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QUALITY COUNCIL® OF INDIA
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राष्ट्रीय अस्पताल और स्वास्थ्यचर्या-प्रदाता प्रत्यायन बोर्ड
National Accreditation Board for Hospitals and Healthcare Providers
NABH

6th EDITION
EFFECTIVE 1st JAN, 2025

NABH ACCREDITATION STANDARDS FOR HOSPITALS

QUALITY : SAFETY : WELLNESS

National Accreditation Board For Hospitals and Healthcare Providers (NABH)

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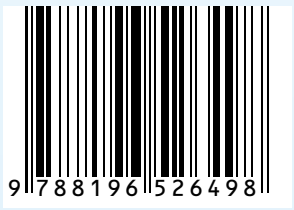

6th Edition Effective 1st Jan, 2025

ISQuaEEA | International Society for Quality in Health Care External Evaluation Association

National Accreditation Board for Hospitals and Healthcare Providers (NABH)

NABH Accreditation Standards for Hospitals - 6th Edition

Awarded by ISQua EEA
following an independent assessment
against the Guidelines and Principles for the
Development of Health and Social Care Standards
5th Edition

The period of Accreditation of these Standards
is from

August 2024 until **August 2028**

Dr Ezequiel García-Elorrio President

Elaine O'Connor Head of Operations

ISQua EEA | International Society for Quality in Health Care External Evaluation Association

National Accreditation Board for Hospitals & Healthcare Providers (NABH)

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following an independent assessment
against the
Guidelines and Standards for
External Evaluation Organisations,
5th Edition

The period of Accreditation for this Organisation

June 2022 is from **June 2026** until

Prof Jeffrey Braithwaite, President

Ms Elaine O'Connor, Head of Operations

FOREWORD

National Accreditation Board for Hospitals and Healthcare Providers (NABH) over the years has established itself as a beacon for creating an ecosystem of quality healthcare in India and has played a crucial role in driving the healthcare landscape by promoting and ensuring a culture of quality, safety, and continuous improvement in the last 19 years.

It is with great pleasure and a sense of accomplishment that I introduce the 6th edition of the NABH Accreditation Standards for Hospitals. As we navigate through the dynamic landscape of healthcare, this edition stands as a testament to the continuous commitment of NABH towards elevating the quality and safety of healthcare services in our nation.

The NABH hallmark methodology of the ten Chapters approach has been retained; but the Objective Elements have been pruned to a total of 639 out of which 105 are in the Core category which will be mandatorily assessed during each assessment, 457 are in Commitment category, which will be assessed during the final assessment, 60 are in Achievement category to be assessed during surveillance and 17 are in Excellence category which will be assessed during re-accreditation.

Healthcare is a rapidly evolving field, marked by advancements in medical science, technology, and a growing awareness among patients about their rights and expectations. In this context, the NABH Accreditation Standards for Hospitals, play a pivotal role in ensuring that healthcare organizations adhere to the highest standards of quality, safety, and patient-centric care. This edition builds upon the foundation laid by its predecessors, incorporating valuable insights gained from the experiences of healthcare providers, professionals, and accreditation experts. It reflects a thorough and thoughtful review of the advancing healthcare landscape, international best practices, and the unique challenges faced by healthcare organizations in our diverse and populous country.

Key highlights of the 6th edition include a comprehensive approach to patient-centered care, a focus on outcomes and continuous quality improvement, and an emphasis on the use of technology to enhance healthcare delivery. It also places increased importance on the well-being and satisfaction of healthcare professionals, recognizing their pivotal role in delivering high-quality care. The integration of sustainable measures within these accreditation standards in its latest edition reflects a forward-thinking and responsible approach towards healthcare delivery. This strategic emphasis on sustainability aligns with the broader global movement towards environmentally conscious and socially responsible practices. 6th edition has also added annexures on Medication errors, Risk Management, Patient Reported Outcome Measures, Patient-Reported Experience Measures and Clinical Audit to help the hospitals in understanding the standards better.

As we move forward, the 6th edition of NABH Accreditation Standards for Hospitals serves as a guide for healthcare organizations aspiring to not only meet the expectations of accreditation but to surpass them and set new benchmarks for excellence. It is not merely a set of guidelines but a roadmap towards achieving a culture of continuous improvement, innovation, and patient safety.

I extend my heartfelt appreciation to the dedicated professionals, healthcare providers, and experts who have contributed their time, expertise, and insights in the development of this edition. Their commitment to excellence has undoubtedly strengthened the fabric of our healthcare system.

In conclusion, the 6th edition of NABH Accreditation Standards for Hospitals is a valuable resource for healthcare organizations committed to providing safe, effective, and patient-centered care. May this edition inspire a new era of excellence in healthcare and contribute towards the collective goal of ensuring that every patient receives the highest quality of care possible.

NABH remains committed to its mission of taking Quality Safety and Wellness to the last man in the line.

Jai Hind

Dr. Atul Mohan Kochhar
CEO, NABH

ACKNOWLEDGEMENTS

I extend my sincere gratitude to all the members whose unwavering dedication and expertise have contributed to the successful development and release of the 6th edition of the NABH Accreditation Standards for Hospitals. This milestone edition represents a collective effort and marks a significant step forward in our continuous pursuit of excellence in healthcare.

I place my heartfelt thanks and deepest gratitude to Shri. Jaxay Shah, Chairman of Quality Council of India, for his vision to take quality to the grassroots and permeate the idea of quality in the DNA of every Indian citizen. This extensive vision has been an inspiration for the development of this edition.

I would like to express my deepest gratitude to Mr. Rizwan Koita, Chairman NABH, who has played a pivotal role in advancing the standards of healthcare excellence in our nation and has been the guiding light throughout the development of this edition. I thank him for his invaluable insights and commitment to improving healthcare standards that have been instrumental in shaping the content of the 6th edition.

I am thankful to Padma Shri Prof. (Dr.) Mahesh Verma, former Chairman NABH, who was one of the chief motivational forces behind the 6th edition standard.

I sincerely thank Mr. Chakravarthy T. Kannan, Secretary General of Quality Council of India for his invaluable contributions to the healthcare community and commitment to fostering excellence in healthcare standards.

I thank all board members of NABH for giving significant real-world insights that have resulted in the continuous improvement of the accreditation standards.

The collective expertise, tireless efforts, and commitment to excellence of the Technical Committee of NABH, have been instrumental in shaping a set of accreditation standards that not only meet the highest benchmarks but also reflect the dynamic nature of the healthcare industry. Their deep understanding of the intricacies of healthcare, coupled with a passion for continuous improvement, has significantly enriched the content of the standards. I express my sincere gratitude towards the invaluable contributions of the committee to the development of the 6th edition of NABH Hospital Accreditation Standards, the reviewing, refining, and enhancing of the accreditation standards have contributed to the evolution of a robust framework that reflects the current realities and future aspirations of the healthcare sector.

I thank all our passionate assessors, management of the hospitals, quality managers, clinicians, nurses and paramedics who gave us extensive feedback to improve upon the standards. Thank you for your contributions, and we look forward to the continued journey of advancing healthcare excellence in India.

I would like to thank all the officers at the NABH Secretariat for working relentlessly in order to ensure the completion of this edition within the time frame.

The 6th edition of NABH Hospital Accreditation Standards, stands as a testament to the collaborative efforts of a diverse and committed healthcare community. Together, we strive towards a healthcare ecosystem that prioritizes quality, safety, sustainability, and patient-centred care.

With sincere appreciation, heartfelt and profound. Thank you

Jai Hind

Dr. Atul Mohan Kochhar
CEO, NABH

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About NABH

National Accreditation Board for Hospitals and Healthcare Providers (NABH) is a constituent board of the Quality Council of India (QCI), set up to establish and operate accreditation programs for healthcare organisations. NABH has been established with the objective of enhancing the health system & promoting continuous quality improvement and patient safety. The board, while being supported by all stakeholders, including industry, consumers, government, has full functional autonomy in its operation.

NABH provides accreditation to hospitals in a non-discriminatory manner regardless of their ownership, size, and degree of independence.

International Society for Quality in Healthcare (ISQua) has accredited NABH as an organisation.

Vision: To be apex national healthcare accreditation and quality improvement body, functioning at par with global benchmarks.

Mission: To operate accreditation and allied programs in collaboration with stakeholders focusing on patient safety and quality of healthcare based upon national/international standards, through process of self and external evaluation.

NABH Activities

NABH Accreditation Programmes: NABH offers accreditation to Hospitals, Small Healthcare Organisations, Digital Health, Blood Banks, Eye Care hospitals/clinics, Care Homes, Ayush (Ayurveda, Homeopathy, Unani, Siddha and Yoga and Naturopathy) hospitals, Medical Imaging Services, Dental Healthcare Service Providers, Allopathic Clinics, Ethics Committees and Panchkarma Clinics.

NABH Certification Programmes: NABH offers certification to Medical Laboratory, Nursing Excellence, Emergency Department, Stroke Center, Dental Healthcare Service Providers, Entry Level for Hospitals, Entry Level for Small Healthcare organisation Entry Level Ayush Hospitals and Entry Level Ayush Centres.

NABH Empanelment: NABH offers empanelment program for CGHS, ECHS and Medical Value Travel Facilitator (MVTF)

NABH International: NABH has started its operations overseas under NABH International (NABH I). It offers all accreditation programs as being offered in India. The program is unique as in addition to the accreditation standards it requires compliance with local regulatory requirements.

Training and Education: NABH conducts Educational/Interactive Workshops, Awareness Programmes, and Programme on Implementation (POI) on a regular basis.

Scope and Purpose of the Standards

Scope of the Standards

These standards are applicable to any Health care organization (HCO) provided the HCO fulfils the following requirements:

- The HCO is currently in operation as a healthcare provider.
- The organisation has more than 50 sanctioned in-patient beds.
- The organisation commits to comply with NABH standards and applicable legal/statutory/regulatory requirements.

These standards are to be used by the whole organisation and not for a specific service within the organisation. It is uniformly applicable to all the services being offered by public as well as private healthcare organizations.

Purpose of the Standards

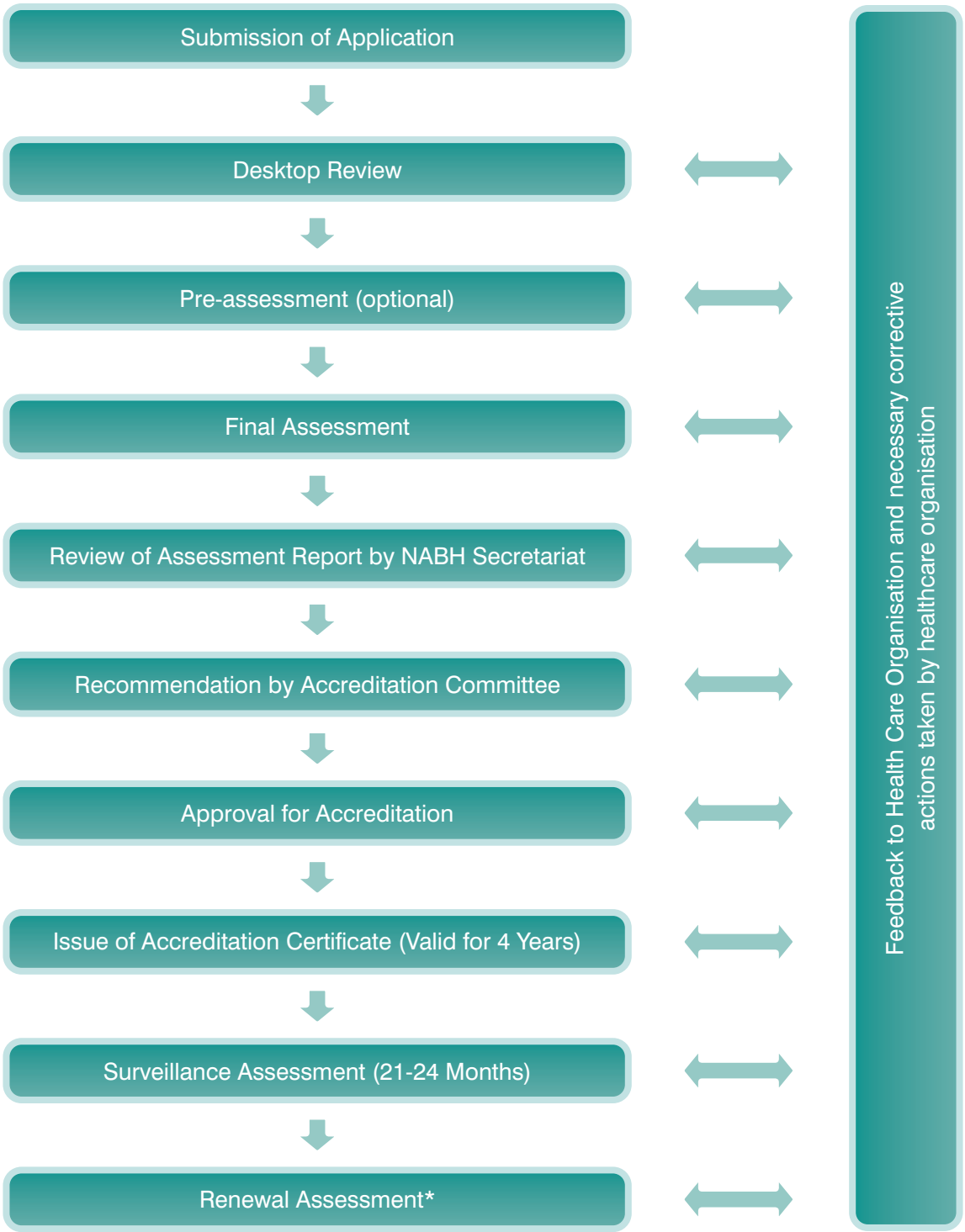
The aim of the standards is to achieve an acceptable level of performance with a view to:

- Improve public trust and community confidence that the organisation is concerned for patient safety and the quality of care;
- Ensure that the organization is sensitive to patients and their families, respect their rights, and involve them in the care process as partners;
- Ensure that the organisations provides a safe and efficient work environment that contributes to staff satisfaction and improves overall professional development;
- Provide an objective system of empanelment by insurance companies and other third parties;

In addition, these standards can also be used to:

- Guide the efficient and effective management of a HCO;
- Guide the organisation in the delivery of patient care services and in its efforts to improve the quality and efficiency of those services;
- Review the important functions of an HCO;
- Provide an opportunity to explore compliance expectations of standards and the additional requirements related to safety and regulation.

Overview of the NABH Accreditation Process



* For Renewal Assessment, the accredited hospital has to apply 6 months prior to expiry of validity of accreditation.

How to read the standard?

The standard focuses on the key points required for providing patient-centred, safe, high-quality care. The interests of various stakeholders have been incorporated into the standard. They provide a framework for quality assurance and quality improvement. The focus is on patient safety and quality of patient care. It sets forth the basic standards that organisations must achieve to improve the quality of care. The requirements have been divided into ten chapters. The first five chapters are "patient centric" and the last five chapters are "organization centric". The ten chapters are:

1. Access, Assessment and Continuity of Care (AAC)
2. Care of Patients (COP)
3. Management of Medication (MOM)
4. Patient Rights and Education (PRE)
5. Infection Prevention and Control (IPC)
6. Patient Safety and Quality Improvement (PSQ)
7. Responsibility of Management (ROM)
8. Facility Management and Safety (FMS)
9. Human Resource Management (HRM)
10. Information Management System (IMS)

Every chapter begins with an 'intent'. The intent states the broad requirements of what the organisation needs to put in place and implement to improve the quality of care. This is followed by the 'summary of standards' which lists all the standards of that chapter. The standards and objective elements are explained after the summary. A list of references is provided at the end of all chapters.

What is a standard?

A standard is a statement of expectation that defines the structures and processes that must be substantially in place in an organisation to enhance the quality of care. The standards are numbered serially, and a uniform system is followed for numbering. The first three letters reflect the name of the chapter and the number following this reflects the order of the standard in the chapter. For example, AAC.1. would mean that it is the first standard of the chapter titled 'Access, Assessment and Continuity of Care '.

What is an Objective Element?

It is that component of standard which can be measured objectively on a rating scale. Acceptable compliance with objective elements determines the overall compliance with a standard. The objective element is scored during assessments to arrive at the compliance. The objective element is numbered alphabetically in a serial order. For example, AAC.1.c. would mean that it is the third objective element of the first standard of the chapter titled 'Access, Assessment, and Continuity of Care'.

What is an Interpretation?

The interpretation provides guidance on what the organisation needs to do to ensure that the requirement(s) of the objective element is met. Where applicable, it provides references and suggests a specific methodology that the organisation needs to adhere to. The word 'shall/should' or 'will/would' is used to reflect a mandatory requirement. The interpretation also lists out desirable aspects for the organisation to implement, and the word 'can/could/may' is used to reflect this. During scoring, the desirable aspects are not considered, and they are only used to reflect on the overall achievement of the standard, which is reflected in the assessment report. At places, the interpretation would not be specific and would have used the words like 'adequate/appropriate'. This has been done keeping in mind the diverse nature of healthcare delivery and adhering to the intent of this standard which is to improve the quality of healthcare and at the same time, be feasible. The expectation is that whenever such a phrase has been used in the interpretation/objective element, the organisation shall base its practice on evidence-based/best practice. In some places, the interpretation has listed out examples. The examples are only illustrative in nature, and the organisation has the liberty to decide what/how to implement. However, the requirement of the objective elements would have to be adhered.

Note: The Interpretation for each objective element has been provided only in the Guidebook to NABH Accredation standarads for Hospitals - 6 Edition

Core Objective Element

Certain Objective Elements in the standard have been designated as Core Objective Element. These are requirements that the organisation should have in place to ensure the quality of care or the safety of people within the organisation. CORE has been used to identify such Objective Element.

Levels

The rest of the Objective Elements have been divided into three levels, namely commitment, achievement, and excellence. This has been done keeping in mind the fact that quality is a journey and that accredited organisations need to improve constantly. Most of the objective elements would be at the commitment level, and these would form the basis for accreditation at the end of the Final assessment. The level of compliance with the standards placed at the achievement and excellence level would also count towards continued accreditation.

Other Sections Included in the Standard Book

- About NABH
- Scope and purpose of the standards
- Overview of the NABH accreditation process
- System Documentation
- Scoring
- Accreditation decision and maintenance of same
- Summary of changes
- Abbreviations
- Glossary
- Index

In the book, certain objective elements require mandatory system documentation. The same have been identified by the * (asterisk) mark. A detailed guide on documentation is provided in the next section.

System Documentation

Introduction

Documentation for systems is complicated and best left to specialists in this line, is a perception that is wrongly carried by even the organisations which have well established, functioning, and externally assessed quality systems. It is a notion that is far removed from the truth. An attempt is made here to clear the concepts of documentation and make it simple enough to be carried out by the staff who is responsible for executing various tasks in the organisation without depending on anyone else. This will keep the documentation closer to reality and flexible in the hands of the organisation. It will also reduce the dependence on external sources for creating documents that are many times far removed from reality.

Why do we need documentation?

The fundamental purpose of documentation is the standardisation of actions across various departments and functional units in the organisation. Documentation is required for clarity on actions, continuity of systems, and information on the established system that is common to all levels of staff. Therefore the documentation has various components:

- **Operation System Documentation:** It defines the procedures and processes that are required to be carried out in a standardised manner.
- **Quality system documentation:** The actions that are specifically required for activities that are related to the quality system and are not covered under operation system documentation
- **Specialised documents:** Safety System Documentation, business continuity documentation.

Type of documents

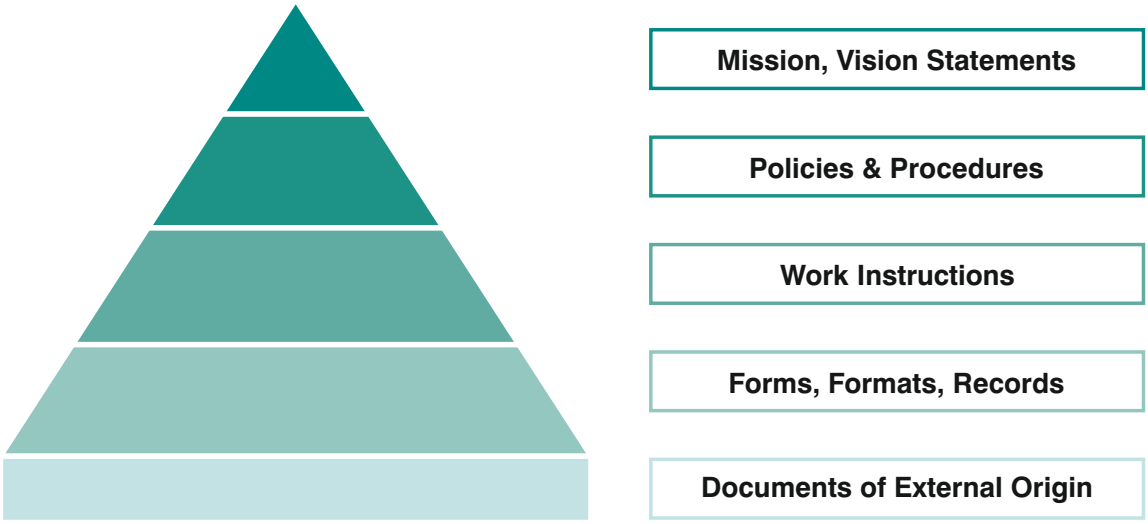
From the top level of planning to the level of maintaining records of activities, the documentation follows a general principle as below:

1. **Policy Documents:** Mission Statement, Vision Statement, Strategic plans, Policies which transcend time and act as guidance in the changing scenarios of the operational, legal, technologically changing environment in which the organisation conducts its activities. They are the principles on which planning is based while adapting to the changes.
2. **System Documentation:** Operational and quality system documentation to carry out the activities in conformance with the mission and vision statement. This includes what is commonly known as Standard Operating Procedures or SOPs.
3. **Work Instructions:** These are instructions in a detailed manner for executing tasks, including the physical steps to be carried out.

4. **Forms and Formats:** These are various forms and formats to capture information as a record of the execution of various activities. The records are filled forms. The forms, formats, and records can be in a physical or electronic form. These can be entries as numerical, text, image, sound, etc.

Many organisations add a fifth category to this as Externally Acquired documents such as licenses, statutory clearances, Legal contracts and Memoranda of Understanding, etc.

The documentation structure, if visualised as a pyramid, appears as below:



Vision Statement: Vision statement defines the direction that the organisation wants to chart.

Mission Statement: Mission statement defines the purpose of the existence of the organisation.

Policies: These are statements that transcend time to decide on the way the activities of the organisation will be executed. These statements connect mission and vision statements with the processes and procedures of the organisation. These may change over a relatively moderate time frame of a few years. Whenever these are developed or altered, the focus of this activity will always be guided by the mission and value statements forming a link between the mission and value statements and the actions on the ground which are documented through the Standard Operating Procedures.

Standard Operating Procedures: These documents define the steps that will be carried out to complete tasks or parts of tasks. These are also known as Operations Documentation or Operations Manual. These can be multiple manuals specific to departments or a group of related tasks and will have documentation for the processes & procedures related to the concerned department, a section or activity. The term standard refers to its being standardised for the time being and does not mean that it cannot be altered. Most of the organisations with actively followed systems will address review of these documents for correctness and adaptation at least once a year and sometimes even twice a year. It is essential that these documents are kept relevant to the requirements of alteration to processes and procedures that are necessary from time to time due to the improvements, change in technology, and changes to statutory norms, etc. The term standard, therefore, refers to its current relevance rather than its permanent nature and everlasting non-alterability. This is important to understand because many organisations have the reluctance to alter these documentations mistaking the word standard for unalterable, sometimes even after the processes have changed.

Forms and formats: For the capture of information in a complete and relevant manner, this must be done in a standardised manner. This is achieved through various forms and formats to maintain the records of activities. The forms can be a single page, multipage or a register in which the entries are made. The purposes can be from just capturing whether an activity was carried out, to a very elaborate capture of values related to many parameters related to the activity. Example of the former being tick marking when some action was carried out and the example of the latter being an elaborate record of the initial assessment of the patient on arrival to the wards. Records are filled forms and formats. Forms and formats can be altered through the set alteration process, but records cannot be altered. Forms, formats, and registers are also a part of the system of controlled documents and must have their identity. It is not always necessary to number each form, and this will depend on whether the organisation wants to assign a separate identity to each filled form. Such is rarely required.

Documents of External Origin: For the sake of making the documentation system inclusive, some organisations include documents of external origin. These are licenses, statutory documents, Memoranda of Understanding with various organisations, etc. These are not alterable.

Temporary Documents: Many notes, documents, records in an informal manner get created during the execution of processes. These help in reducing errors or are intermediaries to further calculations. These are not necessarily maintained in a set format and can be rough entries on notepads, diaries, etc. They need not be preserved if the information content does not have lasting importance and the final entry is anyway going to be made in a set format. Such documents do not form a part of the formal documentation system

Documentation related to processes and procedures

The documentation related to processes and procedures deals with operating procedures, quality system procedures, safety procedures, etc. This is the documentation that is commonly known as Standard Operating procedures or SOPs. This can be documented as steps which are numbered or bulleted or in the format of flow charts. Flowcharts use a method of commonly recognised symbols, such as a circle or ellipse for start or end of the process, rectangle for activity, diamond for decision making step, picture of rolled partially document for the steps where documentation is necessary, etc. Most word processing software applications have these symbols inbuilt for use.

Which processes should be documented?

The organisations sometimes fall into a dilemma about the extent of documentation that should be followed. There are some guidelines which can help. Though the list is not exhaustive, the following processes and procedures require documentation:

- Procedures which are required to be followed uniformly at various locations across the organisation
- Procedures which are required to be followed uniformly across time
- Procedures which, if not followed uniformly and correctly will increase the risk to patients, staff or visitors
- Procedures which, if not followed uniformly, can lead to serious consequences concerning the loss of material, time, physical damage, equipment, etc.
- Procedures which are complicated leading to either missing of some steps or risk of variation in their execution

- Procedures which are required to be followed uniformly in spite of high turnover of human resources
- Procedures which are specific to the organisation as against procedures which are universally accepted or that are part of standard curricula of those professionals who carry out these procedures.

How to develop documentation that is easy to follow?

The following steps can help in developing documentation that is easy to follow:

- Providing a clear plan of documentation architecture. This can be as a print map or in electronic form
- Using the uniform format for the visual appearance of the documents to cover their appearance, fonts, symbols, page layout, etc.
- Adding colour codes, font changes for different documents
- Participation of the staff that is involved in carrying out the activities in the development process for documentation
- Using the same language and form of the structure of language as per the users
- Using a direct form of speech (active) than the indirect form (passive)
- Providing Chapter Index or Index of words
- Sequencing activities as per their actual sequence of execution in time
- If necessary replicate the documentation related to specific processes and procedures within all relevant documentation with a clear reference to the original document
- Making relevant documents available at the location of use
- Keeping relevant documents available all days of the year and all times of day and night as per the requirements of execution of the activities.
- Removing obsolete documents from all locations, other than those retained for archiving

Controlled Documents

As mentioned before, the documents bring uniformity and clarity for the execution of activities in the organisation. It is, therefore, imperative that they are not altered without the knowledge of the creator or the staff who is specifically authorised for this. Such documents are known as Controlled Documents. All types of documents described above come under this category, except for the temporary document.

