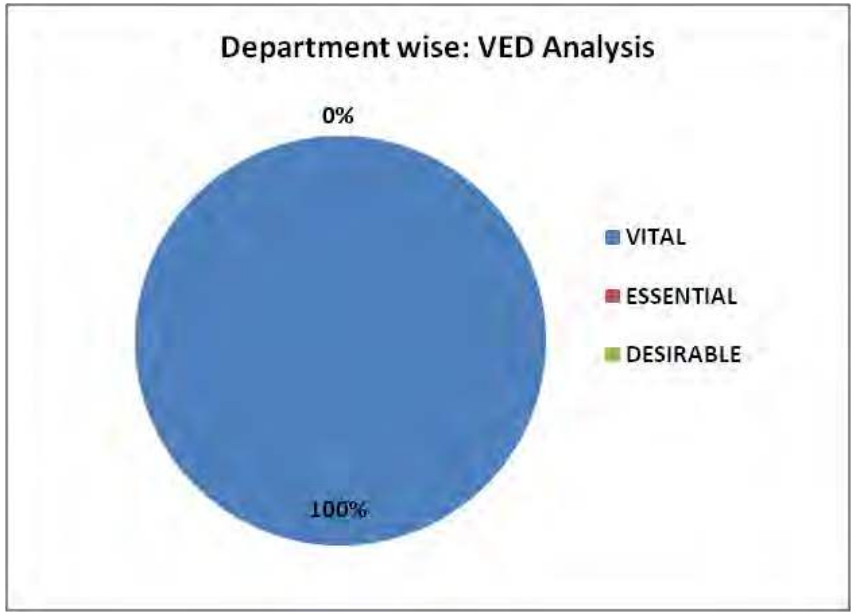
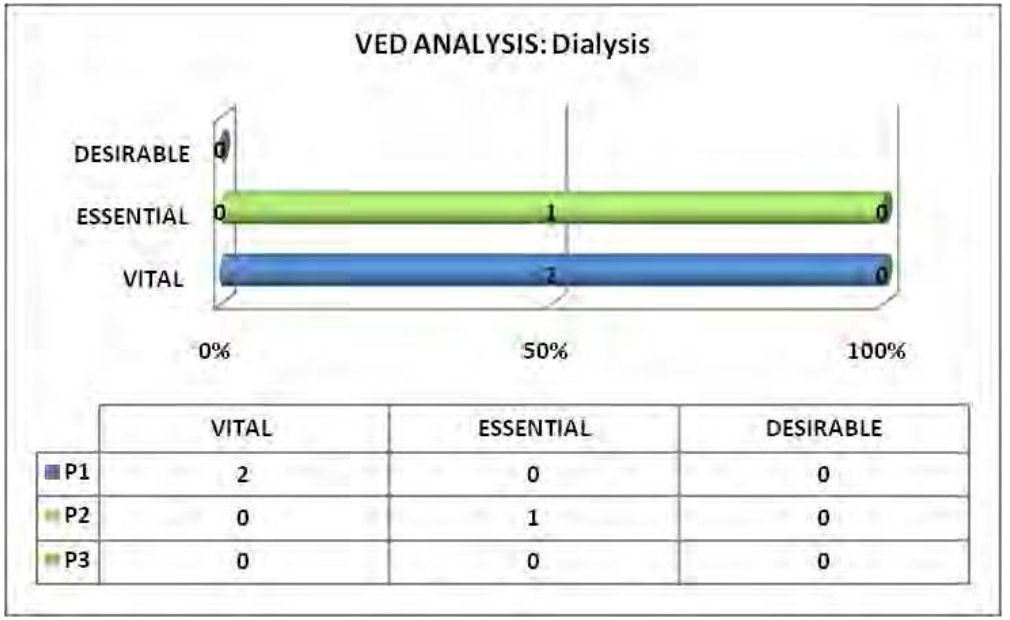
S. NO	OBSERVATIONS	NABH STANDARD	VITAL-ESSENTIAL - DESIRABLE (VED)	PRIORITY WISE (P1,P2,P3)	RECOMMENDATIONS
Blood Bank					
1	Eye wash station was not installed in the bloodbank.	**FMS**	**E**	**P2**	Eye wash station should be installed in blood bank. The area should be easily assessable.
2	There was no space identified for the storage ofchemicalhazards. Storage norms for the hazardous chemicals were notas per HIRA (Hazard Identification and Risk Analysis).They have not been labeled &individualizedthroughoutthedepartment.	**FMS**	**V**	**P1**	Safe storage for hazardous chemicals includes the following: • Safe and secured area needs to be designated for chemical storage so as to reducethe risks of breakage and spills. It is recommended that the storage area should be ventilated, locked, and fire-resistant. • Display of signs/ labels for hazardous chemical storage to ensured so as to assure proper identification. • All chemicals should be stored in the containers designed for chemical storage and appropriate for each type of chemical; ensure that lids are tight. • Storage of all chemicals should be ensured at or beloweyelevel. • Store chemicals by chemical group (chemical class/reactive group) to keep in compatible chemicals away from each other. Appropriate measures may include separation by shelving, and or the use of secondary containment such as clean tubs, buckets, and trays. • Hazard vulnerability assessment should be included in the emergency management program.
3.	Inadequacy of floor plans & fire exit signage's wasobserved	**FMS**	**V**	**P1**	Floor plans depicting the evacuation and escape routes during a fire should be displayed at prominent locations. Additionally, self-illuminated directional and fire exit signage should be installed to ensure the timely and safe exit of staff, patients, and visitors in the event of a fire.





	VITAL	ESSENTIAL	DESIRABLE
P1	2	0	0
P2	0	1	0
P3	0	0	0

Summary: There are a total of 03 observations compiled for infrastructural assessment of Departments. Out of these observations, 02 observations are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 01 of the observations is under the Essential category. While none of the observation is under 0 the Desirable category.

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S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
OPD Services					
1.	There were no grab bars in the OPD toilets. The toilet doors opened inward, preventing easy access. Wheelchairs could not enter the toilet cubicles, and panic alarms were not installed in the OPD toilets.	**FMS**	**E**	**P2**	The washrooms should include the following with respect to patient and staff safety: • Grab bars for support and safety. • Door widths should be adjusted to include provisions for wheelchair access. • Panic alarms should be installed in each toilet to enable quick response in emergencies. • Additionally, outward-opening doors for the toilet facilities are recommended to ensure emergency access for users. A provision for separate disabled-friendly toilets should be made in both the OPD and IPD areas to accommodate individuals with mobility impairments.
2.	Most of the OPDs visited did not have handwashing facilities. Hand hygiene and biomedical waste management posters were not displayed, and instead of liquid soap, hand towels were being used for handwashing.	**IPC**	**V**	**P1**	Handwashing facilities should be provided uniformly across all OPDs. Hand hygiene and biomedical waste management posters should be displayed in multiple languages to ensure clear communication for all staff and visitors. Additionally, it should be ensured that handwash solution is available at all hand hygiene stations.

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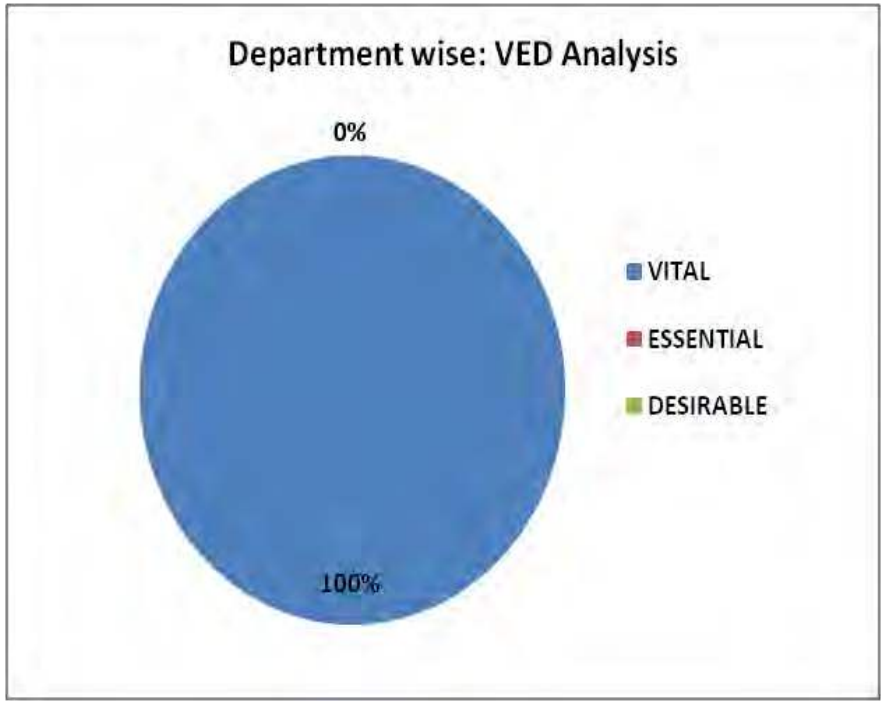

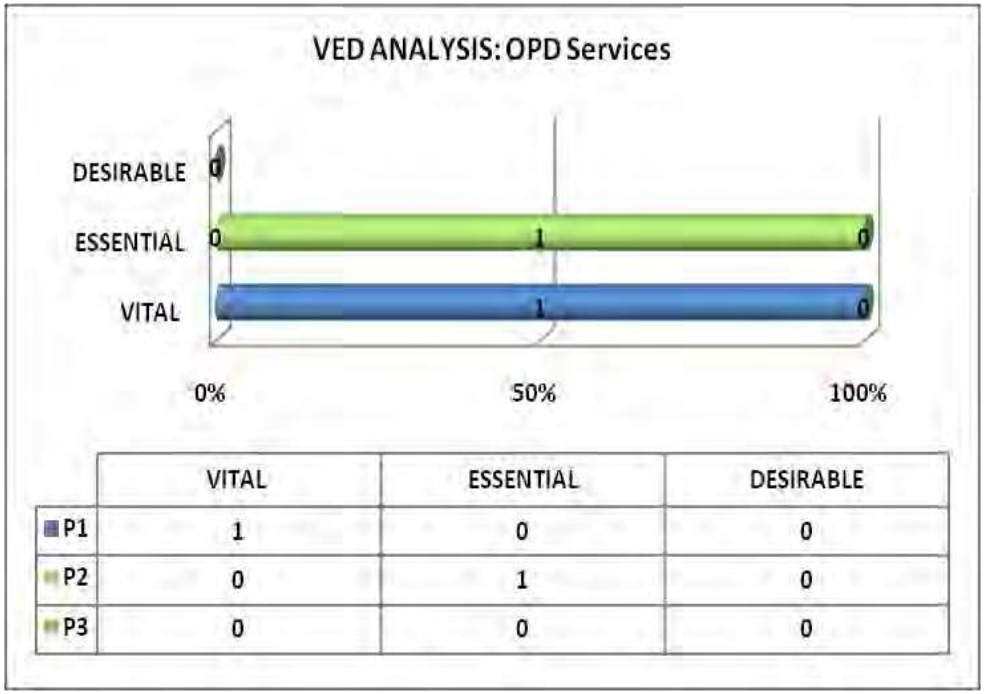

	VITAL	ESSENTIAL	DESIRABLE
P1	1	0	0
P2	0	1	0
P3	0	0	0

Summary: There are a total of 02 observations compiled for infrastructural assessment of Departments. Out of these observations, 01 observation are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 01 of the observations is under the Essential category. While none of the observation is under 0 the Desirable category.

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S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1, P2,P3)	Recommendation
Diagnostics Services					
1.	Hazardious materials were not being stored according to guidelines.	**IPC FMS**	**E**	**P1**	Ensure that all hazardous materials, including chemicals, reagents, and biomedical waste, are stored in designated areas with appropriate labeling and segregation. Store flammable substances in fire-resistant cabinets and ensure that incompatible chemicals are separated as per Material Safety Data Sheets (MSDS) guidelines. Implement a tracking system to monitor inventory levels, expiration dates, and disposal protocols to prevent unnecessary stockpiling or improper handling.
2.	No eye wash stations were present in the lab	**IPC**	**E**	**P1**	Install eye wash stations at strategic locations within the laboratory to ensure immediate access in case of accidental exposure to hazardous substances. Ensure that the eye wash stations comply with safety standards, providing a continuous flow of clean water for at least 15 minutes. Conduct periodic inspections and maintenance to ensure proper functionality and compliance with regulatory requirements.
3.	LPG Gas cylinders were being used in Micro lab which was stored inside the lab	**FMS**	**E**	**P2**	Move all gas cylinders to a designated, ventilated storage area outside the laboratory to minimize risks associated with leaks, fire hazards, and accidental exposure. Secure cylinders in an upright position using chains or brackets to prevent tipping. Clearly label each cylinder and maintain a proper record

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					of inventory, usage, and periodic inspections. Ensure that all staff handling gas cylinders are trained in safe handling, storage, and emergency response procedures.
4.	No PM and caliberation of all equipmenets were uniformly present	**FMS**	**E**	**P2**	Implement a standardized preventive maintenance (PM) schedule to ensure that all laboratory equipment functions optimally. Establish a calibration schedule based on manufacturer recommendations and regulatory requirements to maintain accuracy and reliability. Maintain documentation of maintenance and calibration records, including service dates, findings, and corrective actions. Assign responsible personnel to oversee compliance and coordinate with service providers for timely interventions.
5.	Fire safety signage was missing, fire extinguishers were inaccessible, and sprinklers were absent.	**FMS**	**V**	**P2**	Install self-illuminated directional and fire exit signage at key points to guide staff, patients, and visitors toward safe evacuation routes. Ensure fire extinguishers are strategically placed, clearly marked, and easily accessible, with periodic inspections to confirm operational readiness. Equip the laboratory with an automatic fire sprinkler system to provide an additional layer of fire protection. Conduct regular fire drills, train staff on fire safety protocols, and maintain documentation of all fire safety inspections and drills for compliance purposes.

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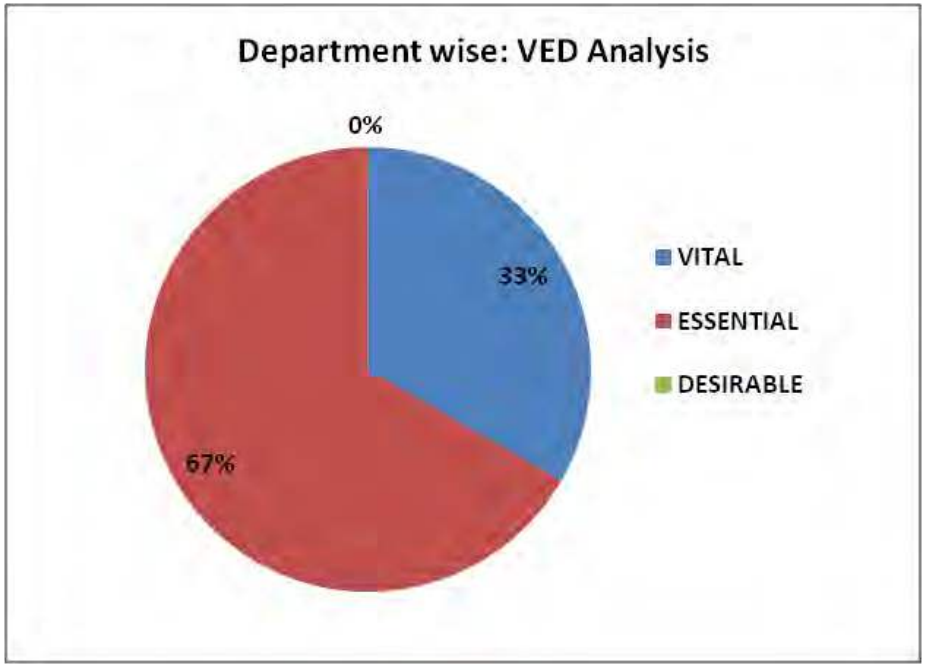

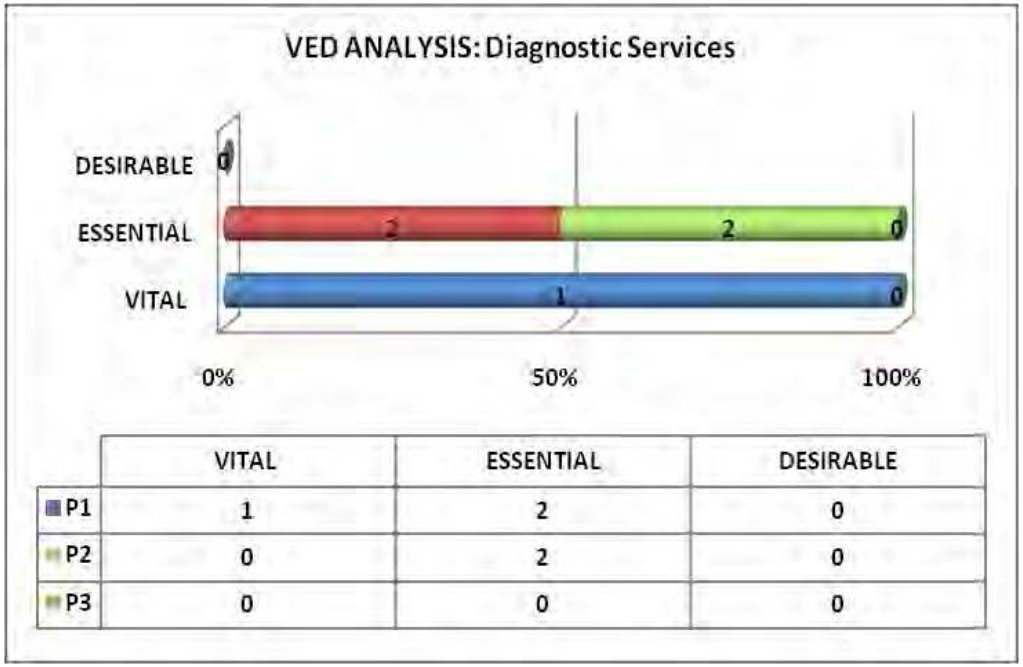

	VITAL	ESSENTIAL	DESIRABLE
P1	1	2	0
P2	0	2	0
P3	0	0	0

Summary: There are a total of 05 observations compiled for infrastructural assessment of Departments. Out of these observations, 01 observation are Vital and need urgent attention as these observations will come in the way of accreditation and are fundamental for patient and health care safety. 04 of the observations is under the Essential category. While none of the observation is under 0 the Desirable category.

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S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1, P2,P3)	Recommendation
Imaging Services					
1.	There were no grab bars in the toilets.	**FMS**	**E**	**P2**	The washrooms should include the following w.r.t topatient&staffsafety • GrabBars • Door width to include provisions for wheelchairaccess • PanicAlarms • Outward door opening of toilet facilities arerecommended for emergency access to the toiletusers.
2.	Firefighting equipment is not compatible for the MRI, compromisingpatient&staffsafety	**FMS**	**V**	**P1**	Firefighting equipment placed near the MRI department should be non-metallic and MRI-compatible to prevent interference with the magnetic field, ensuring both fire safety and patient protection. The use of non-ferrous materials will eliminate the risk of projectile hazards and maintain a safe environment within the MRI suite.
3.	Inadequate AERB and PCPNDT signages, floor plans, and fire exit signage were observed.	**FMS**	**V**	**P1**	Radiation and PCPNDT signages should be displayed as per the guidelines of AERB and PCPNDT. Floor plans depicting evacuation and escape routes during a fire should be displayed at prominent locations. Self-illuminated directional and fire exit signage should be installed to ensure the timely and safe evacuation of staff, patients, and visitors in case of a fire.
4.	MRI compatible stretcher is not evidenced.	**FMS**	**E**	**P1**	An MRI-compatible stretcher should be provided to ensure patient safety and compliance with MRI safety protocols. This specialized stretcher will prevent hazards associated with magnetic field interference, reduce the risk of accidents, and facilitate the safe transport of patients within the MRI suite.

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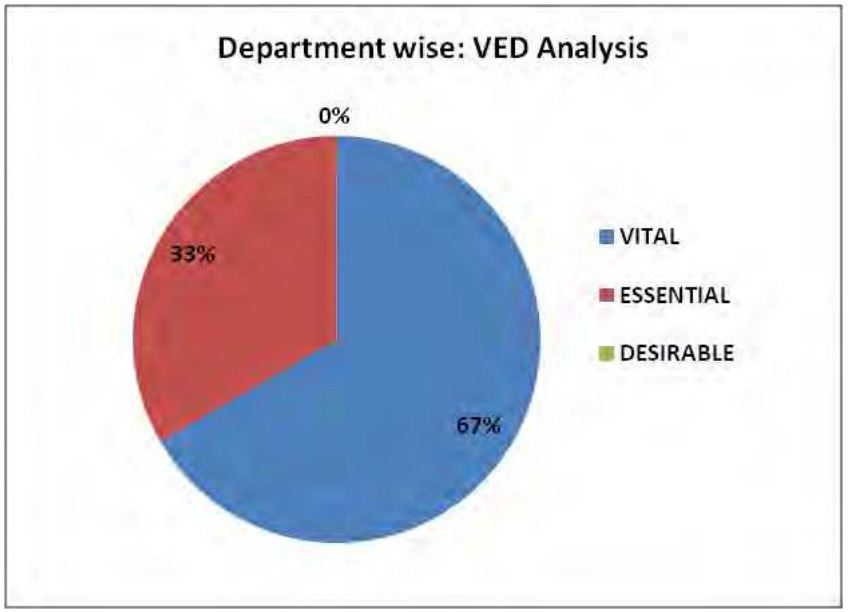
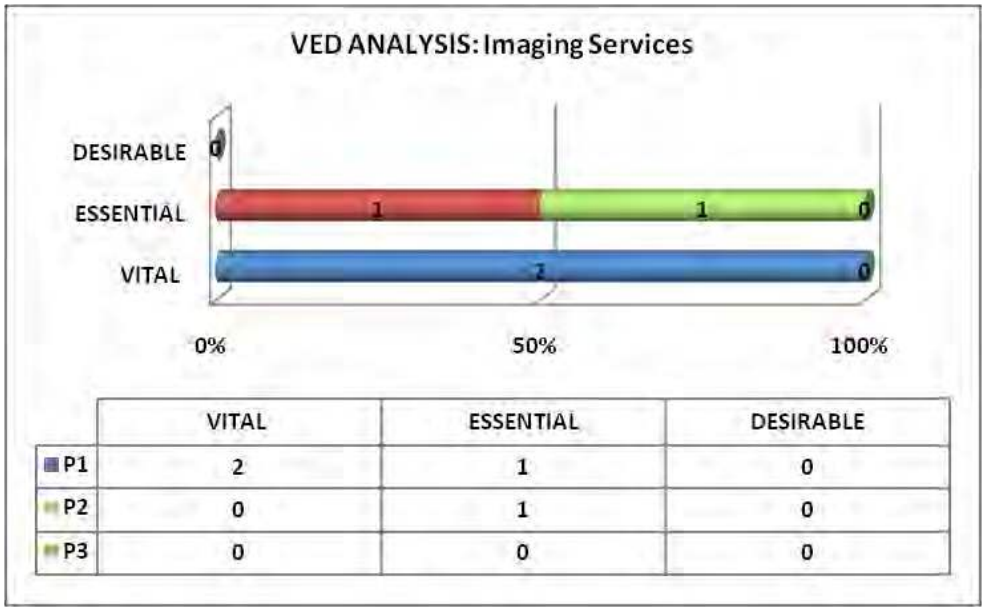
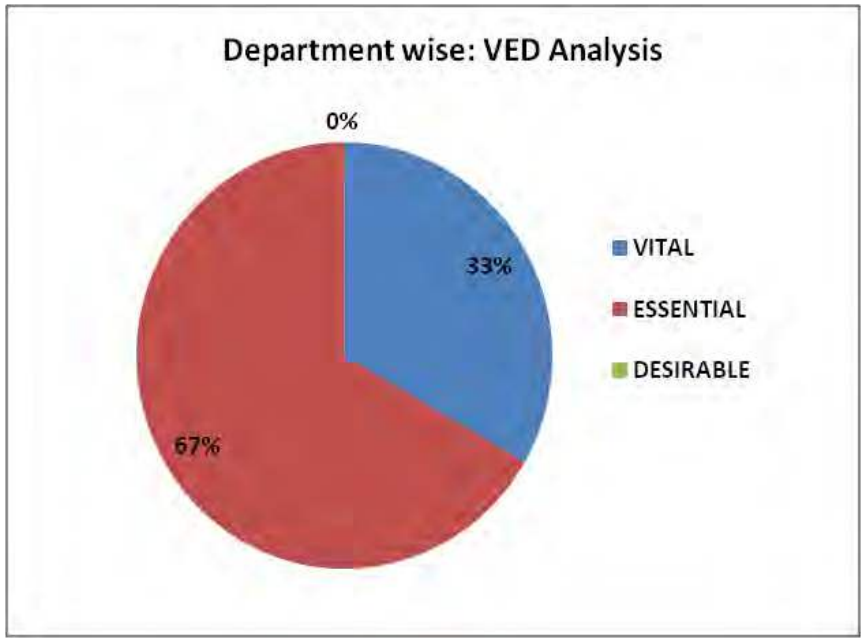


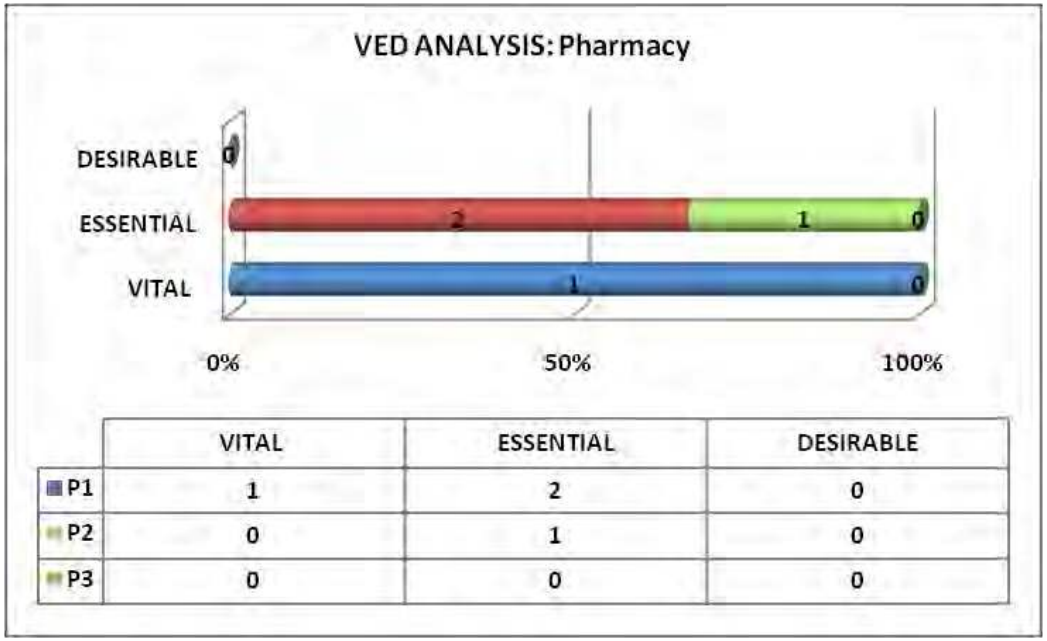


	VITAL	ESSENTIAL	DESIRABLE
P1	2	1	0
P2	0	1	0
P3	0	0	0

Summary: A total of 04 observations were compiled during the infrastructural assessment of the departments. Among these, 02 observations are Vital and require urgent attention, as they are critical for accreditation and fundamental to patient and healthcare safety. 02 observation falls under the Essential category, while 0 is categorized as desirable. Although the desirable observation is not of utmost importance, it should still be addressed as part of the hospital's repair and renovation plan during the accreditation process.

S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
Pharmacy					
1.	Lack of storage space was observed in the in Pharmacy. Medicines & consumable were kept on the floor haphazardly which can lead to fire hazard.	**FMS**	**E**	**P1**	Suitable storage cabinets and shelves inaccordance to Good Storage Practice Guidelines (GSP) and other government/ authority regulations, are required to be made available.
2.	Heavy items were being stored beyond eye level in pharmacy, compromising staff safety.	**FMS**	**E**	**P2**	Heavy items should be shifted to some other place and to be stored on ground level.
3.	The temperature monitoring of medicine refrigerators inpharmacywasnotbeingdone.	**IPC**	**E**	**P1**	A fridge temperature monitoring device should be installed for each refrigerator in the pharmacy. Additionally, the temperature of all medicine refrigerators should be monitored and recorded at regular intervals to ensure compliance with storage requirements.
4.	Inadequacy offloor plans & fire exit signage's was observed	**FMS**	**V**	**P1**	Floor plans depicting the evacuation and escape routesduringfiretobedisplayedatprominentlocations. Self-illuminated directional & fire exit signages should bedisplayed to ensure timely & safe exit of staff, patients and visitors in an event of fire.

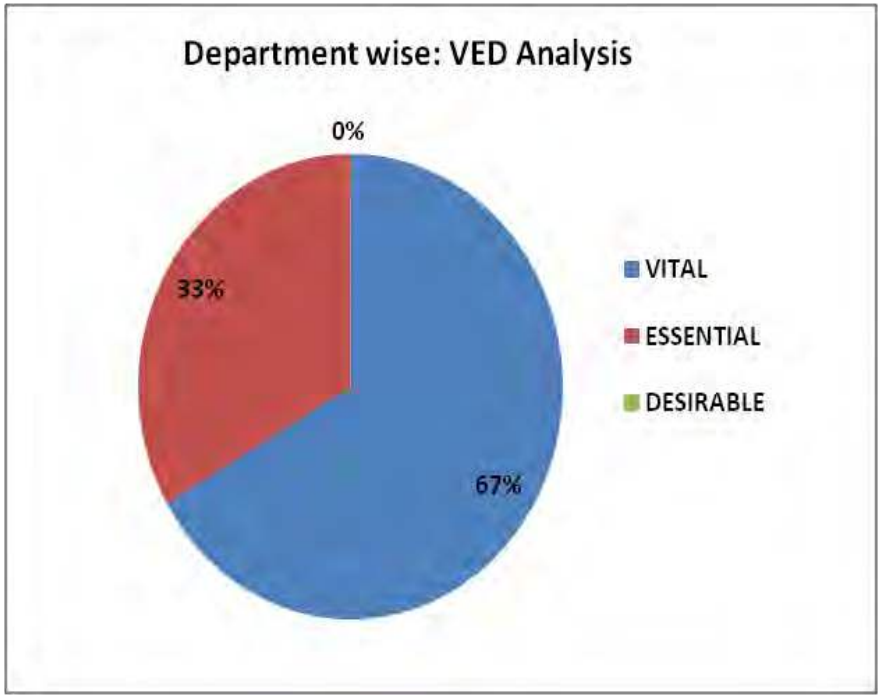


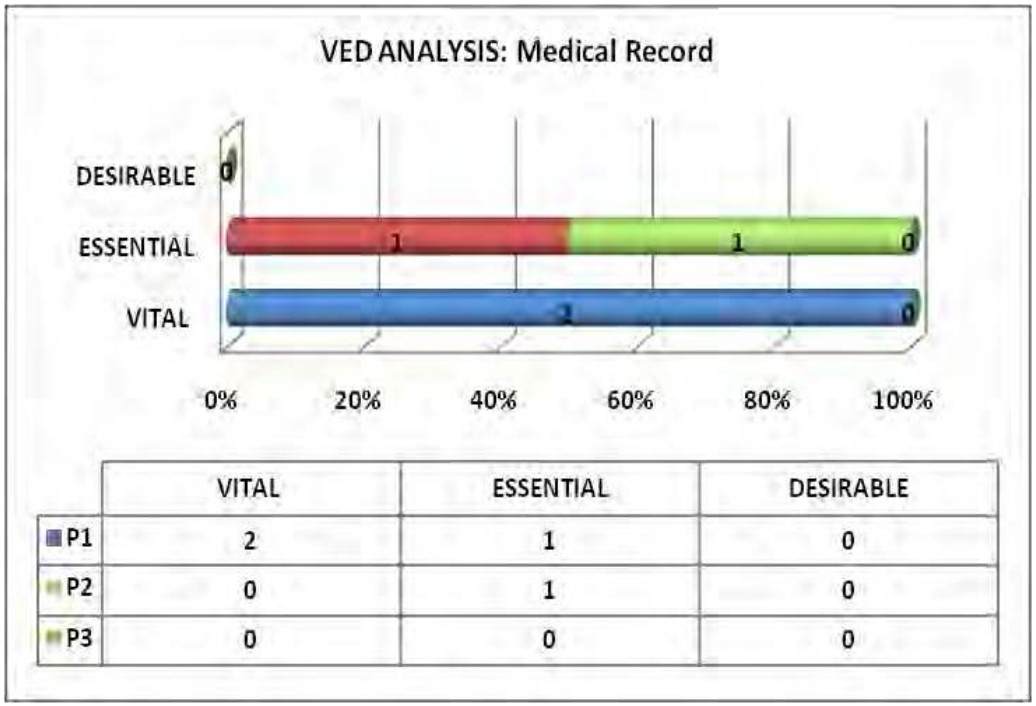


	VITAL	ESSENTIAL	DESIRABLE
P1	1	2	0
P2	0	1	0
P3	0	0	0

Summary: A total of 04 observations were compiled during the infrastructural assessment of the departments. Among these, 01 observation are vital and require urgent attention, as they are critical for accreditation and fundamental to patient and healthcare safety. 03 observation falls under the essential category, while one is categorized as desirable. Although the desirable observation is not of utmost importance, it should still be addressed as part of the hospital's repair and renovation plan during the accreditation process.

S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1, P2, P3)	Recommendations
Medical Record					
1.	Although smoke detectors were installed, they were found to be non-functional at the time of assessment.	**FMS**	**E**	**P2**	• Smoke detectors should be regularly checked to ensure 24/7 functionality. • The most suitable firefighting system for the Medical Record Room is a Compact Automatic Fire Extinguisher. It comes with a fixing bracket for secure ceiling or wall mounting with a single screw and contains dry powder suitable for various fire types. • The automatic extinguisher activates when the glass bulb in the nozzle breaks at 68°C, releasing its contents over a 6-square-meter area until fully discharged, and ensuring effective fire suppression.
2.	Heavy items (medical files) were being stored above eye level on racks, compromising staff safety.	**FMS**	**E**	**P1**	Medical files should be relocated to lower racks to ensure staff safety.
3.	Inadequacy of floor plans & fire exit signage's was observed	**FMS**	**V**	**P1**	Floor plans showing evacuation and escape routes during a fire should be displayed at prominent locations. Self-illuminated directional and fire exit signage should be installed to ensure a timely and safe exit for staff, patients, and visitors in the event of a fire.
4.	It was evidenced that each department maintains its own separate space for medical records, leading to decentralization of record management.	**IMS** **FMS**	**V**	**P1**	It is recommended to establish a centralized Medical Record Department (MRD) for the entire hospital. A centralized system will streamline record-keeping, enhance accessibility, improve data security, and ensure compliance with medical record management standards. Proper infrastructure, digital record-keeping solutions, and staff training should be implemented to facilitate a smooth transition and efficient record management.