Characteristics of controlled documents:

- Each document is named
- The purpose of the document is defined
- There is a date of creation of the document
- There is a date of approval of the document
- There is a date of review of the document
- There may be a date of expiry of the document
- Signatory for creation is defined.
- Signatory for approval is defined.
- The signatory for alterations is defined. This may be the same or different from the creator.

- Each page is numbered.
- The document may have a number assigned to it.

This information about the identity of the document may be contained in the form of a box at the top of the document. If put in this way, such a box is known as Control Box. It may be put at the top of the document without any box format. It is just that this form is an integral part of each Controlled Document. The staff designation signing the document with the corresponding signature is maintained at the bottom of the page. The dates related to the document may be mentioned at the beginning page of the document and may not be there on each page, though most organisations put it on each page. The alphanumeric identity, if assigned to such document must form a system that may include department, a section of the department, purpose or activity referred in the document, version number of the document, page number. The purpose of this exercise is to create a unique identity for each page of the controlled document. It is not mandatory to have an expiry date for the document.

An example of the control box is given below:

Name of Organisation	Document Code	Date of Issue	Date of next revision / validity

A similar box appears at the bottom of the page for the signatory, an example of which is given below:

Authorised by: Designation	Issue No./Version No./	Issued by: Designation
Signature		Signature

Body of Document

There are many formats for the documentation of the contents. One of them is given below:

Name of Organisation	Document Code	Date of Issue	Date of next revision / validity
Dept. Name/Process			

- Name of the Document:
- Purpose of the Process that is documented
- Start point
- End Point
- Procedure:
  Step 1: XXXXXXXXXXXX
  Step 2: XXXXXXXXXXXX
  Step 3: XXXXXXXXXXXX
  Step n: XXXXXXXXXXXX
- Related Records
- Related documents

Authorised by: Designation	Issue No./Version No./	Issued by: Designation
Signature		Signature

MANUALS

One category of controlled documents is manuals. Manuals are documents that are used by various departments as against the SOPs which pertain to a particular department. Some of the examples of manuals are which deal with various specific functions such as infection prevention and control, safety, quality, etc. If the departmental SOPs are vertical and restricted to a particular department, then the manuals are horizontal and are used across many departments. The format of the manual is similar to the SOPs but has reference or duplication of departmental SOPs that have relevance to the subject of the manual and are required to be duplicated for coherence and completeness.

Scoring

The objective elements stated in the standards are scored during the assessment. The same is also used for scoring during the self-assessment. The scoring is to be done using a five-point scale. When applying a score, use the following rationale to determine the level of compliance.

Score	Rationale
1	**No compliance** • No systems in place and there is no evidence of working towards implementation • None or little (≤ 20%) of the samples meet the requirement(s) of the objective element • Non-conformity exists
2	**Poor compliance** • Elementary (limited) systems in place and there is some evidence of working towards implementation • Minimal (between 21-40%) of the samples meet requirement(s) of the objective element • Non-conformity exists
3	**Partial compliance** • Systems are partially in place, and there is evidence of working towards implementation • Some (between 41-60%) of the samples meet the requirement(s) of the objective element • Non-conformity exists
4	**Good compliance** • Systems are in place, and there is evidence of working towards implementation • The majority (between 61-80%) of the samples meet the requirement(s) of the objective element • Non-conformity could exist
5	**Full compliance** • Systems are in place, and there is evidence of implementation across the organisation • Almost all (between 81-100%) of the samples meet the requirement(s) of the objective element • No Non-conformity

The basis for scoring shall be implementation. However, if there is inadequate/inappropriate system documentation, the score could be downgraded by one.

NOT APPLICABLE (NA) CRITERIA

There could be a few standards/objective elements that may not be applicable to some organisations. A standard/objective element may be described as not applicable when the statement/content of the element would never occur in the organisation. The organisation has to identify such standard/objective element before the assessment and inform the NABH secretariat of the same. During the assessment, the assessment team shall discuss the same with the organisation and a final list shall be arrived at.

Accreditation Decision and Maintenance of same

After the completion of the final assessment, the assessment team submits the report and the scoring sheet to the National Accreditation Board for Hospitals and Healthcare Providers (NABH). The organisation is expected to submit evidences of corrective actions/ an action plan with timelines for rectifying the identified non-conformities. The action plan is reviewed by the assessment team, and a comment is placed indicating acceptance or non-acceptance.

The accreditation committee reviews the assessment report, the scoring sheet and the submitted evidences of corrective actions/an action plan with timelines and the assessment team's comments regarding the same. Following the review, a decision is taken.

Accreditation decision criteria following the final assessment

For an organisation to be accredited by NABH, an overall compliance rate of at least 80% must be achieved, and the following rules must be met:

1. The score for every core objective element must not be less than 4.
2. Overall compliance rate of at least 80% for objective elements at 'commitment' level.
3. No individual standard should have more than one objective element scored as 2 or less.
4. The average score for individual standards must not be less than 4.
5. The average score for an individual chapter must not be less than 4.
6. Every objective element with a score of 3 or below should have an accepted action plan with timelines.

Note: The cumulative score obtained for all objective elements is considered for calculating the overall compliance. At the end of the final assessment, only the objective elements marked at 'core and commitment' level are considered for scoring. Hence, the overall compliance of 80% corresponds to a score of numerator (562x4) and denominator (562x5) i.e. 2248/2810 = 80%. In case of the not applicable objective element(s), the scoring is modified accordingly by excluding them from the numerator and denominator.

Award

If the organisation meets the criteria listed above, the organisation will be awarded accreditation status for four years with effect from the date of the Accreditation Committee meeting when the result is formally approved.

Maintaining The Award

The standards are designed to measure and support the continual improvement of an organisation's operation. Continuing accreditation status will be subject to the outcome of the surveillance assessment and the re-accreditation assessment. The criteria for maintaining accreditation following these assessments are listed below.

Accreditation decision criteria following the surveillance assessment

For an organisation to continue to be accredited by NABH, an overall compliance rate of at least 80% must be achieved, and the following rules must be met:

1. Overall compliance rate of at least 80% for objective elements at 'commitment' level.
2. Overall compliance rate of at least 80% for objective elements at 'achievement' level.
3. Improvement in the score of objective elements from the previous assessment, which were scored as 2 or less.
4. The score for every core objective element must not be less than 4.
5. No individual standard should have more than one objective element scored as 2 or less.
6. The average score for individual standards must not be less than 4.
7. The average score for an individual chapter must not be less than 4.
8. Every objective element with a score of 3 or below should have an accepted action plan with timelines.

Note: The cumulative score obtained for all objective elements is considered for calculating the overall compliance. At the end of the surveillance assessment, only the objective elements marked at 'core', commitment' and 'achievement' level are considered for scoring. The compliance of 80% of the 'core' and 'commitment' corresponds to a score of numerator (562x4) and denominator (562x5) i.e. 2248/2810 = 80%. In addition to the 'core' and 'commitment', the compliance of 80% of the achievement level corresponds to the score of numerator (60x4) and denominator (60x5) i.e. 240/300 = 80%. Hence, the cumulative score for 'core', 'commitment' and 'achievement' for surveillance assessment corresponds to the numerator (622x4) and denominator (622x5) i.e. 2488/3110 = 80%. In case of the not applicable objective element(s), the scoring is modified accordingly by excluding them from the numerator and denominator.

Accreditation decision criteria following the re-accreditation assessment

For an organisation to continue to be accredited by NABH, an overall compliance rate of at least 80% must be achieved, and the following rules must be met:

1. Overall compliance rate of at least 80% for objective elements at 'commitment' level.
2. Overall compliance rate of at least 80% for objective elements at 'achievement' level.
3. Overall compliance rate of at least 80% for objective elements at 'excellence' level.
4. Improvement in the score of objective elements from the previous assessment, which were scored as 2 or less.
5. The score for every core objective element must not be less than 4.
6. No individual standard should have any objective element scored as 2 or less.
7. The average score for individual standards must not be less than 4.
8. The average score for an individual chapter must not be less than 4.
9. Every objective element with a score of 3 or below should have an accepted action plan with timelines.

Note: The cumulative score obtained for all objective elements is considered for calculating the overall compliance. At the end of the re-accreditation assessment, all the objective elements marked at 'core', commitment', 'achievement' and 'excellence' level are considered for scoring. The compliance of 80% of the 'core' and 'commitment' corresponds to a score of (562x4) and denominator (562x5) i.e. 2248/2810 = 80%. In addition to the 'core' and 'commitment', the compliance of 80% of the achievement level corresponds to the score of numerator (60x4) and denominator (60x5) i.e. 240/300 = 80% and compliance of 80% of the excellence level, corresponds to score of numerator (17x4) and denominator (17x5) i.e. 68/85 = 80%. Hence, the cumulative score for 'core', 'commitment', 'achievement' and 'excellence' for re-accreditation assessment corresponds to the numerator (639x4) and denominator (639x5) i.e. 2556/3195 = 80%. In case of the not applicable objective element(s), the scoring is modified accordingly by excluding them from the numerator and denominator.

The table below summarises the accreditation decision criteria.

	Final	Surveillance	Re-accreditation
Overall compliance (cumulative score)	≥80%	≥80%	≥80%
Commitment (cumulative score)	≥80%	≥80%	≥80%
Achievement (cumulative score)	NA	≥80%	≥80%
Excellence (cumulative score)	NA	NA	≥80%
Core Objective (individual OE score)	≥ 4	≥ 4	≥ 4
Average score for individual standard	≥ 4	≥ 4	≥ 4
Average score for individual chapter	≥ 4	≥ 4	≥ 4
Improvement in the score of OEs that have been scored ≤ 2 in the previous assessment	NA	Required	Required
Individual standard with OEs < 2 (number)	1	1	0
Accepted action plan with timelines for OEs with a score of ≤ 3	Required	Required	Required

Note: For OE with score ≤ 2 an action plan will be sought from the organisation including carrying out of risk assessment.

Feedback

NABH is committed to continually improve the standards for which all the stakeholders are encouraged to provide feedback on continuous basis. The feedback received from stakeholders will be helpful during the next revision of standards.

Your feedback is solicited on the standards, the objective elements, interpretation, scoring, assessment methodology, documentation requirement in terms of the following:

1. Relevance as per existing knowledge, principles, practices, protocols and technology
2. Ease of understanding of language and content
3. Amenability to be measured objectively
4. Their benefits in terms of safety to patient, employee, organisation, environment and community safety
5. The ease with which they can be implemented and achieved by the Healthcare organisation.

The feedback can be provided by visiting our feedback proforma hosted on the website of NABH www.nabh.co after launch of 6th Edition of the standard.

Summary of Chapters, Standards and Objective Elements

Accreditation Standards for Hospitals						
	Standard	Objective Elements	Core	Commitment	Achievement	Excellence
AAC	13	87	6	68	9	4
COP	20	135	13	107	12	4
MOM	11	68	13	48	6	1
PRE	8	52	12	32	7	1
IPC	8	49	13	33	3	0
PSQ	7	46	8	28	7	3
ROM	6	37	4	23	8	2
FMS	7	43	11	29	2	1
HRM	13	76	16	56	4	0
IMS	7	45	9	33	2	1
Total	100	639	105	457	60	17

SUMMARY OF CHANGES

Access, Assessment and Continuity of Care (AAC)		
5th Edition	**6th Edition**	**Remarks**
AAC Intent	AAC Intent	Intent modifies to emphasise defining scope of each healthcare services, address preventive and promotive healthcare
AAC.1.	AAC.1.	No change
AAC.1.a	AAC.1.a	Interpretation modified to incorporate changing disease pattern in community
AAC.1.b.	AAC.1.b.	Interpretation modified for better clarity
AAC.1.c.	AAC.1.c.	Interpretation modified to emphasise documentation and implementation of services and to be known to staff
AAC.1.d.	AAC.1.d.	No change
AAC.2.	AAC.2.	No change
AAC.2.a.	AAC.2.a.	Interpretation modified for better clarity. General Consent added in Interpretation
AAC.2.b.	AAC.2.b.	No change
AAC.2.c.	AAC.2.c.	No change
AAC.2.d.	AAC.2.d.	Interpretation modifies for minor language correction
AAC.2.e.	AAC.2.e.	Interpretation modified for better clarity on mechanism of prioritisation of patients.
AAC.3.	AAC.3.	No change
AAC.3.a.	AAC.3.a.	Interpretation modified for addition of practise of feedback to referral organisation for transfer in.
AAC.3.b.	AAC.3.b.	Interpretation modified to add that patient transfer shall be done in consultation with patient and/or family.
AAC.3.c.	AAC.3.c.	No change
AAC.3.d.	AAC.3.d.	No change
AAC.4.	AAC.4.	No change
AAC.4.a.	AAC.4.a.	Objective element modified to incorporate Standardisation. Interpretation modified to add reconciliation of medication in initial assessment
AAC.4.b.	AAC.4.b.	Interpretation modified for incorporating psychological, spiritual, cultural, social and economic aspects to be part of initial assessment
AAC.4.c.	AAC.4.c.	No change
AAC.4.d.	AAC.4.d.	Interpretation modified for better clarity on Abridged documentation for daycare
AAC.4.e.	AAC.4.e.	Changed from achievement to core

5th Edition	6th Edition	Remarks
AAC.4.f.	AAC.4.f.	No change
AAC.4.g.	AAC.4.g.	No change
AAC.5.	AAC.5.	No change
AAC.5.a.	AAC.5.a.	Interpretation modified to emphasise reassessment for all patients as applicable
AAC.5.b.	AAC.5.b.	Interpretation modified to emphasise documentation when no follow up is required.
AAC.5.c.	AAC.5.c.	Objective element changed from achievement to commitment
AAC.5.d.	AAC.5.d.	No changes
AAC.5.e.	AAC.5.e.	Interpretation modified to add documentation of effectiveness of early warning system
AAC.6.	AAC.6.	No change
AAC.6.a.	AAC.6.a.	No change
AAC.6.b.	AAC.6.b.	No change
AAC.6.c.	AAC.6.c.	No change
AAC.6.d.	AAC.6.d.	No change
AAC.6.e.	AAC.6.e.	No change
AAC.6.f.	AAC.6.f.	No change
AAC.6.g.	AAC.6.g.	No change
AAC.6.h.	AAC.6.h.	No change
AAC.6.i.	AAC.6.i.	No change
AAC.6.j.	AAC.6.j.	Minor modification in interpretation to address grammar
AAC.7.	AAC.7.	AAC.7. and AAC.8. merged to simplify content.
AAC.7.a.	AAC.7.a.	Interpretation modified to incorporate content of AAC.7.b., AAC.7.d. and AAC.7.e and added POCT.
AAC.7.b.		Deleted
AAC.7.c.	AAC.7.b.	Objective element and interpretation modified to emphasise internal quality control
	AAC.7.c.	New objective element related to external quality control
AAC.7.d.		Deleted
AAC.7.e.		Deleted
AAC.7.f.	AAC.7.d.	No change

5th Edition	6th Edition	Remarks
AAC.8.		Standard deleted and relevant objective elements merged with AAC.7.
AAC.8.a.	AAC.7.e.	No change
AAC.8.b.		Objective element deleted and merged with PSQ1.f.
AAC.8.c.	AAC.7.f.	No change
AAC.8.d.	AAC.7.g.	No change
AAC.9.	AAC.8.	No change
AAC.9.a.	AAC.8.a.	No change
AAC.9.b.	AAC.8.b.	No change
AAC.9.c.	AAC.8.c.	No change
AAC.9.d.	AAC.8.d.	No change
AAC.9.e.		Objective element is deleted since it is getting covered in AAC.10.e.
AAC.9.f.	AAC.8.e.	No change
AAC.9.g.	AAC.8.f.	No change
AAC.9.h.	AAC.8.g.	No change
AAC.9.i.	AAC.8.h.	No change
AAC.9.j.	AAC.8.i.	Addition in the requirement of the imaging quality assurance
AAC.10.		Standard AAC.10. and AAC.11. merged to simplify content.
AAC.10.a.	AAC.9.a.	Objective element AAC.10.a., AAC.10.b and AAC.10.c.are merged
AAC.10.b.		
AAC.10.c.		
AAC.10.d.	AAC.9.b.	No change
AAC.10.e.	AAC.9.c.	No change
AAC.10.f.	AAC.9.d.	No change
AAC.10.g.		Objective element and its interpretation deleted and shifted to FMS.5.c
AAC.10.h.	AAC.9.e.	No change
AAC.11.		Standard deleted and merge with AAC.10.
AAC.11.a.	AAC.9.f.	Interpretation modified to emphasise AERB guidelines for radiation safety.

5th Edition	6th Edition	Remarks
AAC.11.b.		Objective element deleted and merged with PSQ1.f.
AAC.11.c.	AAC.9.g.	No change
AAC.11.d.	AAC.9.h.	No change
AAC.11.e.	AAC.9.i.	No change
AAC.11.f.	AAC.9.j.	No change
AAC.11.g.	AAC.9.k.	Interpretation modified to emphasise imaging signage on procedure rooms and operation theatres
AAC.12.	AAC.10.	No change
AAC.12.a.	AAC.10.a.	No change
AAC.12.b.	AAC.10.b.	No change
AAC.12.c.	AAC.10.c.	No change
AAC.12.d.	AAC.10.d.	No change
AAC.12.e.	AAC.10.e.	Interpretation modified to add safe transfer of patient to imaging services
AAC.12.f.	AAC.10.f.	No change
AAC.12.g.	AAC.10.g.	No change
AAC.12.h.	AAC.10.h.	No change
	AAC.11.	New Standard related to preventive and promotive healthcare
	AAC.11.a.	New objective element
	AAC.11.b.	New objective element
	AAC.11.c.	New objective element
	AAC.11.d.	New objective element
	AAC.11.e.	New objective element
AAC.13.	AAC.12.	No change
AAC.13.a.	AAC.12.a.	No change
AAC.13.b.	AAC.12.b.	No change
AAC.13.c.	AAC.12.c.	No change
AAC.13.d.	AAC.12.d.	Interpretation modified for better clarity in case of death
AAC.13.e.	AAC.12.e.	Interpretation modified to emphasise identification of special needs during discharge planning

5th Edition	6th Edition	Remarks
	AAC.12.f.	New objective element related to domiciliary care
AAC.13.f.	AAC.12.g.	Objective element changed from excellence to commitment
AAC.14.	AAC.13.	No change
AAC.14.a.	AAC.13.a.	No change
AAC.14.b.	AAC.13.b.	Addition of content of discharge summary, Objective element AAC.14.b., AAC.14.c.and AAC.14.d. are merged
AAC.14.c.		
AAC.14.d.		
AAC.14.e.	AAC.13.c.	Interpretation modified to add safe and effective use of medical equipment
AAC.14.f.	AAC.13.d.	Objective element changed from Achievement to commitment Content added to interpretation for better clarity
AAC.14.g.	AAC.13.e.	No change

Care of Patients (COP)		
5th Edition	**6th Edition**	**Remarks**
COP Intent	COP intent	Intent modified to add integration of health care delivery
COP.1.	COP.1.	No change
COP.1.a.	COP.1.a.	Interpretation modified to emphasise implementation. Objective element and its implementation of COP.1.f added.
COP.1.b.	COP.1.b.	Interpretation modified to add details of two identifiers
COP.1.c.		Deleted
COP.1.d.	COP.1.c.	Changed from achievement to commitment
COP.1.e.	COP.1.d.	Interpretation modified to add Clinical pathways to be updated annually
COP.1.f.		Deleted and added COP.1.a
COP.1.g.	COP.1.e.	No change
COP.1.h.	COP.1.f.	No change
COP.2.	COP.2.	No Change
COP.2.a.		Interpretation modified to add Emergency services preferably have triage, resuscitation treatment and patient holding areas
COP.2.b.	COP.2.b.	No change

5th Edition	6th Edition	Remarks
COP.2.c.	COP.2.c.	Objective element and interpretation of COP.2.c. and COP.2.d. are merged
COP.2.d.		
COP.2.e.	COP.2.d.	Interpretation modified to emphasise implementation in paediatric age group
COP.2.f.	COP.2.e.	Interpretation modified to emphasise addition of documentation of findings of re- assessment in emergency
COP.2.g.	COP.2.f.	No change
COP.2.i.	COP.2.g.	No change
COP.2.j.	COP.2.g.	No change
COP.3.	COP.3.	No change
COP.3.a.	COP.3.a.	No change
COP.3.b.	COP.3.b.	No change
COP.3.c.	COP.3.c.	No change
COP.3.d.	COP.3.d.	No change
COP.3.e.	COP.3.e.	Objective element and interpretation modified to merge COP.3.e., COP.3.f and COP.6.g.
COP.3.f.		
COP.3.g.		
COP.3.h.	COP.3.f.	No Change
COP.3.i.	COP.3.g.	Interpretation modified to add pre-hospital emergency care
COP.4.	COP.4.	No change
COP.4.a.	COP.4.a.	No changes
COP.4.b.	COP.4.b.	No change
COP.4.c.	COP.4.c.	No change
COP.4.d.	COP.4.d.	No change
COP.5.	COP.5.	No change
COP.5.a.	COP.5.a.	Interpretation modified to add medical equipment for resuscitation and medications for basic and advanced life support
COP.5.b.	COP.5.b.	No change
COP.5.c.	COP.5.c.	Interpretation modified to incorporate medications and different settings.
COP.5.d.	COP.5.d.	Interpretation modified for better clarity.
COP.5.e.	COP.5.e.	Interpretation modified to specify the frequency of meetings.

5th Edition	6th Edition	Remarks
COP.5.f.	COP.5.f.	No change
COP.6.	COP.6.	No change
COP.6.a.	COP.6.a.	Interpretation of COP.6.a.and COP.6.b.. merged and modified.
COP.6.b.		
COP.6.c.	COP.6.b.	No change
COP.6.d.	COP.6.c.	Changed from excellence to Achievement
COP.6.e.	COP.6.d.	Objective element and interpretation merged since both are related.
COP.6.f.		
COP.6.g.	COP.6.e.	No change
COP.6.h.	COP.6.f.	No change
COP.7.	COP.7.	No change
COP.7.a.	COP.7.a.	No change
COP.7.b.	COP.7.b.	Interpretation modified to bring better clarity to implementation.
COP.7.c.	COP.7.c.	No change
COP.7.d.	COP.7.d.	No change
COP.7.e.	COP.7.e.	Interpretation modified to bring clarity
COP.7.f.		Deleted and shifted to IPC.3.a.
COP.7.g.	COP.7.f.	No change
COP.7.h.	COP.7.g.	No change
COP.8.	COP.8.	No change
COP.8.a.	COP.8.a.	Interpretation modified for better clarity
COP.8.b.		Objective element merged with COP.8.c and interpretation modified.
	COP.8.b.	New objective element for Blood collection, testing, storage and distribution
	COP.8.c.	New objective element for safely storage of blood and components till transfusion
COP.8.c.	COP.8.d.	Interpretation modified for better clarity. Addition of Hospital blood transfusion committee.
COP.8.d.		Objective element with interpretation deleted and added in PRE.4.
COP.8.e.		Objective element with interpretation deleted and added in PRE.4.
COP.8.f.	COP.8.e.	Interpretation modified to emphasise monitoring of turnaround time, and blood components
COP.8.g.	COP.8.f.	Interpretation modified for better clarity

5th Edition	6th Edition	Remarks
COP.8.h.	COP.8.g.	Interpretation modified for better clarity for implementation.
COP.9.	COP.9.	No change
COP.9.a.	COP.9.a.	No change
COP.9.b.	COP.9.b.	No change
COP.9.c.	COP.9.c.	No change
COP.9.d.		Objective element and interpretation deleted and added to FMS.2.a
COP.9.e.	COP.9.d.	No change
COP.9.f.	COP.9.e.	No change
COP.9.g.	COP.9.f.	No change
COP.9.h.	COP.9.g.	Interpretation modified to emphasise documentation/video recording of counselling.
COP.10.	COP.10.	No change
COP.10.a.	COP.10.a.	No change
COP.10.b.	COP.10.b.	No change
COP.10.c.	COP.10.c.	No change
COP.10.d.	COP.10.d.	Interpretation modified to emphasise documentation in Antenatal cards.
	COP.10.e.	New Objective element of birth companion during labour
	COP.10.f.	New objective element of privacy and confidentiality of pregnant women
	COP.10.g.	New Objective element related to danger signs and important care activities of pregnant women and companion
COP.10.e.	COP.10.h.	Documentation of maternal nutrition in ante natal cards emphasised
COP.10.f.	COP.10.i.	No change
COP.10.g.	COP.10.j.	No change
	COP.10.k.	New Objective element to Assisted Reproductive Technology (ART) practices.
COP.11.	COP.11.	No change
COP.11.a.	COP.11.a.	No change
COP.11.b.	COP.11.b.	No change
COP.11.c.	COP.11.c.	No change
COP.11.d.	COP.11.d.	No change
COP.11.e.	COP.11.e.	No change
COP.11.f.	COP.11.f.	No change

5th Edition	6th Edition	Remarks
COP.11.g.	COP.11.g.	No change
	COP.11.h	New Objective element
COP.12.	COP.12.	No change
COP.12.a.	COP.12.a.	Interpretation modified to emphasise implementation in relevant areas.
COP.12.b.	COP.12.b.	Interpretation modified Addition of education of patient and family on post procedural analgesia
COP.12.c.	COP.12.c.	No change
COP.12.d.	COP.12.d.	No change
COP.12.e.	COP.12.e.	No change
COP.12.f.	COP.12.f.	No change
COP.12.g.	COP.12.g.	No change
COP.12.h.	COP.12.h.	Interpretation modified to add availability of emergency medical equipment and supplies based on type of sedation and the age
COP.13.	COP.13.	No change
COP.13.a.	COP.13.a.	No change
COP.13.b.	COP.13.b.	Interpretation modified to emphasise documentation.
COP.13.c.	COP.13.c.	Language of interpretation modified for better clarity.
COP.13.d.	COP.13.d.	No change
COP.13.e.	COP.13.e.	Interpretation modified to emphasise documentation of monitoring during anaesthesia.
COP.13.f.	COP.13.f.	Interpretation modified to add details of transfer of patient from OT to ICU
COP.13.g.	COP.13.g.	No change
COP.13.h.	COP.13.h.	No change
COP.13.i.	COP.13.i.	No change
COP.13.j.	COP.13.j.	No change
COP.14.	COP.14.	No change
COP.14.a.	COP.14.a.	No change
COP.14.b.	COP.14.b.	No change
COP.14.c.	COP.14.c.	No change
COP.14.d.	COP.14.d.	Interpretation modified for better understanding and implementation.
COP.14.e.	COP.14.e.	Addition of post-operative diagnosis, peri-operative complications, amount of blood loss in operative note

5th Edition	6th Edition	Remarks
COP.14.f.	COP.14.f.	No change
COP.14.g.	COP.14.g.	Interpretation modified to emphasise implementation.
COP.14.h.	COP.14.h.	No change
COP.14.i.	COP.14.i.	No change
COP.14.j.	COP.14.j.	No change
COP.15.	COP.15.	No change
COP.15.a.	COP.15.a.	No change
COP.15.b.	COP.15.b.	Interpretation modified for adding care of patient depending on the type of transplant
COP.15.c.	COP.15.c.	No change
COP.15.d.	COP.15.d.	No change
COP.16.	COP.16.	No change
COP.16.a.	COP.16.a.	Interpretation modified to emphasise implementation.
COP.16.b.		Deleted
COP.16.c.	COP.16.b.	No change
COP.16.d.	COP.16.c.	No change
COP.16.e.	COP.16.d.	No change
COP.16.f.	COP.16.e.	No change
COP.17.	COP.17.	No change
COP.17.a.	COP.17.a.	Interpretation modified for better clarity
COP.17.b.	COP.17.b.	Interpretation modified for better clarity
COP.17.c.	COP.17.c.	Interpretation modified to emphasise implementation.
COP.17.d.	COP.17.d.	No change
COP.18.	COP.18.	No change
COP.18.a.	COP.18.a.	No change
COP.18.b.	COP.18.b.	No change
COP.18.c.	COP.18.c.	No change
COP.18.d.	COP.18.d.	No change
COP.18.e.	COP.18.e.	No change
COP.18.f.	COP.18.f.	No change

5th Edition	6th Edition	Remarks
COP.18.g.	COP.18.g.	No change
COP.19.	COP.19.	No change
COP.19.a.	COP.19.a.	No change
COP.19.b.	COP.19.b.	No change
COP.19.c.	COP.19.c.	No change
COP.19.d.	COP.19.d.	No change
COP.19.e.	COP.19.e.	No change
COP.20.	COP.20.	No change
COP.20.a.	COP.20.a.	No change
COP.20.b.	COP.20.b.	No change
COP.20.c.	COP.20.c.	Interpretation modified for better clarity
COP.20.d.	COP.20.d.	Interpretation modified to emphasise training of staff on end-of-life care.
COP.20.e.	COP.20.e.	No change

Management of Medication (MOM)

5th Edition	6th Edition	Remarks
MOM Intent	MOM Intent	Intent modified to add medication safety officer, Reconciliation of medications at transition points and patient care areas
MOM.1.	MOM.1.	Language of the standard is modified to emphasise overall medication management
MOM.1.a.	MOM.1.a.	Interpretation modified to add Medication management activity to be managed by a qualified individual
MOM.1.b.	MOM.1.b.	No change
MOM.1.c.	MOM.1.c.	Objective element changed from Excellence to Achievement and interpretation modified to add Review of medication management on annual basis
MOM.1.d.	MOM.1.d.	No change
MOM.1.e.	MOM.1.e.	No change
MOM.2.	MOM.2.	No change
MOM.2.a.	MOM.2.a.	Interpretation modified to improve language.
MOM.2.b.	MOM.2.b.	No change
MOM.2.c.	MOM.2.c.	No change
MOM.2.d.	MOM.2.d.	Objective element changed from excellence to commitment

5th Edition	6th Edition	Remarks
MOM.2.e.	MOM.2.e.	No change
MOM.2.f.	MOM.2.f.	Interpretation modified to add decision making.
MOM.3.	MOM.3.	No change
MOM.3.a.	MOM.3.a.	Interpretation modified to add vaccination storage as per manufactures guidelines.
MOM.3.b.	MOM.3.b.	Interpretation modified to delete verification audits for stocks.
MOM.3.c.	MOM.3.c.	Interpretation modified to add update of the list of high alert medications
MOM.3.d.	MOM.3.d.	No change
MOM.3.e.	MOM.3.e.	No change
MOM.3.f.	MOM.3.f.	No change
MOM.3.g.	MOM.3.g.	No change
MOM.4.	MOM.4.	No change
MOM.4.a.	MOM.4.a.	No change
MOM.4.b.	MOM.4.b.	Interpretation modified to add digital prescription to reduce errors
MOM.4.c.	MOM.4.c.	Interpretation modified for more clarity
MOM.4.d.	MOM.4.d.	No change
	MOM.4.e.	MOM.4.h is shifted as MOM.4.e
MOM.4.e.	MOM.4.f.	Interpretation modified for more clarity
MOM.4.f.	MOM.4.g.	No change
MOM.4.g.	MOM.4.h.	No change
MOM.4.h.		Shifted as MOM.4.e.
MOM.5.	MOM.5.	No change
MOM.5.a.	MOM.5.a.	No change
MOM.5.b.	MOM.5.b.	No change
MOM.5.c.	MOM.5.c.	Interpretation modified to add hand written medication orders are written in capital letters
MOM.5.d.	MOM.5.d.	No change
MOM.6.	MOM.6.	No change
MOM.6.a.	MOM.6.a.	No change
MOM.6.b.	MOM.6.b.	Interpretation modified to add System of medicine recalls
MOM.6.c.	MOM.6.c.	No change

5th Edition	6th Edition	Remarks
MOM.6.d.	MOM.6.d.	No change
MOM.6.e.	MOM.6.e.	No change
MOM.6.f.	MOM.6.f.	Interpretation modified to add awareness by the organisation of return of medications.
MOM.7.	MOM.7.	No change
MOM.7.a.	MOM.7.a.	No change
MOM.7.b.	MOM.7.b.	No change
MOM.7.c.	MOM.7.c.	Interpretation modified for more clarity
MOM.7.d.	MOM.7.d.	Interpretation to emphasise implementation.
MOM.7.e.	MOM.7.e.	No change
MOM.7.f.	MOM.7.f.	No change
MOM.7.g.	MOM.7.g.	No change
MOM.7.h.	MOM.7.h.	No change
MOM.7.i.	MOM.7.i.	Interpretation modified to add details of infusions to be captured
MOM.7.j.	MOM.7.j.	Modification in language for better clarity
MOM.7.k.	MOM.7.k.	No change
MOM.8.	MOM.8.	No change
MOM.8.a.	MOM.8.a.	Interpretation modified to add monitoring the effect of high alert medications.
MOM.8.b.	MOM.8.b.	Modification in language for better clarity
MOM.8.c.	MOM.8.c.	Interpretation modified to add written guidance on the process to capture near misses, medication errors and adverse drug reactions
MOM.8.d.	MOM.8.d.	No change
MOM.8.e.	MOM.8.e.	No change
MOM.8.f.	MOM.8.f.	No change
MOM.9.	MOM.9.	Radioactive agent replaced by radiopharmaceuticals
MOM.9.a.	MOM.9.a.	Radioactive agent replaced by radiopharmaceuticals
MOM.9.b.	MOM.9.b.	Radioactive agent replaced by radiopharmaceuticals
MOM.9.c.	MOM.9.c.	Radioactive agent replaced by radiopharmaceuticals
MOM.9.d.	MOM.9.d.	Radioactive agent replaced by radiopharmaceuticals
MOM.9.e.	MOM.9.e.	Radioactive agent replaced by radiopharmaceuticals and interpretation modified to add usage, administration, wastage and disposal of narcotic drugs.

5th Edition	6th Edition	Remarks
MOM.10.	MOM.10.	No change
MOM.10.a.	MOM.10.a.	No change
MOM.10.b.	MOM.10.b.	No change
MOM.10.c.	MOM.10.c.	Interpretation modified to add counselling of implantable prosthesis.
MOM.10.d.	MOM.10.d.	No change
MOM.10.e.	MOM.10.e.	Interpretation modified to add record of implantable prosthesis.
MOM.11.	MOM.11.	No change
MOM.11.a.	MOM.11.a.	No change
MOM.11.b.	MOM.11.b.	No change
MOM.11.c.	MOM.11.c.	No change
MOM.11.d.	MOM.11.d.	No change
MOM.11.e.	MOM.11.e.	No change

Patient Rights and Education (PRE)

5th Edition	6th Edition	Remarks
PRE Intent	PRE Intent	Intent modified to emphasise PREM and patient engagement to enhance clinical outcomes
PRE.1.	PRE.1.	No change
PRE1.a.	PRE1.a.	No change
PRE1.b.	PRE1.b.	No change
PRE1.c.	PRE1.c.	No change
PRE1.d.	PRE1.d.	No change
PRE1.e.	PRE1.e.	No change
PRE.2.	PRE.2.	No change
PRE.2.a.	PRE.2.a.	No change
PRE.2.b.	PRE.2.b.	No change
PRE.2.c.	PRE.2.c.	No change
PRE.2.d.	PRE.2.d.	No change
PRE.2.e.	PRE.2.e.	No change
PRE.2.f.	PRE.2.f.	No change

5th Edition	6th Edition	Remarks
PRE.2.g.	PRE.2.g.	No change
PRE.2.h.	PRE.2.h.	No change
PRE.2.i.	PRE.2.i.	No change
PRE.2.j.	PRE.2.j.	No change
PRE.2.k.	PRE.2.k.	No change
PRE.2.l.	PRE.2.l.	No change
PRE.3.	PRE.3.	No change
PRE.3.a.	PRE.3.a.	Objective element PRE.3.a., PRE.3.b. and PRE.3.c. are merged
PRE.3.b.		
PRE.3.c.		
PRE.3.d.	PRE.3.b.	No change
PRE.3.e.	PRE.3.c.	No change
PRE.3.f.	PRE.3.d.	No change
PRE.3.g.	PRE.3.e.	No change
PRE.4.	PRE.4.	No change
PRE.4.a.	PRE.4.a.	Interpretation modified to add HIV and AIDS act 2017
PRE.4.b.	PRE.4.b.	No change
PRE.4.c.	PRE.4.c.	No change
PRE.4.d.	PRE.4.d.	No change
PRE.4.e.	PRE.4.e.	No change
PRE.5.	PRE.5.	No change
PRE.5.a.	PRE.5.a.	No change
PRE.5.b.	PRE.5.b.	No change
PRE.5.c.	PRE.5.c.	No change
PRE.5.d.	PRE.5.d.	No change
PRE.5.e.	PRE.5.e.	Interpretation modified to emphasise paediatric immunization
PRE.5.f.	PRE.5.f.	No change
PRE.5.g.	PRE.5.g.	No change
PRE.5.h.	PRE.5.h.	No change

5th Edition	6th Edition	Remarks
PRE.5.i.	PRE.5.i.	Interpretation modified to add patient and family education needs
	PRE.5.j.	New objective element added related to patient engagement to enhance clinical outcomes
PRE.6.	PRE.6.	No change
PRE.6.a.	PRE.6.a.	No change
PRE.6.b.	PRE.6.b.	No change
PRE.6.c.	PRE.6.c.	No change
PRE.6.d.	PRE.6.d.	No change
PRE.7.	PRE.7.	No change
PRE.7.a.	PRE.7.a.	No change
PRE.7.b.	PRE.7.b.	Interpretation modified to explain patient reported experience measures.
PRE.7.c.	PRE.7.c.	No change
PRE.7.d.	PRE.7.d.	No change
PRE.7.e.	PRE.7.e.	No change
PRE.7.f.	PRE.7.f.	No change
PRE.8.	PRE.8.	No change
PRE.8.a.	PRE.8.a.	No change
PRE.8.b.	PRE.8.b.	No change
PRE.8.c.	PRE.8.c.	Interpretation modified to expand SPIKES
PRE.8.d.	PRE.8.d.	No change
PRE.8.e.	PRE.8.e.	No change

Infection Prevention and Control (IPC)

5th Edition	6th Edition	Remarks
HIC Intent	IPC Intent	Name of Chapter changed from Hospital Infection Control (HIC) to Infection Prevention and Control (IPC). Antibiotics is replaced by antimicrobials in the standards and objective elements
HIC.1	IPC.1.	No change except the name
HIC.1.a.	IPC.1.a.	Interpretation modified to bring better clarity
HIC.1.b.	IPC.1.b.	Interpretation modified to bring better clarity.
HIC.1.c.	IPC.1.c.	No change
HIC.1.d.	IPC.1.d.	No change

5th Edition	6th Edition	Remarks
HIC.1.e.	IPC.1.e.	No change
HIC.1.f.	IPC.1.f.	No change
HIC.1.g.	IPC.1.g.	No change
HIC.1.g.	IPC.1.h.	Interpretation modified to bring better clarity
HIC.1.i.	IPC.1.i.	No change
HIC.1.j.	IPC.1.j.	No change
HIC.2.	IPC.2.	No change
HIC.2a.	IPC.2.a.	Objective elements and interpretation of HIC.2a. and HIC.2.b. are merged
HIC.2.b.		
HIC.2.c.	IPC.2.b.	Interpretation modified to delete apron from personal protective equipment
HIC.2.d.	IPC.2.c.	No change
HIC.2.e.	IPC.2.d.	No change
HIC.3.	IPC.3.	Standard modified to emphasise process.
HIC.3.a	IPC.3.a.	Interpretation modified to emphasise process.
HIC.3.b	IPC.3.b.	No change
HIC.3.c	IPC.3.c.	No change
HIC.3.d	IPC.3.d.	No change
HIC.3.e	IPC.3.e.	Interpretation modified to bring better clarity.
HIC.3.f	IPC.3.f.	Objective element and interpretation HIC.3.f. and HIC.3.g are merged
HIC.3.g		
HIC.4.	IPC.4.	Standard modified to emphasise process.
HIC.4.a.	IPC.4.a.	No change
HIC.4.b.	IPC.4.b.	No change
HIC.4.c.	IPC.4.c.	No change
HIC.4.d.	IPC.4.d.	Objective element modified to emphasise monitoring of biomedical waste management programme.
HIC.4.e.	IPC.4.e.	No change
HIC.4.f.	IPC.4.f.	No change
HIC.5.	IPC.5.	No change
HIC.5.a.	IPC.5.a.	No change

5th Edition	6th Edition	Remarks
HIC.5.b.	IPC.5.b.	No change
HIC.5.c.	IPC.5.c.	Objective element modified to include better terminology.
HIC.5.d.	IPC.5.d.	Objective element modified to emphasise development, implementation and monitoring of care bundle to prevent surgical site infections
HIC.6.	IPC.6.	No change
HIC.6.a.	IPC.6.a.	No change
HIC.6.b.	IPC.6.b.	No change
HIC.6.c.	IPC.6.c.	No change
HIC.6.d.	IPC.6.d.	No change
HIC.6.e.	IPC.6.e.	No change
HIC.6.f.	IPC.6.f.	Objective element modified to add examples of housekeeping services
HIC.6.g.	IPC.6.g.	No change
HIC.6.h.	IPC.6.h.	No change
HIC.6.i.	IPC.6.i.	No change
HIC.7.	IPC.7.	No change
HIC.7.a.	IPC.7.a.	No change
HIC.7.b.	IPC.7.b.	No change
HIC.7.c.	IPC.7.c.	No change
HIC.7.d.	IPC.7.d.	No change
HIC.7.e.	IPC.7.e.	Objective element modified to add mock drill of recall procedure at CSSD.
HIC.8.	IPC.8.	Standard modified to emphasise documentation.
HIC.8.a.	IPC.8.a.	Objective element modified to emphasise documentation of health and safety practices
HIC.8.b.	IPC.8.b.	No change
HIC.8.c.	IPC.8.c.	No change
HIC.8.d.	IPC.8.d.	No change
HIC.8.e.	IPC.8.e.	No change

Patient Safety and Quality Improvement (PSQ)		
5th Edition	**6th Edition**	**Remarks**
PSQ Intent	PSQ Intent	Intent modified to emphasise culture of safety, involvement of clinical departments through capturing of patient reported outcomes
PSQ.1.	PSQ.1.	No change
PSQ.1.a.	PSQ.1.a.	No change
PSQ.1.b.	PSQ.1.b.	No change
PSQ.1.c.	PSQ.1.c.	No change
PSQ.1.d.	PSQ.1.d.	Objective element merged
PSQ.1.e.		
PSQ.1.f.		Objective element deleted and added to PSQ.1.f. along with interpretation for ease of understanding
PSQ.1.g.	PSQ.1.e.	No change
PSQ.1.h.	PSQ.1.f.	Objective element and Interpretation added for ease of understanding .
PSQ.1.i.	PSQ.1.g.	Interpretation modified for better clarity and implementation modified by adding international patient safety goals.
PSQ.2.	PSQ.2.	No change
PSQ.2.a.	PSQ.2.a.	No change
PSQ.2.b.	PSQ.2.b.	Interpretation modified to emphasise utilization reviews for quality improvement.
PSQ.2.c.	PSQ.2.c.	No change
	PSQ.2.d.	New Objective element added focusing appropriateness of clinical care.
PSQ.2.d.	PSQ.2.e.	Interpretation modified to emphasise structured training for the individual co-ordinating the quality improvement programme
PSQ.2.e.	PSQ.2.f.	No change
PSQ.2.f.	PSQ.2.g.	No change
PSQ.2.g.	PSQ.2.h.	No change
PSQ.2.h.	PSQ.2.i.	Interpretation modified to emphasise integration of nursing quality improvement with the quality improvement programme
PSQ.3.	PSQ.3.	No change
PSQ.3.a.	PSQ.3.a.	Interpretation modified to emphasise clinical quality indicators
PSQ.3.b.	PSQ.3.b.	No change
PSQ.3.c.	PSQ.3.c.	No change
PSQ3.d.	PSQ3.d.	No change
PSQ3.e.		Objective element deleted and moved to PSQ.4.d. as a tool for quality improvement.
PSQ3.f.	PSQ3.e.	Interpretation modified to emphasise verification of data.

5th Edition	6th Edition	Remarks
PSQ3.g.	PSQ3.f.	No change
PSQ3.h.	PSQ3.g.	No change
PSQ3.i.	PSQ3.h.	No change
PSQ.4.	PSQ.4.	No change
PSQ.4.a.	PSQ.4.a.	No change
	PSQ.4.b.	New objective element to emphasise implementation in the context of patient care delivery, hospital Quality improvement programme.
PSQ.4.b.	PSQ.4.c.	Objective element PSQ.4.b. , PSQ.4.c. and PSQ.4.d.are merged
PSQ.4.c.		
PSQ.4.d.		
	PSQ.4.d.	Objective element PSQ.3.e deleted and moved to PSQ.4. as PSQ.4.d as a tool of quality.
PSQ.5.	PSQ.5.	No change
PSQ.5.a.	PSQ.5.a.	Interpretation modified to change the frequency of clinical audits.
PSQ.5.b.	PSQ.5.b.	No change
PSQ.5.c.	PSQ.5.c.	No change
PSQ.5.d.	PSQ.5.d.	No change
PSQ.5.e.	PSQ.5.e.	No change
PSQ.5.f.	PSQ.5.f.	No change
PSQ.6.	PSQ.6.	No change
PSQ.6.a.	PSQ.6.a.	No change
PSQ.6.b.	PSQ.6.b.	No change
PSQ.6.c.	PSQ.6.c.	No change
PSQ.6.d.		The Objective elements PSQ.6.d.. and PSQ.6.e.. are merged for ease of implementation.
PSQ.6.e.		
PSQ.6.f.	PSQ.6.f.	No change
PSQ.6.g.	PSQ.6.g.	No change
PSQ.7.	PSQ.7.	No change
PSQ.7.a.	PSQ.7.a.	No change
PSQ.7.b.	PSQ.7.b.	No change

5th Edition	6th Edition	Remarks
PSQ.7.c.	PSQ.7.c.	No change
PSQ.7.d.	PSQ.7.d.	No change
PSQ.7.e.	PSQ.7.e.	No change
PSQ.7.f.	PSQ.7.f.	No change

Responsibility of Management (ROM)		
5th Edition	**6th Edition**	**Remarks**
ROM Intent	ROM Intent	Intent modified to address clinical governance, service continuity plan an clarify the level of leadership.
ROM.1.	ROM.1.	No change
ROM.1.a.	ROM.1.a.	Interpretation modified to emphasise documentation of structure of the governing body
ROM.1.b.	ROM.1.b.	Objective element modified to delete leadership and add of display of vision, mission and values from ROM.2.a.
ROM.1.c.	ROM.1.c.	Interpretation modified to emphasise documentation of strategic and operational plans.
ROM.1.d.	ROM.1.d.	Objective element changed from achievement to commitment. Interpretation modified to include strategic and operational plans
ROM.1.e.	ROM.1.e.	No change
ROM.1.f.	ROM.1.f.	Interpretation modified for better clarity.
	ROM.1.g.	New Objective element on developing clinical governance framework.
ROM.1.g.	ROM.1.h.	Interpretation modified to add defined time frame.
ROM.1.h.	ROM.1.i.	No change
ROM.2.	ROM.2.	Standard modified to replace leaders with governance
	ROM.2.a.	Objective element deleted and merged with ROM.1.b
ROM.2.a.	ROM.2.b.	No change
ROM.2.b.	ROM.2.c.	Interpretation modified to include process for addressing ethical dilemma.
ROM.2.c.	ROM.2.d.	Interpretation added to emphasise explanation about ownership of hospital
ROM.2.d.	ROM.2.e.	No change
	ROM.3.	New Standard added to address environmental, social and economic factors from long term well being of healthcare system and community.
	ROM.3.a	New objective element related to sustainability programme in terms of Environment Social and Governance (ESG) responsibility.
	ROM.3.b	Objective and interpretation moved from FMS.2.g. Interpretation added to emphasise awareness of saving electricity and water
	ROM.3.c	New objective element related to organisation social responsibility

5th Edition	6th Edition	Remarks
	ROM.3.d	Objective element shifted from HRM.9.a. and changed from Achievement to commitment
	ROM.3.e	New Objective element related to sustainable procurement practises
	ROM.3.f	New objective element to encourage employees to use public transport
	ROM.3.g	New objective element to ensure financial sustainability of the hospital.
ROM.3.	ROM.4.	No change
ROM.3.a.	ROM.4.a.	Objective element ROM.3.a. and ROM.3.b. are merged
ROM.3.b.		
ROM.3.c.	ROM.4.b.	No change
ROM.3.d.	ROM.4.c.	Interpretation modified to add explanation related to department leader
ROM.3.e.	ROM.4.d.	No change
ROM.3.f.	ROM.4.e.	No change
ROM.4.	ROM.5.	No change
ROM.4.a.	ROM.5.a.	Interpretation modified to add tool for Strategic planning.
ROM.4.b.	ROM.5.b.	Objective element Changed from achievement to commitment
ROM.4.c	ROM.5.c	No change
ROM.4.d.	ROM.5.d.	No change
ROM.4.e.		Deleted
ROM.4.f.	ROM.5.e.	No change
ROM.4.g.	ROM.5.f.	No change
ROM.5.	ROM.6.	No change
ROM.5.a.	ROM.6.a.	Interpretation modified to emphasise clinical risk assessment.
ROM.5.b.	ROM.6.b.	No change
ROM.5.c.	ROM.6.c.	No change
ROM.5.d.	ROM.6.d.	Interpretation modified to add service continuity plan for fire and non-fire emergency from FMS.7.e
ROM.5.e.	ROM.6.e.	No change
ROM.5.f.	ROM.6.f.	No change

Facility Management and Safety (FMS)		
5th Edition	**6th Edition**	**Remarks**
FMS intent	FMS intent	No change
FMS.1.	FMS.1.	No change
FMS.1.a.	FMS.1.a.	No change
FMS.1.b.	FMS.1.b.	No change
FMS.1.c.	FMS.1.c.	No change
FMS.1.d.	FMS.1.d.	No change
FMS.1.e.	FMS.1.e.	No change
FMS.2.	FMS.2.	No change
FMS.2.a.	FMS.2.a.	Interpretation modified to incorporate the requirement of upgrading of infrastructure from COP.9.d.
FMS.2.b.	FMS.2.b.	Interpretation modified to add ELV and IT network
FMS.2.c.	FMS.2.c.	No change
FMS.2.d.	FMS.2.d.	No change
FMS.2.e.	FMS.2.e.	No change
FMS.2.f.	FMS.2.f.	No change
FMS.2.g.		Objective element and interpretation shifted to ROM.6.d
FMS.3.	FMS.3.	No change
FMS.3.a.	FMS.3.b.	Sequence of objective element and interpretation of FMS.3.a and FMS.3.b interchanged to maintain more clarity
FMS.3.b.	FMS.3.a.	Sequence of objective element and interpretation of FMS.3.a and FMS.3.b interchanged to maintain more clarity
FMS.3.c.	FMS.3.c.	Objective element changed from achievement to commitment to emphasise electrical safety.
FMS.3.d.	FMS.3.d.	No change
FMS.3.e.	FMS.3.e.	No change
FMS.3.f.	FMS.3.f.	No change
FMS.4.	FMS.4.	No change
FMS.4.a.	FMS.4.a.	No change
FMS.4.b.	FMS.4.b.	No change
FMS.4.c.	FMS.4.c	No change
FMS.4.d.	FMS.4.d.	No change
FMS.4.e.	FMS.4.e.	No change

5th Edition	6th Edition	Remarks
FMS.4.f.	FMS.4.f.	No change
FMS.4.g.	FMS.4.g.	Interpretation modified and content added to emphasise implementation.
FMS.4.h.	FMS.4.h.	No change
FMS.5.	FMS.5.	No change
FMS.5.a.	FMS.5.a.	No change
FMS.5.b.	FMS.5.b.	No change
FMS.5.c.	FMS.5.c.	No change
FMS.5.d.	FMS.5.d.	No change
FMS.5.e.	FMS.5.e.	No change
FMS.5.f.	FMS.5.f.	No change
FMS.5.g.	FMS.5.g.	No change
FMS.5.h.	FMS.5.h.	No change
FMS.6.	FMS.6.	No change
FMS.6.a.	FMS.6.a.	No change
FMS.6.b.	FMS.6.b.	The objective element is merged with FMS.6.b. Interpretation of FMS.6.b and FMS.6.c is merged. Reference from FMS.6.c cited at the end of the chapter
FMS.6.c.		
FMS.6.f.	FMS.3.c	Objective element is moved as FMS.3.e.
FMS.6.d.	FMS.6.d.	No change
FMS.6.e.	FMS.6.e.	No change
FMS.7.a	FMS.7.a.	Interpretation modified to emphasise implementation
	FMS.7.b.	New objective element added to emphasise non- fire emergencies.
FMS.7.b.	FMS.7.c.	No change
FMS.7.c.	FMS.7.d.	No change
FMS.7.d.	FMS.7.e.	No change
FMS.7.e.		Objective element shifted to ROM.6.d.