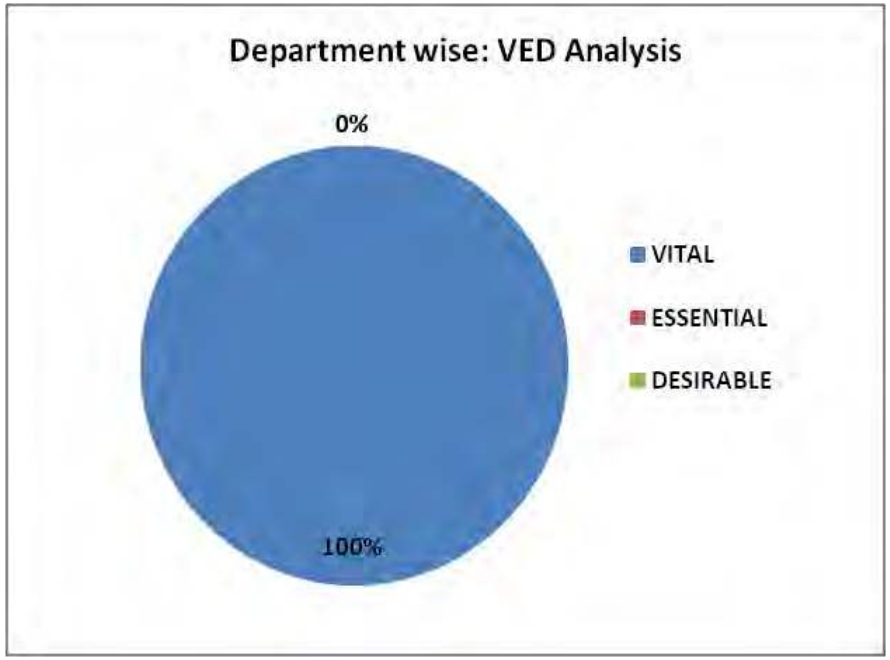


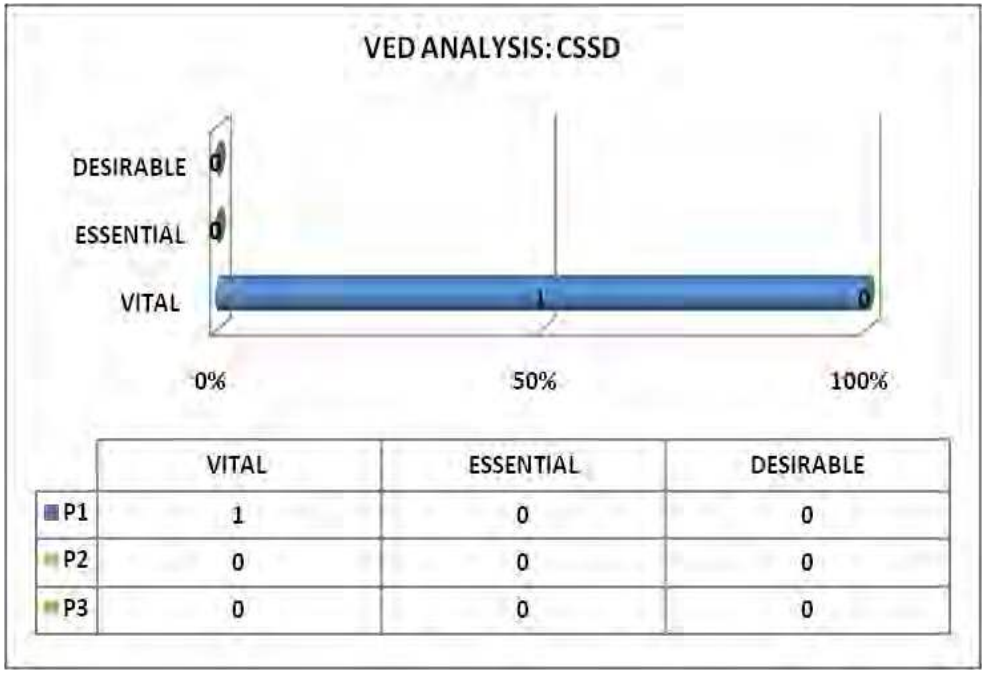


	VITAL	ESSENTIAL	DESIRABLE
P1	2	1	0
P2	0	1	0
P3	0	0	0

Summary: A total of 04 observations were compiled during the infrastructural assessment of the departments. Among these, 02 observations are vital and require urgent attention, as they are critical for accreditation and fundamental to patient and healthcare safety. 02 observation falls under the essential category, while 0 is categorized as desirable. Although the desirable observation is not of utmost importance, it should still be addressed as part of the hospital's repair and renovation plan during the accreditation process.

S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendation
Central Sterile Supply Department (CSSD)					
1.	Cross zoning was observed in the department. The sterile storage area was not up to the requirements. The layout of CSSD did not comply with the concept of proper zoning as per NABH guidelines. These practices led to criss-cross zoning in CSSD, compromising infection control practices.	**IPC**	**V**	**P1**	The CSSD layout should be designed for a unidirectional flow. The CSSD should have four zones for a smooth workflow. a. Unclean and washing area b. Assembly and packing area c. Sterilization area The sterile storage area requires the following criteria to be met: • Dedicated for the intended purpose only for Sterile reprocessed stock and Sterile consumable / pre-packaged stock • A dedicated area to remove transportation packaging boxes of stock prior to entering sterile stock storage area. In the CSSD, the biomedical wastes and the used linens should be carried in closed trolleys till the disposal. The used instrument trolleys should also be carried in closed container to the instrument washing area to comply with the prescribed infection control practices.



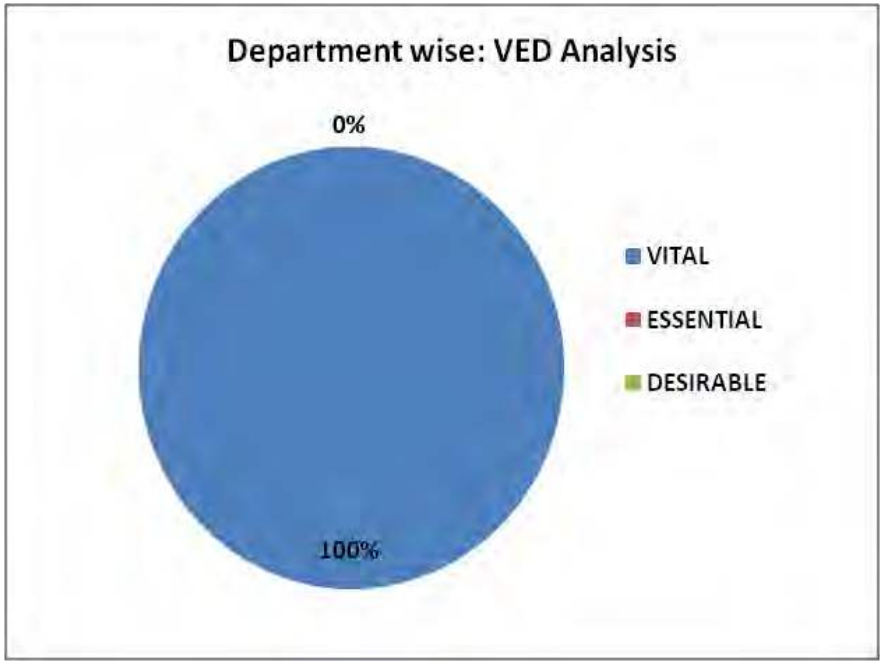


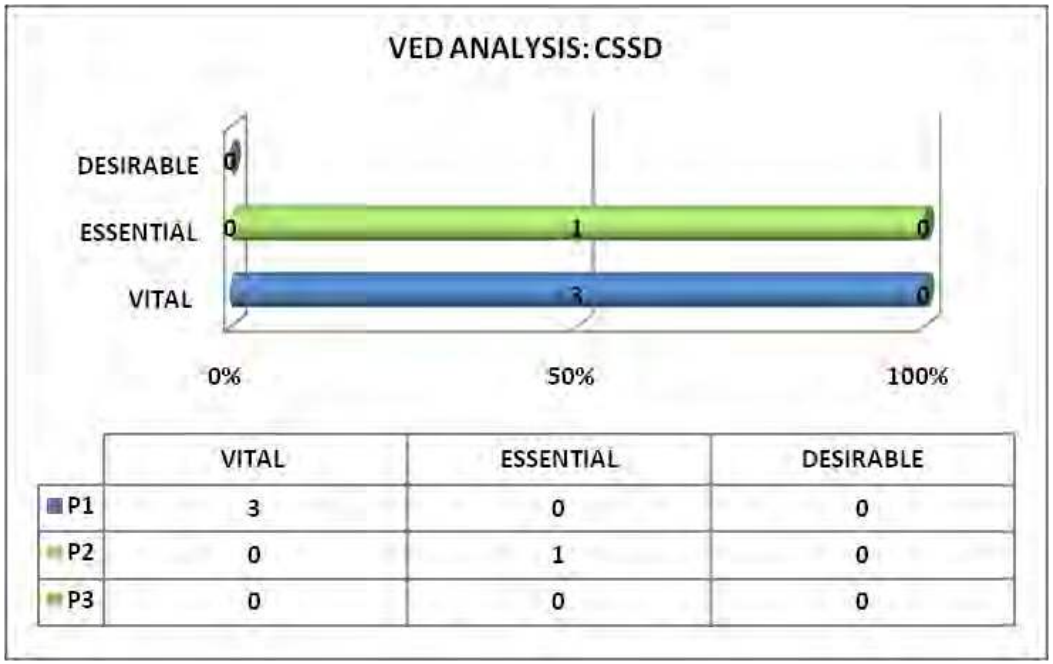
	VITAL	ESSENTIAL	DESIRABLE
P1	1	0	0
P2	0	0	0
P3	0	0	0

Summary: A total of 01 observation was compiled during the infrastructural assessment of the departments. Among these, 01 observation is Vital and requires urgent attention, as they are critical for accreditation and fundamental to patient and healthcare safety. 0 observation falls under the Essential category, while 0 is categorized as Desirable. Although the desirable observation is not of utmost importance, it should still be addressed as part of the hospital's repair and renovation plan during the accreditation process.

S.No.	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendation
Laundry					
1.	Lack of zoning was observed, i.e., defined areas for sorting, storage, and drying of linen being used in different areas of the hospital were not evidenced. The used and clean linen were not having a unidirectional flow. Open trolleys were being used for the same as well. Further, lack of clarity &labeling was observed for segregation and storage of soiled and infected linen, compromising infection control practices. These practices were compromising infection control practices.	**IPC**	**V**	**P1**	There should be functional separation of areas that receive, store, or process soiled linen from areas that process, handle, or store clean fabric. The following may be resorted to ensure zoning in compliance with infection control practices: ▪ Physical Separation (sorting, washing, drying, ironing, packing, dispatch) ▪ Clean & Dirty trolley bays to be identified ▪ Negative air pressure in soiled textile areas ▪ Positive airflow from the clean textile area through the soiled linen area with venting directly to outside ▪ Closed trolleys should be used for the transportation and movement of clean and dirty linens.

2.	Lack of demarcated space was observed for storage of hazardous material. Lack of labelling was observed chemicals used for washing linen.	**FMS**	**E**	**P2**	Safe storage for hazardous chemicals includes the following: • A safe and secured area should be designated for chemical storage to minimize the risk of breakage and spills. It is recommended that this storage area be ventilated, locked, and fire-resistant. • Signs/labels for hazardous chemical storage should be displayed to ensure proper identification. • All chemicals must be stored in containers designed specifically for chemical storage and appropriate for each type of chemical, ensuring tight-fitting lids. • Chemicals should be stored at or below eye level for safe handling. • Chemicals should be stored by chemical group (chemical class/reactive group) to keep incompatible chemicals separate. This may involve using separation by shelving or secondary containment options such as clean tubs, buckets, and trays. • A hazard vulnerability assessment should be included in the emergency management program.
3.	It was observed that transportation & handling of linens is not done in an appropriate way, staffs were handling the linen without using PPE.	**IPC**	**V**	**P1**	The handling of soiled linen should be done appropriately using PPE. Linen should be transported in a closed trolley to prevent contamination. Staff members need to be trained on these procedures to ensure proper handling and safety.
4.	Unwanted scrap material was stored in the laundry.	**FMS**	**V**	**P1**	Process should be developed and implemented for identification and disposal of scrap material.

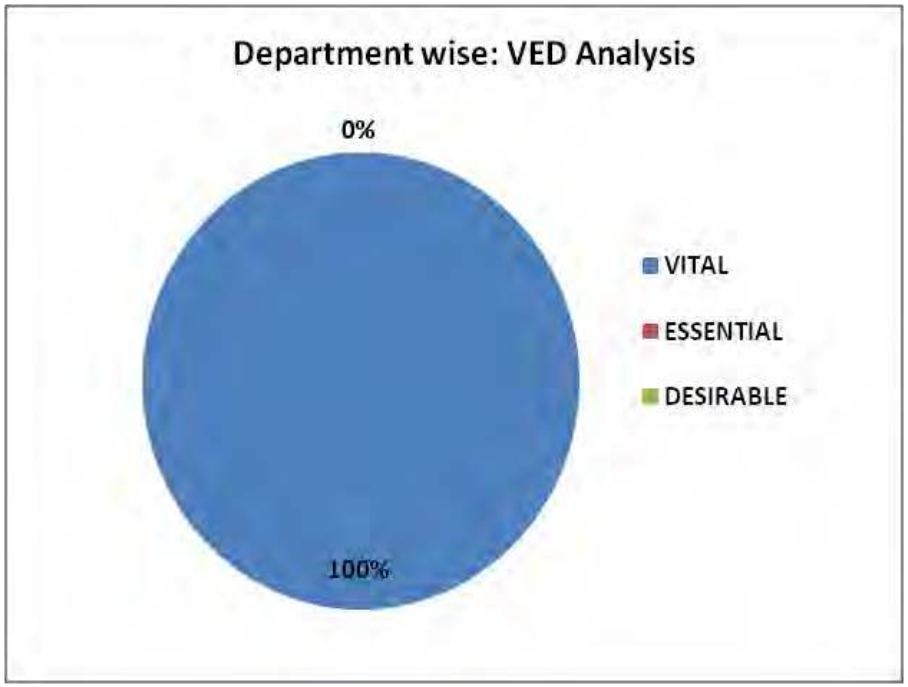


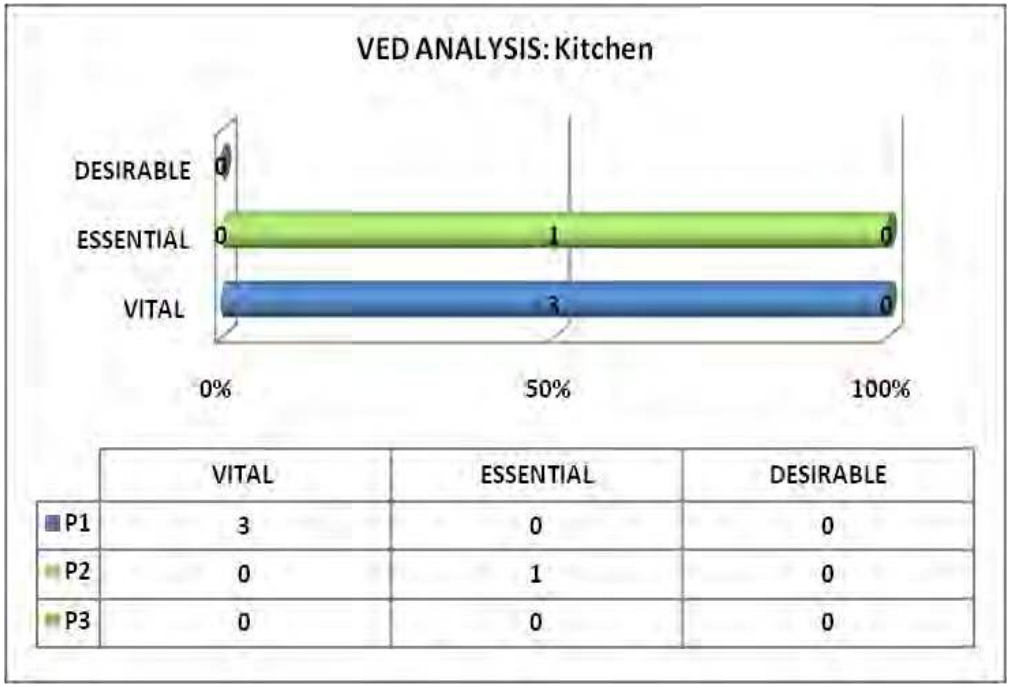


	VITAL	ESSENTIAL	DESIRABLE
P1	3	0	0
P2	0	1	0
P3	0	0	0

Summary: A total of 04 observations were compiled during the infrastructural assessment of the departments. Among these, 03 observations are vital and require urgent attention, as they are critical for accreditation and fundamental to patient and healthcare safety. 01 observation falls under the essential category, while 0 is categorized as desirable. Although the desirable observation is not of utmost importance, it should still be addressed as part of the hospital's repair and renovation plan during the accreditation process.

S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
Kitchen					
1.	Utensils washing area was found dirty and soiled & broken.	**IPC**	**V**	**P1**	The utensil washing area should be kept clean at all times.
2.	Non-availability of gum boots to use by the cleaning staff was evidenced in the kitchen.	**IPC**	**V**	**P1**	Gum boots to be made available for the cleaning staff to ensure staff safety. The kitchen should be regularly monitored by dietician and ICN.
3.	Inadequacy of floor plans.	**FMS**	**V**	**P1**	Floor plans depicting evacuation and escape routes during a fire should be displayed at prominent locations. Self-illuminated directional and fire exit signage should be installed to ensure the timely and safe evacuation of staff, patients, and visitors in the event of a fire.
4.	The kitchen has a gas storage area, but it was not restricted. Additionally, extra cylinders are stored and used inside the kitchen, posing a potential fire hazard.	**FMS**	**V**	**P1**	Gas cylinders should be removed from the kitchen and stored in the gas bank area. The gas bank area should be restricted and only authorized personnel will be allowed.
5.	The garbage was stored in opened area outside the kitchen.	**IPC**	**V**	**P1**	Designated area should be provided for the storage of garbage.

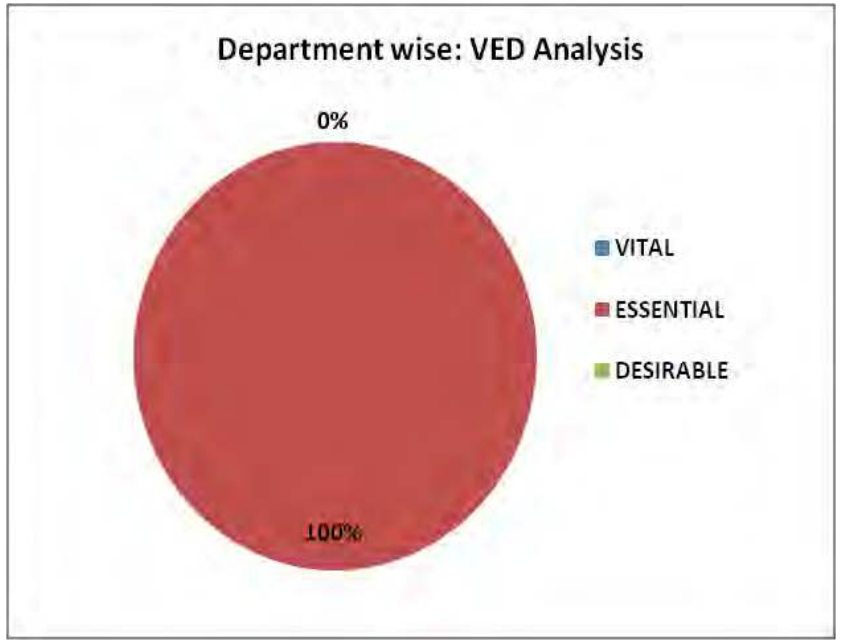


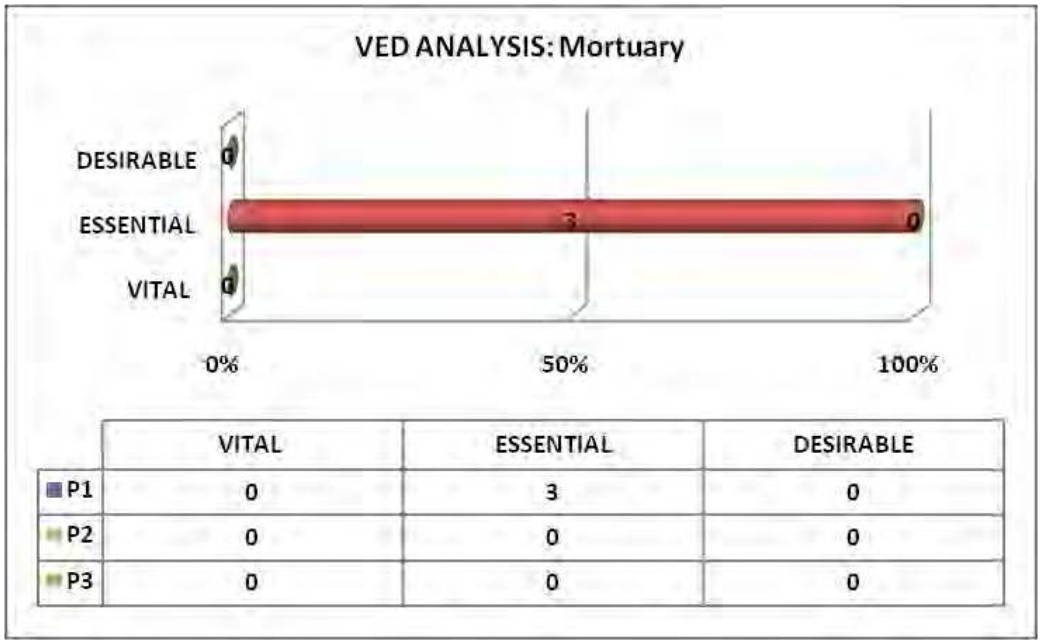


	VITAL	ESSENTIAL	DESIRABLE
P1	3	0	0
P2	0	1	0
P3	0	0	0

Summary: A total of 04 observations were compiled during the infrastructural assessment of the departments. Out of these, 03 observations are vital and require urgent attention, as they are critical for accreditation and essential for patient and healthcare safety. 01 observation is under the Essential category, and 0 of the observations fall under the desirable category.

S. No	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
Mortuary					
1.	The temperature chart monitoring for the dead body storage cabinets in the mortuary was not being properly maintained.	**IPC**	**E**	**P1**	Regular temperature monitoring and documentation should be ensured for the dead body storage cabinets in the mortuary. A standardized temperature chart should be maintained and updated at specified intervals. Staff should be trained on the importance of accurate recording, and periodic audits should be conducted to ensure compliance with monitoring protocols.
2.	The non-availability of Personal Protective Equipment (PPE) was observed during the assessment, and the cleaning record of the mortuary could not be evidenced.	**IPC**	**E**	**P1**	An adequate number of Personal Protective Equipment (PPE) should be made available in the mortuary to ensure staff safety and compliance with infection control practices. Additionally, the cleaning record of the mortuary should be maintained and properly documented to ensure hygiene and regulatory compliance.
3.	In mortuary, dead body freezers was found switched of which compromising the infection control practices.	**IPC**	**E**	**P1**	Dead Body freezers in the mortuary should remain operational at all times to ensure infection control. Regular monitoring and documentation of freezer temperatures should be implemented, along with staff training and periodic audits to ensure compliance.

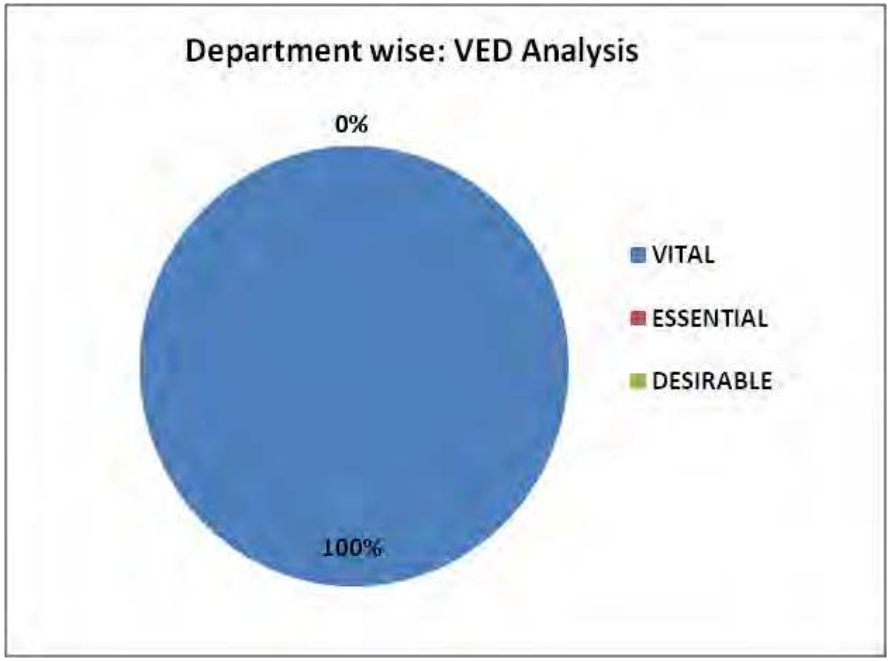


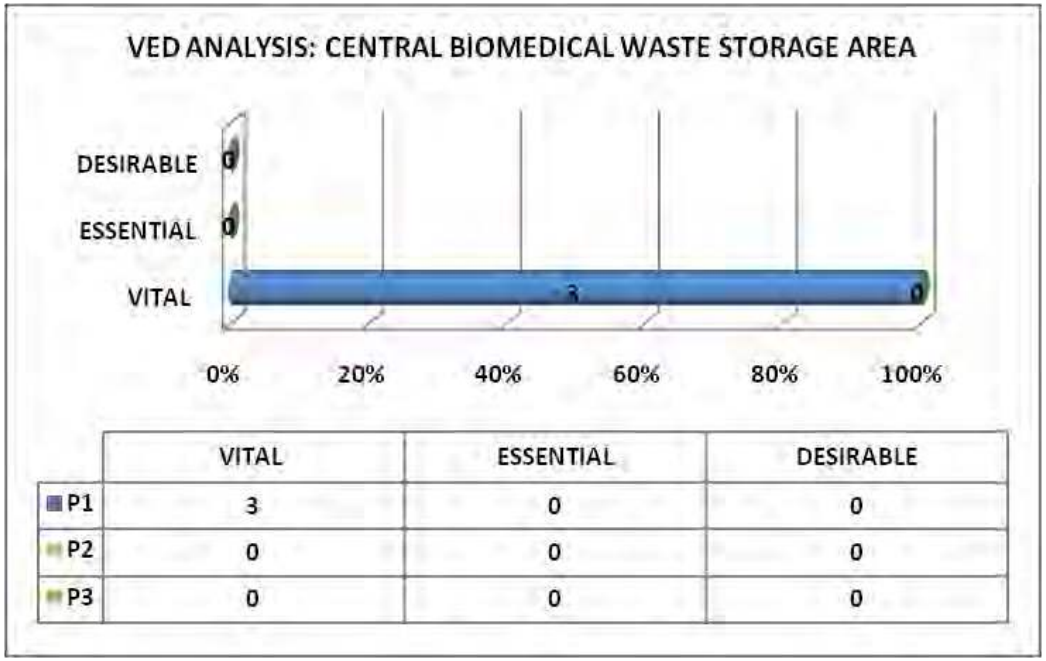


	VITAL	ESSENTIAL	DESIRABLE
P1	0	3	0
P2	0	0	0
P3	0	0	0

Summary: A total of 03 observations were compiled during the infrastructural assessment of the departments. Out of these, 0 observations are vital and require urgent attention, as they are critical for accreditation and 03 Essential for patient and healthcare safety. Three observations are under the essential category, and none of the observations fall under the Desirable category.

S. No.	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
CENTRAL BIOMEDICAL WASTE STORAGE AREA					
1.	The hand washing facility and proper drainage system were not evidenced in the BMW waste area, compromising infection control practices.	**FMS IPC**	**V**	**P1**	A proper hand washing facility and an adequate drainage system should be installed in the BMW waste area to ensure compliance with infection control practices. Regular monitoring should be conducted to ensure cleanliness, and staff should be trained on proper hand hygiene protocols in this area.
2.	Sharp waste was not transported in puncture-proof, leak-proof containers.	**IPC**	**V**	**P1**	Sharp waste should be transported in puncture-proof, leak-proof containers to prevent accidents and ensure safety. These containers should be clearly labeled, and staff should be trained on the correct handling and disposal procedures for sharp waste to maintain compliance with safety and infection control standards.
3.	None of the staff handling the biomedical waste storage and segregation at the BMW storage area were wearing gum boots and other required PPE, compromising infection control practices.	**IPC HRM**	**V**	**P1**	Staff handling biomedical waste storage and segregation should be provided with and required to wear appropriate PPE, including gum boots, gloves, masks, and other necessary protective gear. Regular training on the correct use of PPE and adherence to infection control protocols should be conducted to ensure compliance and safety.

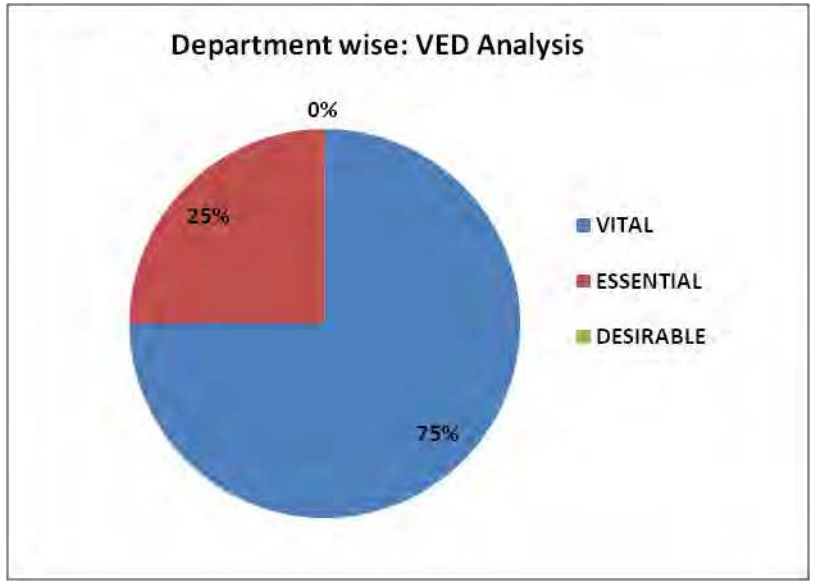


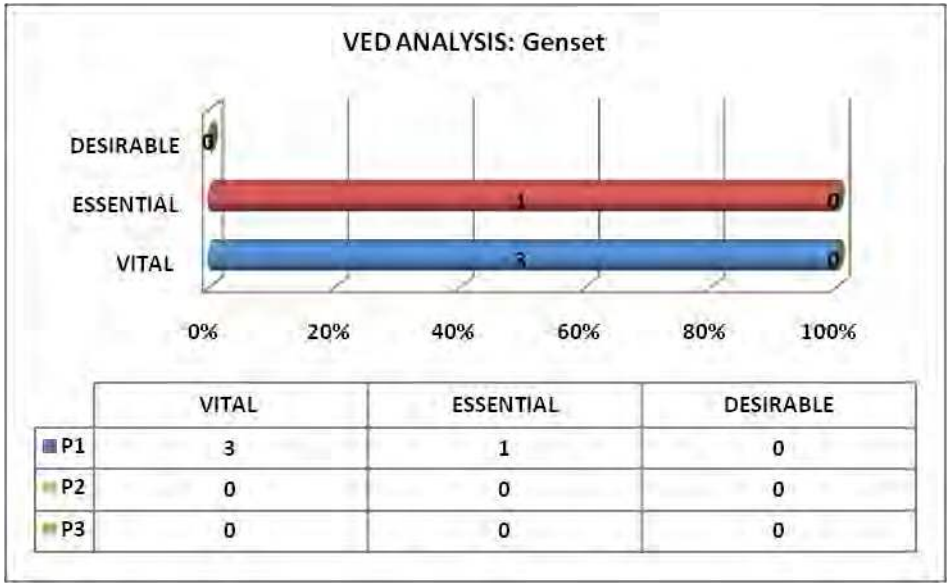


	VITAL	ESSENTIAL	DESIRABLE
P1	3	0	0
P2	0	0	0
P3	0	0	0

Summary: A total of 03 observations were compiled during the infrastructural assessment of the departments. Out of these, 03 observations are vital and require urgent attention, as they are critical for accreditation and essential for patient and healthcare safety. Zero observations are under the essential category, and none of the observations fall under the desirable category.

S. No.	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
Gen Set Area					
1.	The generator set (Gen Set) area was found to be unrestricted, lacking proper restricted access signage.	**FMS**	**V**	**P1**	Designate the Gen Set area as a restricted zone by installing appropriate signage indicating "Restricted Area – Authorized Personnel Only." Additionally, physical barriers or controlled access measures should be implemented to prevent unauthorized entry, ensuring safety and compliance with standard safety protocols.
2.	The generator set (Gen Set) area was found to absence of an electric shock-proof rubber mat, which is essential for personnel safety.	**FMS**	**V**	**P1**	Install an electrical-grade rubber mat in the Gen Set area to provide insulation against electric shocks. The mat should comply with relevant safety standards and cover all areas where personnel may come into contact with electrical components. Regular inspection and maintenance of the mat should also be ensured to uphold workplace safety.
3.	The generator set (Gen Set) area was found to be used for vehicle parking, which poses a safety hazard. Parking in this area can obstruct access during emergencies, increase the risk of fire hazards due to fuel proximity, and compromise routine maintenance activities.	**FMS**	**V**	**P1**	It is recommended to strictly prohibit vehicle parking in the Gen Set area. Clear "No Parking" signage should be installed, and alternative designated parking spaces should be provided. Additionally, physical barriers or markings can be implemented to ensure the area remains unobstructed and safe for operations.
4.	The pump motors were found without proper labeling, which can lead to operational confusion, maintenance difficulties, and potential safety risks due to the inability to identify specific equipment quickly.	**FMS**	**E**	**P1**	Ensure to label all pump motors with clear and durable identification tags, including details such as motor number, capacity, voltage, and operational status. This will facilitate proper maintenance, troubleshooting, and compliance with safety standards. Regular inspections should also be conducted to ensure labels remain intact and legible.





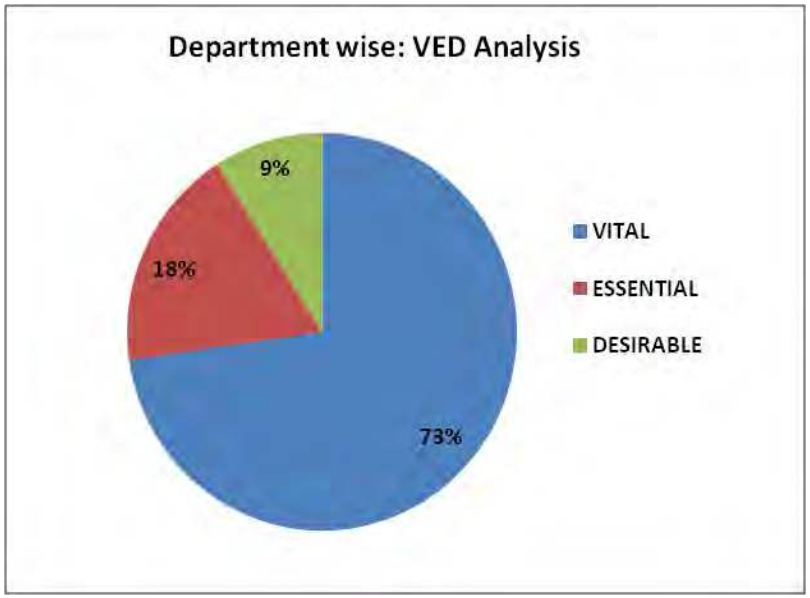
	VITAL	ESSENTIAL	DESIRABLE
P1	3	1	0
P2	0	0	0
P3	0	0	0

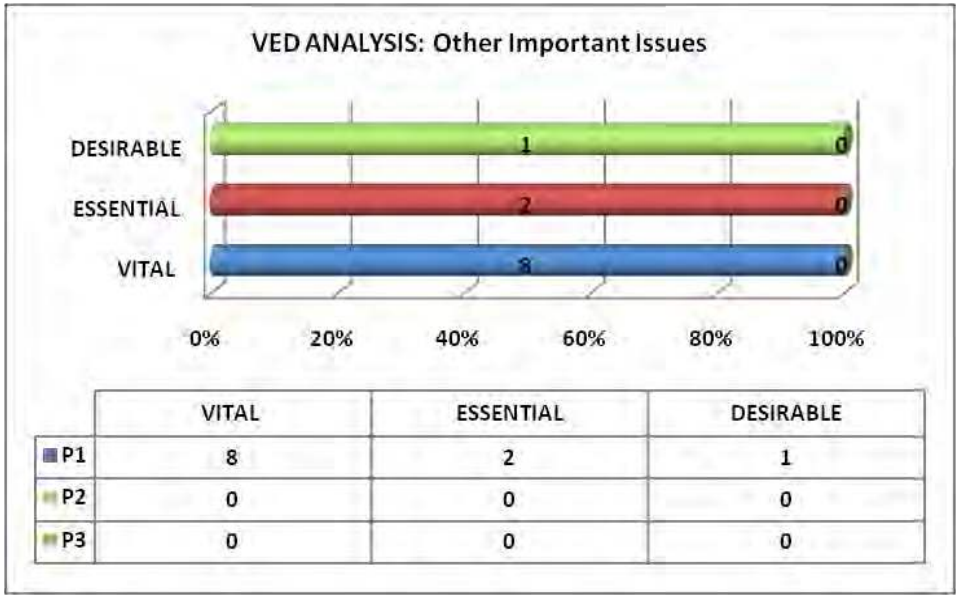
Summary: A total of 04 observations were compiled during the infrastructural assessment of the departments. Out of these, 03 observations are vital and require urgent attention, as they are critical for accreditation and essential for patient and healthcare safety. 01 observation is under the Essential category, and 0 of the observation fall under the Desirable category.