Human Resource Management (HRM)		
5th Edition	**6th Edition**	**Remarks**
HRM intent	HRM intent	Interpretation modified for better clarity related to outsourced staff, volunteers, students and trainees
HRM.1.	HRM.1.	No change
HRM.1.a.	HRM.1.a.	Changed from Excellence to commitment
HRM.1.b.	HRM.1.b.	No chnage
HRM.1.c.	HRM.1.c.	No change
HRM.1.d.	HRM.1.d.	Content added to interpretation to emphasise application of objective element to all 'staff'
HRM.1.e.	HRM.1.e.	No change
HRM.1.f.	HRM.1.f.	Content added to interpretation for better clarity
HRM.1.g.	HRM.1.g.	No change
HRM.2.	HRM.2.	No change
HRM.2.a.	HRM.2.a.	No change
HRM.2.b.	HRM.2.b.	No change
HRM.2.c.	HRM.2.c.	Content added to interpretation to guide implementation.
HRM.2.d.	HRM.2.d.	No change
HRM.3.	HRM.3.	No change
HRM.3.a.	HRM.3.a.	Content added to interpretation for better clarity and emphasise implementation for all staff.
HRM.3.b.	HRM.3.b.	No change
HRM.3.c.	HRM.3.c.	No change
HRM.3.d.	HRM.3.d.	Content added to interpretation to emphasise training on emergency codes
HRM.3.e.	HRM.3.e.	Content added to interpretation to emphasise implementation for all staff
HRM.3.f.	HRM.3.f.	No change
HRM.3.g.	HRM.3.g.	No change
HRM.3.h.	HRM.3.h.	No change
HRM.3.i.	HRM.3.i.	Content added to interpretation to emphasise implementation.
	HRM.3.j.	New Objective element added related to training on information systems, information security, information use and management
HRM.4.	HRM.4.	No change
HRM.4.a.	HRM.4.a.	Interpretation modified to incorporate learning management modules and e- learning modules
HRM.4.b.	HRM.4.b.	Content added to interpretation to emphasise implementation for all staff, detailed related to date and duration of training and digital training records

5th Edition	6th Edition	Remarks
HRM.4.c.	HRM.4.c.	No change
HRM.4.d.	HRM.4.d.	No change
HRM.4.e.	HRM.4.e.	Objective element changed from Excellence to Achievement
HRM.4.f.	HRM.4.f.	No change
HRM.5.	HRM.5.	No change
HRM.5.a.	HRM.5.a.	No change
HRM.5.b.	HRM.5.b.	No change
HRM.5.c.	HRM.5.c.	No change
HRM.5.d.	HRM.5.d.	No change
HRM.5.e.	HRM.5.e.	Content added to interpretation for better clarity to emphasise training on cardiopulmonary resuscitation to the staff related to the roles in the hospital. Requirement with regard to trainers clarified
HRM.5.f.	HRM.5.f.	Content added to interpretation for better clarity to emphasise on anti-microbial policy and anti-microbial stewardship program
HRM.6.	HRM.6.	No change
HRM.6.a.	HRM.6.a.	Content added to interpretation to emphasise training on organisation's safety programme
HRM.6.b.	HRM.6.b.	Content added to interpretation to include chemicals and cytotoxic drugs
HRM.6.c.	HRM.6.c.	No change
HRM.6.d.	HRM.6.d.	Content added to interpretation for example of occupation safety like laser exposure and medical gases
HRM.6.e.	HRM.6.e.	Interpretation modified for better clarity
HRM.6.f.	HRM.6.f.	Interpretation modified to emphasise implementation for non-fire emergencies.
HRM.6.g.	HRM.6.g.	Blood centre added to interpretation
HRM.7.	HRM.7.	No change
HRM.7.a.	HRM.7.a.	No change
HRM.7.b.	HRM.7.b.	No change
HRM.7.c.	HRM.7.c.	No change
HRM.7.d.	HRM.7.d.	Changed from Achievement to commitment
HRM.7.e.	HRM.7.e.	No change
HRM.8.	HRM.8.	No change
HRM.8.a.	HRM.8.a.	No change

5th Edition	6th Edition	Remarks
HRM.8.b.	HRM.8.b.	No change
HRM.8.c.	HRM.8.c.	No change
HRM.8.d.	HRM.8.d.	No change
HRM.8.e.	HRM.8.e.	No change
HRM.8.f.	HRM.8.f.	No change
HRM.9.	HRM.9.	No change
HRM.9.a.		Objective element and interpretation shifted to ROM.3.d
HRM.9.b.	HRM.9.a.	Content of interpretation modified to emphasise written guidance on physical and mental health and addition of second victim in unanticipated adverse events.
HRM.9.c.	HRM.9.b.	No change
HRM.9.d.	HRM.9.c.	No change
HRM.9.e.	HRM.9.d.	No change
HRM.10.	HRM.10.	No change
HRM.10.a.	HRM.10.a.	Objective element modified to provision of personal files in electronic format
HRM.10.b.	HRM.10.d.	No change
HRM.10.c.	HRM.10.c.	Objective element modified for better clarity in implementation, interpretation modified to incorporate electronic training record
HRM.10.d.	HRM.10.d.	No change
HRM.11.	HRM.11.	No change
HRM.11.a.	HRM.11.a.	No change
HRM.11.b.	HRM.11.b.	Content added to interpretation to emphasise implementation by maintaining credentials of each medical staff in personal files
HRM.11.c.	HRM.11.c.	MCI to be changed to National Medical Commission's
HRM.11.d.	HRM.11.d.	No change
HRM.11.e.	HRM.11.e.	No change
HRM.11.f.	HRM.11.f.	No change
HRM.12.	HRM.12.	No change
HRM.12.a.	HRM.12.a.	No change
HRM.12.b.	HRM.12.b.	No change
HRM.12.c.	HRM.12.c.	No change

5th Edition	6th Edition	Remarks
HRM.12.d.	HRM.12.d.	No change
HRM.12.e.	HRM.12.e.	Objective element modified for better clarity
HRM.12.f.	HRM.12.f.	No change
HRM.13.	HRM.13.	No change
HRM.13.a.	HRM.13.a.	No change
HRM.13.b.	HRM.13.b.	No change
HRM.13.c.	HRM.13.c.	No change
HRM.13.d.	HRM.13.d.	Objective element modified for better clarity
HRM.13.e.	HRM.13.e.	No change

Information Management System (IMS)		
5th Edition	**6th Edition**	**Remarks**
IMS Intent	IMS intent	Minor change in the language
IMS.1.	IMS.1.	No change
IMS.1.a.	IMS.1.a.	No change
IMS.1.b.	IMS.1.b.	No change
IMS.1.c.	IMS.1.c.	No change
IMS.1.d.	IMS.1.d.	No change
IMS.1.e.	IMS.1.e.	Interpretation modified to add the down time to be monitored
IMS.1.f.	IMS.1.f.	Objective element changed from Excellence to Commitment
IMS.1.g.	IMS.1.g.	Interpretation modified to add example related to Materiovigilance programme
	IMS.1.h.	New Objective element added related to digital health technology to improve operational efficiency
IMS.2.	IMS.2.	No change
IMS.2.a.	IMS.2.a.	No change
IMS.2.b.	IMS.2.b.	No change
IMS2.c.	IMS2.c.	No change
IMS.2.d.	IMS.2.d.	No change
IMS.2.e.	IMS.2.e.	No change
IMS.3.	IMS.3.	No change

5th Edition	6th Edition	Remarks
IMS.3.a.	IMS.3.a.	Objective element changed from Commitment to Core
IMS.3.b.	IMS.3.b.	Interpretation modified to add example related to content of nursing assessment, nursing care, dietary assessment and physiotherapy assessment.
IMS.3.c.	IMS.3.c.	No change
IMS.3.d.	IMS.3.d.	No change
IMS.3.e.	IMS.3.e.	No change
IMS.3.f.	IMS.3.f.	No change
IMS.3.g.	IMS.3.g.	No change
IMS.4.	IMS.4.	No change
IMS.4.a.	IMS.4.a.	No change
IMS.4.b.	IMS.4.b.	No change
IMS.4.c.	IMS.4.c.	No change
IMS.4.d.	IMS.4.d.	No change
IMS.4.e.	IMS.4.d.	No change
IMS.4.f.	IMS.4.f.	Interpretation modified to add electronic signed medical records.
IMS.4.g.	IMS.4.g.	Interpretation modified to include details of the cause of death in the medical record.
IMS.4.h.	IMS.4.h.	No change
IMS.5.	IMS.5.	No change
IMS.5.a.	IMS.5.a.	No change
IMS.5.b.	IMS.5.b.	No change
IMS.5.c.	IMS.5.c.	Interpretation modified for better clarity.
IMS.5.d.	IMS.5.d.	Interpretation modified to add risk assessment
IMS.5.e.	IMS.5.e.	No change
IMS.5.f.	IMS.5.f.	No change
IMS.6.	IMS.6.	No change
IMS.6.a.	IMS.6.a.	Interpretation modified to emphasise implementation of System documentation
IMS.6.b.	IMS.6.b.	MCI changed to National Medical Commission
IMS.6.c.	IMS.6.c.	No change
IMS.6.d.	IMS.6.d.	No change

5th Edition	6th Edition	Remarks
IMS.7.	IMS.7.	No change
IMS.7.a.	IMS.7.a.	Interpretation modified to emphasise review of medical record in physical and electronic medical record.
IMS.7.b.	IMS.7.b.	No change
IMS.7.c.	IMS.7.c.	No change
IMS.7.d.	IMS.7.d.	Addition of checklist in the review of medical record
IMS.7.e.	IMS.7.e.	No change
IMS.7.f.	IMS.7.f.	No change
IMS.7.g.	IMS.7.g.	No change

ABBREVIATIONS

ABC	Always, Better and Control
ACLS	Advanced Cardiac Life Support
ADL	Activities of Daily Living
ADHD	Attention Deficit Hyperactivity Disorder
ACLS	Advanced Cardiac Life Support
AERB	Atomic Energy Regulatory Board
AHRQ	Agency for Healthcare Research and Quality
AHU	Air Handling Unit
AIDS	Acquired Immuno Deficiency Syndrome
AIS	Automotive Industry Standards
ALARA	As Low As Reasonably Achievable
ANOVA	Analysis of Variance
ART	Assisted Reproductive Technology
ATLS	Advanced Trauma Life Support
BD	Bis in Die
BLS	Basic Life Support
BMW	Bio-Medical Waste
BP	Blood Pressure
CAPD	Continuous Ambulatory Peritoneal Dialysis
CATH	Catheterization
CCTV	Closed-Circuit Television
CDC	Centres for Disease Control and Prevention
CEO	Chief Executive Officer
COO	Chief Operating Officer
COVID-19	Corona Virus Disease 2019
CPR	Cardio-Pulmonary Resuscitation
CSSD	Central Sterile Services Department
CST	Continue same treatment

CT	Computerised Tomography
DDMA	District Disaster Management Authority
DG	Diesel Generator
ECG	Electrocardiogram
ELV	Extra Low Voltage
EMR	Electronic Medical Record
EQA	External Quality Assurance
ERCP	Endoscopic Retrograde Cholangiopancreatography
ESG	Environment Social and Governance
ETO	Ethylene Oxide
ETP	Effluent Treatment Plant
FCU	Fan Coil Unit
FDA	Federal Drug Authority
FMEA	Failure Modes and Effects Analysis
FSN	Fast, Normal, and Slow-moving
G6PD	Glucose-6-Phosphate Dehydrogenase
GNM	General Nursing and Midwifery
HAI	Healthcare-Associated Infection
HAZMAT	Hazardous Material
HBTC	Hospital Blood Transfusion Committee
HCO	Healthcare Organisation
HDU	High Dependency Unit
HIRA	Hazard Identification and Risk Analysis
HIS	Hospital Information System
HISI	Hospital Infection Society-India
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HT	High Tension
HTM	Health Technical Memorandum
HVA	Hazard Vulnerability Analysis

HVAC	Heating Ventilation and Air Conditioning
HvPI	Haemo Vigilance Programme of India
ICD	International Classification of Diseases
ICMR	Indian Council of Medical Research
IPCN	Infection Prevention and Control Nurse
IPCO	Infection Prevention and Control Officer
ICU	Intensive Care Unit
ID	Identification Data
IP	In-Patient
IPCO	Infection prevention and control officer
IPD	In-Patient Department
IPHS	Indian Public Health Standards
IQC	Internal quality control
ISMP	Institute for Safe Medication Practices
ISO	International Organisation for Standardization
IT	Information Technology
IV	Intravenous
IVF	In Vitro Fertilization
LAMA	Leaving Against Medical Advice
LaQshya	Labour Room Quality Improvement Initiative
LASA	Look-Alike Sound-Alike
LASER	Light amplification by stimulated emission of radiation
LIS	Laboratory Information System
LPG	Liquefied Petroleum Gas
LT	Low Tension
MaPSaF	Manchester Patient Safety Framework
MBBS	Bachelor of Medicine and Bachelor of Surgery
MDRO	Multi-Drug Resistant Organisms
MLC	Medico-Legal Case
MoU	Memorandum of Understanding

MoHFW	Ministry of Health & Family welfare
MRD	Medical Records Department
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus aureus
MSDS	Material Safety Data Sheet
MTP	Medical Termination of Pregnancy
MvPI	Materio-Vigilance Programme Of India
NABL	National Accreditation Board for Testing and Calibration Laboratories
NACO	National AIDS Control Organisation
NMC	National Medical Council
NDMA	National Disaster Management Authority
NFPA	National Fire Protection Association
NICU	Neonatal Intensive Care Unit
NRS	Notional Risk Screening
OP	Out-Patient
OPD	Out-Patient Department
OT	Operation Theatre
PALS	Paediatric Advanced Life Support
PC-PNDT	Pre-Conception and Pre-Natal Diagnostic Testing
PDSA	Plan Do Study Act
PHQ	Patient Health Questionnaire
PICU	Paediatric Intensive Care Unit
PPE	Personal Protective Equipment
POCT	Point of Care Testing
POPS	Paediatric Observation Priority Score
PREM	Patient-Reported Experience Measures
PROM	Patient Reported Outcome Measures
PT	Proficiency Testing
PvPI	Pharmaco-Vigilance Programme of IndiaQID
QR	Quick Response

RIS	Radiological Information System
RO	Reverse Osmosis
RTI	Right To Information
SBAR	Situation, Background, Assessment, Recommendation
SDMA	State Disaster Management Authority
SHEA	Society for Healthcare Epidemiology of America
SNOMED CT	Systematized Medical Nomenclature for Medicine–Clinical Terminology
SOP	Standard Operating Procedure
STG	Standard Treatment Guideline
STP	Sewage Treatment Plant
TID	Ter In Die
TLD	Thermo Luminescent Dosimeter
TPR	Temperature, Pulse and Respiratory Rate
TTI	Transfusion Transmissible Infections
UPS	Uninterrupted Power Supply
VED	Vital, Essential and Desirable
VRE	Vancomycin-Resistant Enterococci
WHO	World Health Organization

Chapter 1

Access, Assessment and Continuity of Care (AAC)

Intent of the chapter

Patients are informed of the services provided by the organisation. Scope of each healthcare services including diagnostic and therapeutic services shall be well defined and the same shall be made available to the patients and their families. Only those patients who can be cared for by the organisation are admitted. Emergency patients receive life-stabilising treatment and are then either admitted (if resources are available) or transferred appropriately to an organisation that has the resources to take care of such patients. Out-patients who do not match the organisation's resources are similarly referred to organisations that have the required resources.

Patients that match the organisation's resources are admitted using a defined process. Patients cared for by the organisation undergo an established initial assessment and periodic re-assessments.

These assessments result in the formulation of a care plan.

The organisation provides laboratory and imaging services commensurate to its scope of services. The laboratory and imaging services are provided by competent staff in a safe environment for both patients and staff. Patient care is continuous and multi-disciplinary. Preventive and promotive healthcare services are part of patient care. Transfer and discharge protocols are well defined, with adequate information provided to the patient. Continuity of patient care is extended to the community through home health care services.

SUMMARY OF STANDARDS

AAC.1.	The organisation defines and displays the healthcare services that it provides.
AAC.2.	The organisation has a well-defined registration and admission process.
AAC.3.	There is an appropriate mechanism for transfer (in and out) or referral of patients.
AAC.4.	Patients cared for by the organisation undergo an established initial assessment.
AAC.5.	Patients cared for by the organisation undergo a regular re-assessment.
AAC.6.	Laboratory services are provided as per the scope of services of the organisation.
AAC.7.	There is an established laboratory quality assurance and safety programme.
AAC.8.	Imaging services are provided as per the scope of services of the organisation.
AAC.9.	There is an established quality assurance and safety programme for imaging services.
AAC.10.	Patient care is continuous and multi-disciplinary.
AAC.11.	The preventive and promotive health services are provided in a safe, collaborative and consistent manner.
AAC.12.	The organisation has an established discharge process.
AAC.13.	The organisation defines the content of the discharge summary.

*This implies that the objective element requires documentation

Summary of Objective Elements

Standard	13
Objective elements	87
CORE	6
Commitment	68
Achievement	9
Excellence	4

Objective Element	AAC.1.	AAC.2.	AAC.3.	AAC.4.	AAC.5.	AAC.6.	AAC.7.	AAC.8.	AAC.9.	AAC.10.	AAC.11.	AAC.12.	AAC.13.
a	Commitment	Commitment	Commitment	CORE	CORE	Commitment	Commitment	CORE	Commitment	Commitment	Commitment	Commitment	Commitment
b	Commitment	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Achievement	Commitment	Commitment	Commitment	Commitment
c	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Achievement	Commitment	Commitment	Commitment	Commitment
d	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Excellence	Commitment	Excellence	CORE	Commitment	Commitment	Commitment
e		Achievement		CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Achievement	Commitment
f				Achievement		Commitment	Commitment	Commitment	Commitment	Commitment		Achievement	
g				Excellence		Commitment	Commitment	Commitment	Commitment	Achievement		Commitment	
h						Commitment		Achievement	Commitment	Excellence			
I						Achievement		Commitment	Commitment				
j						Commitment			Commitment				
k									Commitment				

Standards and Objective Elements

Standard

AAC.1.	The organisation defines and displays the healthcare services that it provides.

Objective Elements

Commitment	a.	The healthcare services being provided are defined and are in consonance with the needs of the community.
Commitment	b.	Each defined clinical service shall have diagnostic and treatment services with suitably qualified personnel who provide out-patient, in-patient, daycare and emergency cover.
Commitment	c.	Scope of the clinical services of each department is defined. *
Commitment	d.	The organisation's defined clinical services are prominently displayed.

Standard

AAC.2.	The organisation has a well-defined registration and admission process.

Objective Elements

Commitment	a.	The organisation uses written guidance for registering and admitting patients. *
CORE	b.	A unique identification number is generated at the end of the registration.
Commitment	c.	Patients are accepted only if the organisation can provide the required service.

Commitment	d.	The written guidance also addresses managing patients during non-availability of beds. *
Achievement	e.	Access to the healthcare services in the organisation is prioritised according to the clinical needs of the patient.*

Standard

AAC.3.	There is an appropriate mechanism for transfer (in and out) or referral of patients.

Objective Elements

Commitment	a.	Transfer-in of patients to the organisation is done appropriately.*
Commitment	b.	Transfer- out / referral of patients to another facility is done appropriately.*
Commitment	c.	During transfer or referral, accompanying staff are appropriate to the clinical condition of the patient.
Commitment	d.	The organisation gives a summary of the patient's condition and the treatment given.

Standard

AAC.4.	Patients cared for by the organisation undergo an established initial assessment.

Objective Elements

CORE	a.	The initial assessment of the out-patients, daycare, in-patients and emergency patients is done in a standardised manner. *
Commitment	b.	The initial assessment is performed by qualified personnel. *
Commitment	c.	The initial assessment is performed within a time frame based on the needs of the patient. *

Commitment	d.	Initial assessment of daycare and in-patients includes nursing assessment, which is done at the time of admission and documented.
CORE	e.	The initial assessment for in-patients results in a documented care plan.
Achievement	f.	The care plan is countersigned by the clinician in-charge of the patient within 24 hours.
Excellence	g.	The care plan includes the identification of special needs regarding care following discharge.

Standard

AAC.5.	Patients cared for by the organisation undergo a regular re-assessment.

Objective Elements

CORE	a.	Patients are re-assessed at appropriate intervals to determine their response to treatment and to plan further treatment or discharge.
Commitment	b.	Out-patients are informed of their next follow-up, where appropriate.
Commitment	c.	For in-patients during re-assessment, the care plan is monitored and modified, where found necessary.
Commitment	d.	Staff involved in direct clinical care document re-assessments.
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. *

Standard

AAC.6.	Laboratory services are provided as per the scope of services of the organisation.

Objective Elements

Commitment	a.	Scope of the laboratory services is commensurate to the services provided by the organisation.
Commitment	b.	The infrastructure (physical and equipment) is adequate to provide the defined scope of services.
Commitment	c.	Human resource is adequate to provide the defined scope of services.
Commitment	d.	Qualified and trained personnel perform and supervise the investigations and report the results.
Commitment	e.	Requisition for tests, collection, identification, handling, safe transportation, processing and disposal of a specimen is performed according to written guidance. *
Commitment	f.	Laboratory results are available within a defined time frame. *
Commitment	g.	Critical results are intimated to the person concerned at the earliest. *
Commitment	h.	Results are reported in a standardised manner.
Achievement	i.	There is a mechanism to address the recall / amendment of reports whenever applicable.*
Commitment	j.	Laboratory tests not available in the organisation are outsourced to the organisation(s) based on their quality assurance system. *

Standard

AAC.7.	There is an established laboratory quality assurance and safety programme.

Objective Elements

Commitment	a.	The laboratory quality assurance programme is implemented. *

Commitment	b.	The programme ensures the quality of test results through internal quality control.*
Commitment	c.	Laboratory participates in proficiency testing / external quality assurance scheme.
Excellence	d.	The programme addresses the clinico-pathological meeting(s).
Commitment	e.	The laboratory safety programme is implemented. *
Commitment	f.	Laboratory personnel are appropriately trained in safe practices.
Commitment	g.	Laboratory personnel are provided with appropriate safety measures.

Standard

AAC.8.	Imaging services are provided as per the scope of services of the organisation.

Objective Elements

CORE	a.	Imaging services comply with legal and other requirements.
Commitment	b.	Scope of the imaging services is commensurate to the services provided by the organisation.
Commitment	c.	The infrastructure (physical and equipment) and human resources are adequate to provide for its defined scope of services.
Commitment	d.	Qualified and trained personnel perform, supervise and interpret the investigations.
Commitment	e.	Imaging results are available within a defined time frame. *
Commitment	f.	Critical results are intimated immediately to the personnel concerned. *
Commitment	g.	Results are reported in a standardised manner.

Achievement	h.	There is a mechanism to address the recall / amendment of reports whenever applicable. *
Commitment	I.	Imaging tests not available in the organisation are outsourced to the organisation(s) based on their quality assurance system.

Standard

AAC.9.	There is an established quality assurance and safety programme for imaging services.

Objective Elements

Commitment	a.	The quality assurance programme for imaging services is implemented. *
Achievement	b.	A system is in place to ensure the appropriateness of the investigations and procedures for the clinical indication.
Achievement	c.	The programme addresses periodic internal / external peer review of imaging results using appropriate sampling.
Excellence	d.	The programme addresses the clinico-radiological meeting(s).
Commitment	e.	The programme includes the documentation of corrective and preventive actions. *
Commitment	f.	The radiation-safety programme is implemented.*
Commitment	g.	Patients are appropriately screened for safety / risk before imaging.
Commitment	h.	Imaging personnel and patients use appropriate radiation- safety and monitoring devices where applicable.
Commitment	I.	Radiation-safety and monitoring devices are periodically tested, and results are documented. *
Commitment	j.	Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.
Commitment	k.	Imaging signage is prominently displayed in all appropriate locations.

Standard

AAC.10.	Patient care is continuous and multi-disciplinary.

Objective Elements

Commitment	a.	During all phases of care, there is a qualified individual identified as responsible for the patient's care.
Commitment	b.	Patient care is coordinated in all care settings within the organisation.
Commitment	c.	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.
CORE	d.	The organisation implements standardised hand-over communication during each staffing shift, between shifts and during transfers between units / departments.
Commitment	e.	Patient transfer within the organisation is done safely.
Commitment	f.	Referral of patients to other departments / specialities follow written guidance.*
Achievement	g.	The organisation ensures predictable service delivery by adhering to defined timelines and informs the patient / family and / or caregiver whenever there is a change in schedule.
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.

Standard

AAC.11.	The preventive and promotive health services are provided in a safe, collaborative and consistent manner.

Objective Elements

Commitment	a.	Written guidance governs the implementation of preventive and promotive care as per the scope of services.*

Commitment	b.	Organisation shall define evidenced based and contextual age-appropriate screening for non- communicable diseases.
Commitment	c.	Mental health screening and appropriate intervention is advised for patients wherever applicable.
Commitment	d.	Evidence based and contextual paediatric and adult immunisation shall be advised wherever applicable.
Commitment	e.	A multi-disciplinary approach is adopted in imparting health education on life-style modifications.

Standard

AAC.12.	The organisation has an established discharge process.

Objective Elements

Commitment	a.	The patient's discharge process is planned in consultation with the patient and / or family.
Commitment	b.	The discharge process is coordinated among various departments and agencies involved (including medico-legal and absconded cases).*
Commitment	c.	Written guidance governs the discharge of patients leaving against medical advice.*
Commitment	d.	A discharge summary is given to all the patients leaving the organisation including patients leaving against medical advice.
Achievement	e.	The organisation adheres to planned discharge.
Achievement	f.	The care shall be provided by expanding access to health practices through domiciliary visits, wherever applicable.
Commitment	g.	The organisation monitors the discharge time, sets appropriate benchmarks and makes continual improvement.

Standard

AAC.13.	The organisation defines the content of the discharge summary.

Objective Elements

Commitment	a.	A discharge summary is provided to the patients at the time of discharge.
Commitment	b.	Discharge summary has a standardised content.
Commitment	c.	Discharge summary contains follow-up advice, medication and other instructions in an understandable manner.
Commitment	d.	Discharge summary incorporates instructions about when and how to obtain urgent care.
Commitment	e.	In case of death, the summary of the case also includes the cause of death.

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Chapter 2 Care of Patients (COP)

Intent of the chapter

The organisation provides uniform care to all patients in various settings. The settings include care provided in out-patient units, daycare facilities, in-patient units including critical care units, procedure rooms and operation theatre. When similar care is provided in these different settings, care delivery is uniform. Written guidance, applicable laws and regulations guide emergency and ambulance services, cardio-pulmonary resuscitation, use of blood and blood components, care of patients in the critical care and high dependency units.

Written guidance, applicable laws and regulations also guide the care of patients who are at higher risk of morbidity / mortality, high-risk obstetric patients, paediatric patients, patients undergoing procedural sedation, administration of anaesthesia, patients undergoing surgical procedures and end of life care.

Pain management, nutritional therapy and rehabilitative services are also addressed to provide comprehensive health care.

The management shall have written guidelines for organ donation and procurement. The organ transplant programme ensures that it has the right skill mix of staff and other related support systems to ensure safe and high quality of care.

The delivery of care and services to the patients are coordinated and integrated by all healthcare providers.

The standards aim to guide and encourage patient safety as the overarching principle for providing care to patients.

SUMMARY OF STANDARDS

COP.1.	Uniform care to patients is provided in all settings of the organisation and is guided by written guidance.*
COP.2.	Emergency services are provided in accordance with written guidance, applicable laws and regulations.
COP.3.	Ambulance services ensure safe patient transportation with appropriate care.
COP.4.	The organisation plans and implements mechanisms for the care of patients during community emergencies, epidemics and other disasters.
COP.5.	Cardio-pulmonary resuscitation services are provided uniformly across the organisation.
COP.6.	Nursing care is provided to patients in the organisation in consonance with clinical protocols.
COP.7.	Clinical procedures are performed safely.
COP.8.	Transfusion services are provided as per the scope of services of the organisation, safely.
COP.9.	The organisation provides care in intensive care and high dependency units in a systematic manner.

COP.10.	Organisation provides safe obstetric care.
COP.11.	Organisation provides safe paediatric services.
COP.12.	Procedural sedation is provided consistently and safely.
COP.13.	Anaesthesia services are provided in a consistent and safe manner.
COP.14.	Surgical services are provided in a consistent and safe manner.
COP.15.	The organ transplant programme is carried out safely.
COP.16.	The organisation identifies and manages patients who are at high risk of morbidity / mortality.
COP.17.	Pain management for patients is done in a consistent manner.
COP.18.	Rehabilitation services are provided to the patients in a safe, collaborative and consistent manner.
COP.19.	Nutritional therapy is provided to patients consistently and collaboratively.
COP.20.	End-of-life care is provided in a compassionate and considerate manner.

This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	20
Objective elements	136
CORE	13
Commitment	107
Achievement	12
Excellence	4

Objective Element	COP.1.	COP.2.	COP.3.	COP.4.	COP.5.	COP.6.	COP.7.	COP.8.	COP.9.	COP.10.
a	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
b	CORE	Achievement	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
c	Commitment	CORE	Commitment	Commitment	Commitment	Achievement	Commitment	Commitment	Commitment	Commitment
d	Excellence	Commitment	Commitment	Commitment	Commitment	Commitment	CORE	CORE	Commitment	Commitment
e	Excellence	Commitment	Commitment		Commitment	Commitment	Commitment	Commitment	Commitment	Achievement
f	Commitment	Commitment	Commitment		Commitment	Commitment	Commitment	Achievement	Achievement	Commitment
g		Commitment	Achievement				Commitment	Achievement	Commitment	Commitment
h		Achievement								Commitment
i		Commitment								Commitment
j										Commitment
k										Commitment

Objective Element	COP.11.	COP.12.	COP.13.	COP.14.	COP.15.	COP.16.	COP.17.	COP.18.	COP.19.	COP.20.
a	Commitment	Commitment	Commitment	Commitment	CORE	CORE	Commitment	Commitment	Commitment	Commitment
b	Commitment	Commitment	Commitment	Commitment	Commitment	CORE	Commitment	Commitment	Commitment	Achievement
c	Commitment	Commitment	CORE	Commitment	Commitment	CORE	Commitment	Commitment	Commitment	Commitment
d	Commitment	Commitment	Commitment	CORE	CORE	CORE	Commitment	Commitment	Commitment	Commitment
e	Commitment	Commitment	CORE	Commitment		Commitment		Commitment	Commitment	Commitment
f	Commitment	Commitment	Commitment	Commitment				Commitment		
g	Commitment	Commitment	Commitment	Commitment				Excellence		
h	Excellence	Commitment	Commitment	Commitment						
i			Commitment	Achievement						
j			Achievement	Achievement						

Standards and Objective Elements

Standard

COP.1.	Uniform care to patients is provided in all settings of the organisation and is guided by written guidance.

Objective Elements

Commitment	a.	Uniform care is provided to patients following written guidance . *
CORE	b.	The organisation has a uniform process for identification of patients and uses at least two identifiers.
Commitment	c.	The organisation implements evidence-based clinical practice guidelines and / or clinical protocols to guide uniform patient care.
Excellence	d.	Clinical care pathways are developed, consistently followed across all settings of care, and reviewed periodically.
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.
Commitment	f.	Telemedicine facility is provided safely and securely based on written guidance. *

Standard

COP.2.	Emergency services are provided in accordance with written guidance, applicable laws and regulations.

Objective Elements

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.
Achievement	b.	Prevention of patient over-crowding is planned and crowd management measures are implemented.

CORE Commitment Achievement Excellence

CORE	c.	Emergency care is provided in consonance with statutory requirements including medico-legal cases and as per written guidance. *
Commitment	d.	Initiation of appropriate care is guided by a system of triage. *
Commitment	e.	Patients waiting in the emergency are re-assessed as appropriate for the change in status.
Commitment	f.	Admission, discharge to home or transfer to another organisation is documented.
Commitment	g.	In case of discharge to home or transfer to another organisation, a discharge / transfer note shall be given to the patient.
Achievement	h.	The organisation shall implement a quality assurance programme. *
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. *

Standard

COP.3.	Ambulance services ensure safe patient transportation with appropriate care.

Objective Elements

Commitment	a.	The organisation has access to ambulance services commensurate with the scope of the services provided by it.
Commitment	b.	There are adequate access and space for the ambulance(s).
Commitment	c.	The ambulance(s) is fit for purpose and is appropriately equipped.
Commitment	d.	The ambulance(s) is operated by trained personnel.
Commitment	e.	The ambulance(s) is checked daily for functioning status, medical equipment, emergency medications and consumables.
Commitment	f.	The ambulance(s) has a proper communication system.*

Achievement	g.	The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation.

Standard

COP.4.	The organisation plans and implements mechanisms for the care of patients during community emergencies, epidemics and other disasters.

Objective Elements

Commitment	a.	The organisation identifies potential community emergencies, epidemics and other disasters.*
Commitment	b.	The organisation manages community emergencies, epidemics and other disasters as per a documented plan.*
Commitment	c.	Provision is made for availability of medical supplies, equipment and materials during such emergencies.
Commitment	d.	The plan is tested at least twice a year.

Standard

COP.5.	Cardio-pulmonary resuscitation services are provided uniformly across the organisation.

Objective Elements

Commitment	a.	Cardio-pulmonary resuscitation services are available and provided to patients at all times.
Commitment	b.	During cardio-pulmonary resuscitation, assigned roles and responsibilities are complied with.
Commitment	c.	Medical equipment and medications for use during cardio-pulmonary resuscitation are available in various areas of the organisation.
Commitment	d.	The events during cardio-pulmonary resuscitation are recorded.
Commitment	e.	A multi-disciplinary committee does a post-event analysis of cardio-pulmonary resuscitations.

Commitment	f.	Corrective and preventive measures are taken based on the post-event analysis.

Standard

COP.6.	Nursing care is provided to patients in the organisation in consonance with clinical protocols.

Objective Elements

Commitment	a.	Nursing care is provided to patients in accordance with written guidance.*
Commitment	b.	Assignment of patient care is done as per good clinical / nursing practice.
Achievement	c.	The organisation implements acuity-based staffing to improve patient outcomes.
Commitment	d.	Nursing care is aligned and integrated with overall patient care which is documented.*
Commitment	e.	Nurses are provided with the appropriate and adequate equipment for providing safe and efficient nursing care.
Commitment	f.	Nurses are empowered to make patient care decisions within their scope of practice.

Standard

COP.7.	Clinical procedures are performed in a safe manner.

Objective Elements

Commitment	a.	Clinical procedures are performed based on the clinical needs of the patient.
Commitment	b.	Performance of various clinical procedures is based on written guidance and done in a safe manner. *
Commitment	c.	Qualified personnel order, plan, perform and assist in performing procedures.

CORE	d.	Care is taken to prevent adverse events like a wrong patient, wrong procedure and wrong site. *
Commitment	e.	Informed consent is taken by the personnel performing the procedure, where applicable.
Commitment	f.	Patients are appropriately monitored during and after the procedure.
Commitment	g.	Procedures are documented accurately in the patient record.

Standard

COP.8.	Transfusion services are provided as per the scope of services of the organisation, safely.

Objective Elements

Commitment	a.	Scope of transfusion services is commensurate with the services provided by the organisation.
Commitment	b.	The organisation shall establish and implement processes for blood / component collection, testing, storage and distribution under written guidance.*
Commitment	c.	Blood and components are stored safely from the time of collection till transfusion.
CORE	d.	The organisation ensures safe and rational use of blood and blood components. *
Commitment	e.	Blood / blood components are available for use in emergency and routine situations within a defined time-frame. *
Achievement	f.	The organisation shall ensure that post-transfusion form is collected, reactions if any identified and are analysed for preventive and corrective actions. *
Achievement	g.	The organisation shall implement a quality assurance programme. *

Standard

COP.9.	The organisation provides care in intensive care and high dependency units in a systematic manner.

Objective Elements

Commitment	a.	Care of patients in intensive care and high dependency units is provided based on written guidance. *
Commitment	b.	The defined admission and discharge criteria for intensive care and high dependency units are implemented. *
Commitment	c.	Adequate staff and equipment are available.
Commitment	d.	Defined procedures for the situation of bed shortages are followed. *
Commitment	e.	Infection prevention and control practices are followed. *
Achievement	f.	The organisation shall implement a quality assurance programme. *
Commitment	g.	The organisation has a mechanism to counsel the patient and/or family periodically.

Standard

COP.10.	Organisation provides safe obstetric care.

Objective Elements

Commitment	a.	Obstetric services are organised and provided safely. *
Commitment	b.	The organisation identifies and, provides care to high-risk obstetric cases, and where needed, refers them to another appropriate centre.
Commitment	c.	Persons caring for high-risk obstetric cases are competent.
Commitment	d.	Ante-natal services are provided. *
Achievement	e.	Organisation encourages and welcomes the presence of a birth companion during labour.

Commitment	f.	Organisation treats pregnant woman and her companion cordially and respectfully, ensures privacy and confidentiality for pregnant woman during her stay.
Commitment	g.	The treating doctor explains danger signs and important care activities to pregnant woman and her companion.
Commitment	h.	Obstetric patient's assessment also includes maternal nutrition.
Commitment	i.	Appropriate peri-natal and post-natal monitoring is performed.
Commitment	j.	The organisation caring for high-risk obstetric cases have the facilities to take care of neonates of such cases.
Commitment	k.	Organization shall adhere to legal and defined Assisted Reproductive Technology (ART) practices.

Standard

COP.11.	Organisation provides safe paediatric services.

Objective Elements

Commitment	a.	Paediatric services are organised and provided safely. *
Commitment	b.	Neonatal care is in consonance with the national / international guidelines. *
Commitment	c.	Those who care for children have age-specific competency.
Commitment	d.	Provisions are made for special care of children.
Commitment	e.	Paediatric assessment includes growth, developmental, immunisation and nutritional assessment.
Commitment	f.	The organisation has measures in place to prevent child / neonate abduction and abuse. *
Commitment	g.	The child's family members are educated about nutrition, immunisation and safe parenting.

Excellence	h.	The organisation provides for adolescent friendly health care services.

Standard

COP.12.	Procedural sedation is provided in a consistent and safe manner.

Objective Elements

Commitment	a.	Procedural sedation is administered in a consistent manner. *
Commitment	b.	Informed consent for administration of procedural sedation is obtained.
Commitment	c.	Competent and trained persons administer procedural sedation.
Commitment	d.	The person monitoring sedation is different from the person performing the procedure.
Commitment	e.	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.
Commitment	f.	Patients are monitored after procedural sedation, and the same is documented.
Commitment	g.	Criteria are used to determine the appropriateness of discharge from the observation / recovery area. *
Commitment	h.	Equipment and workforce are available to manage patients who have gone into a deeper level of sedation than initially intended.

Standard

COP.13.	Anaesthesia services are provided in a consistent and safe manner.

Objective Elements

Commitment	a.	Anaesthesia services are provided in a consistent manner.*

CORE	b.	The pre-anaesthesia assessment results in the formulation of an anaesthesia plan which is documented.
Commitment	c.	A pre-induction assessment is performed and documented.
Commitment	d.	The anaesthesiologist obtains informed consent for administration of anaesthesia.
CORE	e.	During anaesthesia, monitoring includes a regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end-tidal carbon dioxide.
Commitment	f.	Patient's post-anaesthesia status is monitored and documented.
Commitment	g.	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area. *
Commitment	h.	The type of anaesthesia and anaesthetic medications used are documented in the patient record.
Commitment	i.	Procedures shall comply with infection prevention and control guidelines to prevent cross-infection between patients.
Achievement	j.	Intra-operative adverse anaesthesia events are recorded and monitored.

Standard

COP.14.	Surgical services are provided in a consistent and safe manner.

Objective Elements

Commitment	a.	Surgical services are provided in a consistent and safe manner. *
Commitment	b.	Surgical patients have a pre-operative assessment, a documented pre-operative diagnosis, and pre-operative instructions are provided before surgery.
Commitment	c.	Informed consent is obtained by a surgeon before the procedure.

CORE	d.	Care is taken to prevent adverse events like the wrong site, wrong patient and wrong surgery. *
Commitment	e.	An operative note is documented before transfer out of patient from recovery.
Commitment	f.	Post-operative care is guided by a documented plan.
Commitment	g.	Patient, personnel and material flow conform to infection prevention and control practices.
Commitment	h.	Appropriate facilities, equipment, instruments and supplies are available in the operating theatre.
Achievement	i.	The organisation shall implement a quality assurance programme. *
Achievement	j.	The quality assurance programme includes surveillance of the operation theatre environment. *

Standard

COP.15.	The organ transplant programme is carried out safely.

Objective Elements

CORE	a.	The organ transplant programme shall be in consonance with the legal requirements and shall be conducted ethically.
Commitment	b.	Care of transplant patients is guided by clinical practice guidelines. *
Commitment	c.	The organisation ensures education and counselling of recipient and donor through trained / qualified counsellors before organ transplantation.
CORE	d.	The organisation shall take measures to create awareness regarding organ donation.

Standard

COP.16.	The organisation identifies and manages patients who are at high-risk of morbidity / mortality.

Objective Elements

CORE	a.	The organisation identifies and manages vulnerable patients. *
CORE	b.	The organisation identifies and manages patients who are at a risk of fall.*
CORE	c.	The organisation identifies 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.*
Commitment	e.	The organisation identifies and manages patients who need restraints. *

Standard

COP.17.	Pain management for patients is done in a consistent manner.

Objective Elements

Commitment	a.	Patients in pain are effectively managed. *
Commitment	b.	Patients are screened for pain.
Commitment	c.	Patients with pain undergo detailed assessment and periodic re-assessment .
Commitment	d.	Pain alleviation measures or medications are initiated and titrated according to the patient's need and response.

Standard

COP.18.	Rehabilitation services are provided to the patients in a safe, collaborative and consistent manner.

Objective Elements

Commitment	a.	Scope of the rehabilitation services at a minimum is commensurate to the services provided by the organisation.
Commitment	b.	Rehabilitation services are provided in a consistent manner.
Commitment	c.	Care providers collaboratively plan rehabilitation services.
Commitment	d.	There are adequate space and equipment to provide rehabilitation.
Commitment	e.	Care is guided by functional assessment and periodic re-assessments which are done and documented.
Commitment	f.	Care is provided adhering to infection prevention and control and safety practices.
Excellence	g.	Care pathways are developed, implemented, and reviewed periodically.

Standard

COP.19.	Nutritional therapy is provided to patients consistently and collaboratively.

Objective Elements

Commitment	a.	Patients admitted to the organisation are screened for nutritional risk. *
Commitment	b.	Nutritional assessment is done for patients found at risk during nutritional screening.
Commitment	c.	The therapeutic diet is planned and provided collaboratively.

Commitment	d.	Patients receive food according to the written order for the diet.
Commitment	e.	When families provide food, they are educated about the patient's diet limitations.

Standard

COP.20.	End-of-life-care is provided in a compassionate and considerate manner.

Objective Elements

Commitment	a.	End-of-life care is provided in a consistent manner in the organisation. *
Achievement	b.	A multi-professional approach is used to provide end-of-life care.
Commitment	c.	End-of-life care is in consonance with the legal requirements.
Commitment	d.	End-of-life care also addresses the identification of the unique needs of such patient and family.
Commitment	e.	Symptomatic treatment is provided and where appropriate measures are taken for the alleviation of pain.

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Chapter 3 Management of Medication (MOM)

Intent of the chapter

The organisation has a safe and organised medication management process. The availability, safe storage, prescription, dispensing and administration of medications is governed by written guidance. The organisation designates a medication safety officer.

The organisation develops, implements and updates the hospital formulary. The pharmacy shall have oversight of all medications stocked out of the pharmacy. The pharmacy shall ensure correct storage (as regards to temperature, light; high-risk medications including look-alike, sound-alike, etc.), expiry dates and maintenance of documentation.

The availability of emergency medication is stressed upon. The organisation shall have a mechanism to ensure that the emergency medications are standardised throughout the organisation, readily available and replenished promptly. There shall be a monitoring mechanism to ensure that the required medications are always stocked and well within expiry dates.

Every high-risk medication order shall be verified by an appropriate person to ensure accuracy of the dose, frequency and route of administration. Safety is paramount when using narcotics, chemotherapeutic agents and radiopharmaceuticals. Reconciliation of medications occurs at transition points of patient care as part of patient safety.

The medication management process also includes monitoring of patients after administration and procedures for reporting and analysing near-misses, medication errors and adverse drug reactions.

Medications also include blood, implants and devices.

Medical supplies and consumables are available for use.

SUMMARY OF STANDARDS

MOM.1.	Pharmacy services and medication management is done safely.
MOM.2.	The organisation develops, updates and implements a hospital formulary.
MOM.3.	Medications are stored appropriately and are available where required.
MOM.4.	Medications are prescribed safely and rationally.
MOM.5.	Medication orders are written in a uniform manner.
MOM.6.	Medications are dispensed in a safe manner.
MOM.7.	Medications are administered safely.
MOM.8.	Patients are monitored after medication administration.
MOM.9.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used safely.
MOM.10.	Implantable prosthesis and medical devices are used in accordance with laid down criteria.
MOM.11.	Medical supplies and consumables are stored appropriately and are available where required.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	11
Objective elements	68
CORE	13
Commitment	48
Achievement	6
Excellence	1

Objective Element	MOM.1.	MOM.2.	MOM.3.	MOM.4.	MOM.5.	MOM.6.	MOM.7.	MOM.8.	MOM.9.	MOM.10.	MOM.11.
a	Commitment	CORE	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
b	Commitment	Commitment	Commitment	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
c	Achievement	Commitment	CORE	Commitment	Commitment	Commitment	Commitment	CORE	Commitment	Commitment	Commitment
d	Commitment	Achievement	Achievement	Excellence	Commitment	CORE	CORE	Commitment	Commitment	Commitment	Commitment
e	Commitment	Commitment	CORE	CORE		CORE	Commitment	Commitment	Commitment	Achievement	Commitment
f		Commitment	Commitment	CORE		Commitment	Commitment	Commitment			
g			CORE	Achievement			Commitment				
h				Achievement			CORE				
i							Commitment				
j							Commitment				
k							Commitment				

Standards and Objective Elements

Standard

MOM.1.	Pharmacy services and medication management is done safely.

Objective Elements

Commitment	a.	Pharmacy services and medication management are implemented following written guidance. *
Commitment	b.	A multi-disciplinary committee guides the formulation and implementation of pharmacy services and medication management.
Achievement	c.	The multi-disciplinary committee updates medication management processes.
Commitment	d.	There is a procedure to obtain medications when the pharmacy is closed or in case of stock outs. *
Commitment	e.	The organisation has a mechanism to inform relevant staff of key changes in pharmacy services and medication management to ensure uninterrupted and safe care.

Standard

MOM.2.	The organisation develops, updates and implements a hospital formulary.

Objective Elements

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.
Commitment	b.	The list is reviewed and updated collaboratively by the multi-disciplinary committee at least annually.
Commitment	c.	The current formulary is available for clinicians to refer to.

CORE Commitment Achievement Excellence

Achievement	d.	The clinicians adhere to the current formulary.
Commitment	e.	The organisation adheres to the procedure for the acquisition of formulary medications. *
Commitment	f.	The organisation adheres to the procedure to obtain medications not listed in the formulary. *

Standard

MOM.3.	Medications are stored appropriately and are available where required.

Objective Elements

CORE	a.	Medications are stored in a clean, safe and secure environment while incorporating the manufacturer's recommendation(s).
Commitment	b.	Sound inventory control practices guide the storage of medications throughout the organisation.
CORE	c.	The organisation defines and updates its list of high-risk medication(s). *
Achievement	d.	High-risk medications are stored in areas of the organisation where it is clinically necessary.
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. *
Commitment	f.	The list of emergency medications is defined and is stored uniformly. *
CORE	g.	Emergency medications are available all the time and are replenished promptly when used.

Standard

MOM.4.	Medications are prescribed safely and rationally.

Objective Elements

Commitment	a.	Medication prescription is in consonance with good practices / guidelines for rational prescription of medications. *
CORE	b.	The organisation adheres to the determined minimum requirements of a prescription. *
Commitment	c.	Drug allergies and previous adverse drug reactions are ascertained before prescribing.
Excellence	d.	The organisation has a mechanism to assist the clinician in prescribing appropriate medication.
CORE	e.	Reconciliation of medications occurs at transition points of patient care.
CORE	f.	Verbal orders are implemented by ensuring safe medication management practices. *
Achievement	g.	Audit of medication orders / prescription is 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.

Standard

MOM.5.	Medications orders are written in a uniform manner.

Objective Elements

Commitment	a.	The organisation ensures that only authorised personnel write orders. *
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.
Commitment	c.	Medication orders are legible, dated, timed and signed.
Commitment	d.	Medication orders contain the name of the medicine, route of administration, strength to be administered and frequency / time of administration.

CORE Commitment Achievement Excellence

Standard

MOM.6.	Medications are dispensed in a safe manner.

Objective Elements

Commitment	a.	Dispensing of medications is done safely. *
Commitment	b.	Medication recalls are handled effectively. *
Commitment	c.	Near-expiry medications are handled effectively. *
CORE	d.	Dispensed medications are labelled. *
CORE	e.	High-risk medication orders are verified before dispensing.
Commitment	f.	Return of medications to the pharmacy is addressed. *

Standard

MOM.7.	Medications are administered safely.

Objective Elements

Commitment	a.	Medications are administered by those who are permitted by law to do so.
Commitment	b.	Prepared medication is labelled before preparation of a second drug.
Commitment	c.	The patient is identified before administration.
CORE	d.	Medication is verified from the medication order and physically inspected before administration.
Commitment	e.	Strength is verified from the order before administration.

Commitment	f.	The route is verified from the order before administration.
Commitment	g.	Timing is verified from the order before administration.
CORE	h.	Measures to avoid catheter and tubing mis-connections during medication administration are implemented. *
Commitment	I.	Medication administration is documented.
Commitment	j.	Measures to govern patient's self-administration of medications are implemented. *
Commitment	k.	Measures to govern patient's medications brought from outside the organisation shall be implemented. *

Standard

MOM.8.	Patients are monitored after medication administration.

Objective Elements

Commitment	a.	Patients shall be monitored after medication administration. *
Commitment	b.	Medications shall be changed based on the monitoring where appropriate.
CORE	c.	The organisation shall capture near misses, medication errors and adverse drug reactions. *
Commitment	d.	Near misses, medication errors and adverse drug reactions shall be reported within a specified time frame. *
Commitment	e.	Near misses, medication errors and adverse drug reactions are collected and analysed.
Commitment	f.	Corrective and / or preventive action(s) are taken based on the analysis.

Standard

MOM.9.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used in a safe manner.

Objective Elements

Commitment	a.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used safely. *
Commitment	b.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are prescribed by appropriate caregivers.
Commitment	c.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals drugs shall be stored securely.
Commitment	d.	Chemotherapy and radio-pharmaceuticals shall be prepared properly and safely and administered by qualified personnel.
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.

Standard

MOM.10.	Implantable prosthesis and medical devices shall be used in accordance with laid down criteria.

Objective Elements

Commitment	a.	Usage of implantable prosthesis and medical devices is guided by scientific criteria for each item and national / international recognised guidelines / approvals for such specific item(s).
Commitment	b.	The organisation implements a mechanism for the usage of the implantable prosthesis and medical devices. *
Commitment	c.	Patient and his / her family are counselled for the usage of the implantable prosthesis and medical device, including precautions if any.

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.
Achievement	e.	Process of recall of implantable prosthesis and medical devices are handled effectively. *

Standard

MOM.11.	Medical supplies and consumables are stored appropriately and are available where required.

Objective Elements

Commitment	a.	The organisation adheres to the defined process for the acquisition of medical supplies and consumables. *
Commitment	b.	Medical supplies and consumables are used in a safe manner, where appropriate.
Commitment	c.	Medical supplies and consumables are stored in a clean, safe and secure environment; incorporating the manufacturer's recommendation(s).
Commitment	d.	Sound inventory control practices guide storage of medical supplies and consumables.
Commitment	e.	There is a mechanism in place to verify the condition of medical supplies and consumables.

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Chapter 4 Patient Rights and Education (PRE)

Intent of the chapter

The organisation defines, protects and promotes the patient and family's rights and responsibilities. The staff is aware of these rights and is trained to protect them. Patients are informed of their rights and educated about their responsibilities at the time of entering the organisation.

The expected costs of treatment and care are explained clearly to the patient and / or family.

The organisation encourages patient engagement to enhance clinical outcomes, safety and quality.

Patients are educated about the mechanisms available for addressing grievances.

Informed consent is obtained from the patient or family for specified procedures / care. The key components of information shall include risks, benefits and alternatives.

Patients and families have a right to get information and education about their healthcare needs in a language and manner that is understood by them.

The organisation has a mechanism to capture the patient experience including patient reported experience measures. (PREM).

The organisation develops effective patient-centred communication.

SUMMARY OF STANDARDS

PRE.1.	The organisation protects and promotes patient and family rights and informs them about their responsibilities during care.
PRE.2.	Patient and family rights support individual beliefs, values and involve the patient and family in decision-making processes.
PRE.3.	The patient and / or family members are educated to make informed decisions and are involved in the care planning and delivery process.
PRE.4.	Informed consent is obtained from the patient or family about their care.
PRE.5.	Patient and families have a right to information and education about their healthcare needs.
PRE.6.	Patients and families have a right to information on expected costs.
PRE.7.	The organisation has a mechanism to capture patient's feedback and to redress complaints.
PRE.8.	The organisation has a system for effective communication with patients and / or families.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	8
Objective elements	52
CORE	12
Commitment	32
Achievement	7
Excellence	1

Objective Element	PRE.1.	PRE.2.	PRE.3.	PRE.4.	PRE.5.	PRE.6.	PRE.7.	PRE.8.
a	Commitment	Commitment	CORE	CORE	CORE	CORE	Commitment	Commitment
b	Achievement	Commitment	Achievement	Commitment	Commitment	Commitment	Achievement	Commitment
c	CORE	Commitment	Commitment	CORE	Commitment	Commitment	CORE	Commitment
d	CORE	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
e	CORE	Commitment	Achievement	CORE	Commitment		Commitment	Achievement
f		Commitment			Commitment		Commitment	
g		CORE			Commitment			
h		Commitment			Commitment			
i		Commitment			Achievement			
j		Commitment			Excellence			
k		Commitment						
l		Achievement						

Standards and Objective Elements

Standard

PRE.1.	The organisation protects and promotes patient and family rights and informs them about their responsibilities during care.

Objective Elements

Commitment	a.	Patient and family rights and responsibilities are documented, displayed, and they are made aware of the same. *
Achievement	b.	Patient and family rights and responsibilities are actively promoted. *
CORE	c.	The organisation protects patient and family rights.
CORE	d.	The organisation has a mechanism to report a violation of patient and family rights.
CORE	e.	Violation of patient and family rights are monitored, analysed, and corrective / preventive action taken by the top leadership of the organisation.