S. No.	Observations	NABH Standard	Vital-Essential-Desirable (VED)	Priority Wise (P1,P2,P3)	Recommendations
Other Important Issues					
1.	Properly designated areas for chemotherapy preparation were not evidenced.	**IPC FMS**	**V**	**P1**	Properly designated areas for chemotherapy preparation are required, with the use of biosafety cabinets for drug preparation to ensure safety and minimize exposure to hazardous substances. These areas should be equipped to meet regulatory standards, and staff must be trained on the proper use of biosafety cabinets and safe handling procedures. Regular monitoring and audits should be conducted to ensure compliance with safety and infection control guidelines.
2.	The lack of display of restricted entry signage and caution signage was observed for areas such as the DG set area, transformer area, manifold room, chillers, terrace, MGPS, load distribution room, lift room, and others.	**FMS**	**V**	**P1**	Restricted entry and caution signage should be prominently displayed in areas such as the DG set area, transformer area, manifold room, chillers, terrace, MGPS, load distribution room, lift room, and similar zones to ensure safety and prevent unauthorized access. Regular audits should be conducted to ensure the signage is clear, visible, and maintained in compliance with safety standards.

3.	There was no space identified for the storage of chemical hazards in most areas of the hospital. The storage norms for hazardous chemicals were not in compliance with HIRA (Hazard Identification and Risk Analysis) standards. Additionally, the chemicals were not labeled or individualized throughout the department.	**FMS**	**V**	**P1**	Safe storage for hazardous chemicals includes the following: • Safe and secured area must be designated for chemical storage to reduce the risks of breakage and spills. It is recommended that the storage area be ventilated, locked, and fire-resistant. • Signs/labels should be displayed to ensure proper identification of hazardous chemical storage. • All chemicals should be stored in containers designed for chemical storage, appropriate for each type of chemical, with tight-fitting lids to prevent spills. • Chemicals should be stored at or below eye level to ensure safe handling. • Chemicals should be stored by chemical group (chemical class/reactive group) to prevent incompatible chemicals from coming into contact. Measures such as separation by shelving or the use of secondary containment (e.g., clean tubs, buckets, and trays) may be employed. • A hazard vulnerability assessment should be included in the emergency management program to ensure preparedness for potential risks.
4.	Inadequacy of floor plans & fire exit signages were observed.	**FMS**	**V**	**P1**	Floor plans illustrating the evacuation and escape routes during a fire should be prominently displayed at strategic locations across the facility to ensure staff, patients, and visitors can quickly and efficiently navigate to safety in an emergency. Self-illuminated directional and fire exit signage should be installed throughout the facility to provide clear guidance and facilitate the timely and safe evacuation of individuals in the event of a fire, ensuring compliance with fire safety regulations.

5.	Uniform color coding for the medical gases pipelines was not evidenced.	**FMS**	**V**	**P1**	A standardized color coding system should be adopted for the medical gas pipeline to ensure easy identification, prevent errors in gas usage, and enhance patient safety by reducing the risk of incorrect administration.
6.	In the lift the emergency call system was not working at the time of assessment.	**FMS**	**V**	**P1**	The calling system should be promptly repaired, and the engineering department must establish a process for its continuous monitoring and maintenance to ensure uninterrupted communication, efficient coordination, and smooth operations within the facility.
7.	Safety net was not evidenced between the open areas of the building.	**FMS**	**D**	**P1**	Safety nets should be installed floor-wise in areas prone to falls to enhance safety measures, prevent accidental falls, and ensure a secure environment for staff, patients, and visitors.
8.	Signages were not evidences as required by the NABH.	**FMS**	**V**	**P1**	Signages, as per NABH guidelines, should be displayed across the facility to educate patients and their families regarding healthcare services, facility protocols, and important safety and emergency procedures, ensuring effective communication and patient awareness.
9.	Rubber mates for the electric panels was not evidenced uniformly	**FMS**	**V**	**P1**	Rubber mats should be uniformly installed in front of all electric panels to mitigate the risk of electrical hazards, provide insulation against electric shocks, and ensure compliance with electrical safety standards.
10.	Unwanted scrap material was stored at various locations in the organization.	**FMS**	**E**	**P1**	A formal policy and structured process should be developed and implemented for the identification, segregation, and disposal of unwanted scrap and obsolete materials. This will help maintain a clutter-free, safe, and organized facility environment.
11.	In central store heavy material was stored beyond the eye level which may leads to injury to the staff.	**FMS**	**E**	**P1**	Heavy materials should be stored at or below eye level to minimize the risk of manual handling injuries, reduce strain on staff, and ensure safe storage practices within the facility.





	VITAL	ESSENTIAL	DESIRABLE
P1	8	2	1
P2	0	0	0
P3	0	0	0

Summary: A total of 11 observations were compiled during the infrastructural assessment of the departments. Out of these, 08 observations are vital and require urgent attention, as they are critical for accreditation and essential for patient and healthcare safety. 02 observations are under the Essential

NABH CHAPTER WISE – QUALITATIVE & QUANTITATIVE ASSESSMENT

GAP –ASSESSMENT BASED ON SYSTEMS, PROCESSESS AND DOCUMENTATION AS PER NABH STANDARDS

Elements			Observations	Score (1,2,3,4,5)	Recommendations
Chapter1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)					
Commitment	a	**The healthcare services being provided are clearly defined and are in consonance with the needs of the community.**	The "Scope of Services" and "Not in Scope Services" were neither defined nor displayed by the hospital.	**1**	The scope of services offered by the organization should be defined, documented, and displayed. The services not being rendered by the organization (Not in Scope Services) should also be defined and displayed.
Commitment	b	**Each defined healthcare service should have diagnostics and treatment facilities with suitably qualified personnel who provide out-patient, in-patientand emergency cover.**	Diagnostic and treatment facilities were in accordance with the scope of services**.**	**5**	The diagnostic and treatment facilities were found to be in accordance with the defined Scope of Services**.** It is recommended to ensure the continued adherence to these standards through periodic reviews and documentation, maintaining alignment with the organization's defined scope.
Commitment	c	**Scope of Services of each department is defined.***	The **"**Scope of Services**"** for each department was neither defined nor displayed.	**1**	Each department should clearly define, document, and display its Scope of Services. The services not being rendered should also be specified and displayed appropriately to ensure transparency and compliance with standards.
Commitment	d	**The organisation's defined healthcare services are prominently displayed.**	The "Scope of Services" for each department was neither defined nor displayed by the hospital.	**1**	The **"**Scope of Services**"** should be displayed at the main entrance or in the OPD waiting areas. It should be displayed in bilingual languages.
Average Score				**2**	
AAC.2: The organization has a well – defined registration and admission process.					

Commitment	a	**The Organisation uses written guidelines for registering and admitting patients.***	The registration form for both OPD and IPD patients was available and implemented. However, there was a lack of documented policies and procedures addressing registration and patient admission.	**2**	The hospital should develop and implement comprehensive, documented policies and procedures for patient registration and admission. These documents should outline standardized processes, ensuring consistency, clarity, and compliance with regulatory requirements. Regular reviews and staff training should be conducted to reinforce adherence to these procedures.
CORE	b	**A unique identification number is generated attheend of registration.**	A unique identification number was generated at the end of the registration process for all patients visiting the hospital.	**4**	To ensure consistency and traceability, the unique identification number should be generated at the beginning of the registration process. Additionally, proper documentation and validation mechanisms should be in place to prevent duplication and ensure seamless patient identification across all hospital departments.
Commitment	c	**Patients are accepted only if the organizations can provide the required service.**	The hospital was accepting patients only for the services and facilities available. However, there was no evident policy or procedure documenting this practice.	**3**	The existing system should be maintained and standardized through a documented policy outlining the criteria for patient admission**,** referral, and transfer. This policy should be implemented and communicated to all relevant staff to ensure transparency, consistency, and compliance with hospital standards.
Commitment	d	**The written guidance also addresses managing patients during non-availability of beds.***	There was no written guidance available for managing patients during the non-availability of beds, and staffs were not aware of the procedure.	**2**	A written policy outlining the management of bed shortages should be developed, documented, and disseminated. The front office staff and other relevant personnel should be trained on the policy to ensure effective patient management during bed unavailability, minimizing inconvenience and ensuring timely referrals or alternative arrangements.

Achievement	e	**Access to the healthcare services in the organisation is prioritized according to the clinical needs of the patient.***	The process to prioritize patients requiring urgent care for both OPD and IPD patients was not evident.	**2**	The hospital should define clear criteria to prioritize patients requiring urgent care in both the OPD and IPD settings. For example, patients presenting with complaints such as giddiness should be seen promptly in the OPD. Additionally, the hospital can establish separate registration counters for senior citizens to ensure they receive timely attention. These processes should be documented, communicated to relevant staff, and regularly reviewed for effectiveness.
Average Score				**2.6**	
AAC.3:There is an appropriate mechanism for transfer (in and out) or referral of patients					
Commitment	a	**Transfer-in of patients to the organisation is to be done appropriately.***	There was no documented policy to guide the transfer-in of patients to the organization, and staffs wereunaware of such a policy.	**2**	A documented policy for the transfer-in of patients should be developed and implemented. All relevant staff members should be trained and made aware of the policy to ensure seamless and efficient patient transfers into the organization.
Commitment	b	**Transfer-Out / Referral of patients to another organization are to be done appropriately.***	There was no documented policy to guide the transfer-out or referral of unstable patients, and staffs were unaware of such a policy.	**2**	A documented policy for the transfer-out or referral of unstable patients should be created and implemented. The policy should clearly define the criteria to identify unstable patients and provide specific guidelines for their transfer or referral. All relevant staff should be made aware of the policy to ensure patient safety during transfers.
Commitment	c	**During Transfer / Referral, accompanying staff are appropriate to clinical condition of the patient.**	There was no documented policy to guide the transfer-out or referral of stable patients, nor were there any documented procedures for staff accompanying a patient during the transfer.	**2**	A documented policy for the transfer-out or referral of stable patients should be developed and implemented. Additionally, the policy should outline the staff responsibilities during the transfer/referral process to ensure patient safety and clarity in operations.

Commitment	d	**The organisation gives a summary of the patient's condition and the treatment given.**	Although patients are being provided with a summary in case of transfer-out, a lack of standardized format for the summary was observed.	**2**	The process for providing transfer summaries should be standardized, and the content of the summary should be clearly defined. A consistent format for transfer summaries should be created, ensuring that all patients being transferred out receive the appropriate and complete documentation.
AverageScore				**2**	
AAC.4: Patient scared for by the organization under- go an established initial assessment.					
CORE	a	**The initial assessment of the out-patients, day-care, in-patients and emergency patients is done in a standardised manner.***	There were no written policy/guidelines defining the contents for conducting the initial assessment of the patient. Initial medical assessments were done for IPD patients, but documentation was not uniform across the hospital.	**2**	A documented policy should be developed to guide doctors and nurses on conducting initial assessments for all patients in IPD, OPD, and Emergency settings. Regular training should be provided to doctors to ensure consistency and accuracy in assessments. A separate form should also be created for nursing and nutrition assessments to ensure all dimensions of patient care are properly addressed.
Commitment	b	**The initial assessment is performed by qualified personnel.***	There were no policy/guidelines available to determine who is authorized to perform the initial assessment.	**2**	A policy should be established to define who is responsible for conducting the initial assessments. Assessments should be performed by each relevant discipline (medical, nursing, dietetics, etc.) within their scope of practice, registration, and in compliance with applicable laws and regulations.
Commitment	c	**The initial assessment is performed within a time-frame based on the needs of the patient.***	A timeframe for completing the initial assessment had not been defined.	**1**	A policy should be documented to define a timeframe for completing initial assessments for all patients being admitted. Doctors and nurses must adhere to the timeframes defined by the hospital to ensure timely and efficient patient care.

Commitment	d	**Initial assessment of day-care and in-patients includes nursing assessment, which is done at the time of admission and documented.**	There was no process evident for conducting initial nursing assessments.	**1**	A format should be developed for conducting the initial nursing assessment for all patients being admitted. Every patient should have a documented initial nursing assessment as part of the hospital's standardized procedures.
CORE	e	**The initial assessment for In-patients results in a documented care plan.**	There was provision available in the initial assessment form to result in a documented plan of care. However, it was not uniformly documented in the medical records.	**3**	A care plan should be prepared and documented following the initial assessment for all patients. This plan must be uniformly recorded in the medical record to ensure that the patient's care is well-managed and tracked.
Achievement	f	**The care plan is countersigned by the clinician- In charge of the patient within 24 hours.**	The initial assessment form allowed for the plan of care to be countersigned by the clinician-in-charge within 24 hours, but it was not uniformly documented in the medical record.	**3**	A policy should be documented defining the timeframe for completing initial assessments and ensuring that the plan of care is countersigned by the clinician-in-charge within 24 hours. Doctors, nurses, and dieticians must adhere to the timeframes set by the hospital for conducting and completing initial assessments.
Excellence	g	**The care plan includes the identification of special needs regarding care followingdischarge.**	The plan of care reflected the desired results of treatment, but there was no provision to document these desired results in the initial assessment form.	**3**	The plan of care should explicitly include the desired results of the treatment or care provided. This parameter should be incorporated into the initial assessment form to ensure comprehensive documentation and clarity in patient care planning.
Average Score				**2.14**	
AAC.5: Patients cared for by the organization undergo a regular reassessment.					
CORE	a	**Patients are re-assessed at appropriate intervalsto determine their response to treatment and to plan further treatment or discharge.**	Although patients are reassessed at appropriate intervals to determine their response to treatment, it is not uniformly documented in the medical record.	**2**	A policy for reassessment should be developed, and every patient must be reassessed at a defined interval as per the policy. All reassessments conducted should be documented in the patient's case sheet to ensure consistency and thorough patient monitoring.

Commitment	**b**	**Out-patients are informed of their next follow-up, where appropriate.**	Outpatients were informed about their next follow-up, but it was not documented in the medical record.	**3**	All outpatients should be informed in writing regarding their next follow-up. The next follow-up date can be included in the OPD prescription slip to ensure that follow-up instructions are clearly communicated and documented for reference.
Commitment	**c**	**For in-patients during reassessment, the Care Plan is monitored and modified, where found necessary.**	For inpatients, monitoring and modification of the care plan was not uniformly documented.	**2**	The care plan should be dynamic and modified as necessary by the treating doctor based on the patient's condition. All modifications and updates to the care plan should be uniformly documented in the patient's medical record to ensure continuity and clarity in care delivery.
Commitment	**d**	**Staff involved indirect clinical care document reassessments.**	Staffs involved in indirect care conduct the reassessment, but it is not documented uniformly in the patient's medical records.	**2**	A policy should be developed and implemented to ensure consistent reassessment documentation. The policy should specifically address the content and procedure for documenting reassessments carried out by indirect care staff to ensure completeness and consistency in patient care records.
Commitment	**e**	**The organisation lays down guidelines and implements processes to identify early warning signs of change or deterioration in clinical conditions for initiating prompt intervention.**	No guidelines/criteria were evident to identify early warning signs of changes or deterioration in clinical conditions for the initiation of prompt intervention.	**1**	Guidelines should be established to identify early warning signs of changes or deterioration in clinical conditions. These guidelines should be implemented to facilitate early intervention. Additionally, a format should be defined and implemented for documenting early warning signs to ensure timely and accurate responses to patient conditions.
Average Score				**02**	
AAC.6: Laboratory Services are provided as per the Scope of Services of the organisation.					
Commitment	a	**Scope of the laboratory services is Commensurate to the services provided by the organisation.**	The lab services provided were able to cater to the needs of the hospital, but their scope was not uniformly displayed.	**4**	The scope of lab services should be clearly defined and uniformly displayed throughout the hospital, ensuring it aligns with the services offered by the organization.
Commitment	b	**The infrastructure (physical and equipment) is adequate to provide the defined scope of services.**	The infrastructure (physical & equipment) was adequate to provide for the defined scope of services.	**3**	The department should ensure the sustainability of the infrastructure to maintain its ability to provide adequate services. This

					includes regular maintenance and updates as needed.
Commitment	c	**Human resource is adequate to provide the defined scope of services.**	Human resources are adequate to provide the defined scope of services.	**5**	Ensure sustenance by continuously evaluating and maintaining adequate staffing levels to meet the ongoing needs of the laboratory.
Commitment	d	**Qualified and trained personnel perform andsupervise the investigations and report the results.**	Qualified and trained personnel perform and supervise investigations and report results.	**5**	Ensure sustenance by regularly updating staff training programs and certification to maintain competency in lab operations.
Commitment	e	**Requisition for tests, collection, identification, handling, safe transportation, processing and disposal of a specimen is performed according to written guidance.***	There were no written policies and procedures to guide the identification and safe transportation of patients to lab services.	**1**	Policies and procedures should be structured for patient identification and safe transportation. Staff should be trained on these procedures to ensure safety and compliance.
Commitment	f	**Laboratory results are available within a defined time frame.***	The turnaround time (TAT) for in-house and outsourced tests was not uniformly evidenced.	**1**	A standardized format should be implemented for calculating TAT for outsourced tests. The TAT should be tracked and documented to ensure timely reporting of results.
Commitment	g	**Critical results are intimated to the person concerned at the earliest.***	There was no method in place to intimate critical results to concerned personnel.	**2**	Critical results must be immediately intimated to the concerned personnel. A register should be developed to document the critical results and actions taken for timely intervention.
Commitment	h	**Results are reported in a standardized manner.**	Laboratory results are reported in a standardized manner.	**4**	The report should include the name of the organization, name of the patient, unique identification number, reference range of the test (where applicable), and the name and signature of the person reporting the results.
Achievement	i	**There is a mechanism to address the recall /amendment of reports whenever applicable.***	There was no mechanism in place to address the recall/amendment of reports whenever applicable.	**2**	A mechanism should be established to address the recall or amendment of reports whenever applicable. This mechanism needs to be documented to ensure accountability and transparency.
Commitment	j	**Laboratory tests not available in the Organizations are outsourced to the organisation(s) based on their quality assurance system.***	While tests not in scope are being outsourced, there is no MOU with the outsourced labs, and the quality of the outsourced labs is not being monitored.	**2**	An MOU should be established with all outsourced labs for tests being sent, ensuring a clear agreement on service standards. Additionally, the quality assurance system of the outsourced labs should be actively

					monitored to ensure compliance with organizational standards.
Average Score				**2.9**	
AAC.7: There is an established Laboratory Quality Assurance and safety Programme.					
Commitment	a	**The laboratory Quality Assurance Programme is implemented.***	Although the lab has a quality assurance program, it is not uniformly followed across all scopes within the hospital.	**3**	The quality assurance program for lab services must be formulated, documented, and uniformly implemented across all lab scopes. Additionally, training on the program should be provided to imaging staff to ensure compliance and consistency.
Commitment	b	**The programme ensures the quality of test results through internal quality control.***	There was no documented process for internal quality control of test results.	**3**	The quality assurance program for lab services must include a documented process for internal quality control. Training on internal quality control procedures should be provided to lab staff to ensure accuracy and reliability of test results.
Commitment	c	**Laboratory participates in proficiency testing / external quality assurances scheme.***	Although an external quality assurance (EQA) program was being conducted, Corrective and Preventive Actions (CAPA**)** for discrepancies was not documented.	**3**	Corrective and preventive actions (CAPA) must be taken to address deviations identified in the EQA program, and the same should be properly documented for audit and review purposes.
Excellence	d	**The programme addresses the Clinico-pathological meeting(s).***	The quality assurance program does not include Clinico-pathological meetings.	**1**	The organization should conduct Clinico-pathological meetings at pre-defined intervals to enhance clinical-laboratory correlation and improve diagnostic accuracy.
Commitment	e	**The Laboratory safety programme is implimented.***	Documentation of the lab safety program was not evident.	**1**	The lab safety program must be formulated, documented, and implemented for laboratory services. Training on lab safety should be conducted for all lab staff, and proper records should be maintained.
Commitment	f	**Laboratory personnel are appropriately trained in safe practices.**	Although staffs are aware of lab safety practices, there was no documented evidence of training records.	**3**	Training sessions on the lab safety program should be conducted and documented. Training records must be maintained in the personal files of staff as proof of compliance with safety protocols.

Commitment	**g**	**Laboratory personnel are provided with appropriate safety measures.**	Laboratory personnel are provided with appropriate safety measures.	**4**	To ensure continued compliance, the hospital should regularly monitor, review, and reinforce safety measures through periodic audits, refresher training sessions, and documented assessments. Any updates in safety protocols should be communicated effectively to all laboratory personnel.
Average Score				**2.5**	
AAC.8: Imaging services are provided as per the scope of services of the organisation.					
CORE	**a**	**Imaging services comply with legal and other requirements.***	Imaging services comply with legal and other requirements.	**4**	To ensure continued compliance, the hospital should conduct regular audits and reviews of imaging services to verify adherence to legal, regulatory, and safety standards. Staff should receive periodic training on updates in regulations, and all compliance-related documentation should be maintained and readily available for inspection.
Commitment	**b**	**Scope of the Imaging services is commensurate to the services provided by the organisation.**	The imaging services provided were able to cater to the hospital's needs, but its scope was not documented and displayed.	**3**	The scope of imaging services should be clearly defined, documented, and displayed at relevant locations, ensuring transparency and alignment with the hospital's service offerings.
Commitment	**c**	**The Infrastructure (physical and equipment) and human resources are adequate to provided for its defined scope of services.**	The infrastructure (physical and equipment) was adequate for its defined scope of services. However, MRI-compatible stretcher and fire extinguisher were not available.	**3**	The sustainability of infrastructure and equipment should be ensured. MRI-compatible stretcher and fire extinguisher must be provided to meet safety and emergency preparedness standards.
Commitment	**d**	**Qualified and trained personnel perform, supervise and interpret the investigations.**	Qualified and trained personnel perform, supervise, and interpret investigations.	**5**	Continue ensuring that qualified and trained personnel perform, supervise, and interpret investigations, maintaining compliance through periodic training and competency assessments.
Commitment	**e**	**Imaging results are available within a defined time frame.***	There was no defined time frame for imaging reports.	**1**	A defined time frame for imaging report availability should be documented and implemented. The cycle time for reporting should not exceed 24 hours to ensure timely patient care.

Commitment	f	**Critical results are intimated immediately to the personnel concerned.***	There was no established method for intimating critical results to concerned personnel.	**1**	A structured process must be developed to ensure immediate intimation of critical results to the concerned personnel. A register should be maintained to record the intimation process for audit and compliance.
Commitment	g	**Results are reported in a standardized manner.**	Reports results were being generated in a standardized manner.	**4**	The reports should include the hospital name, patient name, unique identification number, reference ranges (where applicable), and the name & signature of the reporting personnel.
Achievement	h	**There is a mechanism to address recall /amendment of reports whenever applicable.***	There was no mechanism in place for recalling or amending reports.	**1**	A formal process for recalling or amending imaging reports should be developed and implemented to correct errors and ensure accurate reporting.
Commitment	i	**Imaging tests not available in the organization are outsourced to the organisation(s) based on their quality assurance system.***	The hospital was providing all relevant imaging tests in consonance with its scope of services, with no tests outsourced at the time of assessment.	**4**	The hospital should continue ensuring that imaging tests align with its defined scope and periodically review its capacity to maintain self-sufficiency.
Average Score				**2.8**	
AAC.9: There is an established quality assurance and safety programme for imaging services.					
Commitment	a	**The quality assurance programme for imaging services is implemented.***	There was no written quality assurance program for imaging services.	**1**	The hospital must formulate and document a comprehensive Quality Assurance (QA) program for imaging services. Additionally, training should be provided to imaging staff to ensure adherence to quality standards.
Achievement	b	**A system is in place to ensure the appropriatences of the investigations and procedures for th clinical indication.**	There was no evident system to ensure the appropriateness of imaging investigations and procedures based on clinical indications.	**1**	The quality assurance program for imaging services must address this issue by defining protocols to validate the clinical necessity of imaging investigations before conducting them.
Achievement	c	**The programme addresses periodic internal / external peer review of imaging results using appropriate sampling.**	No program was in place to address internal/external peer reviews of imaging results using appropriate sampling.	**1**	The hospital should document a QA program that includes periodic internal and external peer reviews of imaging protocols and results. The sampling criteria for these reviews must be clearly defined and followed.

Excellence	d	**The programme addresses the clinico-radiological meeting(s).**	There was no program in place to conduct clinico-radiology meetings.	**1**	The hospital should conduct clinico-radiology meetings at pre-defined intervals to ensure collaboration between clinicians and radiologists, improving diagnostic accuracy and patient management.
Commitment	**e**	**The programme includes the documentation of corrective and preventive actions.***	No documentation of corrective and preventive actions (CAPA) was available.	**1**	The quality assurance program for imaging services must include a structured CAPA process to document deviations, corrective measures, and preventive actions. This ensures continuous quality improvement and compliance with best practices.
Commitment	**f**	**The radiation-safety programme is implemented.***	While radiation safety practices were being followed, no documented radiation safety program was evident.	**2**	A radiation safety program for imaging services must be formulated and documented. Training on radiation safety protocols should be provided to imaging staff, and records should be maintained for compliance and audit purposes.
Commitment	**g**	**Patients are appropriately screened for safety / risk before imagining.**	There was no documented process for radiation safety, and adherence was not being followed.	**1**	The radiation safety program for imaging services must be formulated and documented. The program should address all necessary radiation safety protocols, ensuring consistent adherence across the department.
Commitment	**h**	**Imaging personnel and patients use appropriate radiation safety and monitoring devices where applicable.**	While appropriate radiation safety PPE was provided to the staff, adherence was not uniform.	**2**	All imaging personnel should be provided with appropriate radiation safety devices. Specifically, Lead Aprons and Thermo-Luminescent Dosimeter (TLD) badges should be available to all staff working in radiation zones. Staff must also receive training on the proper use of these devices to ensure consistent adherence to safety protocols.
Commitment	**i**	**Radiation-safety and monitoring devices are periodically tested, and results are documented.***	Some of the TLD badges used by staff in the nuclear medicine and radiation oncology departments were found to be expired during the audit.	**2**	Radiation safety devices, including TLD badges, should be periodically tested, and the results of these tests must be documented. Expired devices should be replaced immediately, and their status should be regularly monitored.

Commitment	**j**	**Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.**	No training was being provided to the imaging staff regarding radiation safety measures.	**1**	All imaging personnel should be trained in radiation safety measures, including the proper use of PPE and adherence to protocols. Regular training sessions should be conducted, and training records must be maintained for audit purposes.
Commitment	**k**	**Imaging signage are prominently displayed in all appropriate locations.**	Imaging signage was prominently displayed as per AERB and PC PNDT guidelines in all appropriate locations.	**3**	While the signage is displayed, it can be made more prominent by including bilingual signage (English and Hindi) and increasing the size of the signage, as recommended by AERB and PC PNDT, to enhance visibility and compliance.
Average Score				**1.45**	
AAC.10: Patient care is continuous and multi-disciplinary.					
Commitment	**a**	**During all phases of care, there is a qualified individual identified as responsible for the patient's care.**	Qualified individuals are designated and responsible for the patient care	**5**	Ensure sustenance
Commitment	**b**	**Patient care is coordinated in all care settings within the organisation.**	This was not being adhered as no mechanism for intra hospital transfer could be evidenced. Non-availability of transfer forms (intra transfer) was evidenced compromising effectiveness of communication among care givers.	**2**	Coordination in all care setting within the organization needs to be ensured. Formats for patient transfer intra hospital should be developed and implemented to ensure appropriate communication among care providers at all levels.
Commitment	**c**	**Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.**	Information about the patient's care and response to treatment was not being shared among medical, nursing and other care providers as there were no appropriate processes for doctors and nursing handovers were evidenced during the assessment.	**3**	Information about the patient's care and response to treatment should be shared among medical, nursing and other care providers through appropriate entries into medical record i.e.plan of care, handovers,etc.
CORE	**d**	**The organisation implements standardised hand over communication during shift, between shifts and during transfers between units / departments.**	Though the information was being exchanged but the same was not evidenced documented uring the assessment in case of change of shift between the staff and units.	**2**	Information to be exchanged and documented during each staffing shift, between shifts, and during transfers between units / departments. Inhouse transfer form and hand over forms to be developed and implemented.

Commitment	**e**	**Patient transfer within the organisation is done safely.**	The patients were being transported safely; however, proper handover and takeover were not evidenced.	**2**	The patients should be transported safely, and a proper handover and takeover must be documented. An intra-hospital form can be introduced to standardize this process.
Commitment	**f**	**Referrals of patients to other departments / specialties follow written guidance.***	Although a process was in place for patient referrals, it was not uniformly documented across the hospital. No such policies and procedures were available.	**2**	Policies and procedures should be developed and disseminated among the concerned staff.
Achievement	**g**	**The organisation ensures predictable service delivery by adhering to defined timelines and informs the patient / family and / or care giver whenever there is a change in schedule.**	No mechanism was available to inform the caregiver and patient or family member whenever there was a change in the schedule or a delay in the service.	**1**	A process should be developed to ensure continuity of care by adhering to timelines and informing the patient, family member and caregiver accordingly.
Excellence	**h**	**The organisation has a mechanism in place to monitor whether an adequate clinical intervention has taken place in response to a critical value alert.**	No such mechanism was evident.	**1**	A process needs to be developed to monitor the adequacy of clinical interventions in response to a critical value.
Average Score				**2.25**	
AAC.11: The preventive and promotive health services are provided in a safe, collaborative and consistent manner.					
Commitment	**a**	**Written guidance governs the implementation of preventive and promotive care as per the scope of services.***	No such policy and procedure in place	**1**	Develop and implement written protocols aligned with evidence-based guidelines for preventive and promotive care. Regularly update and monitor adherence to ensure effective service delivery.
Commitment	**b**	**Organisation shall define evidenced based and contextual age-appropriate screening for non-communicable diseases.**	There is no process for contextual age- appropriate screening for non-communicable diseases.	**1**	Age-appropriate NCD screening protocols tailored to the population's epidemiological context must be implemented and documented. Regularly update screening guidelines based on emerging research and healthcare needs.
Commitment	**c**	**Mental health screening and appropriate intervention is advised for patients wherever applicable.**	No provision for Mental health screening and appropriate intervention	**1**	Implement standardized mental health screening tools for early detection and provide timely, evidence-based interventions. Train healthcare providers to ensure proper assessment, referral, and follow-up care.

Commitment	**d**	**Evidence based and contrextualpaedtiatric and adult immunisation shall be advised whenever applicable.**	No such documented process in place	**1**	Pediatric and adult immunization schedules based on national guidelines and local epidemiological data shall be implemted. Ensure timely updates, awareness, and accessibility of vaccines.
Commitment	**e**	**A multi- disciplinary approach is adopted in imparting health education on if- style modifications.**	No documented health education on life style modifications were being provided to the patient	**1**	A documented health education on modification on life style changes need to be given to the patient.
Average Score				**01**	

AAC. 12: The organisation has an established discharge process.					
Commitment	**a**	**The patient's discharge process is planned in consultation with the patient and / or family.**	The patient's discharge process is planned in consultation with the patient and / or family.	**5**	Ensure sustenance.
Commitment	**b**	**The discharge process is coordinated among various departments and agencies involved (including medico-legal and absconded cases).***	No Documented policy was available & staffs were not aware about the policy	**2**	The discharge process should be coordinated among various departments and agencies involved in the discharge process (including medico-legal and absconded cases) & staff needs training on the same.
Commitment	**c**	**Written guidance governs the discharge of patients leaving against medical advice.***	No documented policies addressing LAMA (Left Against Medical Advice) patients and patients discharged on request were found.	**1**	To develop and implement policies for LAMA and discharge on request, ensuring that concerned staff are well-informed and adhere to standardized protocols.
Commitment	**d**	**A discharge summary is given to all the patients leaving the organisation including patients leaving against medical advice.**	Although all patients are provided with a LAMA summary/discharge on request, the content of the discharge summary was not compliant with the required standards.	**3**	The content of the LAMA summary/ discharge summary be reviewed and standardized to ensure compliance with the required guidelines. The summary should include all essential details such as patient condition at discharge, treatment provided, advice on follow-up care, and potential risks of leaving against medical advice (LAMA). Staff should be trained to ensure proper documentation and completeness of discharge summaries.

Achievement	**e**	**The organisation adheres to planned discharge.**	The processes for planed discharges are not uniformly implemented across the hospital.	**2**	The process for planned (24hrs) discharges be standardized and uniformly implemented across the hospital. A structured discharge protocol should be established, ensuring timely planning, proper documentation, patient education, medication reconciliation, and follow-up instructions. Regular audits and staff training should be conducted to ensure compliance and improve discharge efficiency.
Achievement	f	**The care shall be provided by expanding access to health practices through domicillary visits, wherever applicable.**	No such process in place evidenced.	**1**	A documented process shall be implemented on expanding access to health practices through domicillary visits, wherever applicable.
Commitment	**g**	**The organisation monitors the discharge time, sets appropriate benchmarks and makes continual improvement.**	No, defined timeframe was available for discharge of thepatients and the same was not being monitored.	**1**	A timeframe needs to be defined for discharge, and adherence to the timelines should be monitored and documented.
Average Score				**2.14**	
AAC. 13. The Organisation defines the content of the discharge summary.					
Commitment	a	**A discharge summary is provided to the patients at the time of discharge.**	Discharge summary was being given to all the patients getting discharged.	**5**	The discharge summary continue to be provided to all patients at the time of discharge, ensuring it includes all required information in compliance with hospital standards and guidelines. This will help maintain consistency, improve patient care, and support proper documentation.
Commitment	b	**Discharge summary has a standardised content.**	Content of discharge summary was not standardized across the hospital.	**2**	Should be documented uniformly for all the patients.
Commitment	c	**Discharge summary contains follow up advice, medication and other instructions in an understandable manner.**	After-care instructions were notbeing written uniformly in thedischargesummary.	**3**	Medication orders should be written clearly, including the name of the drug, dose, frequency, and route of administration. Terms like BD, TDS, and QID should be avoided. Additionally, other instructions, such as dietary advice and preventive aspects (e.g., smoking cessation, no alcohol consumption, if

					applicable), should be uniformly included in the discharge summary.
Commitment	d	**Discharge summary incorporates instructions about when and how to obtain urgent care.**	The summary did not specify instructions on how to obtain urgent care in a uniform manner within the medical record. .	**3**	The discharge summary includes clear and uniform instructions on how to obtain urgent care. These instructions should be consistently documented in the medical record to ensure patients know how to access timely medical attention when needed.
Commitment	e	**In case of death, the summary of the case also includes the cause of death.**	The cause of death be clearly included in the case summary to ensure accurate documentation and compliance with medical record-keeping standards.	**5**	In the event of a death, the cause of death should be clearly documented in the case summary as per existing guidelines, ensuring compliance and maintaining proper medical record evidence.
Average Score				**3.63**	
Chapter Average Score				**2.26**	
Chapter 2:Care of Patients (COP)					
COP.1: Uniform care to patients is provided in all settings of the organisation and is guided by the written guidance, and applicable laws, regulations and guidelines.					
Commitment	a	**Uniform care is provided following written guidance.***	There was no documented policy guiding staff for uniform patient care.	**1**	A documented policy ensuring standardized, uniform care must be developed and implemented across all departments to maintain consistency in patient management.
CORE	b	**The organisation has a uniform process for identification of patients and at a minimum, uses two identifiers.**	The organization has a uniform process for patient identification; however, the use of two patient identifiers was not consistently followed.	**3**	The mechanism for patient identification should be standardized across the organization. For example, ID bands displaying the patient's name and UHID number should be used to ensure accurate identification and minimize errors.
Commitment	c	**The organisation implements evidence- based clinical practice guidelines and / or clinical protocols to guide uniform patient care.**	The organization follows evidence-based clinical practices and protocols, but documentation for the same was not evident.	**3**	The organization should strictly adhere to norms set by the government under relevant legislations, such as: Clinical Establishment Act, PC-PNDT Act, MTP Act. Also Consent protocols before surgery Providing first aid to emergency patients. In case of MLC- Police intimation in Medico-Legal Cases (MLCs). These guidelines should be documented and effectively implemented.