Standard

PRE.2.	Patient and family rights support individual beliefs, values and involve the patient and family in decision-making processes.

Objective Elements

Commitment	a.	Patients and family rights include respecting values and beliefs, any special preferences, cultural needs, and responding to requests for spiritual needs.
Commitment	b.	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.
Commitment	c.	Patient and family rights include protection from neglect or abuse.
CORE	d.	Patient and family rights include treating patient information as confidential.

CORE Commitment Achievement Excellence

Commitment	e.	Patient and family rights include the refusal of treatment.
Commitment	f.	Patient and family rights include a right to seek an additional opinion regarding clinical care.
CORE	g.	Patient and family rights include informed consent before the transfusion of blood and blood components, anaesthesia, surgery, initiation of any research protocol and any other invasive / high-risk procedures / treatment.
Commitment	h.	Patient and family rights include a right to complain and information on how to voice a complaint.
Commitment	I.	Patient and family rights include information on the expected cost of the treatment.
Commitment	j.	Patient and family rights include access to their clinical records.
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.
Achievement	l.	Patient rights include determining what information regarding their care would be provided to self and family.

Standard

PRE.3.	The patient and / or family members are educated to make informed decisions and are involved in the care planning and delivery process

Objective Elements

CORE	a.	The patient and / or family members are explained about the proposed care (including the risks, benefits, alternatives), expected results and possible complications.
Achievement	b.	The care plan is prepared and modified in consultation with the patient and / or family members.
Commitment	c.	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.
Commitment	d.	The patient and/or family members are explained about any change in the patient's condition in a timely manner.

Achievement	e.	The patient and/or family members are provided multi-disciplinary counselling when appropriate.

Standard

PRE.4.	Informed consent is obtained from the patient or family about their care.

Objective Elements

CORE	a.	The organisation obtains informed consent from the patient or family for situations where informed consent is required. *
Commitment	b.	Informed consent process adheres to statutory 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.
Commitment	d.	The organisation describes who can give consent when a patient is incapable of independent decision making and implements the same. *
CORE	e.	Informed consent is taken by the person performing the procedure.

Standard

PRE.5.	Patient and families have a right to information and education about their healthcare needs.

Objective Elements

CORE	a.	Patient and / or family are educated in a language and format that they can understand.
Commitment	b.	Patient and / or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.
Commitment	c.	Patient and / or family are educated about food-drug interaction.

Commitment	d.	Patient and / or family are educated about diet and nutrition.
Commitment	e.	Patient and / or family are educated about immunisations.
Commitment	f.	Patient and /or family are educated on various pain management techniques, when appropriate.
Commitment	g.	Patient and/or family are educated about their specific disease process, complications and prevention strategies.
Commitment	h.	Patient and/or family are educated about preventing healthcare associated infections.
Achievement	i.	The patients and/or family members' special educational needs are identified and addressed.
Excellence	j.	The organisation has a mechanism to promote patient engagement to enhance clinical outcomes, safety and quality.

Standard

PRE.6.	Patients and families have a right to information on expected costs.

Objective Elements

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).
Commitment	b.	The relevant tariff list is available to patients.
Commitment	c.	The patient and/or family members are explained about the expected costs.
Commitment	d.	Patient and/or family are informed about the financial implications when there is a change in the care plan.

Standard

PRE.7.	The organisation has a mechanism to capture patient's feedback, experience and to redress complaints.

CORE Commitment Achievement Excellence

Objective Elements

Commitment	a.	The organisation has a mechanism to capture feedback from patients, which includes patient satisfaction.
Achievement	b.	The organisation has a mechanism to capture the patient experience.
CORE	c.	The organisation redress patient complaints as per the defined mechanism. *
Commitment	d.	Patient and / or family members are made aware of the procedure for giving feedback and / or lodging complaints.
Commitment	e.	Feedback and complaints are reviewed and / or analysed within a defined time frame.
Commitment	f.	Corrective and / or preventive action(s) are taken based on the analysis where appropriate.

Standard

PRE.8.	The organisation has a system for effective communication with patients and/or families.

Objective Elements

Commitment	a.	Communication with the patients and / or families is done effectively. *
Commitment	b.	The organisation shall identify special situations where enhanced communication with patients and / or families would be required. *
Commitment	c.	Enhanced communication with the patients and/or families is done effectively. *
Commitment	d.	The organisation ensures that there is no unacceptable communication.
Achievement	e.	The organisation has a system to monitor and review the implementation of effective communication.

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Chapter 5 Infection Prevention and Control (IPC)

Intent of the chapter

The organisation implements an effective healthcare associated infection prevention and control programme. The programme is documented and aims at reducing / eliminating infection risks to patients, visitors and providers of care. The programme is implemented across the organisation, including clinical areas and support services.

The organisation provides proper facilities and adequate resources to support the infection prevention and control programme. The organisation measures and acts to prevent or reduce the risk of healthcare associated infection in patients and staff.

The organisation has an effective antimicrobial management programme through regularly updated antimicrobial policy based on local data and monitors its implementation. Programme also includes monitoring of antimicrobials usage in the organisation.

Surveillance activities are incorporated in the infection prevention and control programme.

The programme includes disinfection / sterilisation activities and biomedical waste (BMW) management.

SUMMARY OF STANDARDS

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.
IPC.2.	The organisation provides adequate and appropriate resources for infection prevention and control.
IPC.3.	The organisation implements the infection prevention and control processes in clinical areas.
IPC.4.	The organisation implements the infection prevention and control processes in support services.
IPC.5.	The organisation takes actions to prevent healthcare associated Infections (HAI) in patients.
IPC.6.	The organisation performs surveillance to capture and monitor infection prevention and control data.
IPC.7.	Infection prevention measures include sterilization and / or disinfection of instruments, equipment and devices.
IPC.8.	The organisation takes action to prevent or reduce healthcare associated infections in its staff.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	8
Objective elements	49
CORE	13
Commitment	33
Achievement	3
Excellence	0

Objective Element	IPC.1.	IPC.2.	IPC.3.	IPC.4.	IPC.5.	IPC.6.	IPC.7.	IPC.8.
a	CORE	CORE	CORE	Commitment	Commitment	CORE	Commitment	Commitment
b	Commitment	Commitment	CORE	Commitment	Commitment	Commitment	CORE	Commitment
c	Commitment	CORE	Commitment	CORE	Commitment	Commitment	Commitment	Achievement
d	Achievement	Commitment	CORE	CORE	Commitment	CORE	Commitment	Commitment
e	Commitment		Commitment	Commitment		Achievement	Commitment	Commitment
f	Commitment		CORE	Commitment		CORE		
g	Commitment					Commitment		
h	Commitment					Commitment		
i	Commitment					Commitment		
j	Commitment							

Standards and Objective Elements

Standard

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.

Objective Elements

CORE	a.	The infection prevention and control programme is documented, which aims at preventing and reducing the risk of healthcare associated infections in the hospital. *
Commitment	b.	The infection prevention and control programme identifies high-risk activities and has written guidance to prevent and manage infections for these activities.*
Commitment	c.	The infection prevention and control programme is reviewed and updated at least once a year.
Achievement	d.	The infection prevention and control programme is reviewed based on infection prevention and control assessment tool.
Commitment	e.	The organisation has a multi-disciplinary infection prevention and control committee, which co-ordinates all infection prevention and control activities.*
Commitment	f.	The organisation has an infection Prevention and control team, which coordinates the implementation of all infection prevention and control activities. *
Commitment	g.	The organisation has designated infection prevention and control officer as part of the infection prevention and control team. *
Commitment	h.	The organisation has designated infection prevention and control nurse(s) as part of the infection prevention and control team. *
Commitment	I.	The organisation implements information, education and communication programme for infection prevention and control activities for the community.
Commitment	j.	The organisation participates in managing community outbreaks.

Standard

IPC.2.	The organisation provides adequate and appropriate resources for infection prevention and control.

Objective Elements

CORE	a.	The management makes available resources required for the infection prevention and control programme including allocation of adequate funds from its annual budget.
Commitment	b.	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.
CORE	c.	Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.
Commitment	d.	Isolation / barrier nursing facilities are available.

Standard

IPC.3.	The organisation implements the infection prevention and control processes in clinical areas.

Objective Elements

CORE	a.	The organisation adheres to standard precautions at all times. *
CORE	b.	The organisation adheres to hand-hygiene guidelines. *
Commitment	c.	The organisation adheres to transmission-based precautions. *
CORE	d.	The organisation adheres to safe injection and infusion practices. *
Commitment	e.	Appropriate antimicrobial usage policy is established and documented *
CORE	f.	The organisation implements the antimicrobial stewardship programme and monitors the use of antimicrobial agents.

Standard

IPC.4.	The organisation implements the infection prevention and control processes in support services.

Objective Elements

Commitment	a.	The organisation has appropriate engineering controls to prevent infections. *
Commitment	b.	The organisation designs and implements a plan to reduce the risk of infection during construction and renovation.*
CORE	c.	The organisation adheres to housekeeping procedures. *
CORE	d.	Biomedical waste (BMW) is handled appropriately and safely.
Commitment	e.	The organisation adheres to laundry and linen management processes. *
Commitment	f.	The organisation adheres to kitchen sanitation and food-handling issues. *

Standard

IPC.5.	The organisation takes actions to prevent healthcare associated infections (HAI) in patients.

Objective Elements

Commitment	a.	The organisation takes action to prevent catheter-associated urinary tract Infections.
Commitment	b.	The organisation takes action to prevent ventilator- associated pneumonia.
Commitment	c.	The organisation takes action to prevent central line associated blood stream infections.
Commitment	d.	The organisation takes action to prevent surgical site infections.

Standard

IPC.6.	The organisation performs surveillance to capture and monitor infection prevention and control data.

Objective Elements

CORE	a.	The scope of surveillance incorporates tracking and analysing of infection risks, rates and trends.
Commitment	b.	Verification of data is done regularly by the infection prevention and control team.
Commitment	c.	Surveillance is directed towards the identified high-risk activities.
CORE	d.	Surveillance includes monitoring compliance with hand-hygiene guidelines.
Achievement	e.	Surveillance includes mechanisms to capture the occurrence of multi-drug-resistant organisms.
CORE	f.	Surveillance includes monitoring the effectiveness of housekeeping services.
Commitment	g.	Feedback regarding surveillance data is provided regularly to the appropriate health care provider.
Commitment	h.	The organisation identifies and takes appropriate action to control outbreaks of infections. *
Commitment	I.	Surveillance data is analysed and appropriate corrective and preventive actions are taken.

Standard

IPC.7.	Infection prevention measures include sterilisation and / or disinfection of instruments, equipment and devices.

Objective Elements

Commitment	a.	The organisation provides adequate space and appropriate zoning for sterilisation activities.

CORE	b.	Cleaning, packing, disinfection and / or sterilisation, storing and the issue of items is done as per the written guidance. *
Commitment	c.	Reprocessing of instruments, equipment and devices are done as per written guidance. *
Commitment	d.	Regular validation tests for sterilisation are carried out and documented. *
Commitment	e.	The established recall procedure is implemented when a breakdown in the sterilisation system is identified. *

Standard

IPC.8.	The organisation takes action to prevent or reduce healthcare associated infections in its staff.

Objective Elements

Commitment	a.	The organisation implements occupational health and safety practices as per written guidance to reduce the risk of transmitting microorganisms among health care providers. *
Commitment	b.	The organisation implements an immunisation policy for its staff.*
Achievement	c.	The organisation implements work restrictions for health care providers with transmissible infections.
Commitment	d.	The organisation implements measures for blood and body fluid exposure prevention.
Commitment	e.	Appropriate post-exposure prophylaxis is provided to all staff members concerned. *

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Chapter 6

Patient Safety and Quality Improvement (PSQ)

Intent of the chapter

The standards encourage an environment of patient safety and continual quality improvement. The patient safety and quality programme should be documented and involve all areas of the organisation and all staff members.

The management creates a culture of safety in the organisation. Patient safety officer(s) shall be designated for the implementation of patient-safety programme.

National / International patient-safety goals / solutions / framework shall be implemented.

The organisation shall collect data on structures, processes and outcomes, especially in areas of high-risk situations. Quality indicators specific to clinical specialities shall be used to involve clinical departments in the quality improvement programme. The collected data shall be collated, analysed and trends are used for further improvement. Appropriate quality tools shall be used for carrying out quality improvement projects. Clinical audits shall be used as a tool to improve the quality of patient care in a sustained manner. Department leaders play an active role in patient safety and quality improvement.

The organisation has a mechanism to capture patient reported outcome measures.

The organisation shall have a robust incident reporting system. Sentinel events shall be defined. All incidents are investigated and appropriate action is taken.

The management shall support the patient safety and quality programme.

SUMMARY OF STANDARDS

PSQ.1.	The organisation implements a structured patient safety programme.
PSQ.2.	The organisation implements a structured quality improvement and continuous monitoring programme.
PSQ.3.	The organisation identifies key indicators to monitor the structures, processes and outcomes, which are used as tools for continual improvement.
PSQ.4.	The organisation uses appropriate quality improvement tools for its quality improvement activities.
PSQ.5.	There is an established system for clinical audit.
PSQ.6.	The patient safety and quality improvement programme are supported by the management.
PSQ.7.	Incidents are collected and analysed to ensure continual quality improvement.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	7
Objective elements	46
CORE	8
Commitment	28
Achievement	7
Excellence	3

Objective Element	PSQ.1.	PSQ.2.	PSQ.3.	PSQ.4.	PSQ.5.	PSQ.6.	PSQ.7.
a	CORE	CORE	Commitment	CORE	Commitment	Achievement	CORE
b	Commitment	Commitment	CORE	Achievement	Commitment	Commitment	Commitment
c	Commitment	Excellence	Commitment	Commitment	Achievement	Commitment	Commitment
d	Commitment	Excellence	CORE	Achievement	Commitment	Commitment	Commitment
e	Commitment	Commitment	Commitment		Commitment	Achievement	Achievement
f	Commitment	Commitment	Commitment		Commitment	Excellence	Commitment
g	CORE	Commitment	Commitment				
h		Commitment	Achievement				
i		CORE					

Standards and Objective Elements

Standard

PSQ.1.	The organisation implements a structured patient safety programme.

Objective Elements

CORE	a.	The patient safety programme is developed, implemented and maintained by a multi-disciplinary safety committee. *
Commitment	b.	The patient safety programme is comprehensive and covers all the major elements related to patient safety.
Commitment	c.	The programme covers incidents ranging from “no harm” to “sentinel events”.
Commitment	d.	Designated patient safety officer(s) coordinates implementation of the patient safety programme.
Commitment	e.	The organisation performs proactive analysis of patient safety risks and makes improvements accordingly.
Commitment	f.	The patient safety programme is reviewed and updated at least once a year.
CORE	g.	The organisation adapts and implements national / international patient-safety goals / solutions / framework.

Standard

PSQ.2.	The organisation implements a structured quality improvement and continuous monitoring programme.

Objective Elements

CORE	a.	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee. *
Commitment	b.	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance.*

Excellence	c.	The quality improvement programme improves process efficiency and effectiveness.
Excellence	d.	The quality improvement programme focuses on appropriateness of clinical care.
Commitment	e.	There is a designated individual for coordinating and implementing the quality improvement programme.*
Commitment	f.	The quality improvement programme identifies opportunities for improvement based on the review at pre-defined intervals.*
Commitment	g.	The quality improvement programme is reviewed and updated at least once a year.
Commitment	h.	Audits are conducted 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.*

Standard

PSQ.3.	The organisation identifies key indicators to monitor the structures, processes and outcomes, which are used as tools for continual improvement.

Objective Elements

Commitment	a.	The organisation identifies and monitors key indicators to oversee the clinical structures, processes and outcomes.
CORE	b.	The organisation identifies and monitors the key indicators to oversee infection prevention and control activities.
Commitment	c.	The organisation identifies and monitors key indicators to oversee the managerial structures, processes and outcomes.
CORE	d.	The organisation identifies and monitors key indicators to oversee patient safety activities.
Commitment	e.	Verification of data is done regularly by the quality team.

Commitment	f.	There is a mechanism for analysis of data which results in identifying opportunities for improvement.
Commitment	g.	The improvements are implemented and evaluated.
Achievement	h.	Feedback about care and service is communicated to staff.

Standard

PSQ.4.	The organisation uses appropriate quality improvement tools for its quality improvement activities.

Objective Elements

CORE	a.	The organisation undertakes quality improvement projects.
Achievement	b.	The Quality improvement projects shall include improvements in patient care delivery and hospital operations which will have an impact on cost and efficiency.
Commitment	c.	The organisation uses appropriate analytical managerial and statistical tools for its quality improvement activities.
Achievement	d.	The organisation has a mechanism to capture patient reported outcome measures.

Standard

PSQ.5.	There is an established system for clinical audit.

Objective Elements

Commitment	a.	Clinical audits are performed to improve the quality of patient care.
Commitment	b.	The parameters to be audited are defined by the organisation.
Achievement	c.	Medical and nursing staff participate in clinical audit.

Commitment	d.	Patient and staff anonymity are maintained.
Commitment	e.	Clinical audits are documented.
Commitment	f.	Remedial measures are implemented.

Standard

PSQ.6.	The patient safety and quality improvement programme are supported by the management.

Objective Elements

Achievement	a.	The management creates a culture of safety.
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.
Commitment	c.	Departmental leaders are involved in patient safety and quality improvement.
Commitment	d.	Organisation earmarks adequate funds from its annual budget in this regard.
Achievement	e.	The management identifies organisational performance improvement targets.
Excellence	f.	The management uses the feedback obtained from the work force to improve patient safety and quality improvement programme.

Standard

PSQ.7.	Incidents are collected and analysed to ensure continual quality improvement.

Objective Elements

CORE	a.	The organisation implements an incident management system.*

CORE Commitment Achievement Excellence

Commitment	b.	The organisation has a mechanism to identify sentinel events.*
Commitment	c.	The organisation has established processes for analysis of incidents.
Commitment	d.	Corrective and preventive actions are taken based on the findings of such analysis.
Achievement	e.	The organisation incorporates risks identified in the analysis of incidents into the risk management system.
Commitment	f.	The organisation shall have a process for informing various stakeholders in case of a near miss / adverse event / sentinel event.

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Chapter 7 Responsibilities of Management (ROM)

Intent of the chapter

The management of the healthcare organisation is aware of and manages all the key components of governance. Those responsible for governance are identified and their roles defined. The standards encourage the governance of the organisation professionally and ethically.

Clinical governance framework is established, that includes clinical audits, clinical pathways, education and research. The responsibilities of management are defined. The responsibilities of the leaders at all levels are defined. The management executes its responsibility for compliance with all applicable regulations. Those responsible for governance address the organisations social responsibility.

Leaders ensure that patient-safety and risk-management issues are an integral part of patient care and hospital management. The Organisation has a written guidance in place for change management and service **continu**ity plan.

Note 1: "Responsible for Governance' refers to the governing entity of the healthcare organisation and can exist in many configurations. For example, the owner(s), partners in partnership firm, trustees in charitable trust, the board of directors, or in the case of public hospitals, the respective Ministry (Health / Railways / Labour).

Note 2: "Leadership" refers to appointed leader for example CEO, COO, Managing Director, Dean / Director, Medical Director / Medical Superintendent.

In case of single owner / partners all the standards and objective elements shall be applicable.

SUMMARY OF STANDARDS

ROM.1.	The organisation identifies those responsible for governance and their roles are defined.
ROM.2.	Those responsible for governance manage the organisation in an ethical manner.
ROM.3.	Those responsible for governance ensure sustainability in hospital by addressing environmental, social and economic factors from long term well-being of healthcare system and community.
ROM.4.	The organisation is headed by a leader who shall be responsible for operating the organisation on a day-to-day basis.
ROM.5.	The organisation displays professionalism in its functioning.
ROM.6.	Management ensures that patient-safety aspects and risk-management issues are an integral part of patient care and hospital management.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	6
Objective elements	37
CORE	4
Commitment	23
Achievement	8
Excellence	2

Objective Element	ROM.1.	ROM.2.	ROM.3.	ROM.4.	ROM.5.	ROM.6.
a	CORE	CORE	Commitment	Commitment	Commitment	CORE
b	Commitment	Commitment	Commitment	CORE	Commitment	Commitment
c	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
d	Commitment	Commitment	Commitment	Achievement	Achievement	Achievement
e	Commitment		Excellence	Achievement	Commitment	Commitment
f	Commitment		Achievement		Excellence	Achievement
g	Commitment		Achievement			
h	Achievement					
i	Commitment					

Standards and Objective Elements

Standard

ROM.1.	The organisation identifies those responsible for governance and their roles are defined.

Objective Elements

CORE	a.	Those responsible for governance are identified and their roles and responsibilities are defined and documented. *
Commitment	b.	Those responsible for governance lay down the organisation's vision, mission and values.*
Commitment	c.	Those responsible for governance approve the documented strategic and operational plans and the organisation's annual budget.*
Commitment	d.	Those responsible for governance monitor and measure the performance of the organisation against the stated mission.
Commitment	e.	Those responsible for governance appoint the senior leaders in the organisation.
Commitment	f.	Those responsible for governance support safety initiatives, clinical governance framework and quality improvement plans.*
Commitment	g.	Those responsible for governance shall develop clinical governance framework.
Achievement	h.	Those responsible for governance support the ethical management framework of the organisation.
Commitment	I.	Those responsible for governance inform the public of the quality and performance of services.

Standard

ROM.2.	Those responsible for governance manage the organisation in an ethical manner.

Objective Elements

CORE	a.	The leaders establish the organisation's ethical management framework. *
Commitment	b.	The ethical management framework includes processes for managing issues with ethical implications, dilemmas and concerns.*
Commitment	c.	The organisation discloses its ownership.
Commitment	d.	The organisation honestly portrays its affiliations and accreditations.

Standard

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.

Objective Elements

Commitment	a.	Those responsible for governance address the organisation's sustainability programme in terms of Environment Social and Governance (ESG) responsibility.
Commitment	b.	The organisation takes initiatives towards an energy-efficient and environmentally friendly hospital. *
Commitment	c.	Those responsible for governance address the organisations social responsibility.
Commitment	d.	Staff well-being is promoted.
Excellence	e.	The organisation follows sustainable procurement practices.
Achievement	f.	Hospitals shall encourage employees to use common / public transportation to reduce the environmental impact of commuting and carbon footprint.
Achievement	g.	The organisation ensures financial sustainability of the hospital by balancing the financial aspects of healthcare delivery.

Standard

ROM.4.	The organisation is headed by a leader who shall be responsible for operating the organisation on a day-to-day basis.

Objective Elements

Commitment	a.	The person heading the organisation has requisite and appropriate administrative qualifications and experience.
CORE	b.	The leader is responsible for and complies with the laid-down and applicable legislations, regulations and notifications.
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.
Achievement	d.	The leader ensures that each organisational programme, service, site or department has effective leadership.
Achievement	e.	The performance of the organisation's leader is reviewed for effectiveness.

Standard

ROM.5.	The organisation displays professionalism in its functioning.

Objective Elements

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 consultation with the various stakeholders.
Commitment	b.	The organisation coordinates the functioning with departments and external agencies and monitors the progress in achieving the defined goals and objectives.*
Commitment	c.	The organisation plans and budgets for its activities annually.

Achievement	d.	The functioning of committees is reviewed for their effectiveness.
Commitment	e.	The organisation documents the service standards that are measurable and monitors them.*
Excellence	f.	Systems and processes are in place for change management.*

Standard

ROM.6.	Leadership ensures that patient-safety aspects and risk-management issues are an integral part of patient care and hospital management.

Objective Elements

CORE	a.	Leadership ensures proactive risk management across the organisation.*
Commitment	b.	Leadership provides resources for proactive risk-assessment and risk-reduction activities.
Commitment	c.	Leadership ensures integration between quality improvement, risk-management and strategic planning within the organisation.
Achievement	d.	Leadership ensures implementation of systems for internal and external reporting of system and process failures.*
Commitment	e.	Leadership ensures that it has a documented agreement for all outsourced services that include service parameters.
Achievement	f.	Leadership monitors the quality of the outsourced services and improvements are made as required.

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Chapter 8

Facility Management and Safety (FMS)

Intent of the chapter

The standards guide the provision of a safe and secure environment for patients, their families, staff and visitors. The organisation attends to the facility, equipment, and internal physical environment for improving patient safety and quality of services by consistently addressing issues that may arise out of the same. The organisation does this through proactive risk analysis, safety rounds, training of staff on the enhancement of safety and management of disasters. To ensure this, the organisation conducts regular facility inspection rounds and takes the appropriate action to ensure safety.

The organisation provides for safe water, electricity, medical gases and vacuum systems.

The organisation has a programme for medical and utility equipment management.

The organisation plans for fire and non-fire emergencies within the facilities.

The organisation is a no-smoking area.

The organisation safely manages hazardous materials.

The organisation works towards measures on being energy efficient.

SUMMARY OF STANDARDS

FMS.1.	The organisation has a system in place to provide a safe and secure environment.
FMS.2.	The organisation's environment and facilities operate in a planned manner and promotes environment-friendly measures.
FMS.3.	The organisation's environment and facilities operate to ensure the safety of patients, their families, staff and visitors.
FMS.4.	The organisation has a programme for the facility, engineering support services and utility system.
FMS.5.	The organisation has a programme for medical equipment management.
FMS.6.	The organisation has a programme for medical gases, vacuum and compressed air.
FMS.7.	The organisation has plans for fire and non-fire emergencies within the facilities.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	7
Objective elements	43
CORE	11
Commitment	29
Achievement	2
Excellence	1

Objective Element	FMS.1.	FMS.2.	FMS.3.	FMS.4.	FMS.5.	FMS.6.	FMS.7.
a	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	CORE
b	Commitment	Commitment	Excellence	Commitment	Commitment	CORE	CORE
c	CORE	CORE	Commitment	CORE	CORE	Commitment	Commitment
d	Commitment	CORE	Commitment	Commitment	Commitment	CORE	Commitment
e	Commitment	Commitment	CORE	Commitment	Commitment	Commitment	Commitment
f		Commitment	Commitment	Commitment	Commitment		
g				Achievement	Commitment		
h				Commitment	Achievement		

Standards and Objective Elements

Standard

FMS.1.	The organisation has a system in place to provide a safe and secure environment.

Objective Elements

CORE	a.	Patient safety devices and infrastructure are installed across the organisation and inspected periodically.
Commitment	b.	The organisation has facilities for the differently-abled.
CORE	c.	Facility inspection rounds to ensure safety are conducted at least once a month.
Commitment	d.	Inspection reports of facility rounds are documented and corrective and preventive measures are undertaken.
Commitment	e.	Before construction, renovation and expansion of the existing hospital, risk-assessment is carried out.

Standard

FMS.2.	The organisation's environment and facilities operate in a planned manner and promotes environment-friendly measures.

Objective Elements

Commitment	a.	Facilities and space provisions are appropriate to the scope of services.
Commitment	b.	As built and updated drawings are maintained as per statutory requirements.
CORE	c.	There are internal and external sign postings in the organisation in a manner understood by the patient, families and community.
CORE	d.	Potable water and electricity are available round the clock.