Excellence	d	**Clinical care pathways are developed, consistently followed across all settings of care, and reviewed periodically.**	Clinical protocols, guidelines, and pathways were not evident.	**1**	The organization should develop and implement clinical guidelines for common but critical disease conditions. These guidelines should be readily available with the respective departments for reference and adherence.
Excellence	e	**Multi-disciplinary and multi-speciality care, where appropriate, is planned based on best clinical practices / clinical practice guidelines and delivered in a uniform manner across the organisation.**	Multi-disciplinary and multi-specialty care was not delivered in a uniform manner across the organization.	**1**	A documented process ensuring coordinated multi-disciplinary and multi-specialty care should be developed and implemented. This will ensure that patients receive holistic, integrated care across specialties.
Commitment	f	**Telemedicine facility is provided safely and securely based onwritten guidance.***	NA	**5**	NA
Average Score				**2.3**	
COP.2: Emergency services are provided in accordance with written guidance, applicable laws and regulations.					
Commitment	a	**There shall be an identified area in the organisation which is easily accessible to receive and manage emergency patients, with adequate and appropriate resources.**	A policy on the uniform care of patients could not be evidenced.	**1**	A documented policy guiding the staff for uniform care needs to be developed and implemented.
Achievement	b	**Prevention of patient over-crowding is planned, and crowd management measures are implemented.**	The organisation has auniform process for identification of patients; however use of two patient identifiers could not be evidenced uniformly.	**3**	The mechanism for identification of patients should be uniform across the organisation. For example, use of ID bands with patient's name &UHID no.
CORE	c	**Emergency care is provided in consonance with statutory requirements including medico-legal cases and as per written guidance. ***	Organisation adapts evidenced-based clinical practices guidelines &/ or clinical protocols to guide uniformpatient care but the appropriate documentation for the same not evidenced.	**3**	The organisation should adhere to the norms laiddown by the government through relevant legislation like clinical establishment Act, PC-PNDT act, the MTP act or any such similar legislation. For example, consent before surgery, Providing first aid to emergency patients & police intimation in cases of MLC.
Commitment	d	**Initiation of appropriate care is guided by a system of triage.***	Clinical protocols, guidelines and clinical pathways were not evident.	**1**	The clinical guidelines for some of the most common but important disease conditions should be developed and made available with the concerned departments.

Commitment	e	**Patients waiting in the emergency are reassessed as appropriate for change in status.**	Multi-disciplinary and multi-speciality care, where appropriate, was not delivered in a uniform manner across the organisation.	**1**	Documentation for the same needs to be develop & implemented/.
Commitment	f	**Admission, discharge to home, or transfer to another organisation is documented.**	No documented record was found for the transfer of patients during admission, discharge to home, or transfer to another organization.	**1**	Establish a standardized documentation process for recording patient transfers during admission, discharge to home, or transfer to another organization to ensure continuity of care and compliance with medical record-keeping standards.
Commitment	g	**In case of discharge to home or transfer to another organisation, a discharge note shall be given to the patient.**	Policy on uniform care of patients could not be evidenced.	**1**	A documented policy guiding the staff for the uniform care needs to be developed and implemented.
Achievement	h	**The organisation shall implement a quality assurance programme.***	The organisation has a uniform process for identification of patients; however use of two patient identifiers could not be evidenced uniformly.	**3**	The mechanism for identification of patients should be uniform across the organisation. Forexample, use of ID bands with patient's name &UHID no.
Commitment	i	**The organisation has systems in place for the management of patients found dead on arrival and patients who die within a few minutes of arrival***	The organisation has no system in place for the management of patients found dead on arrival and patients who dies within a few minutes of arrival.	**1**	The documented mechanism or policy to set and implement in the organisation for management of patients found dead on arrival and patients who dies within a few minutes of arrival.
Average Score				**1.6**	
COP.3: Ambulance services ensure safe patient transportation with appropriate care.					
Commitment	a	**The organisation has access to ambulance services commensurate with the scope of the services provided by it.**	The organisation has the access to ambulance services commensurate with the scope of the Services provided by it.	5	Ensure sustenance.
Commitment	b	**There are adequate access and space for the ambulance(s).**	It was evidenced that organisation have the space for ambulance parking but not in a defined and adequate.	**3**	The organization need to define a adequate space and easily access to the ambulance near emergency department. Also a documented process is required to implement.
Commitment	c	**The ambulance(s) is fit for purpose and is appropriately equipped.**	The ambulance is fit for purpose and is appropriately equipped.	**5**	Ensure sustenance.

Commitment	d	**The ambulance(s) is operated by trained personnel.**	The ambulance(s) is operated by trained personnel.	**5**	Ensure sustenance.
Commitment	e	**The ambulance(s) is checked daily for functioning status, medical equipment, emergency medications and consumables.**	No document of daily checking for functioning status, medical equipment, emergency medications and consumables of the ambulance.	1	The defined mechanism parameters need to set for daily checking for functioning status, medical equipment, emergency medications and consumables of the ambulance via. an checklist.
Commitment	f	**The ambulance(s) has a proper communication system.***	The ambulance has a proper communication system in all the available ambulances BLS & ACLS.	**5**	Ensure sustenance.
Achievement	g	**The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation.**	The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation but has no triage mechanism.	**2**	A triage mechanism needs to form and implement for early and immediate treatment when patient is in transit to the organisation.
Average Score				**3.71**	
COP.4: The organisation plans and implements mechanisms for the care of patients during community emergencies, epidemics and other disasters.					
Commitment	a	**The organisation identifies potential community emergencies, epidemics and other disasters. ***	The documented disaster management plan policy could not be evidenced.	**1**	A documented policy is to be developed to identify the potential emergencies.
Commitment	b	**The organisation manages community emergencies, epidemics and other disasters as per a disaster management plan.***	The documented disaster management plan policy could not be evidenced.	**1**	A documented Disaster Management Plan is to be developed and disseminated to all staff.
Commitment	c	**Provision is made for availability of medical supplies, equipment and materials during such emergencies.**	No such provisions were available to ensure the medical supplies, equipment and materials during such emergencies.	**1**	Organization needs to develop a mechanism to ensure adequate supplies of medical consumables and equipment during emergencies.
Commitment	d	**The plan is tested atleast twice a year.**	No such testing was being done as there was no disaster management plan available.	**1**	A disaster management plan needs to be developed and it needs to be tested at least twice in a year.
Average Score				**01**	
COP.5: Cardio-pulmonary resuscitation services are provided uniformly across the organisation.					

Commitment	a	**Cardio-pulmonary Resuscitation services are available and provided to patients at all times.**	Although the Cardio-pulmonary resuscitation services were available in the hospital but a documented policies could not be evident for the management of the patients in cardiac arrest situation.	**1**	A documented policy should be developed defining the prompt system to be followed to manage such patients any where in the hospital.
Commitment	b	**During cardio-pulmonary resuscitation, assigned roles and responsibilities arec omplied with.**	Staffs were not trained in BLS.None of the staffs working incritical areas were trained in ACLS	**2**	Trained personnel should provide trainings on cardio- pulmonary resuscitation. A documented mechanism should be developed for which the staff shall be trained to follow. All staff in the hospital should be trained in a standardized manner on BLS and at least the critical care staff& emergency staff should be trained on ACLS.
Commitment	c	**Medical equipment and medications for use during cardio- pulmonary resuscitation are available in various areas of the organisation.**	Equipment and medications for use during cardio-pulmonary resuscitation were uniformly available in various areas of the organisation.	**1**	Mechanism to deal with the cardio pulmonary resuscitations should be developed and implemented. The practice of documentation of such events should be established along with the cardiac arrest management. A team should be formulated to analyse the post events. Corrective and Preventive actions of all post events analysis done should be discussed, and documented.
Commitment	d	**The events during cardio- pulmonary resuscitation are recorded.**	No such mechanism in place for recording of the event	**1**	
Commitment	**e**	**A multidisciplinary committee does a post-event analysis of cardio-pulmonary resuscitations.**	There was no multidisciplinary committee to do the post-events Analysis of CPR.	**1**	
Commitment	**f**	**Corrective and preventive measures are taken based on the post-event analysis.**	There was no multidisciplinary committee to do the post-events analysis of CPR	**1**	
Average Score				**1.16**	
COP.6: Nursing care is provided to patients in the organisation in consonance with clinical protocols.					
Commitment	a	**Nursing care is provided to patients in accordance with written guidance.***	No documented policies and procedures were evident for the nursing services.	**1**	Documented policies and procedures for all activities of the nursing services to be developed as per current standards and regulations (Indian Nursing Council Act). The training of the staff should be done.

Commitment	b	**Assignment of patient care is done as per current good practice guidelines/ nursing practice guidelines.**	Patient assignment system as per current practice guidelines was not being followed.	**1**	Patient assignment systems to be adopted and followed as per current practice guidelines.
Achievement	c	**The organisation implements acuity-based staffing to improve patient outcome.**	No process in place for acuity- based staffing.	**1**	Patient assignment systems to be adopted and followed as per current practice guidelines.
Commitment	d	**Nursing care is aligned and integrated with overall patient care which is documented.***	Nursing plan of care was not documented. No documentation was evidenced for the care provided by the nursing staff.	**1**	Format should be defined and implemented for the nursing initial assessment and care plan. Training should be imparted to the nursing staff for the documentation.
Commitment	e	**Nurses are provided with appropriate and adequate equipment for providing safe and efficient nursing services.**	Though the nurses were provided with adequate equipment forproviding safe and efficient ursing services, training for useof such equipment could not be evidenced.	**2**	Nurses to be trained on the equipment providedto them. Training record of the same to be maintained in their personal files.
Commitment	f	**Nurses are empowered to make patient care decisions within their scope of practice.**	Nurses were not empowered to take nursing related decisions to ensure timely care of patients.	**1**	A policy on nursing empowerment to be developed and nurses should be empowered for certain situations defined in the policy.
Average Score				**1.16**	
COP.7: Clinical procedures are performed in a safe manner.					
Commitment	a	**Clinical procedures are performed based on the clinical needs of the patient.**	No documented procedures were evidenced toguide the performance of various clinical procedures.	**1**	Documented procedures should be developedand adhered to guide the performance of various clinical procedures.
Commitment	b	**Performance of various clinical procedures is based on written guidance and done in a safe manner.***	No, documented procedures were evidenced toguide the performance of various clinical procedures.	**1**	Documented procedures should be developed and adhered to guide the performance of various clinical procedures.
Commitment	c	**Qualified personnel order, plan, perform and assist in performing procedures.**	Yes, qualified personnel order, plan performs and assists in performing procedures. However, privileges for the same not available	**2**	The personnel performing or assisting a procedure should be privileged for the same.
CORE	d	**Care is taken to prevent adverse events like a wrong patient, wrong procedure and wrong site.***	Documented procedures to prevent adverse events like wrongsite, wrong patient and wrong procedure was not evident.	**1**	Documented procedures should be defined and implemented prevent adverse events like wrong site, wrong patient and wrong procedures to be made.

Commitment	e	**Informed consent is taken by the personnel performing the procedure, where applicable.**	In present scenario informed consents are being taken by the personnel performing the procedures. The uniformity of fill the name of procedure,complication,risks,benefit , alternatives and signature of person performing procedure is not evidenced,	**3**	Informed consent is to be obtained for every procedure and it should be taken by person performing procedure. - The informed consent should include options for writing the name of the procedure, complication, risks, benefit, alternatives, signature of person performing procedure etc. -Informed consent forms should be bilingual
Commitment	f	**Patients are appropriately monitored during and after the procedure.**	Although patients were being monitored during and after procedure but same was not being documented uniformly.	3	A standardized format needs to be developed to monitor the patient during and after procedure. Minimum pulse, heart rate and blood pressure need to be monitored every two hourly and as clinically required.
Commitment	g	**Procedures are documented accurately in the patient record.**	All procedures were not being documented in the patient record uniformly.	2	A procedure note incorporating name of the procedure, the person who performed the procedure, salient steps of the procedure, key findings and the post-procedure care to be documented in the patient record. It needs to be signed, named, timed and dated.
Average Score				**1.85**	
COP.8: Transfusion services are provided as per the scope of services of the organisation, safely.					
Commitment	a	**Scope of transfusion services is commensurate with the services provided by the organisation.**	Yes, Scope of transfusion services is commensurate with the services provided by the organisation.	**5**	Ensure the sustenance.
Commitment	b	**The organisation shall establish and implement processes for blood / component collection, testing, storage and distribution under written guidance.***	No documented process in place for blood / component collection, testing, storage and distribution.	**1**	A documented policy shall be formulatied for blood / component collection, testing, storage and distribution.
Commitment	c	**Blood components are stored safely from the time of collection till transfusion.**	In Compliant	**5**	Ensure sustainace.

CORE	d	**The organisation ensures safe and rational use of blood and blood components.***	No such documented policy on the rational use of the blood and blood products was evident.	**1**	A documented policy should be developed for clinicians to follow while ordering blood for their patients, with reference to NACO and WHO guidelines.
Commitment	e	**Blood / blood components are available for use in emergency and routine situations within a defined time-frame.***	The time-frame documentation could not be evidenced.	**1**	The organization should define the timeframe within which blood must be made available for use in emergency situations.
Achievement	f	**The organisation shall ensure that Post-transfusion form is collected, reactions if any identified and are analysed for preventive and corrective actions.**	The process is in place for reporting of transfusion reaction but the CAPA and analysis of the same coud not be evident	**2**	A post-transfusion report should be collected, and any transfusion reactions must be documented. A mechanism for reporting transfusion errors should be established to ensure these events are analyzed for corrective and preventive actions.
Achievement	g	**The organisation shall implement a quality assurance programme.***	No documentation was evident.	**1**	A written guideline for the implementation of a Quality Assurance Program needs to be developed.
Average Score				**2.2**	
COP.9: The organisation provides care in intensive care and high dependency units in a systematic manner.					
Commitment	a	**Care of patients in intensive care and high dependency units is provided based on written guidance.***	No documented policy guiding the care of patients in Intensive Care Units (ICUs) and High Dependency Units (HDUs) was evidenced.	**1**	Documented policies and procedures should be developed and implemented to guide the care of patients in Intensive Care Units (ICUs) and High Dependency Units (HDUs). These guidelines should ensure standardized protocols for patient management, safety, infection control, staffing, and emergency response in critical care settings.
Commitment	b	**The defined admission and discharge criteria for its intensive care and high dependency units.***	A documented policy on admission and discharge criteria for Intensive Care and High Dependency Units was not available. There was no display of admission and discharge criteria in any of the intensive care areas. Additionally, no training records regarding the same	**1**	Admission and discharge criteria should be displayed in all intensive care areas. These criteria should be disseminated among the staff to ensure awareness and compliance. To monitor adherence to the practice, it can be included in the Medical Audit objectives to

			were evidenced.		assess the suitability of critical patients being admitted to the ICU.
Commitment	c	**Adequate staff and equipment are available.**	Nurses in Intensive Care Units were found to be inadequate, and the nurse-to-patient ratio was not maintained as per Indian Nursing Council guidelines.	**2**	Adequacy of staff to be ensured to maintain the 1:1nurse patient ratio for ventilator patients and 1:2 for non-ventilator patients as per Indian Nursing Council guidelines.
Commitment	d	**Defined procedures for the situation of bed shortages are followed.***	A defined procedure for handling situations of bed shortages was not available. A documented policy governing these aspects was not evidenced.	**1**	Documented procedures to be developed for the same. Usually, 20% of the beds are kept vacantin any ICU to accommodate emergency patients**;** If occupied 100%, thenthe most stable patient is discharged /transferred to otherward.
Commitment	e	**Infection Prevention and Control practices are followed. ***	No infection control practice guidelines, such as the care of patients on ventilators, central lines, and catheters to prevent infections, were evidenced during the assessment. Improper biomedical waste handling and segregation were observed. Staff was not trained in the safe handling, segregation, and disposal of waste.	**1**	Policies and procedures guiding infection control practices in the ICU should be developed, incorporating the care of patients on ventilators, central lines, and catheters to prevent hospital-acquired infections. Staff must adhere to Biomedical Waste (BMW) management guidelines. Hand hygiene facilities should be made functional, as non-compliance with hand hygiene poses a risk of infections to both patients and staff. Staff should be trained in proper hand hygiene techniques.
Achievement	f	**The organisation shall implement a quality assurance programme.***	There was no documented quality assurance program available in the hospital for the ICU and Critical Care Unit.	**1**	Documented quality assurance program for ICUs and recovery area to be developed. This could be either separately documented or integrated with Hospital's quality assurance program.
Commitment	g	**The organisation has a mechanism to counsel the patient and/ or family periodically.**	Patients and their families were being counseled by the concerned doctor regarding significant changes in the patient's condition; however, this was not being documented in the patient medical record. The periodicity of such counseling was also not defined.	**3**	Patients and their families should be counseled by treating doctors regarding significant changes in the patient's condition. The periodicity of such counseling should be defined and documented uniformly for all ICU-admitted patients.
		Average Score		**1.42**	

COP. 10: Organisation provides safe obstetric care.					
Commitment	a	**Obstetric services are organised and provided safely.***	NA	NA	NA
Commitment	b	**The organisation identifies and, provides care to high-risk obstetric cases, and where needed, refers them to another appropriate centre.**	NA	NA	NA
Commitment	c	**Persons caring for high-risk obstetric cases are competent.**	NA	NA	NA
Commitment	d	**Ante-natal services are provided.***	NA	NA	NA
Achievement	e	**Organisation encourages and welcomes the presence of a birth companion during labour.**	NA	NA	NA
Commitment	f	**Organisation treats pregnant woman and her companion cordially and respectfully, ensures privacy and confidentiality for pregnant woman during her stay.**	NA	NA	NA
Commitment	g	**The treating doctors explains danger signs and important care activities to pregnant woman and her companion.**	NA	NA	NA
Commitment	h	**Obstetric patient's assessment also includes maternal nutrition.**	NA	NA	NA
Commitment	i	**Appropriate per- natal and post-natal monitoring is performed.**	NA	NA	NA
Commitment	j	**The organisation caring for high-risk obstetric cases has the facilities to take care of neonates of such cases.**	NA	NA	NA
Commitment	k	**Organisation shall adhere to legal and defined Assisted Reproductive Technology (ART) practices.**	NA	NA	NA
Average Score				**0**	

COP. 11: Organisation provides safe paediatric services.					
Commitment	a	**Paediatric services are organized and provided safely.***	No documented policy and procedure were evident to guide the care of pediatric patients.	**1**	A documented policy and procedure should be developed and implemented to guide the care of pediatric patients.
Commitment	b	**Neonatal care is in consonance with the national /international guidelines.***	NA	NA	NA
Commitment	c	**Those who care for children have age-specific competency.**	Age-specific competencies for doctors and nurses caring for children were not evident during the assessment.	**1**	A pediatric age-specific competency assessment should be conducted for doctors and nurses. Patient admission and assignment should be done as per documented age-specific competency. For example, a nurse competent in handling pediatric cases and PALS-trained should be deputed in the pediatric ward.
Commitment	d	**Provisions are made for special care of children.**	There was no provision for a play area for children; however, a breastfeeding room for mothers was available.	**1**	Provision for a play area in OPD and a breastfeeding room near NICU/Pediatric OPD should be made available.
Commitment	e	**Paediatric assessment includes growth, developmental and immunisation assessment.**	Pediatric assessment does not include the growth, developmental and immunisation assessment.	**1**	A pediatric assessment form should be implemented, incorporating growth, developmental, and immunization assessment.
Commitment	f	**The organisation has measures in place to prevent child/ neonate abduction and abuse.***	Pediatric assessment did not include growth, developmental, and immunization evaluation. No documented policies and procedures were evident to prevent neonate/child abduction and abuse.	**1**	Documented policies and procedures should be developed and implemented to prevent neonatal/child abduction and abuse. Staff training should be conducted on these protocols.
Commitment	g	**The child's family members are educated about nutrition, immunisation and safe parenting.**	No documented evidences were in place which ensures that child's family members are educated about nutrition, immunisation and safe parenting.	**1**	Education on nutrition, immunization, and safe parenting should be incorporated into the pediatric IPD assessment form. The form should also include endorsements from the child's family members upon explanation.
Excellence	h	**The organisation provides for adolescent friendly health care services.**	Adolescent friendly health care services are not standardized across the hospital and no documented process and policy in place	**1**	The organization should ensure dedicated adolescent-friendly clinics with flexible timings and a non-judgmental approach. Privacy and confidentiality must be maintained as per NABH

					guidelines through staff sensitization and private consultation areas. Comprehensive care covering mental health, reproductive health, nutrition, and substance use should be provided using evidence-based protocols. Adolescent engagement in service planning, digital outreach, and periodic monitoring & evaluation through feedback mechanisms should be implemented to enhance service effectiveness and compliance with NABH standards.
Average Score				**0.87**	
COP.12: Procedural sedation is provided in a consistent and safe manner.					
Commitment	a	**Procedural sedation is administered in a consistent manner***	No, document policy was evidenced to guide the administration of moderate sedation.	**1**	Documented procedures and policies should be developed to guide the administration of moderate sedation. The implementation and communication of the policy need to be ensured.
Commitment	b	**Informed consent for administrationof procedural sedation is obtained.**	No separate consent form was available for providing moderate sedation.	**2**	A separate consent form should be developed and implemented for providing moderate sedation.
Commitment	c	**Competent and trained persons administer sedation.**	Trained person administer the sedation. However, the privileging for the same not documented.	**2**	Competent and trained persons should performsedation and privileging should be done accordingly. Documentation of the same needs to be standardized and to be done for every patient going under moderate sedation.
Commitment	d	**The person monitoring sedation is different from the person performing the procedure.**	Doctor performs the procedure.The staff nurse was administering & monitoring the patient.	**1**	Documentation of the same needs to be standardized and to be done for every patient going under moderate sedation.
Commitment	e	**Intra-procedure monitoring includes**	Though the documentation of the same was evident as no separate monitoring form was available for the patient undergoing in moderate sedation.	**2**	Moderate Sedation records should be developed which includes monitoring of patient pre-procedure, during & after procedure.

Commitment	f	**Patients are monitored after sedation, and the same is documented.**	Although patients were being monitored but same were not being documented uniformly.	**2**	Post sedation monitoring to be documented appropriately using a standardized format.
Commitment	g	**Criteria are used to determine the appropriateness of discharge from the observation/ recovery area.***	No standardized criteria were being used to ensure the recovery from moderate sedation.	**2**	Criteria for discharge from the recovery area should be defined and uniformly followed.
Commitment	**h**	**Equipment and work force are available to manage patients who have gone into a deeper level of sedation than initially intended.**	Adequate equipment and manpower were available torescue patients from deeper level of sedations. However, staffs were not privileged.	**3**	The Staff should be privileged to perform sedation services in compliance with applicable laws and regulations. He/she should also possess a certificate on ACLS training.
Average Score				**1.87**	
COP.13: Anaesthesia services are provided in a consistent and safe manner.					
Commitment	a	**Anaesthesia services are provided**	No documented policy for the administration of anesthesia was evident.	**1**	A documented policy should be developed and implemented to standardize anesthesia administration across the hospital, ensuring uniform practices, compliance with infection control guidelines, and proper documentation of anesthesia-related procedures and events.
CORE	b	**The pre- anaesthesia assessment results in the formulation of an anaesthesia plan which is documented.**	Though a pre-anaesthesia assessment format was available, its documentation was not found uniformly in medical records.	**3**	All patients undergoing anesthesia should have a pre-anesthesia assessment and a pre-induction assessment documented uniformly by a qualified anesthesiologist.
Commitment	c	**A pre-induction assessment is performed and documented.**	Pre-anaesthesia assessments were conducted for all patients; however, the same was not evident in the patient medical records.	**3**	All patients undergoing anesthesia should have a pre-anesthesia assessment and a pre-induction assessment uniformly documented by a qualified anesthesiologist.
Commitment	d	**The anaesthesiologist obtains informed consent for administration of anaesthesia.**	No appropriate consent was evidenced during the assessment.	**2**	The anaesthesiologist needs to obtain informed consent for administration of anaesthesia, Patients & / or the family needs to education on risks, benefits & alternatives of anaesthesia.The anaesthesia consent should be separate from the surgery consent.

CORE	e	**During anaesthesia, monitoring includes regular recording of temperature, heart rate, cardiac-rhythm, respiratory rate, blood pressure, oxygen saturation and end-tidal carbon dioxide.**	Though monitoring of such parameters was being done in the anesthesia record, it was not documented in the patient medical records.	**2**	The policy for anaesthesia administration to include monitoring and documentation of these parameters.
Commitment	**f**	**Patient's post-anaesthesia status is monitored and documented.**	The anesthetist monitors the patient's status; however, the documentation of post-anesthesia status was not done uniformly for all patients.	**2**	Each patient's post anaesthesia monitoring to be conducted and documentation of the same to beensured.
Commitment	**g**	**Criteria are used to determine appropriateness of discharge from the observation/ recovery area.***	The criteria for transferring the patient from the recovery area were not defined, and the same was not being filled by the anesthetist.	**1**	The criteria to transfer the patient from the recovery area should be applied and filled up by anaesthetist prior to transfer the patient from OT to ward.
Commitment	**h**	**The type of anaesthesia and anaesthetic medications used are documented in the patient record.**	The type of anesthesia and anesthetic medications used were not documented uniformly in the patient records.	**2**	Type of anaesthesia and anaesthetic medications used needs to be documented in the patient's anaesthesia record.
Commitment	**i**	**Procedures shall comply with infection control guidelines to prevent cross infection between patients.**	No, Documented infection control guidelines for the same was evidenced.	**2**	Anesthesia administration should comply with infection control guidelines, ensuring that all anesthetic equipment is appropriately disinfected and sterilized before use, as per the documented procedure.
Achievement	**j**	**Intra- operative adverse aesthesia events are recorded and monitored.**	No events were being recorded or reported. A mechanism for the same was not evident during the assessment.	**1**	All adverse anesthesia events should be recorded. These events can be documented in a separate "adverse events register" or in the regular OT register. For reporting, an "incident reporting form" should be completed by the anesthetist and submitted to the designated member of the safety committee.
Average Score				**1.9**	
COP.14: Surgical services a re-provided in a consistent and safe manner.					

Commitment	a	**Surgical services are provided in a consistent and safe manner.***	No documented policy or procedure for surgical patient care was evident.	**2**	A documented policy and procedure for surgical patient care should be developed and implemented. This should cover pre-operative, intra-operative, and post-operative care, ensuring standardized practices for patient safety and quality outcomes.
Commitment	b	**Surgical patients have a preoperative assessment, a documented pre-operative diagnosis, and pre-operative instructions a re-provided before surgery.**	The assessments were not being conducted uniformly by the surgeons.	**3**	A pre-operative surgical assessment form should be developed and implemented.
Commitment	c	**Informed consent is obtained by a surgeon before the procedure.**	Though the informed consent form was available for obtaining patient consent for surgery, it was not duly filled. The name of the procedure, complications, risks, alternatives, and benefits were not documented, and the informed consent was not signed by the surgeon performing the procedure.	**2**	An informed consent format for patients undergoing surgical procedures needs to be developed. Informed consent must be duly filled and signed by the surgeon or a designated team member. Complications, risks, alternatives, and benefits should be explained to the patient and documented in the informed consent form.
CORE	d	**Care is taken to prevent adverse events like the wrong site, wrong patient and wrong surgery.***	Surgical Safety Checklist was not evidenced to prevent adverse events like wrong site, wrong patients and wrong surgery.	**2**	A Surgical Safety Checklist is to be developed as WHO norms and same is to be filled for allpatients undergoing surgery to prevent anyadverse event. A documented policy should bedeveloped which may include the “time-out”practice.
Commitment	e	**An operative note is documented before transfer out of patient from recovery.**	A brief operating note was not being written for all patients. However, the same was evidenced incomplete in the medical record. The operative note was not signed by thesurgeon and it did not include all parameters specified by NABH.	**2**	The surgeon should ensure that operative notes include details of the surgery performed, the name of the surgeon(s), the name of the anesthesiologist, salient steps of the procedure, and key intraoperative findings before transferring or shifting the patient. The notes must be signed by the chief operating surgeon.
Commitment	**f**	**Post-operative care is guided by a documented plan.**	Post-operative plan of care was not being documented appropriately in medical records.	**2**	The post-operative plan of care needs to be documented for all patients undergoing surgery and should be incorporated into the operative note.

Commitment	**g**	**Patient, personnel and material flow conform to infection prevention and control practices.**	Traffic pertaining sterilizedand unsterilized items i.e., linen movement, bio medical waste management, instrument trolleys and patient were overlapping each other. Operational practices like linen movement and the biomedical waste movement were observed being done in unappropriated way.	**2**	Closed containerized mechanism to be implemented for transportation of dirty andcleanlinen, BMW and instrument trolley. Zoning for the OT should be redefined to ensure the effective implementation of infection control practices.
Commitment	**h**	**Appropriate facilities, equipment, instruments and supplies are available in the operating theatre.**	Yes, appropriate facilities and equipment/ appliances / instrumentation were available in the operating theatre.	**5**	Sustainability of the present practice needs to be ensured.
Achievement	**i**	**The organisation shall implement a quality assurance programme.***	No documented Quality Assurance program was evidenced for surgical services.	**1**	A documented program should be developed, which can either be an integral part of the hospital's overall Quality Assurance program or a separate document.
Achievement	**j**	**The quality assurance programme includes surveillance of the operation theatre environment. ***	No documented Quality Assurance program was evident for surgical services.	**1**	A documented program should be developed. This program can either be an integral part of the hospital's overall Quality Assurance program or a separate document.
Average Score				**2.2**	
COP.15: The organ transplant programme is carried out safely.					
CORE	a	**The organ transplant programme shall be in consonance with the legal requirements and shall be conducted ethically.**	The hospital's organ transplant program aligns with legal requirements and adheres to ethical guidelines.	4	Ensure periodic audits, staff training, and structured reviews to maintain compliance. Conduct regular sensitization sessions for stakeholders to reinforce ethical practices.
Commitment	b	**Care of transplant patients is guided by clinical practice guidelines.***	The care of transplant patients follows established clinical practice guidelines, ensuring standardized management, post-transplant monitoring, and complication prevention.	4	Regularly update protocols in line with evolving best practices. Conduct periodic staff training and audits to ensure adherence to guidelines and optimal patient outcomes.
Commitment	c	**The organisation ensures education and counseling of recipient and donor through trained / qualified counsellors before organ**	The organization ensures that both recipients and donors receive education and counseling from trained and qualified counselors	4	Maintain detailed records of counseling sessions and periodically assess their effectiveness. Regular training should be provided to counselors to align with updated

		transplantation.	before organ transplantation, covering medical, ethical, and legal aspects.		guidelines and best practices.
CORE	d	**The organisation shall take measures to create awareness regarding organ donation.**	No displays and education being provided to the patient on awerness regarding Organ donation	**2**	Display regarding awerness on Organ Donation to be placed at strategic location.
Average Score				**3.5**	
COP.16: The organisation identifies and manages patients who are at higher risk of morbidity/ mortality.					
CORE	a	**The organisation identifies and manages vulnerable patients.***	No documented policy or procedures were evident for the identification and care of vulnerable groups.	**2**	A documented policy and set of procedures should be defined, developed, and implemented in accordance with prevailing laws and national and international guidelines. Additionally, staff should be provided with appropriate training.
CORE	b	**The organisation identifies and manages patients who are at a risk of fall.***	No, documented evidence was found for identification & managing patients who are at a risk of fall. Lack of staff awareness was evidenced.	**2**	The organisation should identify & manages patients who are at a risk of fall & same needs to be documented & staffs should be aware about the same.
CORE	c	**The organisation identifies and manages patients who are at risk of developing / worsening of Pressure Ulcers.***	The organization did not identify & manages patients who are at risk of developing. The continuous monitoring could not be evidenced during the assessment.	**2**	The organisation needs identify and manages patients who are at risk of developing/ worsening of pressure ulcers.
CORE	d	**The organisation identifies and manages patients who are at risk of developing Deep Vein Thrombosis.***	The organization does not have written document identifiying the risk of developing deep vein thrombosis.	**2**	The organisation needs to identify & manages patients who are at risk of developing deep vein thrombosis.
Commitment	e	**The organisation identifies and manages patients who need restraints.***	No, documented policywas evident to guide the use ofrestraints.	**2**	A documented policy should be developed which may include the situations under which patient can be restraint, authority to order restraint, exceptions etc.
Average Score				**2**	
COP.17: Pain management for patients is done in a consistent manner.					
Commitment	a	**Patients in pain are effectively managed.***	The documented policy for pain management was not available.	**2**	The documented policy needs to be implemented & communicated to staff.

Commitment	b	**Patients are screened for pain.**	Pain screening and assessment were not conducted uniformly by the staff.	**3**	A documented policy should be developed for pain screening, management, and assessment. Nurses should conduct pain screening, while a detailed assessment should be performed by doctors.
Commitment	c	**Patientswith pains undergo detailed assessment and periodic reassessment.**	There was no uniform detailed assessment or periodic re-assessment conducted for pain.	**3**	Patients with pain should undergo a detailed assessment and periodic re-assessment.
Commitment	d	**Pain alleviation measures or medications are initiated and titrated according to the patient'sneed and response.**	Pain alleviation measures or medications were evidenced to be initiated and titrated according to the patient's need and response.	**3**	Pain alleviation measures or medications be initiated and titrated based on the patient's needs and response, ensuring individualized and effective pain management.
Average Score				**2.75**	
COP.18: Rehabilitation services are provided to the patients in a safe, collaborative and consistent manner.					
Commitment	a	**Scope of the rehabilitation services at a minimum is commensurate to the services provided by the organisation**	The scope of rehabilitation services was not clearly defined, but at a minimum, it was found to be commensurate with the services provided by the organization.	1	The organisation should define the rehabilitation services commensurate with its scope of services& same should be displayed.
Commitment	b	**Rehabilitation services are provided in a consistent manner.**	Rehabilitation services were provided consistently; however, documentation for the same was not evidenced.	1	The organization should provide rehabilitation services consistently by adopting or adapting standard treatment guidelines and sound clinical practices.
Commitment	c	**Care providers collaboratively plan rehabilitation services.**	A multidisciplinary rehabilitation team was in place to deliver rehabilitation services.	4	A multidisciplinary team, including the treating doctor, rehabilitation therapist, and rehabilitation nurses, should be available to deliver rehabilitation services effectively.
Commitment	d	**There are adequate space and equipment to provide rehabilitation.**	Adequate space and equipment were available for rehabilitation. However, calibration of the equipment was not evidenced.	4	The sustainability of current practices must be ensured. Additionally, the calibration of equipment should be initiated.
Commitment	**e**	**Care is guided by functional assessment and periodic re-assessments which are done and documented.**	There was no established format for functional and periodic re-assessment of patients as per NABH requirements.	2	A standardized format for functional and periodic re-assessment should be developed and uniformly implemented for both OPD and IPD patients.

Commitment	**f**	**Care is provided adhering to infection control and safety practices.**	Bio medical waste segregation was not followed as per the guidelines.	**2**	Training should be imparted to the staff.
Excellence	**g**	**Care pathways are developed, implemented, and reviewed periodically.**	Care pathway could not be evidenced.	**1**	Care pathways should be based on evidenced or sound clinical practices.
Average Score				**2.14**	
COP.19: Nutritional therapy is provided to patients consistently and collaboratively.					
Commitment	a	**Patients admitted to the organisation are screened for nutritional risk.***	No, documented policy was evident to guide the nutritional therapy. The screening for nutritional assessment could not be evidenced in the patient's file.	**2**	A documented policy addressing nutritional assessments and reassessments should be developed and implemented. This can also be included in the "initial patient assessment policy"
Commitment	b	**Nutritional assessment is done for patients found at risk during nutritional screening.**	Nutritional Assessment for patients could not be evidenced in medical record uniformly.	**1**	A dietician should conduct a nutritional assessment for all patients identified as at risk during nutritional screening.
Commitment	c	**The therapeutic diet is planned and provided collaboratively.**	Provisions for 24 hours availability of a dietician were not available.	**2**	Dietician cover is to be provided for 24 hours toplan the nutritional therapy for every patient incollaborative manner based on the diet order of consultants.
Commitment	d	**Patients receive food according to the written order for the diet.**	The written order for diet wasnot being documented.	1	The diet order should be documented in a uniform location within the medical record.
Commitment	e	**When family provides food, they are educated about the patient's diet limitations.**	Although diet was being provided as per the clinical need of the patient. However, Nutritional assessment was not being conducted uniformly by the dietician as per their clinical needs.	2	A detailed nutritional assessment shouldresult into diet plan in consultation with clinician.
Average Score				**1.6**	
COP.20: End-of-life-care is provided in a compassionate and considerate manner.					
Commitment	a	**End-of-life care is provided in a consistent manner in the organisation.***	There was no documented policy guiding end-of-life care, and special preferences of the patient (religious, spiritual, etc.) were not evidenced.	2	A documented policy should be developed and implemented in consonance with legal requirements. This policy should incorporate special patient preferences (religious, spiritual,

					etc.), ensuring patient-centered end-of-life care. Staff training on the policy should be conducted to ensure proper adherence.
Achievement	b	**A multi-professional approach is used to provide end-of-lifecare.**	No, Documented policy was evident to guide for the "end of Lifecare". However, special preferences of the patient (religious, spiritual etc.) could not be evidenced.	2	A documented policy should be developed in consonance with legal requirements and implemented. This should incorporate special preferences of the patient (religious, spiritualetc.) Staff needs to train on the same.
Commitment	c	**End-of-life care is in consonance with the legal requirements.**	No, Documented policy was evident to guide for the "end of Lifecare". However, special preferences of the patient (religious, spiritual etc.) could not be evidenced.	2	A documented policy should be formulated to ensure compliance with legal requirements. This policy should be implemented, and staff should be trained to understand and adhere to the legal guidelines governing end-of-life care.
Commitment	d	**End of life care also addresses the identification of the unique needs of such patient and family.**	There was no documented policy addressing the unique needs of patients and their families in end-of-life care.	2	A documented policy should be developed to address the specific needs of patients and their families, including emotional, psychological, and cultural aspects. This should be implemented, and staff should receive training on patient-centered care during end-of-life situations.
Commitment	e	**Symptomatic treatment is provided and where appropriate measures are taken for the alleviation of pain.**	Symptomatic treatment and pain alleviation measures were being provided, but no documentation specific to end-of-life care was available.	**3**	The provision of symptomatic treatment and pain management for end-of-life patients should be documented in patient records. A structured pain management protocol should be included in the end-of-life care policy, ensuring consistency and compliance.
Average Score				**2.2**	
Total Chapter Average Score				**1.87**	
Chapter 3:Management of Medication (MOM)					
MOM.1: Pharmacy services and usage of medication is done safely.					
Commitment	a	**Pharmacy services and medication management are implemented following written guidance.***	There was no documented policy or SOP for pharmacy services and medication management was evident.	**1**	A written and documented policy or SOP should be develop, which shall guide about operations of pharmacy services and medication management and use.Also the policy or SOP should be in consonance with applicable laws and regulations.

Commitment	b	**A multidisciplinary committee guides the formulation and implementation of pharmacy services and medication management.**	Pharmaco-therapeutic committee had not been formulated to guide prescriptions, orders & stocking medications by health care practitioners.	**1**	The hospital should formulate a Pharmaco-therapeutic committee. This committee will be responsible to maintain and monitor the medication list and use of medications in the hospital. A drug formulary should be developed and updated at least once in a year.
Achievement	c	**The multi- disciplinary committee updates medication management processes.**	There was no record evidence on medication management processes by the multi- disciplinary committee.	**1**	The hospital should formulate a process and shall conduct Medication Management system review on an annual basis.
Commitment	d	**There is a procedure to obtain medications when the pharmacy is closed or in case of stock outs.***	The present pharmacies are open 24*7. But there was no written procedure document was evidenced in case of medications are stock out.	**4**	As pharmcies are 24*7 are open but there shall also be a stanadard operating procedure to procure the drugs.
Commitment	e	**The organisation has a mechanism to inform relevant staff of key changes in pharmacy services and medication usage to ensure un-interrupted and safe care.**	There was no documented mechanism was evidenced to inform relevant staff of key changes in pharmacy services and medication usage to ensure uninterrupted and safe care.	**1**	The organization shall have a process to communicate medication shortages, includes stock outs to relevant staff (clinicians nurses).
Average Score				**1.6**	
MOM.2. The organisation develops updates and implements a hospital formulary.					
CORE	a	**A list of medications appropriate for the patients and as per the scope of the organisation's clinical services is developed collaboratively by the multi-disciplinary committee.**	There was no multi-disciplinary committee formulated in the hospital to develop a Drug formulary (list of Medications) as per the scope of organizationsclinical services, hence no such list was evident.	**1**	A multidisciplinary committee needs to be formulated to develop a Drug Formulary (list of medication) as per the scope of organisation's clinical services. Also this Drug formulary shall include medication's necessary to meet the organisation's mission, patient needs and scope of services. And also, should be reviewed and updated as annually basis.
Commitment	b	**The list is reviewed and updated collaboratively by the multidisciplinary committee at least annually.**		**1**	
Commitment	c	**The current formulary is available for clinicians to refer to.**	There was no documented drug formulary.	**1**	A formulated drug formulary should be developed and shared with clinicians for reference. Clinicians must adhere to the established formulary to ensure that prescriptions comply with its guidelines.
Achievement	d	**The clinicians adhere to the current formulary.**		**1**	

Commitment	e	**The organisation adheres to the procedure for the acquisition of formulary medications. ***	The drug formulary has not been developed; hence the process of drug acquisition could not be assessed.	**1**	The process for the acquisition of the medicines listed in drug formulary should be defined.
Commitment	f	**The organisation adheres to the procedure to obtain medications not listed in the formulary. ***	The drug formulary has not been developed; hence the process of the same could not be assessed.	**1**	The process for the acquisition of the medicines which are not listed in drug formulary should be defined. Whenever there is local purchase of medications, the organization should have a process to evaluate, authorize and approve the acquisition.
Average Score				**1**	
MOM.3: Medications are stored appropriately and are available where required.					
CORE	a	**Medications are stored in a clean, safe and secure environment; and incorporating the manufacturer's recommendation(s).**	The temperature was not being monitored of any of the medicine refrigerators across all the clinical areas of the hospital including pharmacy. Further, there was no mechanism to ensure the safety of medicines from loss or theft. Medical items were stored indirect sunlight in pharmacy.	**1**	The storage area should be provided with adequate lighting and ventilation facilities. Medications needs to be stored as per the manufacturer's recommendations(s)
Commitment	b	**Sound inventory control practices guide storage of medications throughout the organisation.**	Sound inventory control practices were being followed; medications were stored in alphabetically order.	**3**	The hospital needs to implement sound inventory control practices to observe the discrepancy in physical and computer stock on daily basis. -Implementation of scientific tools such as ABC/VED & FIFO should be done to strengthen the process.
CORE	c	**The organisation defines a list of high-risk medication(s). ***	The list of high-risk medications was not defined.	**1**	A list of high-risk medications is to be developed by pharmaco-therapeutic committee. The list should be displayed at all medication storage areas and nursing stations.
Achievement	d	**High-risk medications are stored in areas of the organisation where it is clinically necessary.**	High-risk medications are not stored in areas of the organisation where it is clinically necessary.	**1**	High-risk medications should be stored in areas of the organisation where it is clinically necessary& needs training for the same.

CORE	e	**High-risk medications including look-alike, sound-alike medications and different concentrations of the same medication are stored physically apart from each other. ***	Sound alike and look alike medications were not identified, hence no practice of storing such medicines separately was evident.	**1**	A policy has to be developed to guide the identification and storage of LASA (Look Alike and Sound Alike) drugs and these drugs needs to be stored as per policy with appropriate labelling.
. Commitment	f	**The list of emergency medications is defined and is stored uniformly. ***	There was no list defined and maintained for emergency medications. Drugs were being stored in a mixed way. The hospital did not have appropriate crash carts in place. Hence uniformity in the storage of medications could not be assessed.	**1**	The list of emergency medications is to bedefined. Emergency medications should be stored in a uniform manner in the crash cart or emergency medication tray. These medications should be appropriately labelled and segregated for easy access during medical emergencies. -Availability of crash cart is to be ensured for Emergency, Dialysis department and on each floor to manage the medical emergencies.
CORE	**g**	**Emergency medications are available all the time and are replenished promptly when used.**	The medications Inventory management was inappropriate as quantity of these medications were not defined. -There was no defined process for the replenishment of emergency medications.	**1**	Quantity of each medicine in crash cart should be defined and these medications should be stocked at all the times. Stock of each medication is to be checked on daily basis with expiry dates. - Crash cart is to be made available at each floor preferably near nursing station and critical care areas. -A process needs to be defined for replenishment of emergency medications after their consumption during medical emergencies.
Average Score				**1.2**	
MOM.4: Medications are prescribed safely and rationally.					
Commitment	a	**Medication prescription is in consonance with good practices /guidelines for the rational prescription of medications. ***	No documented policy on the prescription of medication was available in the hospital; hence inclusion of good practices/ guidelines for rational prescription could not be evidenced. Medication prescriptions were not found in capital letter in most of the clinical areas of the hospital, like ICU,	**2**	A documented policy should be developed for prescription of medicines incorporating the rational prescription guidelines. A content of prescription also needs to be defined in the policy.

			Wards.		
CORE	b	**The organisation adheres to the determined minimum requirements of a prescription. ***	No documented policy on the prescription of medication was available in the hospital; hence inclusion of good practices/guidelines for rational prescription could not be evidenced. Medication prescriptions were not found in capital letter in most of the clinical areas of the hospital,like ICU, Wards.	**2**	A documented policy should be developed for prescription of medicines incorporating the rational prescription guidelines. A content of prescription should also be defined in the policy.
Commitment	c	**Drug allergies and previous adverse drug reactions are as curtained before prescribing.**	Though the known drug allergies were being determined but the same were not observed documented uniformly before prescribing.	**2**	Known drug allergies are to be ascertained and documented before prescribing a medication.
Excellence	d	**The organisation has a mechanism to assist the clinician in prescribing appropriate medication.**	There was no mechanism was evidenced.	**2**	The organization needs to provide its clinicianswith a mechanism(s) to help identify drug interactions, food-drug interactions, Therapeutic duplications, dose adjustments, etc. This could either be in electronic or physical form.
CORE	e	**Reconciliation of medications occurs at transition points of patient care.**	No system was evidenced for reconciliation of medications during transitions/transfer i.e. from one ward setting to other department.	**1**	A process needs to be developed for reconciliation of medications from one ward setting to another department. This aspect should be included into intra hospital transfer forms.
Achievement	f	**Verbal orders are implemented by ensuring safe medication management practices. ***	No evidence of safe medication management practices for verbal orders was identified.	**1**	Implement clear protocols for verbal medication orders, including verification by repeating back, immediate documentation, limiting to emergencies, staff training, and regular audits to ensure compliance and safety
Achievement	g	**Audit of medication orders/ prescription is carried out to check for safe and rational prescription of medications.**	No evidence of medication / prescription audit was identified.	**1**	Audit of medication orders / prescription shouldbe carried out to check for safe and rational prescription of medications.
Achievement	h	**Corrective and /or preventive action(s) is taken based on the audit, where appropriate.**	No such activity was evidenced.	**1**	Corrective and / or preventive actions should be taken based on the analysis, where ever appropriate.

Average Score				**1.5**	
MOM.5: Medications orders are written in a uniform manner.					
Commitment	a	**The organisation ensures that only authorized personnel write orders.***	Documented policy on safe dispensing of medications was not evident.	**1**	A documented policy should be developed for the safe dispensing of medicines.
Commitment	b	**Medication orders are written in a uniform location in the medical records, which also include the patient's name and unique identification number.**	Though the Medication orders were being written in the case sheets, but as such no standardized format was evidenced.	**3**	The medication order chart needs to be developed to standardize the same and is to be included in the prescription policy. The chart should have a provision of patient's name and UHID number.
Commitment	c	**Medication orders are legible, dated, timed and signed.**	It was not being adhered uniformly.	**2**	The doctors have to ensure that each medicationorder should be clear, legible, dated, timed, named and signed.
Commitment	d	**Medication orders contain the name of the medicine, route of administration, strength to be administered and frequency/ time of administration.**	Medication orders were not being completed uniformly.	**2**	Medication orders should contain the name of the medicine, route of administration and frequency / time of administration.
Average Score				**2**	
MOM.6: Medications are dispensed in a safe manner.					
Commitment	a	**Dispensing of medications is done safely.***	Documented policy on safe dispensing of medications was not evident. The staffs were not aware about the same.	**2**	A documented policy should be developed for the safe dispensing of medicines & training of staff needs to be done.
Commitment	b	**Medication recalls are handled effectively.***	Documented policy on recall of medications was evidenced. The staffs were not aware about the same.	**2**	A documented policy should be developed on medication recall and this recall could be on basis either internal complaint or a letter from local government authority & training of staff needs to be done.
Commitment	c	**Near-expiry medications are handled effectively.***	There was no policy available toaddress near expiry medications. -Lack of policy on the process on the same has led to accumulation of near expired medications in	**2**	Policy on near expiry medications is to bedeveloped and implemented. It should be ensured that the policy is adhered in all the areas of the hospital & training of staff needs to be done.

			Pharmacy and emergency department.		
CORE	d	**Dispensed medications are labeled.***	The medicines were being distributed in packs without labelling name, strength, frequency etc. for IPD and OPD patients. -Though multi drug dose medicines were being used, non- availability of the date of opening in the same was evidenced.	**2**	Labeling requirements of medication should be documented incorporating minimum drug name, strength, frequency of administration (in a language the patient understands) and expiry dates. This is to be implemented in all dispensing areas. -It should be ensured that the medicines and solution being opened are labelled adequately to determine the date of opening.
CORE	e	**High-risk medication orders are verified before dispensing.**	High – risk medicationorderswere not verified prior to dispensing.	**1**	High – risk medication orders should be verified twice prior to dispensing. The same to be incorporated in the dispensing policy.
Commitment	f	**Return of medications to the pharmacy is addressed.***	The documented policy was not available to direct the return of medication to the pharmacy.	**1**	The organisation should have written guidance to direct the return of medications to the pharmacy. The policy should address the list of medications which would be accepted for return (either by inclusion or exclusion & minimum conditions to be met for return of medications.
			Average Score	**1.6**	
MOM.7: Medications are administered safely.					
Commitment	a	**Medications are administered by those who are permitted by law to do so.**	The medicines were being administered by the nurses who are permitted by law to do so.	**5**	Ensure the sustenance of the practice where medicines are administered only by nurses authorized by law, maintaining compliance with regulatory requirements and ensuring patient safety.
Commitment	b	**Prepared medication is labeled before preparation of a second drug.**	Labeling of prepared medications was not being done. - Evidences for its date of preparation, name, drug and strength could not be witnessed uniformly.	**2**	The person preparing the medicine should label (name of drug, strength and date, time of preparation) the first drug before the preparation of second drug.

Commitment	c	**The patient is identified before administration.**	No such identification prior to administration was being done as patient ID band was not available to identify the patient.	**1**	Patient should be identified prior to administration and the same is to be documented. Only nursing staff should take responsibility to administer drugs, whether in form of tablets or injections. Patient ID band should be made available.
CORE	d	**Medication is verified from the medication order and physically inspected before administration.**	No documented evidenced for the same, during the gap assessment.	**1**	Medications are to be verified from the order prior to administration.
Commitment	e	**Strength is verified from the order before administration.**	No documented evidenced for the same, during the gap assessment.	**1**	Dosage to be is verified from the order prior to administration.
Commitment	f	**The route is verified from the order before administration.**	No documented evidenced for the same, during the gap assessment.	**1**	Route is to be verified from the order prior to administration.
Commitment	g	**Timing is verified from the order before administration.**	It was not evidenced during the gap assessment.	**1**	Timing is to be verified from the order prior to administration.
CORE	h	**Measures to avoid catheter and tubing mis-connections during medication administration are implemented. ***	No documented measures were evidenced to avoid catheter and tubing mis-connections during medication administration are implemented.	**1**	A written policy needs to be developed & implemented.
Commitment	i	**Medication administration is documented.**	There was a medication administration record sheet available but it was not being filled uniformly.	**2**	Medication administration policy should include this aspect. The medications administration should be documented in the medication administration record sheet.
Commitment	j	**Measures to govern patient's self-administration of medications are implemented. ***	No, documented policy was evident to govern patient's self administration of medication.	**2**	The organization should document the measures to govern patients self- of medications are implemented.
Commitment	k	**Measures to govern patient's medications brought from outside the organisation are implemented. ***	Documented policy was not evident to govern patient's medications brought from outside the organization. The patients are not aware about the same.	**2**	Staffs & patients' needs to be made aware about the same.
Average Score				**1.72**	
MOM.8: Patients are monitored after medication administration.					

Commitment	a	**Patients are monitored after medication administration. ***	No, documented procedure to capture near miss, medication error and adverse event was evidenced. The staffs training could not be evidenced.	**2**	Documented procedure to capture near miss, medication error and adverse drug event to be developed. -A culture of encouraging reporting of adverse events should be encouraged. A committee should be formulated to review and analyse the reasons/ cause of the adverse event, corrective and preventive actions to be taken to prevent their occurrence in future.
Commitment	b	**Medications shall be changed based on the monitoring where appropriate.**	Yes, medications were being changed where appropriate based on the monitoring but the same was not being followed uniformly.	**3**	Uniform adherence to the present practice needs to be ensured.
CORE	c	**The organisation shall capture near misses, medication errors and adverse drug reactions. ***	No, documented procedure to capture near miss, medication error and adverse event was evidenced. -Near miss, medication error and adverse drug events were not defined. The communications of the same to staff were not evidenced.	**2**	Documented procedure to capture near miss, medication error and adverse drug event to be developed. -A culture of encouraging reporting of adverse events should be encouraged. A committee should be formulated to review and analyze the reasons/ cause of the adverse event, corrective and preventive actions to be taken to prevent their occurrence in future. The staff needs training for the same.
Commitment	d	**Near miss, medication errors and adverse drug reactions shall be reported within a specified time frame. ***	No, system available for reporting of adverse events, the time frame for reporting was defined. No such events were being collected and analyzed with corrective and preventive actions.	**2**	The training of staff needs to be conducted for adverse drug events reporting and handling should include this aspect.
Commitment	**e**	**Near miss, medication error and adverse drug reaction are collected and analyzed.**	Adverse drug events were not being collected and analyzed with corrective and preventive actions.	**1**	Near miss, medication error and adverse drug reaction needs to be collected and analysed.
Commitment	**f**	**Corrective and/ or preventive action(s) are taken based on the analysis.**	As there was no reporting done for of adverse events, hence analyzed with corrective and preventive actions could not be evidenced.	**1**	Corrective and / or preventive action(s) should be taken based on the analysis where appropriate.
Average Score				**1.83**	

MOM.9: Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used in a safe manner.					
Commitment	a	**Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio- pharmaceuticals are used safely. ***	The policies for the use of narcotic drugs and psychotropic substances were not evident.	**2**	The policy to guide use of narcotic drugs and psychotropic substances should be developed in consonance with local and national regulations & implementation for the same needs to be done uniformly throughout the hospital.
Commitment	b	**Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio- pharmaceuticals are prescribed by appropriate caregivers.**	No, documented policies and procedures were available, consonance with laws and regulations. Narcotic drugs and psychotropic substances are prescribed by appropriate caregivers not uniformly maintained.	**2**	Policies and procedures need to be documented & implemented consonance. -License for handling of narcotics should be obtained from state authorities and these drugs are to be handled in accordance with laws and national regulations.
Commitment	c	**Narcotic drugs and psychotropic substances, Chemotherapeutic agents and radio-pharmaceuticals drugs are stored securely.**	The proper storage of Narcotics drugs & psychotropic substances was not done uniformly. The physical stock quantity does not match with the documented maintain register. Near Expiry were found.	**2**	A written guidance needs to be developed & implemented.
Commitment	d	**Chemotherapy and radio-pharmaceuticals are prepared properly and safely and administered by qualified personnel.**	Documented policies and procedures govern usage of radioactive drugs was not evidenced. However, agents are prepared properly and safely and administered by qualified personnel.	**3**	Policies and procedures to govern usage of radioactive drugs should be documented and implemented.
Commitment	e	**A proper record shall be kept of the usage, administration and disposal of narcotic drugs and psychotropic substances, chemotherapeutic agents and radio- pharmaceuticals.**	No proper documented evidence was found for the usage & disposal of narcotic drugs and psychotropic substances.	**2**	The policy to guide usage, administration and disposal of narcotic drugs and psychotropic substances should be developed and implemented. Register should be maintained for the disposal of narcotics drugs.

Average Score				**2.2**	
MOM.10: Implant able prosthesis and medical devices are used in accordance with laid down criteria.					
Commitment	a	**Usage of the implantable prosthesis and medical devices is guided by scientific criteria foreach item and national/ international recognized guidelines/ approvals for such specific item(s).**	Documented policy was not available to guide the usage of implantable prosthesis and medical devices	**2**	The organisation should ensure the relevant & sufficient scientific data are available before selection. & Same should be documented. The multidisciplinary committee shall be responsible for approving the use of a particular implant.
Commitment	b	**The organisation implements a mechanism for the usage of the implantable prosthesis and medical devices.***	No, documented policy to guide the procurement, storage and issuance of implantable prosthesis was available.	**1**	The organisation should have written guidance to direct procurement, storage/ stocking, issuance & usage of the implantable prosthesis & medical devices. This should address statutory regulations/ guidelines & manufacturers recommendations.
Commitment	c	**Patient and his/ her family are counselled for the usage of the implantable prosthesis and medical device, including precautions if any.**	Patients were being verbally counselled for the usage of implantable prosthesis and medical devices.	**3**	An educational material could be provided to the patients for usage and precaution of implantable prosthesis.
Commitment	d	**The batch and the serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record, the master logbook and the discharge summary.**	The batch and serial number of implantable prosthesis were not being uniformly recorded.	**2**	A process to document the batch & serial number of implantable prosthesis on patient's record, discharge summary and master log book is to be developed. -The master log book is to be maintained by OT department.
Achievement	e	**Process of recall of implantable prosthesis and medical devices are handled effectively.***	No, documented policy evidenced for recall implantable prosthesis & medical devices. Implementation of the same not evidenced.	**2**	Register should be maintained for recall implantable prosthesis & medical devices. Staff needs to be trained on the same.
Average Score				**2**	
MOM.11: Medical supplies and consumables are stored appropriately and are available where required.					
Commitment	a	**The organisation adheres to the defined process for the acquisition of medical supplies and consumables.***	While a defined process for the acquisition of medical supplies and consumables exists, there was no documented policy to support it.	**2**	The organization should formulate and implement a documented policy outlining the process for acquiring medical supplies and consumables. This policy should include: Procurement procedures (vendor selection,

					ordering process), Inventory management (stock monitoring, reordering levels), Quality checks and compliance (ensuring supplies meet regulatory standards), Emergency procurement measures (handling urgent stock shortages). This will ensure standardization, transparency, and regulatory compliance in the procurement process.
Commitment	b	**Medical supplies and consumables are used in a safe manner, where appropriate.**	Medical supplies and consumables were being used in a safe manner uniformly, where appropriate.	**3**	To ensure sterility and integrity, the organization should implement standard precautions for handling opened and used items. This should include: -Proper storage of partially used consumables to prevent contamination. -Labeling of opened items with date and time to monitor usability. -Adherence to aseptic techniques while handling sterile medical supplies. -Regular training of staff on maintaining sterility and safe usage protocols.
Commitment	c	**Medical supplies and consumables are stored ina clean, safe and secure environment; and incorporating the manufacturer's recommendation(s).**	Unchained medical gas cylinders were found in various hospital areas, including the wards, ICUs, and OT, compromising patient and staff safety.	**2**	The hospital must ensure that all medical gas cylinders are properly secured with chains or appropriate holders in compliance with safety regulations. This includes: -Securing cylinders to walls or designated stands to prevent accidental falls. -Ensuring proper ventilation in storage areas to mitigate risks. -Training staff on the safe handling and storage of medical gases. -Regular monitoring and audits to ensure compliance with safety protocols.
Commitment	d	**Sound inventory control practices guides to storage of medical supplies and consumables.**	Inventory control practices were guiding the storage of medical supplies and consumables, but scientific tools for efficient inventory control were not being used.	**3**	The organization should implement scientific inventory management techniques such as: ABC Analysis; FIFO (First-In, First-Out); FSN (Fast-moving, Slow-moving, and Non-moving); Lead Time Analysis; Automated Inventory Tracking. Implementing these practices will enhance

					efficiency, reduce wastage, and ensure uninterrupted availability of critical medical supplies.
Commitment	e	**There is a mechanism in place to verify the condition of medical supplies and consumables**	There was no mechanism available to verify the condition of medical supplies and consumables.	**1**	A standardized process should be developed and implemented to verify the condition, usability, and expiration of medical supplies and consumables.
Average Score				**2.2**	
Chapter Average Score				**1.71**	
Chapter 4: Patient Rights And Education (PRE)					
PRE.1.Theorganisation protects and promotes patient and family rights and informs them about their responsibilities during care.					
Commitment	a	**Patient and family rights and responsibilities are documented, displayed and they are made aware of the same.***	Patient and family rights and responsibilities were not displayed, documented, or actively communicated.	**1**	Patient and family rights and responsibilities must be documented and prominently displayed at key locations (e.g., OPD, IPD, emergency, and waiting areas). Staff should be trained to inform patients and families about their rights during admission and consultation.
Achievement	b	**Patient and family rights and responsibilities are actively promoted.***	Patient and family rights and responsibilities were not actively promoted.	**0**	The organization should conduct awareness programs, distribute pamphlets, and use audio-visual aids to educate patients and families.
CORE	c	**The organisation's leaders protect patient and family rights.**	The organization's leaders do not have adequate measures in place to protect patient and family rights.	**2**	Leadership should actively oversee the implementation and protection of patient rights through policies and monitoring mechanisms.
CORE	d	**The organisation has a mechanism to report a violation of patient and family rights.**	There is no formal mechanism to report violations of patient and family rights.	**1**	A Documented grievance redressal mechanism should be established, including: -A dedicated helpline or complaint box. -Anonymity protection for complainants. -Clear timelines for addressing grievances. And Staff should be trained on how to handle and escalate complaints effectively.
CORE	e	**Violation of patient and family rights are monitored, analysed, and**	There was no record available to evidence the monitoring, analysis, or corrective/preventive actions	**1**	The organization should establish a structured mechanism to monitor, document, and analyze violations of patient and family rights. A Patient

		corrective/ preventive action taken by the top leadership of the organisation.	taken by the top leadership regarding violations of patient and family rights.		Rights Grievance Register must be maintained, recording violations, actions taken, and preventive measures. Regular leadership reviews should be conducted to ensure compliance and implement corrective & preventive actions (CAPA).
Average Score				**1**	
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.					
Commitment	a	**Patients and family rights include respecting Values and beliefs, any special preferences, cultural needs, and responding to requests for spiritual needs.**	Patient rights not were defined and documented to address special preferences, spiritual and cultural needs.	**2**	The patient rights document must include provisions to respect patients' values, beliefs, cultural needs, and spiritual requests. Staff should be trained to recognize and respond appropriately to these needs.
Commitment	b	**Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.**	Patient rights were not defined and documented to include respect for personal dignity and privacy during examination, procedures and treatment.	**2**	The patient rights document must include explicit provisions ensuring respect for personal dignity and privacy. Staff should be oriented and trained on maintaining these rights during patient care.
Commitment	c	**Patient and family rights include protection from neglect or abuse.**	Patient rights were not defined and documented to include protection from physical abuse or neglect.	**2**	The patient rights policy must clearly state the protection of patients from abuse and neglect, and a mechanism for reporting any such incidents should be in place.
CORE	d	**Patient and family rights include treating patient information as confidential.**	Patient rights were not defined or documented to include confidentiality of patient information.	**2**	The policy must explicitly state that patient information is confidential and can only be shared as per legal and ethical standards. Staff should be trained on data privacy regulations.
Commitment	e	**Patient and family rights include refusal of treatment.**	Patient rights were not defined or documented to include the right to refuse treatment.	**2**	Patients should be clearly informed about their right to refuse treatment, and proper documentation of refusal should be maintained.
Commitment	f	**Patient and family have a right to seek an additional opinion regarding clinical care.**	Patient rights were not defined and documented to address additional opinion regarding clinical care.	**2**	The policy should explicitly mention that patients have the right to seek a second opinion, and the process for doing so should be made transparent and accessible.
CORE	g	**Patient and family rights include informed consent before transfusion of blood and blood components,**	Patient rights were not defined or documented to include informed consent for anesthesia, blood and	**2**	The policy should mandate informed consent before any anesthesia, blood transfusion, surgery, research participation, or

		anesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures/ treatment.	blood product transfusions, invasive/high-risk procedures, and treatment. Uniform assessment was not observed.		invasive/high-risk procedures. Staff should ensure uniform compliance with this process.
Commitment	h	**Patient and family rights include right to complain and information on how to voice a complaint.**	Patient rights were not defined or documented to include how to voice a complaint, and no visible display of complaint mechanisms was observed.	**2**	The hospital must define, document, and display the complaint process at prominent locations. Patients should be informed about their right to file a complaint and the process for redressal.
Commitment	i	**Patient and family rights include information on the expected cost of the treatment.**	Patient rights were not defined or documented to include information on the expected cost of treatment, and this was not provided in all cases.	**2**	The hospital should ensure that cost estimates are clearly communicated to patients before treatment and documented as part of the informed consent process.
Commitment	j	**Patients & family rights include access to their clinical records.**	Patient rights were not defined and documented to include access to their clinical records.	**2**	Patients should have the right to access their clinical records, and a structured process should be established for them to request and receive their records in a timely manner.
Commitment	k	**Patient and family rights include information on the name of the treating doctor, care plan, progress and information on their health care needs.**	Patient rights were not defined or documented to include information on the treating doctor, care plan, progress, and healthcare needs.	**2**	The hospital should ensure that patients receive clear and timely information about their care plan, treating physician, and progress. Staff should be trained to regularly update patients and their families.
Achievement	l	**Patient rights include determining what information regarding their care would be provided to self and family.**	Patient rights were not defined or documented to include the right to determine what medical information is shared with self or family.	**2**	Patients should have the right to decide what health information is shared with family members, and this should be documented in the patient rights policy. Consent protocols should be in place to respect patient confidentiality and autonomy.
Average Score				**1.83**	
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.					
CORE	a	**The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits, excepted results and possible complications.**	There was no uniform evidence in medical records that the patient and/or family members were being explained about the proposed care, risks, alternatives, benefits, expected results, and possible	**2**	A structured documentation process should be implemented to ensure that the discussion on proposed care, risks, alternatives, and benefits is recorded in the medical file. And a standardized consent form or checklist should be used to capture this discussion, ensuring

			complications.		uniformity and compliance.
Achievement	b	**The care plan is prepared and modified in consultation with patient and/or family members.**	While the patient and/or family members were being explained about the expected results, documentation of the discussion was not evident.	**3**	The care plan must be documented in the patient record, including modifications made after consultation with the patient and/or family.
Commitment	c	**The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.**	The patient and/or family members were informed about the results of diagnostic tests and the diagnosis, and compliance was evidenced.	**4**	Continue ensuring that test results and diagnoses are communicated clearly and promptly to patients and families. Also maintain written documentation in medical records as evidence of communication
Commitment	d	**The patient and/ or family members are explained about any changes in patient condition in timely manner.**	Changes in patient condition were verbally communicated to the patient and/or family in a timely manner, but no written documentation was evident.	**2**	A structured format or progress notes should be used to ensure timely and consistent documentation of such updates.
Achievement	e	**The patient and/or family members are provided multi-disciplinary counselling when appropriate.**	Multi-disciplinary counseling was provided verbally, but no written documentation was evident.	**2**	A documentation protocol should be implemented to record all multi-disciplinary counseling sessions in the patient's medical record. Or A standardized counseling form should be developed to capture date, specialists involved, discussion points, and patient/family feedback to ensure comprehensive documentation.
Average Score				**2.6**	
PRE.4: Informed consent is obtained from the patient or family about their care.					
CORE	a	**The organisation obtains informed consent from the patient or family for situations where informed consent is required.***	The organisation obtains informed consent from the patient or family for situations where informed consent is required but no standard form is present.	**3**	The standard form of informed consent should be formulated and implemented.

Commitment	b	**Informed consent process adheres to statutory norms.**	Not evidenced the proper Informed consent process adheres that to statutory norms.	**1**	There should be a proper documented process for informed consent in consideration with the statuary norms.
CORE	c	**Informed consent includes information regarding the procedure; it's risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.**	The existing informed consent form does not include the proper mannar of information regarding the procedure; its risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.	**2**	The updation of the existing informed consent form need to formulate in which the required information regarding the procedure should include its risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.
Commitment	d	**The organisation describes who can give consent when a patient is incapable of independent decision making and implements the same.***	No documented record / policy was evident regarding who can give consent when a patient is incapable of independent decision making and implements the same.	**1**	A documented policy should be formulated that describes who can give consent when a patient is incapable of independent decision making in the organisation and implements the same.
CORE	e	**Informed consent is taken by the person performing the procedure.**	It was evident that some of the consents were taken by the person performing the procedure.	**2**	The proper documented policy need to formulate for taking appropriate manner informed consent forms, especially for the performing procedures.
Average Score				**1.8**	
PRE.5: Patient and families have a right to information and education about their healthcare needs.					
CORE	a	**Patient and/or family are educated in a language and format they can understand.**	It was evidenced that Patient and/or family were educated in a language and format they can understand. However the documentation of the same could not be evidenced uniformly.	**3**	The counselling done should be documented & use of printouts, audio/video aids should be used to educate the patients & /or family.
Commitment	b	**Patient and families are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.**	No practice of patient and family's education was evidenced to educate about the safe and effective use of medication and the potential side effects of the medication.	**2**	Patient and families are to be educated about the safe and effective use of medication and the potential side effects of the medication. Educational brochures could be made for the same.
Commitment	c	**Patient and/or family are educated about food-drug interaction.**	No practice was evidenced for educating patient and families about food-drug interaction.	**1**	Patient and families should be educated about food-drug interaction through some educational brochures.

Commitment	d	**Patient and/or family are educated about diet and nutrition.**	The practice was evidenced for educating patient and families about diet and nutrition.	**3**	Brochures to guide the patients/relatives about diet requirement can be used and patient and families to be educated about diet and nutrition.
Commitment	e	**Patient and/or family are educated about immunizations.**	The practice was evidenced for educating patient and families about immunization.	**5**	Ensure the Sustenance
Commitment	f	**Patients &/or family are educated on various pain management techniques, when appropriate.**	The practices were evidenced for educating the Patients &/or family on various pain management techniques	**5**	Ensure the Sustenance
Commitment	g	**Patient and/or family are educated about their specific disease process, complications and prevention strategies.**	Practice was evidenced for educating patient and families about diet and nutrition, specific disease process, complications and prevention strategies and about preventing healthcare associated infections., when appropriate, However, there was a lack of evidences.	**3**	Patient and families are educated about their specific disease process, complications and prevention strategies. Brochure or informative display, leaflets & videos could be made for the same.
Commitment	h	**Patient and/or family are educated about preventing healthcare associated infections.**	Although patient and families were educated about preventing healthcare associated infections. Lacks of evidences were observed about preventing healthcare associated infections.	**3**	This could be done through the educational display in the ward about preventing healthcare associated infections. (e.g, Hand washing, avoiding overcrowding near patient.)
Achievement	i	**The patients and/or family members' special educational needs are identified and addressed.**	The patients and/or family members' special educational needs are identified and addressed. However, lack of evidences was observed.	**3**	Patients and family are taught in a language and format that they can understand. This can be included in the patient education policy.
Excellence	j	**The organisation has a mechanism to promote patient engagement to enhance clinical outcomes, safety and quality.**	There is no such mechanism evidenced regarding patient engagement to enhance clinical outcomes, safety and quality	**1**	There should be a documented formed mechanismto promote patient engagement to enhance clinical outcomes, safety and quality.
Average Score				**2.9**	
PRE.6: Patients and families have a right to information on expected costs.					

CORE	a	**The patient and / or family members are made aware of the pricing policy in different settings (out-patient, emergency, ICU and In-patient).**	Written tariffs were available for various procedures in the hospital. However, the policy for the same could not be evidenced.	**3**	A written pricing policy and updated tariffs should be developed.
Commitment	b	**The relevant tariff list is available to patients.**	The tariff list was available for patients and the same was being verbally explained.	**4**	The tariff list should be displayed and to be made available for patients.
Commitment	c	**The patient and /or family members are explained about the expected costs.**	The policy was not defined. The patients and family were not educated about the estimated cost of treatment documentation could not be evidenced.	**3**	All patients should be explained and educated on the expected cost of treatment. The same should be documented.
Commitment	d	**Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.**	Though the patients and family are educated about the financial implications when there is a change in the patient condition or treatment setting however documentation of the same could not be evidenced.	**3**	A standardised process to be developed and documented. Documentation of the same to be ensured for all such cases.
Average Score				**3.25**	
PRE.7: The organisation has a mechanism to capture patient's feedback and redressal of complaints.					
Commitment	a	**The organisation has a mechanism to capture feedbacks from patients which includes patient satisfaction and patient's experience.**	The hospital does not have a mechanism to capture feedbacks from patients which includes patient satisfaction and patient's Experience.	**3**	Feedback forms should be developed for both in patient's out-patients separately.
Achievement	b	**The organisation has a mechanism to capture patient experience.**		**3**	
CORE	c	**The organisation redress patient complaints as per the defined mechanism.***	No, defined mechanism was evidenced.	**2**	The written guidance should be incorporate the mechanism for lodging complaint (including verbale or telephonic complaints), method of compiling then, analyzing complaints including the time frame, the person(s) responsible & documenting the action taken.
Commitment	d	**Patient and/or family members are made aware of the procedure for giving feedback and /or lodging complaints.**	The patients and /or family members were not aware of the procedure for lodging complaints.	**2**	Process of lodging complaints and suggestion needs to be defined and displayed at prominent locations of the hospital.