Commitment	e.	Alternate sources for electricity and water are provided as a backup for any failure / shortage.
Commitment	f.	The organisation tests the functioning of these alternate sources at a predefined frequency.

Standard

FMS.3.	The organisation's environment and facilities operate to ensure the safety of patients, their families, staff and visitors.

Objective Elements

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.*
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 retrofitting of existing hospitals.
Commitment	c.	The organisation conducts electrical safety audits for the facility.
Commitment	d.	There is a procedure which addresses the identification and disposal of material(s) not in use in the organisation. *
CORE	e.	Hazardous materials are identified and used safely within the organisation.*
Commitment	f.	The plan for managing spills of hazardous materials is implemented. *

Standard

FMS.4.	The organisation has a programme for the facility, engineering support services and utility system.

Objective Elements

Commitment	a.	The organisation plans for utility and engineering equipment in accordance with its services and strategic plan.

Commitment	b.	Equipment is inventoried, and proper logs are maintained as required.
CORE	c.	The documented operational and maintenance (preventive and breakdown) plan is implemented. *
Commitment	d.	Utility equipment, are periodically inspected and calibrated (wherever applicable) for their proper functioning.
Commitment	e.	Competent personnel operate, inspect, test and maintain equipment and utility systems.
Commitment	f.	Maintenance staff is contactable round the clock for emergency repairs.
Achievement	g.	Downtime for critical equipment breakdowns is monitored from reporting to inspection and implementation of corrective actions.
Commitment	h.	Written guidance supports equipment replacement, identification of unwanted material and disposal. *

Standard

FMS.5.	The organisation has a programme for medical equipment management.

Objective Elements

Commitment	a.	The organisation plans for medical equipment in accordance with its services and strategic plan.
Commitment	b.	Medical equipment is inventoried and proper logs are maintained as required.
CORE	c.	The documented operational and maintenance (preventive and breakdown) plan for medical equipment is implemented. *
Commitment	d.	Medical equipment is periodically inspected and calibrated for their proper functioning.
Commitment	e.	Qualified and trained personnel operate and maintain medical equipment.
Commitment	f.	Written guidance supports medical equipment replacement and disposal. *

Commitment	g.	There is monitoring of medical equipment and medical devices related to adverse events, and compliance hazard notices on recalls.*
Achievement	h.	Downtime for critical equipment breakdown is monitored from reporting to inspection and implementation of corrective actions.

Standard

FMS.6.	The organisation has a programme for medical gases, vacuum and compressed air.

Objective Elements

Commitment	a.	Written guidance governs the implementation of procurement, handling, storage, distribution, usage and replenishment of medical gases. *
CORE	b.	Medical gases are handled, stored, distributed and 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. *
CORE	d.	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.
Commitment	e.	The organisation regularly tests the functioning of these alternate sources.

Standard

FMS.7.	The organisation has plans for fire and non-fire emergencies within the facilities.

Objective Elements

CORE	a.	The organisation has plans and provisions for early detection, abatement, containment of fire and evacuation in the event of fire emergencies. *
CORE	b.	The organisation has plans and provisions 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.
Commitment	d.	Mock drills are held at least twice a year.
Commitment	e.	There is a maintenance plan for fire-related equipment and infrastructure *

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Chapter 9 Human Resource Management (HRM)

Intent of the chapter

The most important resource of the organisation is its human resource. Human resources are an asset for the effective and efficient functioning of the organisation. The management plans on identifying the right number and skill mix of staff required to render safe care to the patients.

Recruitment of staff is accomplished by having a uniform and standardised system. The organisation must orient the staff including outsourced staff, volunteers, students and trainees to its environment and also orient them to specific duties and responsibilities related to their position. The organisation should plan to have an ongoing professional training / in-service education to enhance the competencies and skills of the staff continually.

A systematic and structured appraisal system must be used for staff development. The organisation uses this as an opportunity to discuss, motivate, identify gaps in the performance of the staff.

The organisation promotes the physical and mental well-being of staff. A grievance handling mechanism and disciplinary procedure should be in place.

Credentialing and privileging of health-care professionals (medical, nursing and other para-clinical professional) are done to ensure patient safety.

A document containing all such personal information has to be maintained for all staff.

Note:

The term "employee" refers to all salaried personnel working in the organisation. The term "staff" refers to all personnel working in the organisation including employees, "fee for service" medical professionals, part-time workers, contractual personnel and volunteers.

SUMMARY OF STANDARDS

HRM.1.	The organisation has a documented system of human resource planning.
HRM.2.	The organisation implements a defined process for staff recruitment.
HRM.3.	Staff are provided induction training at the time of joining the organisation.
HRM.4.	There is an on-going programme for professional training and development of the staff.
HRM.5.	Staff are appropriately trained based on their specific job description.
HRM.6.	Staff are trained in safety and quality-related aspects.

*This implies that the objective element requires documentation.

HRM.7.	An appraisal system for evaluating the performance of staff exists as an integral part of the human resource management process.
HRM.8.	Process for disciplinary and grievance handling is defined and implemented in the organisation.
HRM.9.	The organisation addresses their health and safety needs of the staff.
HRM.10.	There is documented personal information for each staff member.
HRM.11.	There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.
HRM.12.	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.
HRM.13.	There is a process for credentialing and privileging of para-clinical professionals, permitted to provide patient care without supervision.

Summary of Objective Elements

Standard	13
Objective elements	76
CORE	16
Commitment	56
Achievement	4
Excellence	0

Objective Element	HRM.1.	HRM.2.	HRM.3.	HRM.4.	HRM.5.	HRM.6.	HRM.7.	HRM.8.	HRM.9.	HRM.10.	HRM.11.	HRM.12.	HRM.13.
a	Commitment	CORE	CORE	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	CORE	CORE	CORE
b	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment
c	Achievement	CORE	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	CORE
d	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	Commitment	CORE	CORE	Commitment	CORE	CORE	Commitment
e	Commitment		Commitment	Achievement	CORE	CORE	Commitment	Commitment			Commitment	Commitment	Commitment
f	Commitment		Commitment	Achievement	Commitment	CORE		Commitment			Commitment	Commitment	
g	Achievement		Commitment			Commitment							
h			Commitment										
i			Commitment										
j			Commitment										

Standards and Objective Elements

Standard

HRM.1.	The organisation has a documented system of human resource planning.

Objective Elements

Commitment	a.	Human resource planning supports the organisation's current and future ability to meet the care, treatment and service needs of the patient.
CORE	b.	The organisation maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.*
Achievement	c.	The organisation has contingency plans to manage long and short-term workforce shortages, including unplanned shortages.
Commitment	d.	The job specification and job description are defined for each category of staff.
Commitment	e.	The organisation performs a background check of new staff.
Commitment	f.	Reporting relationships are defined for each category of staff. *
Achievement	g.	Exit interviews are conducted and used as a tool to improve human resource practices.

Standard

HRM.2.	The organisation implements a defined process for staff recruitment.

Objective Elements

CORE	a.	Written guidance governs the process of recruitment. *
Commitment	b.	A pre-employment medical examination is conducted on the staff.
CORE	c.	The organisation defines and implements a code of conduct for its staff.

Commitment	d.	Administrative procedures for human resource management are documented.*

Standard

HRM.3.	Staff are provided induction training at the time of joining the organisation.

Objective Elements

CORE	a.	Staff are provided with induction training.
Commitment	b.	The induction training includes orientation to the organisation's vision, mission and values.
Commitment	c.	The induction training includes awareness on staff rights and responsibilities and patient rights and responsibilities.
Commitment	d.	The induction training includes training on safety.
Commitment	e.	The induction training includes training on cardio-pulmonary resuscitation for staff.
Commitment	f.	The induction training includes training in hospital infection prevention and control.
Commitment	g.	The induction training includes orientation to the service standards of the organisation.
Commitment	h.	The induction training includes an orientation on administrative procedures.
Commitment	i.	The induction training includes an orientation on relevant department / unit / service / programme's policies and procedures.
Commitment	j.	Staff is trained on information systems, information security, information use and management.

Standard

HRM.4.	There is an on-going programme for professional training and development of the staff.

Objective Elements

CORE	a.	Written guidance governs training and development policy for the staff.*
Commitment	b.	The organisation maintains the training record.
Commitment	c.	Training also occurs when job responsibilities change/new equipment is introduced.
Commitment	d.	Feedback mechanisms are in place for improvement of training and development programme.
Achievement	e.	Evaluation of training effectiveness is done by the organisation.
Achievement	f.	The organisation supports continuing professional development and learning.

Standard

HRM.5.	Staff are appropriately trained based on their specific job description.

Objective Elements

Commitment	a.	Staff involved in blood transfusion services are trained in the handling of blood and blood products.
Commitment	b.	Staff are trained in handling vulnerable patients.
Commitment	c.	Staff are trained in control and restraint techniques.
Commitment	d.	Staff are trained in healthcare communication techniques.
CORE	e.	Staff involved in direct patient care are provided training on cardio-pulmonary resuscitation periodically.
Commitment	f.	Staff are provided training on infection prevention and control.

Standard

HRM.6.	Staff are trained in safety and quality-related aspects.

Objective Elements

Commitment	a.	Staff are trained in the organisation's safety programme.
Commitment	b.	Staff are provided training in the detection, handling, minimisation and elimination of identified risks within the organisation's environment.
Commitment	c.	Staff members are made aware of procedures to follow in the event of an incident.
Commitment	d.	Staff are trained in occupational safety aspects.
CORE	e.	Staff are trained in the organisation's disaster management plan.
CORE	f.	Staff are trained in handling fire and non-fire emergencies.
Commitment	g.	Staff are trained in the organisation's quality improvement programme.

Standard

HRM.7.	An appraisal system for evaluating the performance of staff exists as an integral part of the human resource management process.

Objective Elements

Commitment	a.	Performance appraisal is done for staff within the organisation.*
Commitment	b.	The staff are made aware of the system of appraisal at the time of induction.
Commitment	c.	Performance is evaluated based on the pre-determined criteria.
Commitment	d.	The appraisal system is used as a tool for further development.
Commitment	e.	Performance appraisal is carried out at defined intervals and is documented.

Standard

HRM.8.	Process for disciplinary and grievance handling is defined and implemented in the organisation.

Objective Elements

Commitment	a.	Written guidance governs disciplinary and grievance handling mechanisms.*
Commitment	b.	The disciplinary and grievance handling mechanism is known to all categories of staff of the organisation.
Commitment	c.	The disciplinary policy and procedure are based on the principles of natural justice.
CORE	d.	The disciplinary and grievance procedure is in consonance with the prevailing laws.
Commitment	e.	There is a provision for appeals in all disciplinary cases.
Commitment	f.	Actions are taken to redress the grievance.

Standard

HRM.9.	The organisation addresses their health and safety needs of the staff.

Objective Elements

Commitment	a.	Health problems of the staff, including occupational health hazards, are taken care of in accordance with the organisation's policy.*
Commitment	b.	Health checks of staff dealing with direct patient care are done at least once a year and the findings / results are documented.
Commitment	c.	Organisation provides treatment to staff who sustain workplace-related injuries.
CORE	d.	The organisation has measures in place for prevention and handling workplace violence.*

Standard

HRM.10.	There is documented personal information for each staff member.

Objective Elements

Commitment	a.	Personal files are maintained with respect to all staff, and their confidentiality is ensured.
Commitment	b.	The personal files contain personal information regarding the staff's qualification, job description, verification of credentials and health status.
Commitment	c.	Records of in-service training and education are maintained.
Commitment	d.	Personal files contain results of all evaluations and remarks.

Standard

HRM.11.	There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.

Objective Elements

CORE	a.	Medical professionals permitted by law, regulation and the organisation provide patient care without supervision are identified.
Commitment	b.	The education, registration, training and experience of the identified medical professionals are documented and updated periodically.
Commitment	c.	The information about medical professionals is appropriately verified when possible.
CORE	d.	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.
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.
Commitment	f.	Medical professionals admit and care for patients as per their privileging.

Standard

HRM.12.	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.

Objective Elements

CORE	a.	Nursing staff permitted by law, regulation and the organisation to provide patient care without supervision are identified.
Commitment	b.	The education, registration, training and experience of nursing staff are documented and updated periodically.
Commitment	c.	The information about the nursing staff is appropriately verified when possible.
CORE	d.	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.
Commitment	e.	The requisite services to be provided by the nursing staff are known to them as well as the concerned departments / units of the organisation.
Commitment	f.	Nursing professionals care for patients as per their privileging.

Standard

HRM.13.	There is a process for credentialing and privileging of para-clinical professionals, permitted to provide patient care without supervision.

Objective Elements

CORE	a.	Para-clinical professionals permitted by law, regulation and the organisation to provide patient care without supervision are identified.
Commitment	b.	The education, registration, training and experience of para-clinical professionals are appropriately verified, documented and updated periodically.
CORE	c.	Para-clinical professionals are granted privileges in consonance with 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.
Commitment	e.	Para-clinical professionals care for patients as per their privileging.

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Chapter 10 Information Management System (IMS)

Intent of the chapter

Information management includes Management Information System(MIS) and Hospital Information System(HIS) as well as all modalities of information communicated to staff, patients, visitors and community in general.

The goal of information management in the organisation is to ensure that the right information is available to the right person at the right time.

Data and information management shall be directed to meet the organisation's needs and support the delivery of quality patient care. The information requirements shall be met in an authenticated, secure and accurate manner at the right time and place.

Confidentiality, integrity and security of records, data and information shall be maintained. Confidentiality of protected health information is paramount and shall be safe guarded across all information processing, storing and disseminating platforms.

Information management shall also include periodic review, revision and withdrawal of obsolete information to avoid confusion amongst staff, patients and visitors .

The organisation shall maintain a complete and accurate medical record for every patient. Various aspects of the medical record like contents, staff authorised to make entries and retention of records are addressed effectively by the organisation. The medical record shall be available to appropriate care providers. The medical records shall be reviewed at regular intervals.

SUMMARY OF STANDARDS

IMS.1.	Information needs of the patients, visitors, staff, management and external agencies are met.
IMS.2.	The organisation has processes in place for management and control of data and information.
IMS.3.	The patients cared for by the organisation have a complete and accurate medical record.
IMS.4.	The medical record reflects the continuity of care.
IMS.5.	The organisation maintain confidentiality, integrity and security of records, data and information.
IMS.6.	The organisation ensures availability of current and relevant documents, records, data and information and provide for retention of the same.
IMS.7.	The organisation carries out a review of medical records.

*This implies that the objective element requires documentation.

Summary of Objective Elements

Standard	7
Objective elements	45
CORE	9
Commitment	33
Achievement	2
Excellence	1

Objective Element	IMS.1.	IMS.2.	IMS.3.	IMS.4.	IMS.5.	IMS.6.	IMS.7.
a	CORE	Commitment	CORE	Commitment	CORE	CORE	CORE
b	Commitment	Commitment	Commitment	Commitment	CORE	CORE	Commitment
c	Commitment	Commitment	CORE	Commitment	CORE	Commitment	Commitment
d	Commitment	Commitment	Commitment	Commitment	Achievement	Commitment	Commitment
e	Achievement	Commitment	Commitment	Commitment	Commitment		Commitment
f	Commitment		Commitment	Commitment	Commitment		Commitment
g	Commitment		Commitment	Commitment			Commitment
h	Excellence			Commitment			

Standards and Objective Elements

Standard

IMS.1.	Information needs of the patients, visitors, staff, management and external agencies are met.

Objective Elements

CORE	a.	The organisation identifies the information needs of the patients, visitors, staff, management, external agencies and community. *
Commitment	b.	Identified information needs are captured and/or disseminated.*
Commitment	c.	Information management and technology acquisitions are commensurate with the identified information needs.
Commitment	d.	A maintenance plan for information technology and communication network is implemented.
Achievement	e.	Contingency plan ensures continuity of information capture, integration and dissemination.
Commitment	f.	The organisation ensures that information resources are accurate and meet stakeholder requirements.
Commitment	g.	The organisation contributes to external databases in accordance with the law and regulations.
Excellence	h.	The organisation shall make efforts to use digital health technology to improve operational efficiency, patient safety and patient experience.

Standard

IMS.2.	The organisation has processes in place for management and control of data and information.

Objective Elements

Commitment	a.	Processes for data collection are standardised.

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Commitment	b.	Data is analysed to meet the information needs.
Commitment	c.	The organisation disseminates the information in a timely and accurate manner.
Commitment	d.	The organisation stores and retrieves data according to its information needs. *
Commitment	e.	Clinical and managerial staff participate in selecting, integrating and using data for meeting the information needs.

Standard

IMS.3.	The patients cared for by the organisation have a complete and accurate medical record.

Objective Elements

CORE	a.	A unique identifier is assigned to the medical record.
Commitment	b.	The contents of the medical record are identified and documented. *
CORE	c.	The medical record provides a complete, up-to-date and chronological account of patient care.
Commitment	d.	Authorised staff make the entries in the medical record. *
Commitment	e.	Entry in the medical record is signed, dated and timed.
Commitment	f.	The author of the entry can be identified.
Commitment	g.	The medical record has only authorised abbreviations.

Standard

IMS.4.	The medical record reflects the continuity of care.

Objective Elements

Commitment	a.	The medical record contains information regarding reasons for admission, diagnosis and care plan.
Commitment	b.	The medical record contains the details of assessments, re-assessments and consultations.
Commitment	c.	The medical record contains the results of investigations and the details of the care provided.
Commitment	d.	Operative and other procedures performed are incorporated in the medical record.
Commitment	e.	When a patient is transferred to another organisation, the medical record shall contain the details of the transfer.
Commitment	f.	The medical record contains a signed copy of the discharge summary.
Commitment	g.	In case of death, the medical record contains a copy of the medical certificate of the cause of death.
Commitment	h.	Care providers have access to current and past medical record.

Standard

IMS.5.	The organisation maintains confidentiality, integrity and security of records, data and information.

Objective Elements

CORE	a.	The organisation maintains the confidentiality of records, data and information.*
CORE	b.	The organisation maintains the integrity of records, data and information.
CORE	c.	The organisation maintains the security of records, data and information.*
Achievement	d.	The organisation uses developments in appropriate technology for improving confidentiality, integrity and security.
Commitment	e.	The organisation discloses privileged health information as authorised by the patient and / or as required by law.

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Commitment	f.	Request for access to information in the medical records by patients / physicians and other public agencies are addressed consistently. *

Standard

IMS.6.	The organisation ensures availability of current and relevant documents, records, data and information and provides for retention of the same.

Objective Elements

CORE	a.	The organisation has an effective process for document control.*
CORE	b.	The organisation retains patient's clinical records, data and information according to its requirements. *
Commitment	c.	The retention process provides expected confidentiality and security.
Commitment	d.	The destruction of medical records, data and information are in accordance with the written guidance. *

Standard

IMS.7.	The organisation carries out a review of medical records.

Objective Elements

CORE	a.	The medical records are reviewed periodically.
Commitment	b.	The review uses a representative sample based on statistical principles.
Commitment	c.	The review is conducted by identified individuals.
Commitment	d.	The review of records is based on identified parameters.
Commitment	e.	The review process includes records of both active and discharged patients.
Commitment	f.	The review points out and documents any deficiencies in records.
Commitment	g.	Appropriate corrective and preventive measures are undertaken.

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GLOSSARY

The commonly-used terminologies in the NABH standards are briefly described and explained herein to remove any ambiguity regarding their comprehension. The definitions narrated have been taken from various authentic sources. Notwithstanding the accuracy of the explanations given, in the event of any discrepancy with a legal requirement enshrined in the law of the land, the provisions of the latter shall apply.

Term	Definition
Access / Accessible	Ability of patients/service users or potential patients/service users to obtain required or available services when needed within an appropriate time.
Accreditation	Accreditation is self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to improve the health care system continuously.
Accreditation assessment	The evaluation process for assessing the compliance of an organisation with the applicable standards for determining its accreditation status.
Activities of daily living (ADL)	An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating, and moving from one place to another.
Acuity	Acuity refers to the severity or complexity of a patient's medical condition. It is often used in healthcare settings to determine the level of care required and the allocation of resources. Acuity levels help healthcare providers prioritize patients, assign appropriate staff, and ensure that patients receive the right level of medical attention and resources based on the severity of their condition.
Advance life support	The preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.
Adverse drug event	An injury resulting from a medical intervention related to a medication, including harm from an adverse drug reaction or a medication error.

Term	Definition
Adverse drug reaction	A response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function.
Adverse event	An injury related to medical management, in contrast to complications of the disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable.
Age-specific competency for Paediatric patients	Age specific competency spans the unique physiologic, anatomic, motor, sensory, cognitive and psychosocial aspects of the life cycle from the neonate to the adolescent. This competency will review general age-specific growth and development milestones and behavioral markers across 0 -18 years. Age-specific competencies are skills that you use to give care that meets each patient's unique needs.
Antimicrobial stewardship	A program implemented in a health care organisation to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies including the monitoring and reviews of antimicrobial usage.
Appropriate	The degree to which something is suitable for a specific purpose. This may be that a service is consistent with a patient/service user's expressed requirements.
Appropriate care	Patients are receiving the right care, and the right amount of care according to their needs and preferences, at the right time. The care offered should also be based on the best available evidence.
Appropriateness	Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.
Assessment	All activities including history taking, physical examination, laboratory investigations that contribute towards determining the prevailing clinical status of the patient.
Audit	A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.

Term	Definition
Barrier nursing	The nursing of patients with infectious diseases in isolation to prevent the spread of infection. As the name implies, the aim is to erect a barrier to the passage of infectious pathogenic organisms between the contagious patient and other patients and staff in the hospital, and hence to the outside world. The nurses wear gowns, masks, and gloves, and they observe strict rules that minimise the risk of passing on infectious agents.
Basic life support	Basic life support (BLS) is the level of medical care which is used for patients with life-threatening illnesses or injuries until the patient can be given full medical care. The preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.
Benchmarking	A process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).
Best practice	Clinical, scientific, or professional technique, method, or process, that is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice.
Best-practice guidelines	A set of recommended actions that are developed using the best available evidence. They provide healthcare providers with evidence-informed recommendations that support clinical practice, and guide healthcare provider and patient decisions about appropriate health care in specific clinical practice settings and circumstances.
Bias	The difference between the sample statistic and the population statistic caused by factors other than random error. If a sample statistic is biased, then repeating the survey many times would produce a distribution of sample statistics that would be centred around something other than the population value for the statistic. Thus, a biased sample statistic would have a tendency to be either too small or too large as an estimate of the population statistic. One common source of bias in all surveys occurs when the non-respondents have different characteristics from the respondents.

Term	Definition
Breakdown maintenance	Activities which are associated with the repair and servicing of site infrastructure, buildings, plant or equipment within the site's agreed building capacity allocation which have become inoperable or unusable because of the failure of component parts.
Byelaws	A rule governing the internal management of an organisation. It can supplement or complement the government law but cannot countermand it, for example municipal by-laws for construction of hospitals/nursing homes, for disposal of hazardous and/or infectious waste.
Calibration	Set of operations that establish, under specified conditions, the relationship between values of quantities indicated by a measuring instrument or measuring system, or values represented by a material measure or a reference material, and the corresponding values realised by standards.
Care Plan	A plan that identifies patient care needs, lists the strategy to meet those needs, documents treatment goals and objectives, outlines the criteria for ending interventions, and documents the individual's progress in meeting specified goals and objectives. The format of the plan may be guided by specific policies and procedures, protocols, practice guidelines or a combination of these. It includes preventive, promotive, curative and rehabilitative aspects of care.
Catch-up immunization	Catch-up immunization refers to the action of vaccinating an individual who, for whatever reason, is missing or has not received doses of vaccines for which they are eligible, per the national immunization schedule.
Child Abuse	A violation of the basic human rights of a child. It includes all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.
Citizen's charter	Citizen's Charter is a document which represents a systematic effort to focus on the commitment of the organisation towards its citizens in respects of standard of services, information, choice and consultation, non-discrimination and accessibility, grievance redress, courtesy and value for money.
Cleaning	Removal of visible foreign material (for example, soil, organic material) from objects and surfaces, which is normally accomplished manually or mechanically using water with detergents or enzymatic products.
Clinical alarm	A component of some medical devices that is designed to notify caregivers of an important change in the patient's physiologic status. A clinical alarm typically provides audible and/or visible notification of the changed patient status.

Term	Definition
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical care pathway	Clinical care pathways are standardised evidence-based, multidisciplinary management plans. They identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group.
Clinical practice guidelines	Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Clinical practice guidelines are used in making care decisions and developing clinical care processes for diagnosis and conditions and often require clinical pathways and clinical protocols.
Community	A community refers to a group of people within certain geographical boundaries or who share common characteristics such as health risks or disease processes. Individuals, families, groups and organisations that usually reside in the same locality.
Competence	Demonstrated ability to apply knowledge and skills. Knowledge is the understanding of facts and procedures. Skill is the ability to perform a specific action. A determination of an individual's skills, knowledge, and capability to meet defined expectations, as frequently described in a job description.
Competency	The knowledge, skills, abilities, behaviours, experience and expertise to be able to perform a particular task and activity.
Continuity	The provision of unbroken services that is coordinated across a continuum of health care, over time within and across programs and organizations, as well as during the transition between levels of services.
Continuity of care	The degree to which the care of individuals is coordinated among practitioners, among organizations, and over time.

Term	Definition
Confidentiality	The restricted access to data and information to individuals who have a need, a reason and permission for such access. It also includes an individual's right to personal privacy as well as the privacy of information related to his/her healthcare records.
Consent	1. The willingness of a party to undergo examination/procedure/ treatment by a healthcare provider. It may be implied (for example patient registering in OPD), expressed which may be written or verbal. Informed consent is a type of consent in which the healthcare provider has a duty to inform his/her patient about the procedure, its potential risk and benefits, alternative procedure with their risk and benefits so as to enable the patient to make an informed decision of his/her health care. 2. In law, it means active acquiescence or silent compliance by a person legally capable of consenting. In India, the legal age of consent is 18 years. It may be evidenced by words or acts or by silence when silence implies concurrence. Actual or implied consent is necessarily an element in every contract and every agreement.
Control Charts	The statistical tool used in quality control to (1) analyse and understand process variables, (2) determine process capabilities, and to (3) monitor effects of the variables on the difference between target and actual performance. Control charts indicate upper and lower control limits, and often include a central (average) line, to help detect the trend of plotted values. If all data points are within the control limits, variations in the values may be due to a common cause and process is said to be 'in control'. If data points fall outside the control limits, variations may be due to a special cause, and the process is said to be out of control.
Coordinate / Coordination	The process of working together effectively with collaboration among providers, organisations, teams and services in and outside the organisation to avoid duplication, gaps, or breaks.
Correction	Action to eliminate the detected non-conformity.
Corrective action	Action to eliminate the cause of a non-conformity and to prevent recurrence.
Credentialing	The process of obtaining, verifying and assessing the qualification of a healthcare provider.