Commitment	e	**Feedback and complaints are reviewed and/or analysed within a defined timeframe.**	No mechanism was available to review and analyze complaint for corrective and preventive actions.	**1**	All patient complaints should be reviewed, analysed resulting in a corrective and preventive actions.
Commitment	f	**Corrective and/or preventive action(s) are taken basedon the analysis where appropriate.**	No mechanism was available to review and analyze complaint for corrective and preventive actions.	**1**	Corrective and /or preventive actions should be taken based on the analysis where appropriate.
Average Score				**02**	
PRE.8: The organisation has a system for effective communication with patients and / or families.					
Commitment	a	**Communication with the patients and/or families is done effectively.***	No, Documented policy was evidenced to guide the effective communication with the patients and/or families. The implementation of the same could not be evidenced, as none of the staffs were trained in patients' rights & responsibility.	**3**	A documented policy needs to be developed to guide the effective communication with the patients and families. Training of the staff needs to be done in an effective manner.
Commitment	b	**The organisation shall identify special situations where enhanced communication would be required.***	Special situations where enhanced communication would be required has been identified and defined. The implementation of the same could not be evidenced, as none of the staffs were aware about the policy.	**3**	This policy needs to incorporate the situation where enhanced communication is required &implemented.
Commitment	c	**Enhanced communication with the patients and / or families is done effectively.***	No, Documented policy was evidenced to guide the effective communication with the patients and/or families. The implementation of the same could not be evidenced, as none of the staffs were trained on the same.	**2**	Approach for effective communication in such identified situations needs to be defined in the policy& implemented.
Commitment	d	**The organisation ensures that there is no unacceptable communication.**	No, Documented policy was evidenced to define unacceptable communications. Training of staff could not be evidenced.	**2**	Constitute unacceptable communication needs to be defined in the policy.
Achievement	e	**The organisation has a system to monitor andreview the implementation of effective communication.**	The organisation has no appropriate system to monitor & review the implementation of effective communication; however it was not	**2**	A process needs to be developed to monitor and review the policy on effective communication. Feedback from patients & other stakeholders.

			done uniformly across the hospital.		
Average Score				**2.4**	
Total Chapter Average Score				**2.22**	
Chapter 5: Infection Prevention and Control (IPC)					
IPC.1: The organisation has a comprehensive and coordinated Infection Prevention and Control (IPC) programme aimed at reducing/ eliminating risks to patients, visitors, providers of care and community.					
CORE	a	**The Infection Prevention and Control (IPC) programme is documented, which aims at preventing and reducing the risk of healthcare associated infections in the hospital.***	It was evidenced that the hospital has a documented Infection Prevention and Control (IPC) program in place, focusing on the prevention and reduction of the risk of healthcare-associated infections (HAIs).	**4**	It is evidenced that the hospital has a documented Infection Prevention and Control (IPC) program in place, focusing on the prevention and reduction of healthcare-associated infection risks. To ensure its effectiveness, the hospital should regularly review and update the IPC program, conduct periodic training sessions for staff, and implement a robust monitoring mechanism to assess compliance with infection control protocols.
Commitment	b	**The infection prevention and control programmeidentifies high-risk activities, and has written guidance to prevent and manage infections for these activities. ***	It was evidenced that the infection prevention and control program identifies high-risk activities and has written guidelines in place to prevent and manage infections associated with these activities.	**4**	The infection prevention and control program continue to identify high-risk activities and ensure the availability of written guidance to prevent and manage infections associated with these activities. Regular review and updates of these guidelines should be conducted based on audit findings and emerging infection control practices.
Commitment	c	**The infection prevention and control programmeis reviewed and updated at least once a year.**	It was infection prevention and control programme is reviewed and updated at least once a year.	**5**	Ensure Sustenance.
Achievement	d	**The infection prevention and control programmeis reviewed based on infection prevention control assessment tool.**	The infection prevention and control program is in place; however, its review using the Infection Prevention Control Assessment Tool is not consistently documented. There is partial compliance with periodic assessments, and opportunities for improvement exist in ensuring structured evaluations,	**3**	The hospital to ensure the structured and consistent review of the infection prevention and control program using the Infection Prevention Control Assessment Tool. The assessment should be documented, and findings should be analyzed to identify gaps. Corrective and preventive actions should be implemented, and periodic reviews should be conducted to enhance compliance and

			documentation, and implementation of corrective actions based on assessment findings.		effectiveness.
Commitment	e	**The organisation has a multi-disciplinary infection prevention and control committee, which co-ordinates all infection prevention and control activities.***	The hospital has multi- disciplinary infection control committee, which could coordinate and implement infection prevention and control activities.	**4**	The hospital to ensure that multidisciplinary Infection Control Committee to coordinate and implement infection prevention and control activities, develop policies, monitor infection trends, and ensure effective measures are in place. The committee should also meet at a defined frequency and document the minutes of each meeting.
Commitment	f	**The organisation has an infection control team, which coordinates implementation of all infection prevention and control activities.***	During the gap assessment, infection control team was available.	**5**	The hospital has a define an Infection Control Team, including the ICCO and ICNs, responsible for monitoring infection control practices through daily rounds, audits, and activities across various areas of the hospital.
Commitment	g	**The Organisation has designated infection control officer as part of the infection prevention and control team.***	During the gap assessment, five infection control nurses and the microbiologist (ICCO) were present to ensure the monitoring of infection control practices and conduct audits throughout the hospital.	**5**	The hospital should ensure continuous monitoring of infection control practices by strengthening the role of Infection Control Nurses (ICNs) with link nurses and the Microbiologist (ICCO). Regular infection control audits should be conducted, documented, and reviewed to identify gaps and implement corrective actions. Additionally, training sessions should be organized to enhance staff awareness and compliance with infection prevention protocols.
Commitment	h	**The organisation has designated infection prevention and control nurse(s) as part of the infection control team.***		**5**	
Commitment	i	**The organisation implements information, education and communication programme for infection prevention and control activities for the community.**	It was evidenced that infection prevention and control activities for the community were implemented uniformly. The organization has a structured Information, Education, and Communication (IEC) program in place to promote infection prevention and control measures within the community.	**4**	Ensure the uniform implementation of infection prevention and control (IPC) activities for the community. Regular Information, Education, and Communication (IEC) programs should be conducted to raise awareness and promote best practices. These activities should be systematically documented, periodically reviewed for effectiveness, and tailored to address the specific infection control needs of the community.

Commitment	j	**The organisation participates in managing community outbreaks.**	It was evidenced that a documented procedure is in place for identifying and handling an outbreak of infection.	**4**	The hospital should ensure the effective implementation of a documented procedure for identifying and managing infection outbreaks. This includes establishing a clear protocol for outbreak detection, reporting, containment, and corrective measures. Regular drills, staff training, and periodic reviews should be conducted to assess the effectiveness of the outbreak management plan and ensure compliance with infection control guidelines.
Average Score				**4.3**	
IPC.2: The organisation provides adequate and appropriate resources for infection prevention and control.					
CORE	a	**The management makes available resources required for the infection prevention and control programme including allocation of adequate funds from its annual budget.**	Partial compliance with the use of personal protective equipment (PPE), including gloves, masks, eye protection, and other protective gear, was observed among hospital staff. Additionally, there was an insufficiency of resources, such as PPE and hand hygiene facilities, in the Biomedical Waste (BMW) management area. The central BMW collection area was also without gumboots. Furthermore, the organization had not defined a specific budgetary provision for infection control activities. All expenses related to infection control were being covered under the common hospital budget, rather than through a dedicated budget for these critical activities.	**3**	The hospital should enhance compliance with the use of personal protective equipment (PPE) by conducting regular training sessions and awareness programs for staff and implementing strict monitoring mechanisms. Adequate resources, including sufficient PPE, hand hygiene facilities, and protective gear such as gumboots, should be provided in all areas, especially in the Biomedical Waste (BMW) management area and kitchen. The organization should establish a dedicated budget for infection control activities to ensure sufficient funding for essential resources and related expenses. Additionally, a system for regular audits and inspections should be implemented, with active involvement from the infection control team to monitor and address gaps in infection control practices.
Commitment	b	**Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.**	It was observed that compliance with the use of PPE and soaps was low among hospital staff.	**2**	The hospital should ensure the provision of adequate and appropriate hand hygiene facilities in all patient-care areas to guarantee accessibility for healthcare providers.

CORE	c	**Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.**	Low compliance to use of PPEs, soaps was observed in the hospital.	**2**	The hospital should ensure adequate availability of PPE and handwashing items throughout the facility. Staff should be educated on the correct use of PPE through regular training sessions. Additionally, hand wash disinfectant must be provided at every handwashing facility across the hospital to promote effective hand hygiene.
Commitment	d	**Isolation/ barrier nursing facilities are available.**	The isolation rooms in hospital were not available with the recommended guidelines.	**1**	An Isolation facility needs to be designed as perthe recommended guidelines of NABH and negative pressure is to be maintained.
Average Score				**1.75**	
IPC 3: The organization implements the infection prevention and control processes in clinical areas.					
CORE	a	**The organisation adheres to standard precautions at all times.***	Documented standard precaution adheres to infection prevention and control practices could not be evidenced.	**1**	The organisation should adhere to standard precautions in every area of the organization & it should be implemented & communicated to the staffs.
CORE	b	**The organisation adheres to hand-hygiene guidelines.***	The compliance to the handhygiene was not being monitored uniformly. Hand wash technique poster was not displayed uniformly in any of the hand hygiene facility.	**3**	Display of hand wash technique should be done each hand wash facility to make staff aware of the hand hygiene techniques. Monitoring of hand hygiene compliance is to be done for various categories of staff.
Commitment	c	**The organisation adheres to transmission-based precautions.***	The policy and procedure for transmission-based precautions, including droplet and contact modes of transmission, was documented.	**4**	The hospital ensures the effective implementation of the documented policy and procedure on transmission-based precautions, including droplet and contact modes of transmission. Regular staff training, periodic audits, and adherence monitoring should be conducted to reinforce compliance. Additionally, updates to the policy should be made as per evolving infection control guidelines and best practices.
CORE	d	**The organisation adheres to safe injection and infusion practices.***	The documented safe injection & infusion practice was evidenced.	**4**	Training on safe injection & infusion practices should be provided to the staff. Adherence of the same should be monitored and documented.

Commitment	e	**Appropriate antimicrobial usage policy is established and documented***	No documented Antibiotic policy evidenced.	**2**	A documented Antibiotic policy needs to be developed and implemented within the hospital.
CORE	f	**The organisation implements the antimicrobial stewardship programme and monitors the use of antimicrobial agents.**	No evidence was found of the implementation of an antibiotic stewardship programme.	**2**	The organization should implement an antibiotic stewardship program to promote the appropriate and necessary use of antibiotics. This program should encompass key components such as leadership commitment, clear accountability, drug expertise, targeted actions, regular tracking, transparent reporting, and comprehensive education for staff.
Average Score				**1.6**	
IPC.4: The organisation implements the infection prevention and control processes in support services.					
Commitment	a	**The organisation has appropriate engineering controls to prevent infections.***	No, written policy on engineering controls for prevention of infection was evidenced.	**1**	The organization needs to document the processof engineering controls to prevent infections. Implementation of the same to be ensured.
Commitment	b	**The organisation designs and implements a plan to reduce therisk of infectionduring construction and renovation.***	No plan was designed and implemented to reduce the risk of infection during construction and renovation.	**1**	The organization needs to design and implements a plan to reduce the risk of infection during construction and renovation.
CORE	c	**The organisation adheres to housekeeping procedures.***	A written housekeeping procedure was available. It was observed that housekeeping staff was handling BMW without PPE.	**3**	The hospital ensure strict adherence to the written housekeeping procedure, particularly regarding Biomedical Waste (BMW) handling. Housekeeping staff should be provided with appropriate Personal Protective Equipment (PPE) and trained on its mandatory use. Regular monitoring and audits should be conducted to ensure compliance, and corrective actions should be taken for any deviations.
CORE	d	**Biomedical waste (BMW) is handled appropriately and safely.**	The proper separation of biomedical waste as per color coding was evidenced in Central biomedical waste area. But Entry restriction with barricading could not be evidenced in central biomedical storage area.	**3**	The hospital ensures proper entry restriction and barricading of the central biomedical waste storage area to prevent unauthorized access and enhance safety. Clear signage, physical barriers, and restricted access protocols should be implemented in compliance with biomedical waste management guidelines. Regular

					monitoring should be conducted to ensure adherence to these safety measures.
Commitment	e	**The organisation adheres to laundry and linen management processes.***	Documented policies with written processes for laundry and linen management were evident. However, despite the existence of these processes, they were not being followed. During the assessment, it was observed that the transportation of soiled linen was not being carried out in an appropriate manner.	**3**	The hospital should ensure strict adherence to the documented laundry and linen management processes. Soiled linen must be transported in designated, closed trolleys to prevent contamination. Additionally, clear segregation should be maintained, with separate washing, drying, and storage areas for hospital and staff linen. Regular monitoring, staff training, and compliance audits should be conducted to reinforce infection control practices.
Commitment	f	**The organisation adheres to kitchen sanitation and food-handling issues.***	There were no written documented processes available for kitchen sanitation and food handling procedures.	**3**	The organization should develop written processes for kitchen sanitation and food handling, train staff accordingly, and conduct regular audits to ensure compliance.
Average Score				**2.3**	
IPC.5: The organisation takes actions to prevent healthcare associated infections (HAI) in patients.					
Commitment	a	**The organisation takes action to prevent catheter-associated urinary tract Infections.**	Appropriate monitoring of the Urinary Tract Infection rate could not be evidenced.	**2**	The Urinary Tract Infection rates should be monitored and calculated at defined periodicity.
Commitment	b	**The organisation takes action to prevent infection- related ventilator associated complication/ ventilator-associated pneumonia.**	Appropriate monitoring of the Ventilator Associated Pneumonia Rate could not be evidenced.	**2**	The Ventilator Associated Pneumonia Rate should be monitored and calculated at defined periodicity.
Commitment	c	**The organisation takes action to prevent catheter linked blood stream infections.**	Appropriate Monitoring of catheter linked blood stream infections could not be evidenced.	**2**	The catheter-related infections should be tracked and analyzed to calculate the infection rates.
Commitment	d	**The organisation takes action to prevent Surgical site infections.**	Appropriate Monitoring of Surgical Site Infection Rate could not be evidenced.	**2**	Surgical site infections should be tracked and analyzed regularly to calculate infection rates and identify trends.
Average Score				**02**	
IPC.6: The organisation performs surveillance to capture and monitor infection prevention and control data.					

CORE	a	**The scope of surveillance incorporates tracking and analysing of infection risks, rates and trends.**	The scope of surveillance includes tracking and analyzing infection risks, rates, and trends, with regular data verification by the infection control team. However, the identification of high-risk areas is only partial, leading to gaps in targeted infection control measures. While surveillance is directed towards identified high-risk activities, opportunities for improvement exist in ensuring comprehensive identification of all high-risk areas and the consistent implementation of appropriate surveillance activities.	**3**	The hospital should ensure the comprehensive identification of all high-risk areas and implement a structured surveillance plan. Appropriate surveillance activities should be systematically planned and consistently implemented to cover all potential infection risks. Regular data verification by the infection control team should be complemented with in-depth analysis to identify trends and areas requiring intervention. Additionally, staff training and periodic audits should be conducted to enhance compliance with surveillance protocols.
Commitment	b	**Verification of data is done regularly by the infection control team.**		**2**	
Commitment	c	**Surveillance is directed towards the identified high-risk activities.**		**2**	
CORE	d	**Surveillance includes monitoring compliance with hand-hygiene guidelines.**	Partially Surveillance for monitoring compliance with hand hygiene was evidenced. However, in many areas, handwash technique posters were not displayed at hand hygiene facilities, limiting visual guidance for staff and visitors.	**3**	Display of hand wash technique should be done near each hand wash facility to make staff aware about the hand hygiene techniques. Proper Monitoring of hand hygiene compliance is to be done for various categories of staff.
Achievement	e	**Surveillance includes mechanisms to capture the occurrence of multi-drug-resistant organisms and highly virulent infections.**	Partial infection control surveillance was conducted to monitor the occurrence of epidemiologically significant diseases, multidrug-resistant organisms, and highly virulent infections.	**3**	The organization should ensure that pain screening, detailed assessment, and periodic reassessment are conducted uniformly for all patients. A documented policy should be developed outlining standardized procedures for pain screening by nurses and comprehensive assessment by doctors. Additionally, pain alleviation measures or medications should be initiated and titrated according to the patient's needs and responses. Regular training and audits should be conducted to ensure adherence to these guidelines.

CORE	f	**Surveillance includes monitoring the effectiveness of housekeeping services.**	The surveillance of monitoring the effectiveness of housekeeping services was being conducted but not done uniformly.	**2**	The infection control surveillance activities should incorporate the monitoring of effectiveness of housekeeping services. Need to strengthen the audits.
Commitment	g	**Feedback regarding surveillance data is provided regularly to the appropriate healthcare provider.**	Mechanism of providing feedback to concerned staff could be evidenced among all staffs.	**2**	The Hospital acquired infection rates needs to be monitored and it shall be disseminated to the doctors and the nurses periodically.
Commitment	h	**The organisation identifies and takes appropriate action to control outbreaks of infections.**	Documented procedures to identify and handle an outbreak of infection were not evident. The implementation of the same could not be evidenced.	**2**	Organisation should have a documented procedure for identifying and handling of an outbreak situation. The procedure of handling outbreaks will also include the prevention of such situation in future. Implementation of the same needs to be ensured during a situation of an infection outbreak. Organisation participates in managing community outbreaks.
Commitment	i	**Surveillance data is analysed and appropriate corrective and preventive actions are taken.**	No, appropriate corrective and preventive actions was evidenced.	**2**	Surveillance data needs to be analysed, and appropriate corrective and preventive actions are taken.
Average Score				**2.3**	
IPC.7: Infection prevention measures include sterilisation and/ or disinfection of instruments, equipment and devices.					
Commitment	a	**The organisation provides adequate space and appropriate zoning for sterilization activities.**	Though the appropriate & adequate space and appropriate zoning available. However, the cris crossing of activities were observed during the gap assessment.	**2**	The sterile storage area requires the following criteria to be met: • Dedicated for the intended purpose only for Sterile reprocessed stock and Sterile consumable/pre- packaged stock • A dedicated area to remove transportation packaging & boxes of stock prior to entering sterile stock storage area. • Controlled to prevent contamination of sterile stock • Free of dust, insects' vermin • Protected from direct sunlight • Temperature range between 18 – 22 degrees Celsius Relative Humidity range between 35% –68%

CORE	b	**Cleaning, packing, disinfection and/or sterilisation, storing and the issue of items is done as per the written guidance.***	No proper documented procedure guiding the cleaning, packing, disinfection and/or sterilisation, storing & issue of items was available in the hospital.	**2**	Documented procedure addressing the cleaning, packing, disinfection and/or sterilisation, storing & issue of items to be developed & implemented.
Commitment	c	**Reprocessing of instruments, equipment and devices are done as per written guidance.***	No, policy and procedure on reprocessing of instruments & equipment was evident.	**2**	Documented policy and procedure for reprocessing of instruments & equipment should be developed and implemented.
Commitment	d	**Regular validation tests for sterilisation are carried out and documented.***	No record was evidenced of regular validation tests for sterilization.	**1**	The validation tests/indicators for each sterilizer need to be done and its results should be kept for record. A retention policy is to be developed to define the time period for retention of such records.
Commitment	e	**The established recall procedure is implemented when a breakdown in the sterilisation system is identified.***	No, documented policy & procedure on the sterilized (issued) item recall was evident the same is not being followed in the hospital.	**1**	A recall procedure of sterilized (issued) itemsneeds to be developed which addresses identification of breakdown of sterilization system.
Average Score				**1.6**	
IPC.8: The organisation takes action to prevent or reduce healthcare associated infections in its staff.					
Commitment	a	**The organisation implements occupational health and safety practices as per written guidance to reduce the risk of transmitting microorganisms among healthcare providers.**	There was inadequate implementation of occupational health and safety practices to mitigate the risk of microorganism transmission among healthcare providers.	**2**	The healthcare facility should strengthen occupational health and safety protocols by ensuring adherence to infection prevention and control (IPC) measures. This includes: ▪ **Standard Precautions:** Enforcing hand hygiene, use of personal protective equipment (PPE), safe injection practices, and proper handling of contaminated materials. ▪ **Immunization:** Ensuring healthcare workers receive recommended vaccinations, including Hepatitis B and influenza. ▪ **Workplace Safety Training:** Conducting regular training on biosafety, handling of sharps, and post-exposure prophylaxis (PEP) protocols. ▪ **Monitoring and Compliance:** Implementing routine audits and compliance checks to

					assess adherence to safety guidelines. ▪ **Provision of Safety Equipment:** Ensuring availability of PPE, disinfectants, and biomedical waste disposal facilities to minimize exposure risks.
Commitment	b	**The organisation implements an immunisation policy for its staff.***	No, documented policy was evidenced to implements an immunisation for its staff.	**2**	The organizations immunization policy for its staff should be in consonance with the available evidence & all staff shall be immunized.
Achievement	c	**The organisation implements work restrictions for health care providers with transmissible infections.**	The proper work restrictions were not implemented to prevent the transmissible infections.	**1**	The organisation should implement work restrictions for health care providers with transmissible infections.
Commitment	d	**The organisation implements measures for blood and bodyfluid exposure prevention.**	During the assessment it was observed that use of appropriate PPE to prevent blood & body fluid exposure were not followed.	**2**	The organisation should ensure the healthcare providers use appropriate personnel protective equipment to prevent blood body fluid exposure. & The organisation should strive to eliminate the use of needle devices wherever safe & effective alternatives are available.
Commitment	e	**Appropriate post-exposure prophylaxis is provided to all staff members concerned.***	Protocol for appropriate pre & post – exposure prophylaxis was not available, however not all staffs were about the same.	**2**	The staff involved in patient care and handling biomedical waste should be vaccinated as per documented pre- and post-exposure prophylaxis protocol. A protocol on the same should be developed and disseminated to the staff.
Average Score				**1.8**	
Chapter Average Score				**2.20**	
Chapter.7: Patient Safety&Quality Improvement (PSQ)					
PSQ.1: The organisation implements a structured patient-safety programme.					
CORE	a	**The patient-safety programme is developed, implemented and maintained by a multi-disciplinary safety committee.***	Patient safety committee has not been formed & documented patient safety programme was not evidenced, Therefore, The implementation of the same could not be evidenced.	**1**	A multi-disciplinary committee needs to be formulated. The committee needs to ensure documentation and implementation the patient- safety programme. Patient-safety programme needs to be developed and documented & implemented.

Commitment	b	**The patient-safety programme is comprehensive and covers all the major elements related to patient safety.**	Documented patient safety programme was not evident to address major elements related to patient safety & risk management.	**1**	Patient-safety programme needs to be developed covering major elements related to patient safety & risk management. The implementation of the same need to be done across the hospital.
Commitment	c	**The programme covers incidents ranging from"noharm"to"sentinel events".**	The dissemination of the same could not be evidenced.	**1**	Patient-safety programme needs to be developed addressing the description of adverse events ranging from “no harm” to “sentinel events. Same needs to be communicated to all.
Commitment	d	**Designated patient safety officer(s) coordinates implementation of the patient safety programme.**	There was no designated ndividual for coordination & implementation of the programme.	**1**	A patient Safety Officer is to be designated for implementation of patient safety programme.
Commitment	e	**The organisation performs proactive analysis of Patient safety risks and makes improvements accordingly.**	No patient safety risks management activities were being performed in the hospital as no patient safety risk management plan was documented.	**1**	A patient safety risk management activity whichincludes risk identification, prioritization and alleviation should be done using tools like HIRA (Hazard identification and risk analysis), FMEA (Failure modes and effects analysis). A patient safety risk management plan needs to be documented.
Commitment	f	**The patient-safety programme is reviewed and updated at least once a year.**	No, documented patient safety programme was evident. Feedback mechanism could not be evidenced.	**2**	A quality improvement programme needs to be documented and is to be reviewed by quality improvement committee. The review should be based on periodic audits and feedbacks.
CORE	g	**The organisation adapts and implements National / international patient-safety goals / solutions / framework.**	The organization has adopted the national/ International Patient Safety Goals. The implementation of the same could not be evidenced uniformly across the hospital.	**2**	Patient-safety program needs to incorporate the International Patient Safety Goals and the same needs to be implemented uniformly in the organization.
Average Score				**1.2**	
PSQ.2: The organisation implements a structured quality improvement and continuous monitoring programme.					
CORE	a	**The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.***	Multidisciplinary committee has not been formed & documented patient safety programme.	**2**	A multi-disciplinary committee needs to be formulated. The committee needs to ensure documentation and implementation the patient- safety programme. Patient-safety programme needs to be

					developed and documented & implemented.
Commitment	b	**The quality improvement programme is comprehensive and covers all the major elements related to quality assurance.***	No, quality improvement programme is comprehensive and covers all the major elements relating to the quality assurance of various department were documented.	**2**	A comprehensive hospital wide quality improvement programme should be documented and implemented to ensure quality assurance. A quality improvement activity includes data collection, indicators, frequency of mock drills, audits, committees, policies and implementation of CAPA.
Excellence	c	**The quality improvement programme improves process efficiency and effectiveness.**	No, quality improvement program documented in the organization. The impact of the managerial process innovation to improve patient safety, improve care delivery, to reduce costs, to introduce environmentally–friend measures, etc. could not be evidenced.	**2**	Quality improvement programme is to be documented which promotes and demonstrate the use of innovations to improve the processes.
Excellence	d	**The quality improvement programme focuses on appropriateness of clinical care.**	No, quality improvement programme documented on clinical care in the organisation.	**1**	The organization should implement a Quality Improvement program involving doctors and nurses in utilization reviews, focusing on the appropriateness of length of stay, procedures, investigations, and treatments.
Commitment	e	**There is a designated individual for coordinating and implementing the quality improvement programme. ***	The hospital has designated individual to guide on implementation of hospitals quality improvement programme.	**4**	The hospital should designate an individual and a team, such as quality champions, with the requisite qualifications and experience to coordinate and implement the quality improvement program. The designated person should be well-versed in accreditation standards and capable of explaining their implementation. They should also undergo structured training on the NABH program, including standards, statutory requirements, hospital quality improvement principles, evaluation methodologies, and hospital operations.
Commitment	f	**The quality improvement programme identifies opportunities**	The quality improvement programme was documented but no	**2**	A quality improvement programme needs to bedocumented and is to be reviewed by quality

		for improvement based on there view at pre-defined intervals. *	mechanism for periodic review was evidenced.		improvement committee. The review should be based on periodic audits and analysis.
Commitment	g	**The quality improvement programme is reviewed and updated at least once a year.**	No, quality improvement programme was documented.	**2**	A quality improvement programme needs to be documented and is to be reviewed by quality improvement committee. The review should be based on periodic audits and feedbacks.
Commitment	h	**Audits are conducted at regular intervals as a means of continuous monitoring.***	No audits were being conducted for continuous monitoring.	**1**	Audits should be conducted by a multi-disciplinary team at regular intervals as a means of continuous monitoring.
CORE	i	**There is an established process in the organisation to monitor and improve the quality of nursing care.***	There was no documented process evidenced in the organization to monitor & improve quality of nursing care.	**1**	The organization needs to monitor & improve quality of nursing & complete patient care. Clinical and nursing audits can be conducted for the same.
Average Score				**1.8**	
PSQ.3: The organisation identifies key indicators to monitor the structures, processes and outcomes, which are used as tools for continual improvement.					
Commitment	a	**The organisation identifies and monitor's key indicators to oversee the clinical structures, processes and outcomes.**	Records pertaining to the monitoring of key indicators used to oversee clinical structures, processes, and outcomes were not available.	**1**	The hospital needs to establish a system to regularly monitor key indicators related to clinical structures, processes, and outcomes. Proper documentation of these indicators should be maintained to ensure effective oversight and continuous improvement.
CORE	b	**The organisation identifies and monitors the key indicators to oversee infection prevention and control activities.**	Appropriate record pertaining to infection control activities could not be evidenced during the assessment.	**1**	The hospital maintains proper records of all infection control activities, ensuring they are documented systematically and made readily available for review and assessment.
Commitment	c	**The organisation identifies and monitor's key indicators to oversee the managerial structures, processes and outcomes.**	Record pertaining to themonitoring of key indicators to oversee the managerial structures, processes and outcomes could not be evidenced during the assessment.	**1**	The monitoring should be done as per the NABH mandatory indicators. -Indicators like: Utilization rates, satisfaction rate, waiting rate etc.
CORE	d	**The organisation identifies and monitors key indicators to oversee patient safety activities.**	Proper record pertaining to the monitoring of key indicators to oversee the patient safety activities could not be evidenced during the assessment.	**1**	It is mandatory to monitoring and be conducted in accordance with the NABH mandatory indicators to ensure compliance with accreditation standards and facilitate continuous improvement in infection control practices.

Commitment	e	**Verification of data is done regularly by the quality team.**	The verification could not be assessed during the assessment.	**1**	Data of quality indicators needs to be captured and verification by the quality team.
Commitment	f	**There is a mechanism for analysis of data which results in identifying opportunities for improvement.**	Mechanism for analysis of data and benchmarks for quality indicators could not be evidenced.	**1**	Data of quality indicators needs to be captured and analysis of data needs to be done for identification of opportunities for improvement. (Benchmarks need to be set).
Commitment	g	**The improvements are implemented and evaluated.**	Opportunities for quality improvement was not implemented and evaluated.	**1**	Data of quality indicators needs to be captured and it should be reviewed for identification of opportunities for improvement and same shall be documented.
Achievement	h	**Feedback about care and service is communicated to staff.**	No communication to staff was observed.	**1**	The feedbacks shall include the rates, trends and opportunities for improvement and this should be communicated to staff.
Average Score				**01**	
PSQ.4: The organisation uses appropriate quality improvement tools for its quality improvement activities.					
CORE	a	**The organisation under takes quality improvement projects.**	No documentation related to quality improvement programs was available in the hospital, and there were no appropriate analytical, managerial, or statistical tools in place for quality improvement activities.	**1**	The hospital should prepare Standard Operating Procedures (SOPs) for quality improvement programs, ensuring proper implementation and comprehensive documentation. Additionally, appropriate analytical, managerial, and statistical tools should be utilized to support these activities, facilitating effective monitoring, evaluation, and continuous improvement. This will lead to improvements in patient care delivery and hospital operations, ultimately enhancing cost efficiency and overall performance.
Achievement	b	**The quality improvement projects shall include improvements in patient care delivery and hospital organizations which will have an impact on cost and efficiency.**		**1**	
Commitment	c	**The organisation uses appropriate analytical managerial and statistical tools for its quality improvement activities.**		**1**	
Achievement	d	**The organisation has a mechanism to capture patient reported outcome measures.**	The organization does not have a mechanism in place to capture patient-reported outcome measures.	**1**	The organization needs to implement a system to capture patient-reported outcome measures (PROMs) to assess and improve patient care. This system should be integrated into routine clinical practices, ensuring proper documentation and analysis, which will help inform and drive quality improvement initiatives.
Average Score				**01**	
PSQ.5: There is an established system for clinical audit.					

Commitment	**a**	**Clinical audits are performed to improve the quality of patient care.**	The organization does not have a mechanism in place for performing clinical audits to improve the quality of patient care. Although parameters to be audited are defined, clinical audits are not conducted consistently. Medical and nursing staffs are involved in the audit process, and patient and staff anonymity are maintained, but remedial measures are not always implemented.	**1**	The organization needs to establish and implement a systematic mechanism for conducting clinical audits aimed at improving patient care quality. The parameters for auditing should be clearly defined, and audits should be performed regularly. Medical and nursing staff should actively participate in these audits, ensuring the anonymity of both patients and staff. Additionally, the organization should ensure that remedial measures are promptly implemented based on audit findings to foster continuous improvement in clinical practices.
Commitment	**b**	**The parameters to be audited are defined by the organisation.**		**1**	
Achievement	**c**	**Medical and nursing staffs participate in clinical audit.**		**1**	
Commitment	**d**	**Patient and staff anonymity are maintained.**		**1**	
Commitment	**e**	**Clinical audits are documented.**		**1**	
Commitment	**f**	**Remedial measures are implemented.**		**1**	
Average Score				**01**	
PSQ.6: The patient safety and quality improvement programme are supported by the management.					
Achievement	**a**	**The management creates a culture of safety.**	It was observed that there was not document that ensures organization have culture of Safety for patients.	**1**	Documentation and awareness among staff need to be ensures that organization have culture of safety for patients.
Commitment	**b**	**The leaders at all levels in the organisation are aware of the intent of the patient safety and quality improvement programme and the approach to its implementation.**	Documented of patient safety and quality improvement was not evidenced, its awareness and intent to all leaders were assessed.	**1**	Leaders of the hospital should be aware of intent of patient safety and quality improvement program and the approach to its implementation
Commitment	**c**	**Departmental leaders are involved in patient safety and quality improvement.**	No, Designated person / leader is involved in patient safety and quality improvement.	**1**	Departmental leaders are involved in patient safety and quality improvement
Commitment	d	**Organisation earmarks adequate funds from its annual budget in this regard.**	No budgetary provision has been defined by the organization.	**1**	Provision in the budget should be made to include special provision for the quality improvement programme.
Achievement	**e**	**The management identifies organizational performance improvement targets.**	No such targets have been identified.	**1**	Management should identify organizational Performance improvement targets.
Excellence	**f**	**The management uses the feedback obtained from the workforce to improve patient safety and quality improvement programme.**	No such Feedback mechanisms could be evidenced.	**1**	A feedback mechanism needs to be developed for staff and to improve patient safety and quality improvement programme.
Average Score				**1**	

PSQ.7: Incidents are collected and analyzed to ensure continual quality improvement.					
CORE	a	**The organisation implements an incident management system. ***	The hospital does not have a defined incident management system in place, and there is insufficient awareness among staff regarding its implementation and procedures.	**2**	The organization needs to develop and implement a comprehensive incident management system. Furthermore, staff training should be strengthened to ensure that all employees are well-informed and capable of effectively managing incidents in accordance with the system's procedures.
Commitment	b	**The organisation has a mechanism to identify sentinel events. ***	Sentinel events were not defined in the hospital, and there was a deficiency of awareness among the staff regarding the same.	**2**	The hospital needs to implement a defined system and establish clear protocols for the identification and management of sentinel events. Additionally, staff should undergo training and awareness programs to ensure they are well-informed about sentinel events and their significance in improving patient safety.
Commitment	c	**The organisation has established processes for analysis of incidents.**	The organization has no established processes for the analysis of incidents. Corrective and preventive actions are not consistently taken based on incident analysis findings. Additionally, the organization has not incorporated risks identified from incident analyses into the risk management system.	**1**	The organization needs to establish formal processes for incident identification, analysis, and management. The Corrective and preventive actions should be based on incident findings to prevent recurrence and enhance patient safety. Identified risks should be integrated into the organization's risk management system for ongoing monitoring and mitigation. Regular training and communication should be provided to staff to ensure they understand the importance of incident reporting and follow through on safety measures.
Commitment	d	**Corrective and preventive actions are taken based on the findings of such analysis.**		**1**	
Achievement	e	**The organisation incorporates risks identified in the analysis of incidents into the risk management system.**		**1**	
Commitment	f	**The organisation shall have a process for informing various take holders in case of a near miss/ adverse event/ sentinel event.**	Process of informing various stakeholders in case of any incident (near miss / adverse event) could not be evidenced.	**1**	The organization needs to develop a process for informing various stakeholders in the event of a near miss or adverse event. This process should ensure timely communication, maintain transparency, and include appropriate follow-up actions to address the incident and prevent recurrence.
Average Score				**1.3**	

Total Chapter Average Score				1.18	
Chapter 7: Responsibilities of Management (ROM)					
ROM.1: The Organisation identifies those responsible for governance and their roles are defined.					
CORE	a	**Those responsible for governance are identified, and their roles and responsibilities are defined and documented.***	Those responsible for governance were identified; however, their roles and responsibilities were not defined or documented. Additionally, the minutes of the meetings could not be evidenced.	**3**	Those responsible for governance should be accountable for the quality of care and actively support the healthcare organization in achieving its goals. Governance meetings should be conducted at regular intervals, and the minutes of these meetings should be properly documented and maintained.
Commitment	b	**Those responsible for governance lay down the organisation's vision, mission and values. ***	The governing body has defined the vision, mission, and values; however, their display was not evidenced uniformly across the hospital.	**3**	The vision, mission, and values should be prominently displayed at key locations throughout the hospital to ensure uniform visibility and awareness among staff, patients, and visitors.
Commitment	c	**Those responsible for governance approve the documented strategic and operational plans and the organisation's annual budget.***	Strategic and operational plans, as well as budget allocation for quality assurance and infection control, could not be evidenced.	**2**	The healthcare facility should develop and document strategic and operational plans for quality assurance and infection control, ensuring appropriate budget allocation to support effective implementation and sustainability.
Commitment	d	**Those responsible for governance monitor and measure the performance of the organisation against the stated mission.**	Monitoring to measure performance against the stated mission was not evident.	**2**	A systematic process should be established to regularly monitor and evaluate performance against the stated mission, ensuring alignment with organizational goals and continuous improvement.
Commitment	e	**Those responsible for governance appoint the senior leaders in the organisation.**	Organogram was not evidenced & documented during assessment	**1**	Organogram should be developed & documented.
Commitment	f	**Those responsible for governance support safety initiatives, clinical governance framework and quality improvement plans.***	It was evidenced that reports ofquality and safety committee and CAPA for the same was not available.	**2**	A Quality and Safety Committee should be formed to conduct risk assessments and implement risk reduction activities. Governance should support these initiatives by allocating necessary funds for corrective measures to mitigate identified risks effectively.

Commitment	g	**Those responsible for governance shall develop clinical governance framework.**	No clinical governance framework of the organization was evidenced.	**1**	Develop and implement a comprehensive clinical governance framework to ensure accountability, improve clinical quality, and promote patient safety. This framework should include policies on clinical audits, risk management, staff training, and continuous quality improvement initiatives, aligning with NABH standards.
Achievement	i	**Those responsible for governance support the ethical management frame work of the organisation.**	No ethical management framework of the organization was evidenced.	**1**	The organization should establish a well-defined ethical management framework to ensure adherence to ethical principles in decision-making, patient care, and organizational practices. This framework should be documented, communicated, and implemented across all levels of the organization.
Commitment	h	**Those responsible for governance inform the public of the quality and performance of services.**	As the quality initiative was at a nascent stage, the display of quality and performance of services could not be evidenced.	**2**	The organization should establish a structured mechanism to track, evaluate, and display quality and performance indicators. This will enhance transparency, promote continuous improvement, and ensure staff and patient awareness of service quality.
Average Score				**2.12**	
ROM.2: Those responsible for governance manage the organisation in an ethical manner.					
CORE	a	**The leaders establish the organisation's ethical management framework.***	The organization was following the Code of Medical Ethics; however, a documented policy for its establishment and uniform implementation was not evident.	**3**	A formal, documented policy on the Code of Medical Ethics should be developed and implemented uniformly across the organization to ensure consistency, compliance, and accountability in ethical medical practices.
Commitment	b	**The ethical management framework includes processes for managing issues with ethical implications, dilemmas and concerns.***	The ethical management framework was documented, including processes for managing issues with ethical implications, dilemmas, and concerns. However, there was a lack of awareness among the staff regarding its implementation.	**3**	Regular training and awareness programs should be conducted to ensure that all staff members are well-informed about the ethical management framework and its application in daily practices.

Commitment	c	**The organisation discloses it sownership.**	The hospital was a government organization.	**4**	Governance and operational policies should align with government regulations and guidelines to ensure compliance, efficiency, and the effective delivery of healthcare services.
Commitment	d	**The organisation honestly portrays sits affiliations and accreditations.**	----	**---**	-----
Average Score				**3.33**	
ROM.3: Those responsible for governance ensure sustainability in hospitals by addressing environmental, social and economic factors from long term well-being of healthcare system and community.					
Commitment	**a**	**Those responsible for governance address the organisation's sustainability sustainability programme in terms of environment social and governance (ESG) responsibility.**	There is no evidence that those responsible for governance address the organization's sustainability program in terms of Environmental, Social, and Governance (ESG) responsibilities.	**2**	Establish a structured ESG framework as part of the organization's governance agenda. This should include policies and initiatives focusing on environmental sustainability, social responsibility, and ethical governance practices, with regular reviews and documentation to align with NABH standards and global best practices.
Commitment	**b**	**The organisation takes initiatives towards an energy-efficient and environmentally friendly hospital.***	The hospital has implemented landscaping, solar energy utilization, and plantation initiatives.	**4**	Regular maintenance and monitoring should be conducted to ensure the sustainability and effectiveness of these initiatives, enhancing environmental sustainability and the overall hospital environment.
Commitment	**c**	**Those responsible for governance address the organisations social responsibility.**	There is no evidence that those responsible for governance address the organization's social responsibility.	**2**	Incorporate social responsibility into the governance framework by developing and implementing initiatives that contribute to community welfare, patient education, and staff well-being. Ensure these efforts are documented and periodically reviewed to align with NABH standards and demonstrate the organization's commitment to social accountability.
Commitment	**d**	**Staff well- being is promoted.**	There was no mechanism for promoting staff well-Being	**1**	The organization should take proactive steps to ensure staff well-being.
Excellence	**e**	**The organisation follows sustainable procurement practices.**	There is no evidence that the organization follows sustainable procurement practices.	**2**	Adopt sustainable procurement practices by integrating environmental, social, and economic considerations into the procurement process. This includes sourcing eco-friendly products,

					supporting local suppliers, and ensuring ethical supply chain practices, with proper documentation to align with NABH standards and promote sustainability.
Achievement	**f**	**Hospitals shall encourage employees to use common / public transportation to reduce the environment impact of commuting and carbon footprint.**	The hospital does not encourage employees to use common or public transportation to reduce the environmental impact of commuting and carbon footprint.	**1**	Promote the use of common or public transportation among employees by implementing initiatives such as transportation allowances, carpool programs, or shuttle services. These measures can help reduce the environmental impact of commuting, lower the organization's carbon footprint, and align with sustainability goals under NABH standards.
Achievement	**g**	**The organisation ensures financial sustainability of the hospital by balancing the financial aspects of the healthcare delivery.**	There is no evidence that the organization ensures the financial sustainability of the hospital by balancing the financial aspects of healthcare delivery.	**2**	Establish a financial sustainability framework that includes budgeting, cost control, revenue optimization, and regular financial audits. This will ensure a balance between the financial aspects of healthcare delivery and the quality of services, aligning with NABH standards and supporting long-term organizational stability.
Average Score				**02**	
ROM.4: The organisation is headed by a leader who shall be responsible for operating the organisation on a day-to-day basis.					
Commitment	a	**The person heading the organisation has requisite and appropriate administrative qualifications and experience.**	It was observed that the person heading the organization possessed the requisite and appropriate administrative qualifications.	**5**	The organization should ensure that leadership qualifications and competencies are periodically reviewed and documented to maintain effective governance and administrative efficiency.
CORE	b	**The leader is responsible for and complies with the laid down and applicable legislations, regulations and notifications.**	Yes, the management was conversant with the laws and regulations and aware of their applicability to the organization. Although licenses, certifications, and registrations were being updated, no tracker was observed to monitor their validity.	**3**	The organization should develop a structured tracking system to monitor the validity and renewal timelines of licenses, certifications, and registrations, ensuring compliance and preventing lapses. Additionally, the sustainability of the current practice should be ensured. Although the organization regularly updates licenses, registrations, and certifications, a formal tracker should be implemented to systematically monitor their

					validity and expiry.
Commitment	c	**The leader appoints/ participates in the recruitment of department leaders of the organisation who will assist in the day-to-day functioning of the organisation.**	There was a designated senior leadership team in the organization that assisted in its day-to-day functioning.	**5**	The roles and responsibilities of the senior leadership, including the Director or Medical Superintendent, Nursing Head, Head of Human Resources, and other key personnel, should be clearly defined and documented. This will ensure efficient governance, accountability, and seamless operational management of the organization.
Achievement	d	**The leader ensures that each organizational programme, service, site or department has effective leadership.**	Though leaders have been designated to provide leadership at all levels, the organization needs to develop metrics for measuring leadership effectiveness.	**3**	The organization should establish clear performance metrics and evaluation frameworks to assess leadership effectiveness. Regular assessments and feedback mechanisms should be implemented to ensure continuous improvement and accountability. Each leader should possess the requisite qualifications and experience to effectively direct their respective department. Additionally, leaders should have domain-specific knowledge relevant to their department to ensure informed decision-making and efficient management.
Achievement	e	**The performance of the organisation's leader is reviewed for effectiveness.**	The mechanism of performance appraisal is being conducted for the leaders in the organization.	**4**	The organization should ensure that the performance appraisal system is structured, transparent, and aligned with predefined leadership effectiveness metrics. Regular feedback and improvement plans should be incorporated to enhance leadership performance and organizational efficiency.
Average Score				**04**	
ROM.5: The organisation displays professionalism in its functioning.					
Commitment	a	**The organisation has strategic and operational plans, including long-term and short-term goals commensurate to the organisation's vision, mission and values in**	Strategic and operational plans, including long-term and short-term goals aligned with the organization's vision, mission, and values, in consultation with various	**1**	The organization should develop and document strategic and operational plans in alignment with its vision, mission, and values. A structured approach, including stakeholder consultations and the use of appropriate planning tools,

		consultation with the various stakeholders.	stakeholders, were not evidenced during the assessment. Additionally, the organization is not using any tool for the same.		should be adopted to ensure effective goal setting, implementation, and monitoring.
Commitment	b	**The organisation coordinates the functioning with departments and external agencies and monitors the progress in achieving the defined goals and objectives.***	Monitoring of performance against stated goals and objectives could not be evidenced.	**1**	Monitoring of performance against stated goals and objectives should be conducted during management review meetings. If performance targets are not achieved, appropriate corrective actions should be taken. The organization should establish a structured mechanism to regularly track, measure, and review performance against defined goals and objectives. This should include periodic assessments, key performance indicators (KPIs), and documented reports to ensure continuous improvement and alignment with organizational objectives.
Commitment	c	**The organisation plans and budgets for its activities annually.**	Annual budget allocation was made for the organization; however, no provision for quality assurance and infection control was evident. .	**2**	The organization should ensure dedicated budget allocation for quality assurance and infection control activities. This will support continuous improvement initiatives, staff training, infection prevention measures, and compliance with healthcare standards.
Achievement	d	**The functioning of committees is reviewed for their effectiveness.**	No committee with a defined Term of Responsibility (TOR) has been formulated in the organization.	**1**	The organization should establish various committees with clearly defined TORs, outlining their roles, responsibilities, and scope of work. This will enhance accountability, streamline decision-making, and ensure structured governance for key operational areas.
Commitment	e	**The organisation documents the service standards that are measurable and monitors them.***	Service standards of the organization have not been defined.	**1**	The organization should develop and document clear service standards to ensure consistency, quality, and accountability in service delivery. These standards should align with best practices, regulatory requirements, and patient expectations, and should be regularly reviewed for continuous improvement.
Excellence	f	**Systems and processes are in place for change management.**	There are no systems and processes in place for change management.	**1**	The organization should establish a structured change management framework to effectively

					plan, implement, and monitor changes. This should include documented procedures, stakeholder involvement, risk assessment, and training to ensure smooth transitions and minimal disruptions to operations.
Average Score				**1.16**	
ROM.6: Leadership ensures that patient-safety aspects and risk-management issues area an integral part of patient care and hospital management.					
CORE	a	**Leadership ensures proactive risk management across the organisation. ***	Risk management (clinical & non-clinical) activities were being performed in the hospital; however, no documented risk management plan was available.	**2**	The organization should develop and document a comprehensive risk management plan covering both clinical and non-clinical risks. This plan should include risk identification, assessment, mitigation strategies, monitoring mechanisms, and periodic reviews to enhance patient safety and operational efficiency.
Commitment	b	**Leadership provides resources for proactive risk- assessment and risk reduction activities.**	No risk assessment and reduction activities were being performed in the hospital.	**2**	The organization should establish a structured framework for risk assessment and reduction. This should include identifying potential risks, evaluating their impact, implementing mitigation strategies, and conducting regular reviews to ensure continuous improvement in patient safety and hospital operations.
Commitment	c	**Leadership ensures integration between quality improvement, risk management and strategic planning within the organisation.**	The risk management andstrategic planning within theorganisation could not be assessed.	**2**	The management should ensure the integration of risk management and strategic planning within the organization. Additionally, quality improvement initiatives should incorporate risk management aspects to enhance patient safety, operational efficiency, and overall organizational resilience. A structured approach should be adopted, including risk assessment, mitigation strategies, and continuous monitoring.
Achievement	d	**Leadership ensures implementation of systems for internal and external reporting of system and process failures. ***	The system for internal and external reporting of system and process failures was not in place.	**1**	The organization should establish a structured system for reporting internal and external system and process failures. This system should include clear reporting channels, proper documentation, root cause analysis, and corrective and preventive actions. Regular

					reviews should be conducted to enhance accountability and support continuous improvement. For example, in the event of a critical equipment breakdown in the diagnostics department, the Head of Department should be informed internally, while patients should be notified externally to manage expectations and minimize disruptions.
Commitment	e	**Leadership ensures that it has a documented agreement for all outsourced services that include service parameters.**	A documented agreement was available for all outsourced services; however, service parameters were not incorporated into these agreements.	**3**	The organization should ensure that all outsourced service agreements include clearly defined service parameters, such as performance expectations, quality standards, turnaround times, and compliance requirements. This will help in monitoring service delivery, ensuring accountability, and maintaining quality standards.
Achievement	f	**Leadership monitors the quality of the outsourced services and improvements are made as required.**	The monitoring is not done for quality of the outside services & Improvements.	**1**	The management should establish a structured system to monitor the quality of outsourced services and drive continuous improvements. This should include defining key performance indicators (KPIs), conducting regular audits, obtaining feedback, and implementing corrective actions to ensure compliance with service agreements and maintain high-quality standards.
Average Score				**1.83**	
Total Chapter Average Score				**2.40**	
Chapter 8: Facility Management and Safety (FMS)					
FMS.1: The organisation has a system in place to provide a safe and secure environment.					
CORE	a	**Patient safety devices and infrastructure are installed across the organisation and inspected periodically.**	Side rails for beds and stretchers, as well as safety belts for wheelchairs, were uniformly available. However, patient toilets lacked grab bars, and there was no evidence of signposting or warning signs for biohazards.	**2**	The organization should install grab bars in patient toilets to enhance safety and accessibility, especially for elderly and physically challenged patients. Additionally, proper signposting and warning signs for biohazards should be placed in appropriate areas to ensure patient and staff safety. Regular

					audits should be conducted to maintain compliance with safety standards.
Commitment	b	**The organisation has facilities for the differently-abled.**	Provisions for physically challenged and vulnerable persons were not evidenced uniformly throughout the hospital.	**2**	The organization should ensure uniform accessibility measures across all hospital areas. This includes installing ramps, handrails, accessible washrooms, designated seating, and clear signage. Grab bars should be installed in patient toilets to enhance safety, and special toilets for physically challenged individuals should be provided. Regular assessments should be conducted to ensure compliance with accessibility standards and improve inclusivity for all patients.
CORE	c	**Facility inspection rounds to ensure safety are conducted atleast once a month.**	Facility safety rounds were not being conducted.	**1**	The organization should implement a structured system for conducting regular facility safety rounds. These rounds should focus on identifying potential hazards, ensuring compliance with safety protocols, and addressing any risks related to patient and staff safety. Findings should be documented, and corrective actions should be taken to maintain a safe healthcare environment.
Commitment	d	**Inspection reports of facility rounds are documented, and corrective and preventive measures are undertaken.**	An inspection report tracker was not being maintained.	**1**	An inspection report tracker should be maintained to systematically record findings from facility safety rounds and other inspections. Additionally, corrective and preventive measures should be implemented based on the reports to ensure continuous improvement in safety and compliance. Regular reviews of the tracker should be conducted to monitor progress and address recurring issues effectively.
Commitment	e	**Before construction, renovation and expansion of existing hospital, risk assessments are carried out.**	No plan was developed or implemented for risk assessment prior to the construction, renovation, or expansion of the	**1**	The organization should develop and implement a structured risk assessment plan before undertaking any construction, renovation, or expansion activities. This plan

			existing hospital.		should include identifying potential hazards, assessing their impact on patient care and hospital operations, and implementing mitigation strategies. Regular monitoring and stakeholder involvement should be ensured to minimize risks and maintain safety standards during infrastructure modifications.
Average Score				**1.4**	
FMS.2: The organization's environment and facilities operate in a planned manner and promotes environment-friendly measures.					
Commitment	a	**Facilities and space provisions are appropriate to the scope of services.**	Yes, the facilities were appropriate and aligned with the scope of services provided by the organization.	**5**	The organization should ensure that facilities remain aligned with the scope of services by regularly assessing infrastructure, equipment, and resource adequacy. Periodic reviews and necessary upgrades should be implemented to meet evolving patient care needs, regulatory requirements, and best practices in healthcare service delivery. Additionally, measures should be taken to ensure the sustainability of these practices for long-term operational efficiency and quality care.
Commitment	b	**As-built and updated drawings are maintained as per statutory requirements.**	Though, up-to-date and approved drawings were available. However, the same was not displayed in the various departments and corridors of the hospital. The same was not displayed in the patient room as well.	**3**	Floor plans and fire escape routes should be prominently displayed across the hospital premises, including patient rooms, corridors, waiting areas, and other key locations. This will enhance staff and patient awareness of emergency evacuation procedures, ensuring a swift and organized response in case of fire or other emergencies. Regular audits should be conducted to verify the visibility and accuracy of these displays.
CORE	c	**There are internal and external sign postings intheorganisation in a manner understood by the patient, families and community.**	Internal and external sign postingwas inadequate, floor plans andfire escape routes were notdisplayed uniformly.	**2**	All internal and external signage need to bedisplayed adequately and, in a language, understood by patients, families and community.All floor plans and fire escape route need to bedisplayed.
CORE	d	**Potable water and electricity are**	Potable water and electricity were available round the clock. However,	**3**	A preventive maintenance plan should be established for the water dispensers, ensuring

		available round the clock.	the small water dispensers installed at various locations were not serviced or cleaned regularly, and no preventive maintenance plan was in place.		regular servicing and cleaning at a defined frequency to maintain hygiene and functionality.
Commitment	e	**Alternate sources for electricity and water are provided as a backup for any failure / shortage.**	Alternative sources for water and electricity are available as backup during failures or shortages.	**5**	The facility should ensure the availability of reliable backup sources for water and electricity to prevent service disruptions. Regular maintenance and testing of backup systems should be conducted to ensure their functionality during failures or shortages.
Commitment	f	**The organisation tests the functioning of these alternate sources at a predefined frequency.**	Periodic testing of alternate sources of water and electricity could not be evidenced.	**1**	Hospital needs to ensure checking of these alternate water and electrical sources periodically. (Water and UPS & DG functioning check).
Average Score				**3.16**	
FMS.3: The organisation's environment and facilities operate to ensure the safety of patients, their families' staff and visitors.					
Commitment	a	**Operational planning identifies areas which need to have extra security and describes access to different areas in the hospital by staff, patients, and visitors.***	Operational planning identifies areas which need to have extra security and describes access to different areas in the hospital by staff, patients, and visitors were not evidenced.	**1**	Operation Planning should be done for the areas which need to have extra security and describes access to different areas in the hospital by staff, patients, and visitors was not evidenced.
Excellence	b	**Patient safety aspects in terms of structural safety of hospitals especially of critical areas are considered while planning, design and construction of new hospitals and re-planning, assessment, and retro-fitting of existing hospitals.**	Patient safety aspects related to the structural safety of the hospital were not evidenced uniformly.	**3**	The organization should ensure uniform implementation of patient safety measures related to structural safety across all hospital areas. This includes regular structural assessments, reinforcement of critical infrastructure, and installation of safety features such as handrails and anti-slip flooring, and compliance with building safety codes. Periodic audits should be conducted to identify and address any gaps in structural safety.
Commitment	c	**The organisation conducts electrical safety audits for the facility.**	No such audits were evidenced.	**1**	The organization should conduct regular electrical safety audits to identify and mitigate potential electrical hazards, ensuring the safety of both personnel and property. Preventive and

					corrective measures should be implemented based on audit findings to enhance overall electrical safety and compliance with regulatory standards.
Commitment	d	**There is a procedure which addresses the identification and disposal of material(s) not in use in the organisation.***	The procedure for the identification and disposal of materials was not evident. Scrap and other waste materials were found accumulated in various locations within the hospital.	**2**	The organization should establish a documented procedure for the identification and disposal of materials, ensuring proper segregation and timely removal of scrap and other waste. Regular monitoring and designated disposal areas should be implemented to maintain cleanliness and prevent accumulation in various hospital locations.
CORE	e	**Hazardous materials are identified and used safely within the organisation. ***	Hazardous materials were not identified and storage norms of hazardous materials were not as per HIRA (Hazard Identification and Risk Analysis). The hazardous materials were also not being labeled.	**1**	The organization should develop a comprehensive list of all hazardous materials used across different departments. These materials must be handled, stored, and labeled in compliance with Hazard Identification and Risk Assessment (HIRA) guidelines to ensure safety and regulatory adherence.
Commitment	f	**The plan for managing spills of hazardous materials is implemented.***	A documented plan on handling spills of hazardous materials was not evidenced. Spill kits were not available at various potential points in the hospital. Staff were not aware about handling hazardous spills	**2**	The organization should establish and enforce guidelines for the proper disposal of hazardous waste to ensure awareness and effective implementation at all levels. Additionally, staff should be trained based on a documented spill management plan to enhance preparedness and compliance.
Average Score				**1.66**	
FMS.4: The organisation has a programme for the facility, engineering support services and utility system.					
Commitment	a	**The organisation plans for utility and engineering equipment in accordance with its services and strategic plan.**	Though engineering equipment was planned in accordance with the scope of services, a documented plan for the same could not be evidenced.	**2**	The organization should develop and maintain a documented plan for engineering equipment procurement, maintenance, and replacement. This plan should align with the scope of services and ensure that all equipment is adequately maintained, regularly inspected, and upgraded as needed to meet operational and patient care

					requirements. A documented plan for engineering equipment (e.g., DG set, LT panel, and air compressor room) should be formulated, implemented, and reviewed annually.
Commitment	b	**Equipment is inventoried and proper logs are maintained as required.**	Engineering equipment was not uniformly inventoried and logged.	**3**	The organization should establish a systematic process for the inventory and logging of all engineering equipment. This includes creating a centralized database with details such as equipment type, location, maintenance history, and calibration status. Regular audits should be conducted to ensure the accuracy of the inventory, facilitating effective maintenance, risk management, and compliance with regulatory standards.
CORE	c	**The documented operational and maintenance (preventive and breakdown) plan is implemented.***	No documented operational and maintenance (preventive and breakdown) plan were evidenced for engineering equipment.	**2**	A calendar for the Preventive Maintenance (PM) and Calibration should be maintained and these to be done as the calendar.
Commitment	d	**Utility equipment, are periodically inspected and calibrated (wherever applicable) for their proper functioning.**	Calibration and inspection of utility equipment were not being conducted.	**1**	Calibration and inspection of utility equipment, such as pressure gauges of steam sterilizers and temperature gauges of medication refrigerators, should be conducted periodically. If performed by an outsourced agency, a traceability certificate must be maintained.
Commitment	e	**Competent personnel operate, inspect, test and maintain equipment and utility systems.**	A competent person was designated to operate, inspect, test, and maintain equipment and utility systems.	**4**	The organization should designate an engineer to operate, inspect, test, and maintain equipment and utility systems.
Commitment	f	**Maintenance staff is contactable round the clock for emergency repairs.**	The maintenance staff were available in the hospital round-the-clock (at night) in the electrical panel room and gas manifold.	**4**	Staff should be available in the hospital round-the-clock to assess and address emergency repairs.
Achievement	g	**Downtime for critical equipment breakdowns is monitored from reporting to inspection and implementation of corrective actions.**	The record could not be evidenced.	**1**	A complaint attendance register (physical or electronic) should be maintained to record the date and time of complaint receipt, the date and time of complaint resolution, job allotment, and job completion. The completion of each job

					should be ratified by the user department. An indicator of response time should also be captured by the engineering department.
Commitment	h	**Written guidance supports equipment replacement, identification of unwanted material and disposal.***	A documented policy for engineering equipment disposal and replacement was not evidenced.	**2**	A documented procedure for equipment replacement and disposal needs to be developed. A condemnation committee should be formed for the same.
Average Score				**2.37**	
FMS.5: The organisation has a programme for medical equipment management.					
Commitment	a	**The organisation plans for medical equipment in accordance with its services and strategic plan.**	The planning of biomedical equipment was in accordance with the scope of services of the hospital; however, a documented plan for biomedical equipment was not evidenced.	**2**	A documented plan for biomedical equipment management should be developed. Its implementation must be ensured, and the plan should be reviewed annually.
Commitment	b	**Medical equipment is inventoried and proper logs are maintained as required.**	Biomedical equipment was not uniformly inventoried and logged.	**2**	The biomedical engineering department should maintain proper logs for all hospital equipment.
CORE	c	**The documented operational and maintenance (preventive and breakdown) plan for medical equipment is implemented.***	A documented operational and maintenance plan (preventive and breakdown) for biomedical equipment under AMC/CMC was not evidenced.	**2**	A calendar for Preventive Maintenance (PM) and Calibration should be maintained for all equipment, and these activities should be carried out as per the schedule.
Commitment	d	**Medical equipment is periodically inspected and calibrated for their proper functioning.**	The calibration and inspection of biomedical equipment could not be evidenced.	**2**	Calibration and inspection of biomedical equipment need to be conducted periodically. If performed by an outsourced agency, the traceability certificate must be maintained.
Commitment	e	**Qualified and trained personnel operate and maintain medical equipment.**	A dedicated person was available for handling biomedical equipment in the organization.	**4**	A dedicated person and team should be available for handling biomedical equipment in the organization.
Commitment	f	**Written guidance supports medical equipment replacement and disposal.***	No documented policy for biomedical equipment disposal and replacement was evidenced.	**2**	A documented procedure for equipment replacement and disposal needs to be developed. A condemnation committee should be formed for this purpose.

Commitment	g	**There is monitoring of medical equipment and medical devices related to adverse events, and compliance hazard notices on recalls.***	The process of recall for medical equipment was not evidenced.	**1**	Recalls should be based on letters or hazard notices issued by manufacturers or regulatory authorities. Whenever the hospital authorities receive or become aware of such recalls, immediate action should be taken, and the said medical equipment should not be put into further clinical use until the issue is resolved.
Achievement	h	**Downtime for critical equipment breakdown is monitored from reporting to inspection and implementation of corrective actions.**	The monitoring of response time could not be evidenced.	**1**	A complaint log should be maintained to record the date and time of receipt of a complaint, the date and time of attending to the complaint, job allotment, and job completion. The completion of the job should always be ratified by the user department.
Average Score				**02**	
FMS.6: The organisation has a programme for medical gases, vacuum and compressed air.					
Commitment	a	**Written guidance governs the implementation of procurement, handling, storage, distribution, usage and replenishment of medical gases.***	Documented procedure for procurement, handling, storage, distribution and replenishment of medical gases was not evident.	**2**	A documented procedure governing the procurement, handling, storage, distribution, usage, and replenishment of medical gases should be prepared. Proper signage should be displayed to ensure safety and compliance with regulatory guidelines.
CORE	b	**Medical gases are handled, stored, distributed and used in a safe manner.**	Storage of medical gases was inappropriate in the gas manifold room as filed cylinders were not chained and labeled.	**2**	Medical gases should be handled, stored, distributed &used in a safe manner.
Commitment	c	**There is an operational, inspection, testing and maintenance plan for piped medical gas, compressed air and vacuum installation.***	A documented policy for the procurement, handling, storage, distribution, usage, and replenishment of medical gases should be developed and implemented.	**1**	In case of piped medical gases there should be maintenance plan for piped medical gas, compressed air and vacuum installation.
CORE	d	**Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.**	Yes, alternative sources for medical gases, vacuum, and compressed air were available in case of failure.	**5**	Sustainability of the present practice needs to beensured.

Commitment	e	**The organisation regularly tests the functioning of these alternate sources.**	Testing of alternate sources of medical gases could not be evidenced.	**1**	The organization should regularly test the alternative sources of medical gases, vacuum, and compressed air, and maintain proper documentation of the testing.
Average Score				**2.2**	
FMS.7: The organisation has plans for fire and non-fire emergencieswith in the facilities.					
CORE	a	**The organisation has plans and provisions for early detection, abatement and containment of the fire, and evacuation in the event of fire emergencies.***	A written policy was not evidenced. -Smoke detectors and sprinklers were installed in the hospital for early detection and fire abatement.	**2**	A plan for non-fire emergencies should be prepared, ensuring that all potential emergencies are covered. In the Medical Record Room, the most suitable firefighting system is a Compact Automatic Fire Extinguisher. This automatic extinguisher comes with a fixing bracket (secured to the ceiling or wall with one screw) and is filled with dry powder, making it effective for various types of fires.
CORE	b	**The organisation has plans and provisions for identification, and management of non-fire emergencies.***	A documented plan for handling non-fire emergencies was not evident.	**2**	A documented plan should be defined and implemented for identification and management of non-fire emergencies.
Commitment	c	**The organisation has a documented and displayed exit plan in case of fire and non- fire emergencies.**	The organization did not have a documented safe exit plan for fire and non-fire emergencies.	**1**	The organization should develop and document a safe exit plan for fire and non-fire emergencies. The exit plan should be an integral part of the emergency management plan.
Commitment	d	**Mockdrills are held atleast twice a year.**	No mock drills were being conducted.	**1**	The training of the staff should be tested during the mockdrills. The shortcomings found during these mock drills should be noted and worked upon.
Commitment	e	**There is a maintenance plan for fire-related equipment and infrastructure***	No documented maintenance plan for fire-related equipment was evidenced.	**1**	A maintenance plan for fire-related equipment should be developed and effectively implemented.
Average Score				**1.4**	
Total Chapter Average Score				**2.02**	
Chapter 9:Human Resource Management (HRM)					
HRM.1. The organisation has a documented system of human resource planning.					

Commitment	a	**Human resource planning supports theorganisation's current and future ability to meet the care, treatment and service needs of the patient.**	The human resource planning was being done as per national medical commission (NMC) guideline.	**5**	Ensure sustenance.
CORE	b	**The organisation maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient. ***	Adequate no. of nursing staff was not available as per Staff Inspection Unit (SIU) Norms.Position of Patient safety officer was not available.	**2**	Adequacy and mix of the staff as per defined parameters and scales should be ensured to meet the care and treatment needs of the patients. Adequate number of staff should be made available to meet the NABH standard requirement.
Achievement	c	**The organisation has contingency plans to manage long- and short-term workforce shortages, including unplanned shortages.**	The organization does not have contingency plans to manage long- and short-term workforce shortages, including unplanned shortages.	**2**	The organization should have contingency plans to manage both long-term and short-term workforce shortages, including unplanned shortages.
Commitment	d	**The job specification and job description are defined for each category of staff.**	During the assessment it was observed that the job descriptions had not been developed for all categories of staff at various levels.	**1**	Job specifications and descriptions should be prepared for each staff category and made available in their personal files. The same should also be distributed to all staff members.
Commitment	e	**The organisation performs a background check of new staff.**	The evidences of background check was evidenced in the sampled files	**5**	Ensure sustenance.
Commitment	f	**Reporting relationships are defined for each category of staff.***	Reporting relationships aredefined for each category of staff. Communication of the same to staff is not done.	**3**	The organization should document the hierarchy; line of control, along with functions at various levels.Training of the staff needs to be done.
Achievement	g	**Exit interviews are conducted and used as a tool to improve human resource practices.**	The documents were not evidenced during thea ssessment.	**1**	The organization should conduct exit-interviews to obtain feedback from employees leaving theorganization.
Average Score				**2.71**	
HRM.2.Theorganisation implements a defined process for staff recruitment.					
CORE	a	**Written guidance governs the process of recruitment.***	Documented policy of recruitment was not evident.	**1**	A documented policy should be developed for process of recruitment and implement the same
Commitment	b	**A pre-employment medical examination is conducted on the staff.**	Documented policy of pre-employment medical examinationis conducted on the staff was not evident as per NABH.	**1**	A documented policy should be developed for pre-employment medical examination and implement the same

CORE	c	**The organisation defines and implements a code of conduct for its staff.**	No evidence of a defined and implemented code of conduct for staff was found.	**3**	The organization should define and implement a code of conduct for its staff, ensuring alignment with its values and ethics framework. Staff should be trained on the same.
Commitment	d	**Administrative procedures for human resource management are documented.***	Administrative policies and procedures for each department were not evident.	**2**	All administrative procedure slike attendance, leave, conduct, replacement, etc. needs to bedocumented as per the requirement of NABH standards. These policies need to be implemented and disseminated to all the departments in the organization.
Average Score				**1.75**	
HRM.3: Staff are provided induction training at the time of joining the organisation.					
CORE	a	**Staffs are provided with induction training.**	Induction Training was conducted but records not evidenced also the content was not as per NABH requirement.	**1**	All newly joined staff should undergo inductiontraining& the documented policy on defining the timelines and contents of induction need to be define & documented.
Cmmitment	b	**The induction training includes orientation to the organisation's vision, mission and values.**		**1**	The induction program needs to be developed including the organization's vision, mission, values etc.
Commitment	c	**The induction training includes awareness on staff rights and responsibilities and patient rights and responsibilities.**		**1**	The hospital needs to define the employee &patients' rights and responsibilities. These should be included in the induction program.
Commitment	d	**The Induction training includes training on safety.**		**1**	Staff-safety program should be developed, documented and implemented. Subsequently training program needs to be formulated to ensure its communication to all the staff.
Commitment	e	**The induction training includes training on cardio-pulmonary resuscitation for staff.**		**1**	Trained personnel should provide trainings oncardio-pulmonary resuscitation. A documented mechanism should be developed for which thestaff shall be trained to follow. All staff in the hospital should be trained in a standardized manner on BLS and at least the critical care staff & emergency staff should be trained on ACLS.

Commitment	f	**The induction training includes training in hospital infection prevention and control.**		**1**	A training program/calendar to be prepared on an annual/monthly basis to educate the staff on infection control practices. Records of all trainings should be maintained.
Commitment	g	**The induction training includes orientation to the service standards of the organisation.**		**1**	Awareness orientation to the service standardsof the organization needs to be initiated and this should also be included in the induction program.
Commitment	h	**The induction training includes an orientation on administrative procedures.**		**1**	This should include all administrative procedurelike attendance, leave, conduct etc. which needs to be communicated to staff during induction training.
Commitment	i	**The induction training includes an orientation on relevant department/ unit/ service/ programme's policies and procedures.**		**1**	Organizations and department specific policies and procedure need to be included in the induction and orientation program.
Commitment	j	**Staff is trained on information systems, information security, information use and management.**		**1**	Training on information systems, information security, information use and management should be included in induction programme.
Average Score				**01**	
HRM.4. There is an on-going programme for professional training and development of the staff.					
CORE	a	**Written guidance governs training and development policy for the staff. ***	A documented policy on training and development was not evident.	**2**	A documented policy should be developed for staff training and development. -Training calendar needs be made & training should be done accordingly. - Staff should be trained in occupational safety aspects & softskills. - In case of outsourced staff are training shall be giving.
Commitment	b	**The organisation maintains the training record.**	The training calendar was not evidenced.	**1**	Training records need to be maintained for all trainings conducted in the hospital.
Commitment	c	**Training also occurs when job responsibilities change/ new equipment is introduced.**	Training records were not evidenced during the assessment.	**1**	Job descriptions should be updated as and when an employee's department or position changes, and training on new responsibilities

					should be provided.
Commitment	d	**Feedback mechanisms are in place for improvement of training and development programme.**	Training records for job responsibility changes or the introduction of new equipment could not be evidenced.	**1**	A feedback mechanism for training needs to be developed to evaluate and monitor its effectiveness.
Achievement	e	**Evaluation of training effectiveness is done by the organisation.**	No feedback mechanisms for training could be evidenced.	**1**	Pre- and post-training evaluations should be conducted for all trainings to assess their effectiveness.
Achievement	f	**The organisation supports continuing professional development and learning.**	No evaluation of training could be evidenced.	**1**	The organization supports continuing professional development and learning by encouraging and providing resources for staff to attend courses and conferences.
Average Score				**1.16**	
HRM.5: Staff are appropriatelytrained based on their specific job description.					
Commitment	a	**Staffs involved in blood transfusion services are trained in the handling of blood and blood products.**	No training of staff on blood transfusion services was evident.	**2**	A documented policy should be developed, and staff should be trained accordingly. Training records for the same should be maintained.
Commitment	b	**Staffs are trained in handling vulnerable patients.**	No written policy and procedure were available, and training on the same was not being conducted.	**2**	A policy for the care of vulnerable groups should be developed, and staff should be trained on the same. Records of the training conducted should be maintained.
Commitment	c	**Staffs are trained in control and restraint techniques.**	The training of staff on the policy was not being conducted.	**2**	Staff should be trained as per the documented policy, and training records should be maintained.
Commitment	d	**Staffs are trained in healthcare communication techniques.**	BLS training was not being conducted for staff, and none of the staff placed in critical areas were trained in ACLS.	**2**	Training on the policy of effective communication with patients and families should be imparted to various categories of staff. Records of the training conducted should be maintained.
CORE	e	**Staffs involved in direct patient care are provided training on cardiopulmonary resuscitation periodically.**	No training of staff on blood transfusion services was evident.	**2**	Trained personnel should provide trainings on Cardio-pulmonary resuscitation. A documented mechanism should be developed for which the staff shall be trained to follow. All staff in the hospital should be trained in a standardized manner on BLS and at least the critical care staff

					& emergency staff should be trained on ACLS.
Commitment	f	**Staffs are provided training on infection prevention and control.**	Training for all staffs could not be evidenced.	**2**	The organization should conduct appropriate in-service training sessions for all staff on infection prevention and control.
Average Score				**02**	
HRM.6. Staff are trained in safety and quality-related aspects.					
Commitment	a	**Staffs are trained on the organisation's safety programme.**	No records of staff training on the organization's safety program were evidenced.	**1**	All staff should be trained on the organization's safety program.
Commitment	b	**Staffs are provided training in the detection, handling, minimisation and elimination of identified risks within the organisation's environment.**	Training of staff on the detection, handling, minimization, and elimination of identified risks within the organization's environment was not evidenced.	**2**	The hospital safety manual should incorporate all possible risks within the organization's environment. A structured training program for hospital staff should be developed and implemented.
Commitment	c	**Staff members are made aware of procedures to follow in the event of an incident.**	Not all staffs were trained.	**2**	A structured training program for hospital staff should be developed and implemented to ensure they can demonstrate actions to eliminate or minimize risks.
Commitment	d	**Staffs are trained in occupational safety aspects.**	Training on occupational safety was not evident.	**1**	A structured training program should also be developed to train staff on occupational safety aspects.
CORE	e	**Staffs are trained in the organisation's disaster management plan.**	Staffs were not trained in the organization's disaster management plan.	**1**	A disaster management plan needs to be developed, and staff should be trained accordingly.
CORE	f	**Staffs are trained in handling fire and non-fire emergencies.**	Lack of aware was observed in staffs.	**2**	The staff needs to be trained for their roles in managing emergency situations, and the training should be documented.
Commitment	g	**Staffs are trained on the organisation's quality improvement programme.**	Training of the same could not be evidenced.	**2**	A training program should be developed to communicate and educate staff on the quality improvement program. Staff should be made aware of accreditation, the quality program, and quality assurance relevant to their department.
Average Score				**1.57**	

HRM.7. An appraisal system for evaluating the performance of staff exists as an integral part of the human resource management process.					
Commitment	a	**Performance appraisal is done for staff with in the organisation.***	The hospital has a performance appraisal system in place; however, competency assessment for the same was not evidenced.	**2**	A policy on the performance appraisal system needs to be documented and implemented, incorporating competency assessment.
Commitment	b	**The staffs are made aware of the system of appraisal at the time of induction.**	Staff awareness on the same could not be assessed.	**2**	All staff in the organization should be made aware of the appraisal policy, and this aspect should be included in the induction and orientation program.
Commitment	c	**Performance is evaluated based on the pre-determined criteria.**	A structured mechanism on staff's performance evaluations was evidenced. The same need to communicate to staff through training.	**2**	Performance should be evaluated based on predetermined criteria, and the policy should be implemented uniformly while ensuring transparency.
Commitment	d	**The appraisal system is used as a tool for further development.**		**2**	The performance appraisal should lead to the identification of training needs for employees.
Commitment	e	**Performance appraisal is carried out at defined intervals and is documented.**		**2**	The appraisal policy should also include the periodicity of appraisal and the same should be documented.
Average Score				**2**	
HRM.8: Process for disciplinary and grievance handling is defined and implemented in the organisation.					
Commitment	a	**Written guidance governs disciplinary and grievance handling mechanisms.***	No, Documented policy on disciplinary and grievance-handling was evident.	**2**	The same needs to be implemented across the hospital.
Commitment	b	**The disciplinary and grievance handling mechanism is known to all categories of staff of the organisation.**	The implementation of disciplinary and grievance-handling procedures could not be evidenced; hence, staff awareness on the same could not be assessed.	**2**	A documented policy needs to be developed and implemented for disciplinary and grievance-handling procedures. A structured training program for staff should be developed and implemented.
Commitment	c	**The disciplinary policy and procedure are based on the principles of natural justice.**	A disciplinary policy was not available based on the principles of natural justice.	**2**	The policy should be developed, implemented, and distributed across the hospital.
CORE	d	**The disciplinary and grievance procedure is in consonance with the prevailing laws.**	The disciplinary policy was not available in consonance with the prevailing laws.	**2**	The policy should be developed, implemented, and distributed across the hospital.

Commitment	e	**There is a provision for appeals in all disciplinary cases.**	Provisions/ process of appeals were done; however, the related documents could not be Assessed during the audit	**2**	The policy should be developed, implemented, and distributed across the hospital.
Commitment	f	**Actions are taken to redress the grievance.**	Documented actions to address grievances were not evidenced.	**2**	The policy should be developed, implemented, and distributed across the hospital. Additionally; all actions taken must be documented.
Average Score				**02**	
HRM.9. The organisation addresses their health and safety needs of the staff.					
Commitment	a	**Health problems of the staff, including Occupational health hazards are taken care of in accordance with the organisation'spolicy.***	No employee health policy was evident in the hospital.	**1**	A policy addressing employee health issues tobe documented and implemented. The occupational hazards need to be identified and documented policy shall be made to check them.
Commitment	b	**Health checks of staff dealing with direct patient care are done at least once a year and the findings/ results are documented.**	Annual health check-ups for all employees were not being done.	**1**	A policy addressing employee health issues tobe documented and health check-ups to be doneas per the policy.
Commitment	c	**Organisation provides treatment to staff who sustains workplace-related injuries.**	Policy on the same was evidenced could not be evidenced	**2**	Organisation should provide the treatment to staff who sustains workplace-related injuries.
CORE	d	**The organisation has measures in place for prevention and handling workplace violence.***	The organisation has not documented such measures inplace for prevention and handling workplace. However, implementation could not be evidenced.	**2**	The organisation should have a mechanism in place to handle workplace violence. Signage's need to be displayed & training of staff for the same should be done.
Average Score				**1.5**	
HRM.10: There is documented personal information for each staff member.					
Commitment	a	**Personal files are maintained with respect to all staff, and their confidentiality is ensured.**	Though personal files were maintained employees but the files were not updated regularly according to the standard checklist.	**2**	It should be ensured that the file of every employee is complete and regularly updated as required, following a standard checklist.

Commitment	b	**The personal files contain personal information regarding the staff's qualification, job description, verification of credentials and health status.**	Personal files for all employees are maintained; however, they lack critical documents such as Job Descriptions (JDs), annual health check-up records, immunization records, competency assessments, and training cards.	**2**	It is recommended to update employee personal files to include essential documents such as Job Descriptions (JDs), annual health check-up records, immunization records, competency assessments, and training cards to ensure compliance with NABH standards and promote effective workforce management.
Commitment	c	**Records of in-service training and education are maintained.**	No records of in-service training and education were evidenced.	**1**	All in-service training and education records of staff need to be maintained in personal files.
Commitment	d	**Personal files contain results of all evaluations and remarks.**	No records of in-service training and education were evidenced; hence, no evaluation for the same was found.	**1**	Personal files should contain the results of all evaluations and remarks.
Average Score				**1.5**	
HRM.11: There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.					
CORE	a	**Medical professionals permitted by law, regulation and the organisation to provide patient cares without supervision are identified.**	Qualified medical staffs havebeen identified in theorganization but there is no defined process as per NABH requirements.	**2**	A credentialing and privileging policy should be developed and implemented. The credentialing of all medical staff should be completed and recorded in their personnel files.
Commitment	b	**The education, registration, training and experience of the identified medical professionals are documented and updated periodically.**	Personal files of the doctor's werenot being maintained uniformly e.g., professional training&records of CME could not be evident in sampled doctor personal file.	**2**	Personal files of paramedical staff should be maintained uniformly and should include the following: • Educational details • Registration details • Training details • Staff experience, etc. These personal files should be updated regularly.
Commitment	c	**The information about medical professionals is appropriately verified when possible.**	The verification of information related to medical professionals is conducted appropriately whenever feasible.	**4**	Ensure a standardized process for verifying the credentials, qualifications, and professional details of all medical professionals, with documented evidence to maintain compliance with NABH standards and enhance patient safety.

CORE	d	**Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.**	The services provided by the medical professionals were inconsonance with their qualification, training and registration. However, no documents could be evidenced to support clinical privileges inthe personal files of medical professionals.	**2**	The credentialing and privileging policy should be documented and implemented. All medical professionals need to be privileged as per their qualifications and experience.
Commitment	e	**The requisite services to be provided by the medical professionals are known to them as well as the various departments/ units of the organisation.**	The inadequate awareness of hospital staff was evident in their lack of knowledge about the services provided by medical professionals.	**1**	Every new medical professional who joins can be introduced to the staff through a circular addressed to every department in the hospital.
Commitment	f	**Medical professionals admit and care for patients as per their privileging.**	The process of privileging for medical professionals was not evident. No document for clinical privileging was found during the assessment.	**1**	A credentialing and privileging policy should be developed and implemented.
Average Score				**02**	
HRM.12: There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.					
CORE	a	**Nursing staff permitted by law, regulation and the organisation to provide patient care without supervision are identified.**	The process of credentialing the nurses was not evident.	**1**	A qualified infection control nurse should be designated in the hospital. The credentialing policy should be developed and implemented. Credentialing of all nursing staff should be carried out as per the policy.
Commitment	b	**The education, registration, training and experience of nursing staff are appropriately verified, documented and updated periodically.**	Although personal files of the nursing staff are maintained, training records are not included in these files.	**2**	It is recommended to incorporate comprehensive training records into the personal files of nursing staff to ensure proper documentation of skill enhancement, compliance with NABH standards, and to support continuous professional development.
Commitment	c	**The information about the nursing staff is appropriately verified whenpossible.**	The credentials of the nursing staff were verified prior to recruitment.	**4**	Continue to ensure thorough verification of nursing staff credentials during recruitment, including educational qualifications, licenses, and certifications, to maintain compliance with NABH standards and uphold the quality of care.

CORE	d	**Nursing staff are granted privileges inconsonance with their qualification, training, experience and registration.**	Though the nurses were assigned the work according to their experience, qualification, training and registration, documented privileges were not available to support the same.	**2**	Privileging for nursing should be done as pertheir qualification, training, experience andregistration.
Commitment	e	**The requisite services to be provided by the nursing staff are known to them as well as the various departments/ units of the organisation.**	Inadequate awareness of the hospital staff was evidenced on the services provided bythe nursing staff.	**2**	Every new nursing staff joined can be introduced to the staff by a circular addressed to every department in the hospital.
Commitment	f	**Nursing professionals care for patients as per their privileging.**	Process of privileging for nursing staff was not evident. No document for clinical privileging was evidenced during the assessment.	**1**	Credentialing and privileging policy to be developed and implemented.
Average Score				**2**	
HRM.13: There is a process for credentialing and privileging of para-clinical professionals, permitted to provide patientcare without tsupervision.					
CORE	a	**Para-clinical professionals permitted by law, regulation and the organisation to provide patient care without supervision is identified.**	Qualified paraclinical professionals have been identified in the organization. Credentialing process was notevident.	**2**	Credentialing and privileging policy should be developed and implemented. Credentialing of all para-medical staff to be completed and recorded in their personnel files.
Commitment	b	**The education, registration, training and experience of para clinical professionals are appropriately verified, documented and updated periodically.**	Personal files of the paraclinical professionals were not being maintained uniformly	**2**	Personal files of paramedical staff should be maintained uniformly and should include the following: • Educational details • Registration details • Training details • Staff experience, etc. These personal files should be updated regularly to ensure accuracy and compliance.
CORE	c	**Para-clinical professionals are granted privileges in consonance with their qualification, training, experience and registration.**	Para-clinical professionals are granted privileges based on their qualifications, training, experience, and registration; however, no documented evidence was found to support this.	**2**	Privileging for paramedical staff should be done as per their qualification, training, experience and registration.

Commitment	d	**The requisite services to be provided by the Para-clinical professionals are known to them as well as the concerned departments/ units of the organisation.**	No evidence was found of hospital staff being aware of the services provided by para-clinical professionals.	**2**	Every new medical staff member who joins should be introduced to the hospital staff through a circular addressed to each HOD.
Commitment	e	**Para-clinical professionals care for patients as per their privileging.**	Though the patients are cared for by the para clinical professionals based on their experience and qualifications, no documents could be evidenced to support clinical privileging.	**2**	A policy on clinical privileging should be developed and implemented for the paramedical staff.
Average Score				**2**	
Chapter Average Score				**1.79**	
Chapter10: Information Management System (IMS)					
IMS.1: Information needs of the patients, visitors, staff, management andexternal agencies are met.					
CORE	a	**The organisation identifies the information needs of the patients, visitors, staff, management external agencies and community.***	A documented policy could not be evidenced.	**2**	The organization establishes a mechanism to identify and address the information needs of patients, visitors, staff, management, external agencies, and the community. These needs should be documented and effectively implemented. • For patients, information needs may include OPD timings, availability of services, and other relevant details. • For visitors, it may include visiting hours, age restrictions, and hospital policies. • For staff, essential information should cover leave policies, standard operating procedures (SOPs), and internal guidelines. • For management, it should include reports such as the daily census, utilization rates, and performance metrics. • For the community, it should include updates on new services, induction of new medical professionals, and other public health initiatives.

Commitment	b	**Identified information needs are captured and/ or disseminated.**	Written documentation was not evidenced, indicating a lack of formal records to support compliance with established processes and guidelines. This may lead to inconsistencies in implementation, monitoring, and accountability.	**2**	Ensure that all necessary documentation is properly created, maintained, and updated as per standard protocols. Relevant policies, procedures, and records should be documented in a structured manner and made accessible to concerned personnel to ensure compliance and effective implementation. Regular audits should be conducted to verify the availability and adequacy of documentation.
Commitment	c	**Information management and technology acquisitions are commensurate with the identified information needs.**	The acquisition of information management and technology systems is aligned with the identified information needs. However, the adequacy, accessibility, and effectiveness of these systems were not fully assessed.	**5**	Ensure regularly evaluate the effectiveness of information management and technology acquisitions to ensure they meet operational and clinical requirements. This includes assessing system usability, data security, interoperability, and staff training. Continuous upgrades and enhancements should be implemented as per evolving information needs.
Commitment	d	**A maintenance plan for information technology and communication network is implemented.**	A maintenance plan for the information technology and communication network was not available. The absence of a structured plan may lead to system failures, data security risks, and disruptions in hospital operations.	**1**	Organization needs to develop and implement a comprehensive maintenance plan for information technology and communication networks. This plan should include regular system updates, preventive maintenance schedules, cybersecurity measures, backup protocols, and contingency plans to ensure uninterrupted functionality. Additionally, designated personnel should be assigned to monitor and address IT-related issues proactively.
Achievement	e	**Contingency plan ensures continuity of information capture, integration and dissemination.**	No contingency plan was evidenced to ensure continuity of information capture, integration and dissemination.	**1**	The organisation develop and implement a comprehensive contingency plan covering IT system failures, communication network disruptions, power outages, cybersecurity threats, and critical service interruptions. The plan should include risk assessment, backup procedures, alternate communication methods, and staff training to ensure a prompt and

					effective response. Regular drills and audits should be conducted to test the plan's effectiveness.
Commitment	f	**The organisation ensures that information resources are accurate and meet stakeholder requirements.**	Information resources are available through the hospital's website, brochures, newsletters, and flyers. However, the adequacy, accessibility, and periodic updates of these resources were not assessed.	**4**	Ensure that all information resources are comprehensive, up-to-date, and easily accessible to patients, visitors, and staff. Regular reviews should be conducted to verify the accuracy of information on the website, brochures, newsletters, and flyers. Additionally, multilingual resources and digital accessibility features should be considered to enhance reach and effectiveness.
Commitment	g	**The organisation contributes to external data bases in accordance with the law and regulations.**	Data on deaths, births, and other notifiable diseases were being sent to the state authorities. Also, the process for data reporting, timeliness, and documentation of submissions was fully assessed.	**5**	Ensure that the reporting of death, birth, and notifiable diseases follows a standardized protocol with clear timelines and proper documentation. A tracking system should be implemented to monitor data submissions, confirm receipt by state authorities, and address any discrepancies. Regular audits and staff training should be conducted to maintain compliance with public health reporting requirements.
Excellence	h	**The organisation shall make efforts to use digital health technology to improve operational efficiency, patient safety and patient experience.**	No structured processes were incorporated to enhance operational efficiency, patient safety, and patient experience.	**2**	It is recommended to integrate digital technology into hospital operations to enhance efficiency, safety, and patient experience. This may include: • Operational Efficiency: Implementing Hospital Information Systems (HIS), digital appointment scheduling, and automated workflow solutions. • Patient Safety: Adopting Electronic Medical Records (EMR), automated alerts for high-risk medications, and telemedicine services. • Patient Experience: Utilizing self-check-in kiosks, mobile health apps, real-time patient feedback systems, and digital wayfinding solutions. Regular assessments, staff training, and system

					upgrades should be conducted to optimize the use of digital technology in healthcare delivery.
Average Score				**2.75**	
IMS.2.Theorganisation has processes in place for management and control of data and information.					
Commitment	a	**Processes for data collection are standardised.**	Data collection formats were not standardized, leading to inconsistencies in data recording and reporting.	**2**	Standardize data collection formats to ensure uniformity and reliability in documentation and reporting.
Commitment	b	**Data is analysedtomeet the information needs.**	The information needs of the organization were not identified, impacting data-driven decision-making.	**2**	The MIS/HIS data should be collected based on the hospital's information needs and systematically analyzed. To ensure effective data analysis, adequate resources, including manpower, materials, and technology, should be made available.
Commitment	c	**The organisation disseminates the information in a timely and accurate manner.**	No evidence of data analysis was observed, which affected the ability to derive insights and trends.	**1**	The analyzed data should be disseminated to all relevant stakeholders, ensuring transparency and informed decision-making. A policy should be developed to define which data needs to be shared, with whom, and at what frequency.
Commitment	d	**The organisation stores and retrieves data according to its information needs.***	Documented policy could not be evidenced for storage & retrieval of data according to its information needs. Medical record storage was not uniformly maintained across the healthcare organization.	**2**	A documented policy should also be established for the storage and retrieval of data, aligning with the hospital's information needs and regulatory requirements. Also Ensure uniform storage of medical records by defining clear guidelines and protocols for record-keeping.
Commitment	e	**Clinical and managerial staff participates in selecting, integrating and using data for meeting the information needs.**	No multidisciplinary committee was formed to guide the selection of indicators, measurement of trends, and initiation of corrective actions.	**1**	A multidisciplinary committee, comprising both clinical and managerial staff, should be formed to provide guidance on the selection of key indicators, measurement of trends, and initiation of corrective actions for continuous quality improvement.
Average Score				**1.6**	
IMS.3. The patients cared for by the organisation have a complete and accurate medical record.					
CORE	a	**The unique identifier is assigned to the medical record.**	Each medical record had a unique identifier; ensuring individual patient records could be tracked.	**5**	Every medical record should have a unique identifier, ensuring proper tracking and retrieval. A documented policy should be

					developed and implemented to standardize this process.
Commitment	b	**The contents of the medical record are identified and documented.***	The organization had identified authorized personnel for making entries in medical records; however, this was not documented in a policy.	**2**	Medical records should be systematically organized, with all identified sheets filed in a sequential order. Additionally, medical-legal case records should include all mandatory information to meet compliance requirements.
CORE	c	**The medical record provides a complete, up-to-date and chronological account of patient care.**	Medical records were arranged chronologically, maintaining a sequential account of patient care. Also Completion of medical records could not be evidenced, indicating potential gaps in documentation.	**3**	Medical record should have all the identified sheets filed in a sequence order. It should ensure that all medical legal case records have mandatoryinformation. All pages in medical records should be numbered to maintain record integrity and facilitate easy reference.
Commitment	d	**Authorised staff makes the entry in the medical record.***	Authorised satff signatures were not identifiable, and stamps for doctors were not available, making verification of records challenging.	**2**	To improve adherence and implementation, stamps with doctors' names should be introduced, ensuring clear identification and reducing documentation errors.
Commitment	e	**Entry in the medical record is signed, dated and timed.**	Medical record entries were inconsistent in terms of naming, signing, dating, and timing, impacting record integrity.	**3**	The process of ensuring complete and properly documented medical records requires significant time and effort. Therefore, the hospital should emphasize regular reinforcement and training, particularly for doctors, to enhance compliance.
Commitment	f	**The author of the entry can be identified.**	Consultant signatures were not identifiable, and stamps for doctors were not available, making verification of records challenging.	**2**	A policy on the use of abbreviations should be developed, along with a standardized list of accepted abbreviations, to ensure consistency and prevent misinterpretation in medical documentation.
Commitment	g	**The medical record has only authorized abbreviations.**	A documented policy on the use of abbreviations was not available, increasing the risk of misinterpretation.	**1**	The organization needs to develop a policy on usage of abbreviations and a list based on accepted practices.
Average Score				**2.57**	
IMS.4.The medical record reflects continuity of care.					

Commitment	A	**The medical record contains information regarding reasons for admission, diagnosis and care plan.**	The medical record contains information regarding reasons for admission and diagnosis. However, a documented plan of care could not be evidenced.	**3**	A standardized process should be developed for defining the content of medical records, ensuring consistency and completeness. Additionally, a structured format should be established for documenting the care plan, facilitating uniformity and adherence to best practices.
Commitment	b	**The medical record contains the details of assessments, re-assessments and consultations.**	The medical records contain details of assessments, re-assessments, and consultations. However, the frequency and documentation of re-assessments were not evidenced uniformly during the assessment. This inconsistency may lead to gaps in patient care continuity, delayed clinical decision-making, and non-compliance with standard documentation practices.	**3**	Establish a standardized process for documenting re-assessments at defined intervals as per clinical requirements. Training should be provided to healthcare providers on the importance of uniform documentation. Regular audits and monitoring mechanisms should be implemented to ensure compliance with the documentation of re-assessments, enhancing patient safety and adherence to accreditation standards.
Commitment	c	**The medical record contains the results of investigations and the details of the care provided.**	Yes, the medical record contains the results of tests carried out & the care provided.	**5**	Sustainability of the present practice needs to beensured.
Commitment	d	**Operative and other procedures performed are incorporated inthe medical record.**	Yes, operative & other procedures performed were incorporated in the medical record.	**5**	Sustainability of the present practice needs to beensured.
Commitment	e	**When a patient is transferred to another organisation, the medical record contains the details of the transfer.**	No such record was evident.	**1**	A process of transferneeds to be recorded. The date of transfer, the reason for the transfer andthe name of the receiving hospital needs to be mentioned.
Commitment	f	**The medical record contains a copy of the discharge summary.**	The medical records were having discharge summary but it wasnot consistently signed by treating consultant.	**3**	The discharge summary needs to be consistently signed by treating consultant.
Commitment	g	**In case of death, the medical record contains a copy of the cause of death report.**	Yes, medical record contains the copy of death report.	5	Sustainability of the present practice needs to be ensured.
Commitment	h	**Care providers have access to current and past medical record.**	A structure process was evidenced.	5	Sustainability of the present practice needs to be ensured.

Average Score				3.75	
IMS.5.Theorganisation maintains confidentiality, integrity and security of records, data and information.					
CORE	a	**The organisation maintains the confidentiality of records, data and information. ***	Documented policy was not evident. Usage of tracer card could not be evidenced.	**2**	The usage of the tracer card should be used for the movement of file in & out of the MRD.
CORE	b	**The organisation maintains the integrity of records, data and information. ***	A documented policy was not evident. Instances of data tampering were observed in some medical records.	**2**	The staffs need to be trained on the policy & any correction that need to be done it should be done in accordance with the organizations'defined policy.
CORE	c	**The organisation maintains the security of records, data and information. ***	Documented policy was not evident. The records of pest &rodent control measures also could notbeevidenced.	**2**	The organisation needs to develop & implement the same. For physical records, pest & rodent control measures need to be done & for electrical data, there should be protection against virus/ Trojans & a proper backup procedure should be produced & implemented.
Achievement	d	**The organisation uses developments inappropriate technology for improving confidentiality, integrity and security.**	Documented policy was not evident.	**1**	A documented policy should be developed and implemented to ensure the confidentiality, integrity, and security of medical records within the hospital. This policy should outline measures for data protection, access control, storage, and retrieval, ensuring compliance with regulatory standards and safeguarding patient information.
Commitment	e	**The organisation discloses privileged health Information as authorized by the patient and/ or as required by law.**	No such documented Policy / system could be evidenced.	**1**	A written procedure for the communication of privileged health information should be developed and implemented. This procedure should define authorized personnel, modes of communication, confidentiality safeguards, and compliance with legal and ethical guidelines to ensure secure and appropriate information sharing.
Commitment	f	**Request for access to information in the medical records by patients/ physicians and other public agencies are addressed consistently. ***	No Documented policy was evident to address such cases.	**1**	A policy should be developed and implemented to guide the response to queries, ensuring clarity, consistency, and adherence to confidentiality and regulatory requirements. This policy should outline authorized personnel,

					response timelines, documentation procedures, and escalation mechanisms for efficient query resolution.
Average Score				**1.5**	
IMS.6. The organisation ensures availability of current and relevant documents, records, data and information and provides for retention of the same.					
CORE	a	**The organisation has an effective process for document control.***	The process on document control was not available.	**2**	A document control process should be developed and strictly adhered to for all forms, formats, and registers used in the hospital. This process should ensure that all documents required by the Quality Management System (QMS) are under the control of Top Management across both clinical and non-clinical departments. It should include version control, authorization, periodic review, accessibility, and archival procedures to maintain document integrity and compliance.
CORE	b	**The organisation retains patient's clinical records, data and information according to its requirements.***	A documented policy on data storage and retrieval was not evidenced.	**2**	The hospital develops and implements a standardized policy to ensure secure, systematic, and accessible storage and retrieval of data in compliance with regulatory and operational requirements.
Commitment	c	**The retention process provides expected confidentiality and security.**	Documented policies and procedures for maintaining confidentiality and security of information could not be evidenced. .	**2**	The hospital should develop and implement documented policies and procedures to ensure the confidentiality, integrity, security, and proper retention of patient information. These should include: • Access control measures to restrict unauthorized access. • Data encryption and secure storage protocols. • Retention and disposal guidelines to ensure that medical records are stored for the required duration and securely disposed of after the retention period. • Guidelines for sharing privileged health information in compliance with legal and ethical standards.

					• Regular audits and training to ensure staff awareness and adherence. • Incident response procedures for data breaches or unauthorized access. This structured approach will ensure compliance with regulatory requirements while safeguarding patient data.
Commitment	d	**The destruction of medical records, data and information is in accordance with the written guidance.***	Documented policy was not evident.	**2**	A documented destruction policy for medical records, data, and information should be developed and implemented. .
Average Score				**02**	
IMS.7.The organisation carries out review of medical records.					
CORE	a	**The medical records are reviewed periodically.**	The process for reviewing medical records was not documented, and a medical audit checklist was not available.	**2**	A structured system for reviewing medical records should be integrated with the Medical Audit process to ensure comprehensive evaluation.
Commitment	b	**There view uses a representative sample based on statistical principles.**	There was no established system for medical record review, and the absence of an audit checklist hindered systematic evaluation.	**2**	A structured system for reviewing medical records should be integrated with the Medical Audit process to ensure comprehensive evaluation.
Commitment	c	**The review is conducted by identified individuals.**	The organization has not designated or authorized individuals responsible for conducting medical record reviews.	**1**	The organisation should identify & authorized such individuals.
Commitment	d	**The review of records is based on identified parameters.**	A formal review process for medical records was not in place. No specific parameters were identified for assessing the completeness and accuracy of medical records.	**2**	The parameters for reviewing of records need to be identified. Parameters include the completeness of consent forms, availability of operation / procedure notes etc.
Commitment	e	**The review process includes records of both active and discharged patients.**	The process for reviewing medical records was observed only for discharged patients.	**2**	For a comprehensive study, both current and past medical records should be reviewed to assess the overall performance of medical record-keeping practices.

Commitment	f	**The review points out and documents any deficiencies in records.**	There was no documented process for medical record review, and as a result, Corrective and Preventive Actions (CAPA) could not be evidenced during the assessment.	**2**	This review shall lead to new recommendations for enhancing medical record maintenance and completion. Based on the review team's suggestions, necessary actions should be implemented to address identified gaps and improve overall practices.
Commitment	g	**Appropriate corrective and preventive measures are undertaken.**	The absence of a structured medical record review process prevented the implementation and evaluation of CAPA measures.	**2**	A structured process for medical record review should be established and implemented to facilitate the identification of gaps, ensure compliance, and enable the effective implementation and evaluation of Corrective and Preventive Actions (CAPA).
Average Score				**1.85**	
Chapter Average Score				**2.28**	

7.1 Summary of Score of various Chapters:

Based on a detailed gap assessment of each standard and objective element of NABH, the following conclusions can be drawn.

S.No.	Chapter	Average Score
1	AAC	2.26
2	COP	1.87
3	MOM	1.71
4	PRE	2.22
5	IPC	2.20
6	PSQ	1.18
7	ROM	2.40
8	FMS	2.02
9	HRM	1.79
10	IMS	2.28
	Overall Average	**1.99**

Note:

1. An overall compliance rate of at least 80% for objective elements at the "Commitment Level."
2. An overall compliance rate of at least 80% for objective elements at the "Achievement Level."
3. An overall compliance rate of at least 80% for objective elements at the "Excellence Level."
4. Improvement in the scores of objective elements that were rated 3 or lower in the previous assessment.
5. The score for every core objective element must not be less than 4.
6. No individual standard should have more than one objective element scored as 2 or lower.
7. The average score for individual standards must not be less than 4.
8. The average score for individual chapters must not be less than 4.
9. Every objective element with a score of 3 or below must have an accepted action plan with defined timelines.

The above table projects the area which need improvement and focus, although detailed remarks against each objective element have been mentioned in gap assessment toolkit.

Equal efforts should be made for all chapters to meet the stated accreditation requirements. However, the highest priority should be given to the Care of Patients, Management of Medications, Infection Prevention and Control (IPC), Patient Safety & Quality Improvement, Facility Management and Safety, and Human Resource Management, as these chapters have the lowest scores compared to others.

8. *Recommendations*

.....Paving the path for future

On the basis of detailed Gap Assessment conducted on every standard and objective element of NABH 6th edition, following recommendations are being suggested:

A detailed set of recommendations to address infrastructural and operational deficiencies in the hospital. Below are key observations and action points to ensure compliance, safety, and efficiency:

➢ Operation Theatre (OT) & CSSD

1. Ensure proper design and zoning of the Operation Theatre (disposal, protective, clean, and sterile zones) based on activity type, circulation pattern, and sterility requirements.
2. Designate a dedicated area for CSSD, following zoning principles with a unidirectional flow to ensure efficiency.
3. CSSD should have four zones: unclean & washing area, assembly & packing area, sterilization area, and sterile storage.
4. Laundry layout should follow unidirectional flow, including unclean & washing, assembly & packing, sterilization, and sterile storage areas.

➢ Fire Safety

5. Install adequate fire safety measures, including smoke detectors and sprinklers in all hospital areas.
6. Identify and ensure obstruction-free fire exit routes for safe evacuation.
7. Ensure fire doors are compliant and install smoke seals.
8. Improve fire safety signage and pressurize lifts and staircases for enhanced safety.

➢ Biomedical Engineering & Equipment Maintenance

9. Employ a Biomedical Engineer to maintain logs, conduct periodic inspections, and ensure equipment calibration and functionality.
10. Ensure 24/7 availability of maintenance staff for immediate equipment repairs.
11. Maintain proper logs for all engineering and biomedical equipment.
12. Establish and consistently follow preventive maintenance and calibration schedules for biomedical equipment.

➢ Medicine Storage & Emergency Preparedness

13. Ensure proper storage of medicines across the hospital, including pharmacy areas.
14. Equip all departments with crash carts for emergency medicine storage and accessibility.
15. Display high-alert and LASA (Look-Alike Sound-Alike) drugs, ensuring proper labeling and storage.
16. Stores cut medication strips with accurate details and segregate expired drugs with proper labeling.

➢ Hazardous Material Management

17. Segregate hazardous materials based on their nature (flammable & corrosive) and store them in a well-ventilated, designated location.
18. Ensure proper Material Safety Data Sheets (MSDS) are available for hazardous material storage.
19. Improve biomedical waste management by ensuring proper drainage and using puncture-proof, leak-proof containers for sharps disposal.
20. Centralize biomedical waste, DG area, and transformer area with restricted entry and proper barricading.

➢ Structural & Facility Enhancements

21. Address infrastructural issues such as building damages, debris clearance, and seepage through an annual maintenance plan.
22. Implement risk assessment mechanisms for new construction or renovations, addressing air quality, infection control, and fire safety.
23. Ensure isolation rooms have proper differential pressure monitoring and infection control measures.

➢ Patient Safety & Accessibility

24. Install safety devices, including side rails for patient beds, safety belts for stretchers, and grab bars in washrooms.
25. Install emergency call bells in patient washrooms and bedsides for accessibility.
26. Ensure food distribution follows IPSG (International Patient Safety Goals) standards and designate a room for RT feed preparation.

➢ Clinical & Operational Improvements

27. Modify and standardize hospital consent forms, ensuring availability and strict adherence to usage.
28. Strengthen narcotics management processes to ensure compliance with regulatory requirements.
29. Implement environmental monitoring for temperature and humidity in ward medicine rooms, pharmacy stores, and CSSD consumable storage areas.

30. Designate proper areas for chemotherapy preparation and ensure biosafety cabinet usage.

➢ Hospital Staffing & Training

31. Strengthen staffing for Quality Team, Quality Nurses, Infection Control Nurses (ICN), Fire Safety Officers, and Biomedical Engineering Team.
32. Conduct regular training and skill-building exercises for hospital staff, including medical, paramedical, and support staff.
33. Implement sustained monitoring, supervision, and evaluation of service delivery to ensure continuous improvement.

➢ Documentation & Record-Keeping

34. Strengthen clinical documentation processes, including regular review and updates by a multidisciplinary team.
35. Establish a centralized medical record department for better accessibility and management.
36. Display patient rights and responsibilities, scope of services, and departmental sub-scopes in prominent locations.

➢ Security & Surveillance

37. Install clear signage for restricted areas and unauthorized access points.
38. Strategically place CCTV cameras to provide full coverage of hospital premises.
39. Improve medication inventory management to prevent stock shortages and ensure timely replenishment.

These recommendations prioritize infrastructure improvements, safety compliance, and operational enhancements to ensure a well-structured, safe, and efficient healthcare environment.

9. Conclusion

The team, in its concluding remarks, would like to emphasize both the hospital's existing strengths and the critical areas that require further strengthening. While the hospital has demonstrated commendable performance in areas such as Pharmacy, Blood Bank, and Biomedical Waste Management Storage, which have scored the highest against the NABH criteria, there remain significant gaps in Facility Management System, Patient Safety & Quality Improvement, Patient Rights & Education, Infection Prevention and Control (IPC), Human Resource Management, and Medication Management, which necessitate immediate attention.

To ensure sustained quality care, the hospital must document and institutionalize processes, procedures, and mechanisms that facilitate a structured and efficient workflow. A structured approach to risk assessment and mitigation (HIRA) should be implemented, particularly for segregating hazardous materials based on their nature to reduce occupational hazards. Additionally, a hospital-wide infection prevention and control program should be reinforced, ensuring that all departments are aligned with the highest safety and hygiene standards.

The fully met NABH standards should be continuously monitored and sustained, while the gaps in compliance must be addressed as a priority. Special focus should be placed on standards that are completely unmet, as they pose the most significant risks to quality, safety, and compliance. Through structured policy formulation, effective implementation, and continuous monitoring, the hospital can achieve a robust quality management system that ensures excellence in patient care and operational efficiency.