Term	Definition
Criteria	The expected levels of achievement or specifications against which performance or quality may be compared. For example, criteria for appropriate initial care of a patient with a headache may be a measurement of body temperature and blood pressure and performance of a neurological examination. The specific steps to be taken, or activities to be done, to reach a decision or a standard.
Critical result	A variance from normal range that represents a pathophysiologic state that is high-risk or life-threatening, is considered urgent or emergent in nature, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic occurrence.
Culture / Cultural needs	A shared system of values, beliefs and behaviours. The design and delivery of services consistent with the cultural values of those who use them.
Culture of safety	A collaborative environment in which skilled clinicians treat each other with respect; leaders drive effective teamwork and promote psychological safety; teams learn from errors and near misses; caregivers are aware of the inherent limitations of human performance in complex systems (stress recognition); and there is a visible process of learning and driving improvement through debriefings. Staff members are able to report concerns about safety or quality of care without fear of retaliation from health care organization leaders or other staff.
Data	Data is a record of the event.
Department / service leaders	The individuals who manage and direct the varied services of the organization, commonly referred to as departments, services, and/or units.
Disaster preparedness	The ability of the health care organization to maintain operations, respond to the potentially increased volume and acuity of patients, and meet the needs of the community affected by the disaster.
Discharge summary	A part of a patient record that summarises the reasons for admission, significant clinical findings, procedures performed, treatment rendered, patient's condition on discharge and any specific instructions given to the patient or family (for example follow-up medications).
Disciplinary procedure	A sequence of activities to be carried out when staff does not conform to the laid-down norms, rules and regulations of the healthcare organisation.

Term	Definition
Drug dispensing	The preparation, packaging, labelling, record keeping, and transfer of a prescription drug to a patient or an intermediary, who is responsible for the administration of the drug.
Drug Administration	The giving of a therapeutic agent to a patient, for example by infusion, inhalation, injection, paste, pessary, suppository or tablet.
Effective communication	Effective Communication is a communication between two or more persons wherein the intended message is successfully delivered, received and understood. The effective communication also includes several other skills such as non-verbal communication, engaged listening, ability to speak assertively, etc.
Efficiency	The degree to which resources are brought together to achieve desired results most cost effectively, with minimal waste, re-work and effort.
Effectiveness	The degree to which services, interventions or actions are provided in accordance with current best practice in order to meet goals and desired outcome(s) for the patient.
Employees	All members of the healthcare organisation who are employed full time and are paid suitable remuneration for their services as per the laid-down policy.
End-of-life Care	An approach to a terminally ill patient that shifts the focus of care to symptom control, comfort, dignity, quality of life and quality of dying rather than treatments aimed at cure or prolongation of life. It includes physical, emotional, social, and spiritual support for patients and their families. The goal of end-of-life care is to control pain and other symptoms so the patient can be as comfortable as possible.
Enhanced communication	Enhanced communication is using the methods of communication to ensure meaning and understanding through the recognition of the limitations of others. The intent is to ensure purposeful, timely and reliable communication. The communication must be sensitive, empathetic and inclusive.
Ethics/Ethical	Moral principles that govern a person's or group's behaviour. An acknowledged set of principles which guide professional and moral conduct.

Term	Definition
Evaluation	A formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.
Evidence-based medicine	Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.
Family	The person(s) with a significant role in the patient's life. It mainly includes spouse, children and parents. It may also include a person not legally related to the patient but can make healthcare decisions for a patient if the patient loses decision-making ability.
Failure Mode and Effect Analysis (FMEA)	A systematic approach to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to help organizations create design improvements that will have the most benefit. This tool assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur.
Formulary	An approved list of drugs for use. Drugs contained in the formulary are generally those that are determined to be cost-effective and medically effective.
Framework	An outline, overview, or skeleton of interconnected items that can be modified at any time by adding or deleting items.
Generic medication	A medication created to be the same as an existing approved brand-name medication in dosage form, safety, strength, route of administration, quality, and performance characteristics.
Goal	A broad statement describing a desired future condition or achievement without being specific about how much and when. The term "goals" refers to a future condition or performance level that one intends to attain. Goals can be both short- and longer-term. Goals are ends that guide actions.
Governance	The set of relationships and responsibilities established by a healthcare service between its management, workforce and stakeholders (including patients and consumers). Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. Governance structures will be tailored to the size and complexity of an organisation. The function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.

Term	Definition
Grievance-handling procedures	The sequence of activities carried out to address the grievances of patients, visitors, relatives and staff.
Haemovigilance	A set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to patients, to their follow-up. It includes monitoring, reporting, investigating and analysing adverse events related to the donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.
Handoff / Handover	The process by which one healthcare provider transfers responsibility for a patient's care to another care provider. A handoff involves communicating essential patient-specific information, including medication-related information, to the next care provider. The transfer of responsibility for a patient and the patient's care that is achieved through effective communication (for example, between health care practitioners; from one department, unit, or service of the organization to another; between the organization and other levels of health care; between staff and patients/families).
Hazard vulnerability analysis (HVA)	A tool used for the identification of potential emergencies and the direct and indirect effects those emergencies may have on the organization's operations and demand for its services.
Hazardous materials	Substances dangerous to human and other living organisms. Types of hazardous materials and waste include pharmaceutical, chemical, cytotoxic, radioactive and infectious.
Hazardous waste	Waste materials dangerous to living organisms. Such materials require special precautions for disposal. They include the biologic waste that can transmit disease (for example, blood, tissues) radioactive materials, and toxic chemicals. Other examples are infectious waste such as used needles, used bandages and fluid-soaked items.
Healthcare-associated infection	Healthcare-associated infection (HAI), also referred to as "nosocomial" or "hospital" infection, is an infection occurring in a patient during the process of care in a health care organisation or other health care facility which was not present or incubating at the time of admission.
Healthcare organisation	The generic term is used to describe the various types of organisation that provide healthcare services. This includes ambulatory care centres, hospitals, laboratories, etc.

Term	Definition
Health literacy	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make informed healthcare decisions, promoting better health outcomes and patient empowerment. Health literacy is divided into two components – individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.
Health promotion	Activities that increase an individual's control over his or her own health, thereby improving it. These activities may occur at the individual, family, community, and system levels; they promote healthy behaviours and other changes that decrease the risk for acute and chronic diseases and injury. The process of actively supporting and enabling people to increase control over and improve their health.
Health technology assessment (HTA)	A scientific research methodology to inform policy and clinical decision-making on the value of new health technologies (such as drugs, devices, and medical services) compared to existing standards of care. It involves a review of clinical and economic information to determine how best to allocate limited healthcare resources to new technologies.
High-dependency unit (HDU)	A high-dependency unit is an area for patients who require more intensive observation, treatment and nursing care than are usually provided for in a ward. It is a standard of care between the ward and full intensive care.
High Risk/High Alert Medications	High-risk/high-alert medications are medications involved in a high percentage of medication errors or sentinel events and medications that carry a high risk for abuse, error, or other adverse outcomes. Examples include medications with a low therapeutic index, controlled substances, psychotherapeutic medications, and look-alike and sound-alike medications.
ICD-11	The 11th edition of the International Classification of Diseases, an updated version of the coding system that provides a more detailed and comprehensive classification of diseases, disorders, and related health conditions.

Term	Definition
Implantable medical device	A medical device that is permanently placed into a surgically or naturally formed cavity of the body to continuously assist, restore, or replace a function or structure of the body throughout the useful life of the device. Examples include a prosthesis (such as a hip), a stent, a pacemaker, and an infusion pump.
Incident reporting	It is defined as written or verbal reporting of any event in the process of patient care, that is inconsistent with the deserved patient outcome or routine operations of the healthcare facility.
Informed consent	The process of informing a patient about a procedure, treatment, or research so that the patient can make a voluntary, informed decision to accept or refuse to have the procedure or treatment. The patient must be fully informed and understand the information that he or she is provided before giving consent. The elements of informed consent include, but are not limited to, information about, and potential benefits and risks of, the proposed procedure, treatment, clinical trial/research study; and possible alternatives to the procedure/treatment.
In-service education/training	Organised education/training, usually provided in the workplace for enhancing the skills of staff members or to teach them new skills relevant to their jobs/tasks and disciplines.
Independent Double Check	An independent double check is a process in which a second practitioner conducts a verification. Such verification can be performed in the presence or absence of the first practitioner. In either case, the most critical aspect is to maximize the independence of the double check by ensuring that the first practitioner does not communicate what he or she expects the second practitioner to see, which would create bias and reduce the visibility of an error.
Indicator	Performance measurement tool that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process, and outcomes and are rate based, i.e. have a numerator and denominator so that they can be compared and benchmarked.
Information	Processed data which lends meaning to the raw data.
Intent	A brief explanation of the rationale, meaning and significance of the standards laid down in a particular chapter.

Term	Definition
Invasive / Clinical procedure	The puncture or incision of the skin, insertion of an instrument, or insertion of a foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, endoscopy, bronchoscopy, bone marrow biopsy, lumbar puncture and cardiac catheterization. Venipuncture is not categorized as an invasive / clinical procedure.
Inventory control	The method of supervising the intake, use and disposal of various goods in hands. It relates to supervision of the supply, storage and accessibility of items in order to ensure an adequate supply without stock-outs/excessive storage. It is also the process of balancing ordering costs against carrying costs of the inventory so as to minimise total costs.
Isolation	Separation of an ill person who has a communicable disease (for example,measles, chickenpox, mumps, SARS) from those who are healthy. Isolation prevents transmission of infection to others and also allows the focused delivery of specialised health care to ill patients. The period of isolation varies from disease-to-disease. Isolation facilities can also be extended to patients for fulfilling their individual, unique needs.
Job description	1. It entails an explanation pertaining to duties, responsibilities and conditions required to perform a job. 2. A summary of the most important features of a job, including the general nature of the work performed (duties and responsibilities) and level (i.e., skill, effort, responsibility and working conditions) of the work performed. It typically includes **job specifications** that include employee characteristics required for competent performance of the job. A job description should describe and focus on the job itself and not on any specific individual who might fill the job.
Job specification	1. The qualifications/physical requirements, experience and skills required to perform a particular job/task. 2. A statement of the minimum acceptable qualifications that an incumbent must possess to perform a given job successfully.
Maintenance	The combination of all technical and administrative actions, including supervision actions, intended to retain an item in, or restore it to, a state in which it can perform a required function.
Material safety data sheet (MSDS)	A formal document with information about the characteristics and actual or potential hazards of a substance; includes instructions related to first aid, spills, and safe storage, among other information.

Term	Definition
Materiovigilance	Materiovigilance is the coordinated system of identification, collection, reporting, and analysis of any untoward occurrences associated with the use of medical devices and protection of patient's health by preventing its recurrences.
Medical device	An instrument, apparatus, or machine that is used in the prevention, diagnosis, or treatment of illness or disease, or for detecting, measuring, restoring, correcting, or modifying the structure or function of the body for health care purposes.
Medical equipment	Any fixed or portable non-drug item or apparatus used for diagnosis, treatment, monitoring and direct care of a patient.
Medical record	A written or electronic documentation of varied patient health information, such as assessment findings, treatment details, progress notes, and discharge summary.
Medication error	A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labelling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.
Medication Order	A written order by a physician, dentist, or other designated health professionals for a medication to be dispensed by a pharmacy for administration to a patient.
Mission	A written expression that sets forth the purpose of an organization or one of its components. The generation of a mission statement usually precedes the formation of goals and objectives. A broad written statement in which the organisation states what it does and why it exists.
Monitoring	The performance and analysis of routine measurements aimed at identifying and detecting changes in the health status or the environment, for example monitoring of growth and nutritional status, air quality in operation theatre. It requires careful planning and use of standardised procedures and methods of data collection.
Multidisciplinary	A generic term which includes representatives from various disciplines, professions or service areas.

Term	Definition
Natural justice	A common law doctrine that provides procedural rights in administrative decision-making to support people being treated fairly and without bias. Those who are affected by a decision that is made by the Commission have access to natural justice provisions through review processes such as reconsiderations. Or, may receive a notice of intent that sets out a decision that may be made in the absence of any response from the recipient. The bias rule in administrative law requires that a decision-maker must approach a matter with an open mind that is free of prejudgment and prejudice.
Near-miss	A near-miss is an unplanned event that did not result in injury, illness, or damage--but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorised as near-misses.
No harm	This is used synonymously with a near miss. However, some authors draw a distinction between these two phrases.A near-miss is defined when an error is realised just in the nick of time,and abortive action is instituted to cut short its translation. In no harm scenario, the error is not recognised,and the deed is done,but fortunately for the healthcare professional, the expected adverse event does not occur. The distinction between the two is important and is best exemplified by reactions to administered drugs in allergic patients. A prophylactic injection of cephalosporin may be stopped in time because it suddenly transpires that the patient is known to be allergic to penicillin (near-miss). If this vital piece of information is overlooked,and the cephalosporin administered, the patient may fortunately not develop an anaphylactic reaction (no harm event)
Notifiable disease	Certain specified diseases, which are required by law to be notified to the public health authorities. Under the international health regulation (WHO's International Health Regulations 2005), the following diseases are always notifiable to WHO: a. Smallpox b. Poliomyelitis due to wild-type poliovirus c. Human influenza caused by a new subtype d. Severe acute respiratory syndrome (SARS). In India, the following is an indicative list of diseases which are also notifiable, but may vary from state to state: a. Polio b. Influenza c. Malaria d. Rabies e. HIV/AIDS f. Louse-borne typhus g. Tuberculosis h. Leprosy I. Leptospirosis j. Viral hepatitis k. Dengue fever

Term	Definition
Nursing empowerment	Empowerment for nurses may consist of three components: a workplace that has the requisite structures to promote empowerment; a psychological belief in one's ability to be empowered; and acknowledgement that there is power in the relationships and caring that nurses provide. It could include structural empowerment and psychological empowerment. Structural empowerment refers to the presence or absence of empowering conditions in the workplace. Kanter's (1993) theory of structural empowerment includes a discussion of organisational behaviour and empowerment. According to this theory, empowerment is promoted in work environments that provide employees with access to information, resources, support, and the opportunity to learn and develop. Psychological empowerment is related to a sense of motivation towards the organisational environment, based on the dimensions of meaning, competence, self-determination, and impact. Evidence of nursing empowerment include initiating and carrying out CPR even in the absences of physicians, implementing standard protocols in the ICU such as weaning a patient off ventilator, tapering or titrating inotropic as per standard policies, nurse-led discussions during patient rounds, preparing nursing budgets, decisions to procure equipment that aid and ease nursing care, empowered to correct, stop non-compliance to protocols defined by the hospital.
Objective	A specific statement of a desired short-term condition or achievement includes measurable end-results to be accomplished by specific teams or individuals within time limits.
Objective element	It is that component of standard which can be measured objectively on a rating scale. Acceptable compliance with the measurable elements will determine the overall compliance with the standard.
Occupational health hazard	The hazards to which an individual is exposed during the course of the performance of his job. These include physical, chemical, biological, mechanical and psychosocial hazards.
Operational plan	A plan which clearly defines the actions that the organisation will take within a defined timeframe to deliver its stated objectives and enable the organisation to meet its longer-term strategic objectives. The operational plan provides detailed information about how the organisation will achieve its stated objectives and identifies what activities must be undertaken; who has responsibility for undertaking each of the stated activities; the timeframes in which the activities must be completed; and the resources (financial, human and other) required to achieve the identified activities.

Term	Definition
Organogram	A graphic representation of the reporting relationship in an organisation.
Orientation	A formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation. The process by which staff become familiar with all aspects of the work environment and their responsibilities.
Outsourcing	Hiring of services and facilities from other organisation based upon one's own requirement in areas where such facilities are either not available or else are not cost-effective. For example, outsourcing of house-keeping, security, laboratory/certain special diagnostic facilities. When an activity is outsourced to other institutions, there should be a memorandum of understanding that clearly lays down the obligations of both organisations: the one which is outsourcing and the one who is providing the outsourced facility. It also addresses the quality-related aspects.
Palliative Care	The coordinated support for individuals and families who are living with a life-threatening illness, usually at an advanced stage. It focuses on physical, psychological, social, cultural, emotional and spiritual needs of the ill person and his or her family.
Patient-care setting	The location where a patient is provided health care as per his needs, for example ICU, speciality ward, private ward and general ward.
Patient-centred Care	An approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among healthcare providers and patients. Care that is respectful of and responsive to individual patient preferences, needs, and values and ensures patient values guide all clinical decisions; care that is coordinated, communicative, and supportive.
Patient engagement	The process of building the capacity of patients, families, carers as well as health care providers, to facilitate and support the active involvement of patients in their own care, in order to enhance safety, quality and people centredness of health care service delivery. World Health Organization. Patient Engagement: Technical Series on Safer Primary Care 2016.
Patient record/ medical record/ clinical record	A document which contains the chronological sequence of events that a patient undergoes during his stay in the healthcare organisation. It includes demographic data of the patient, assessment findings, diagnosis, consultations, procedures undergone, progress notes and discharge summary.

Term	Definition
Patient-reported experience measures (PREMs)	Patient-reported experience measures are questionnaires measuring the patients' perceptions of their experience whilst receiving care.
Patient-reported outcome measures (PROMs)	Patient-reported outcomes represent the patient's report of a health condition and its treatment. Patient-reported outcome measures are questionnaires measuring the patients' views of their health status.
Patient Safety Solutions	Patient Safety Solutions are defined as any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.
Patient Satisfaction	Patient satisfaction is a measure of the extent to which a patient is content with the health care which they received from their health care provider. Patient satisfaction is thus a proxy but a very effective indicator to measure the success of Health care providers.
Patient Experience	Patient Experience is the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care. It is a holistic perception that the patient forms about the healthcare provider based on the overall interactions/ care touchpoints.
Performance appraisal	It is the process of evaluating the performance of staff during a defined period of time with the aim of ascertaining their suitability for the job, the potential for growth as well as determining training needs.
Point-of-care testing (POCT)	POCT is a form of testing in which the analysis is performed near or at the site of a patient with the result leading to possible change in the care of the patient. Point of care testing is defined as a quality-assured pathology service using analytical devices (including test kits and analysers such as blood gas and critical care analysers and meters for glucose, urinalysis and other metabolites) provided near to the patient rather than in the traditional environment of a clinical laboratory. POCT Machine examples; Glucometer, ABG Analyser, iStat Lab at ICU/ER, portable USG etc.

Term	Definition
Policies	They are the guidelines for decision-making, for example admission, discharge policies, antimicrobial policy, etc.
Prescription	A prescription is a document given by a physician or other healthcare practitioner in the form of instructions that govern the care plan for an individual patient. Legally, it is a written directive, for compounding or dispensing and administration of drugs, or for other service to a particular patient.
Preventive action	Action to eliminate the cause of a potential non-conformity.
Preventive maintenance	It is a set of activities that are performed on plant equipment, machinery, and systems before the occurrence of a failure in order to protect them and to prevent or eliminate any degradation in their operating conditions. The maintenance carried out at predetermined intervals or according to prescribed criteria and intended to reduce the probability of failure or the degradation of the functioning of an item.
Privileging	It is the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications and skills.
Privileged communication	Confidential information furnished (to facilitate diagnosis and treatment) by the patient to a professional authorised by law to provide care and treatment.
Procedural sedation	Procedural sedation is a technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function. Procedural sedation and analgesia (PSA) is intended to result in a depressed level of consciousness that allows the patient to maintain oxygenation and airway control independently.
Procedure	1. A specified way to carry out an activity or a process. 2. A series of activities for carrying out work which when observed by all help to ensure the maximum use of resources and efforts to achieve the desired output.

Term	Definition
Process	A set of interrelated or interacting activities which transforms inputs into outputs.
Proficiency testing	The testing of unknown samples sent to a laboratory by a proficiency-testing program for the purpose of determining performance related to specific tests and measurements and to monitor continuing performance.
Programme	The programme identifies needs, lists strategies to meet those needs, includes staff involved, and sets goals and objectives. The format of the programme may include policies and procedures, plans, protocols, practice guidelines, clinical pathways, or a combination of these.
Protocol	A detailed plan, or set of steps, to be followed in a study, an investigation, or an intervention, as in the management of a specific clinical condition. Systematically developed statements to assist practitioners and patients with decisions about appropriate health care for specific clinical circumstances.
Quality	1. Degree to which a set of inherent characteristics fulfil requirements. Characteristics imply a distinguishing feature. Requirements are a need or expectation that is stated, generally implied or obligatory. 2. Degree of adherence to pre-established criteria or standards.
Quality assurance	Part of quality management focussed on providing confidence that quality requirements will be fulfilled.
Quality improvement	Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers/patients.
Quality Policy	Overall intentions and directions of an organization related to quality as formally expressed by top management. Generally, it is consistent with the overall policy of the organization and provides a framework for setting quality objectives.

Term	Definition
Radiation Safety	**Radiation safety** refers to safety issues and protection from radiation hazards arising from the handling of radioactive materials or chemicals and exposure to Ionizing and Non-Ionizing Radiation. This is implemented by taking steps to ensure that people will not receive excessive doses of radiation and by monitoring all sources of radiation to which they may be exposed. In a Healthcare setting, this commonly refers to X-ray machines, CT/PET CT Scans, Electron microscopes, Particle accelerators, Cyclotron etc. Radioactive substances and radioactive waste are also potential Hazards. **Imaging Safety** includes safety measures to be taken while performing an MRI, Radiological interventions, Sedation, Anaesthesia, Transfer of patients, Monitoring patients during imaging procedure etc.
Radiopharma-ceuticals	Radio-pharmaceuticals are radioisotopes bound to biological molecules able to target specific organs, tissues or cells within the human body. These radioactive drugs are used for the diagnosis and, increasingly, for the therapy of diseases.
Re-assessment	It implies a continuous and ongoing assessment of the patient, which is recorded in the medical records as progress notes.
Reconciliation of medications	Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
Referral	Referral is a recommendation by a primary care physician for a patient to see a specialist or receive specific medical services beyond the primary care provider's scope of practice.
Rehabilitation services	Rehabilitation services refer to medical treatments, therapies, and interventions aimed at restoring physical, cognitive, or functional abilities lost due to injury, illness, or disability.
Resources	It implies all inputs in terms of men, material, money, machines, minutes (time), methods, metres (space), skills, knowledge and information that are needed for the efficient and effective functioning of an organisation.

Term	Definition
Restraints	Any practice, device or action used to ensure safety by restricting and controlling a person's movement. Many facilities are "restraint-free" or use alternative methods to help modify behaviour. Restraint may be physical or chemical (by use of sedatives).
Risk abatement	Risk abatement means minimising the risk or minimising the impact of that risk.
Risk assessment	Risk assessment is the determination of the quantitative or qualitative value of risk related to a concrete situation and a recognised threat (also called hazard). This is followed by prioritizing areas for improvement based on the actual or potential impact on care, treatment, or services provided. Risk assessment is a step in a risk management procedure.
Risk management	Clinical and administrative activities to identify, evaluate and reduce the risk of injury.
Risk management framework	A set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management throughout the organisation. The framework should be embedded within the organisation's overall strategic and operational policies and practices.
Risk mitigation	Risk mitigation is a strategy to prepare for and lessen the effects of threats and disasters. Risk mitigation takes steps to reduce the negative effects of threats and disasters.
Risk reduction	The conceptual framework of elements considered with the possibilities to minimise vulnerabilities and disaster risks throughout society to avoid (prevention) or to limit (mitigation and preparedness) the adverse impacts of hazards, within the broad context of sustainable development. It is the decrease in the risk of a healthcare facility, given activity, and treatment process with respect to patient, staff, visitors and community.
Risk register	A risk register is a document that is used as a risk management tool to identify potential risks in the organisation. This process aims to collectively identify, analyse, and solve risks before they become problems. A risk register document, otherwise known as a risk register log, tracks potential risks specifically in the organisation. It also includes information about the priority of the risk and the likelihood of it happening.

Term	Definition
Root Cause Analysis (RCA)	An analytic tool that can be used to perform a comprehensive, system-based review of critical incidents. It includes the identification of the root and contributory factors, determination of risk reduction strategies, and development of action plans along with measurement strategies to evaluate the effectiveness of the plans.
Safety	The degree to which the risk of an intervention/procedure, in the care environment is reduced for a patient, visitors and healthcare providers.
Safety programme	A programme focused on patient, staff and visitor safety.
Scope of services	Range of clinical and supportive activities that are provided by a healthcare organisation.
Screening	A process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.
Second victim	A health care practitioner involved in an unanticipated adverse patient event, a medical error, and/or a patient-related injury who becomes victimized in the sense that the practitioner is traumatized by the event.
Security	Protection from loss, destruction, tampering, and unauthorised access or use.
Sedation	The administration to an individual, in any setting for any purpose, by any route, moderate or deep sedation. There are three levels of sedation: **Minimal sedation** (anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are not affected. **Moderate sedation**/analgesia (conscious sedation) - A drug-induced depression of consciousness during which patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation. No interventions are needed to maintain a patent airway. **Deep sedation**/analgesia - A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. Patients may need help in maintaining a patent airway.

Term	Definition
Sentinel events	An unanticipated event or occurrence involving death or serious physical or psychological injury not related to the patient's illness, but related to the medical equipment, supplies, or care being provided.
Service standards	A service standard specifies requirements that should be fulfilled by a service to establish its fitness for purpose. A service standard helps to define what a customer can expect from a service and how it should be delivered by the service provider, for example in terms of timeliness, accuracy and suitability.
Social responsibility	A balanced approach for an organisation to address economic, social and environmental issues in a way that aims to benefit people, communities and society,for example adoption of villages for providing health care, holding of medical camps and proper disposal of hospital wastes.
Sound clinical practice	Practitioner decisions based on available knowledge, principles and practices for specific clinical situations.
Special Educational needs of the patient	In addition to routine carried by the healthcare professionals, patients and family have special educational needs depending on the situation. For example, a post-surgical patient who has to take care of his wound, nasogastric tube feeding, patient on tracheostomy getting discharged who has to be taken care of by the family etc. The special educational needs are also greatly influenced by the literacy, educational level, language, emotional barriers and physical and cognitive limitations. Hence it is important for the staff to determine the special educational needs and the challenges influencing the effective education.
Staff	All personnel working in the organisation including employees, "fee-for-service" medical professionals, part-time workers, contractual personnel and volunteers.
Stakeholder	Individuals, organisations or groups that have an interest or share in services.
Standard precautions	1. A method of infection prevention and control in which all human blood and other bodily fluids are considered infectious for HIV, HBV and other blood-borne pathogens, regardless of patient history. It encompasses a variety of practices to prevent occupational exposure, such as the use of personal protective equipment (PPE), disposal of sharps and safe housekeeping 2. A set of guidelines protecting first aiders or healthcare professionals from pathogens. The main message is: "Don't touch or use anything that has the victim's body fluid on it without a barrier." It also assumes that all body fluid of a patient is infectious, and must be treated accordingly. **Standard Precautions** apply to blood, all body fluids, secretions, and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin and mucous membranes

Term	Definition
Standards	A statement of expectation that defines the structures and process that must be substantially in place in an organisation to enhance the quality of care.
Sterilisation	It is the process of killing or removing microorganisms including their spores by thermal, chemical or irradiation means.
Strategic plan	Strategic planning is an organisation's process of defining its strategy or direction and making decisions on allocating its resources to pursue this strategy, including its capital and people. Various business analysis techniques can be used in strategic planning, including SWOT analysis (Strengths, Weaknesses, Opportunities and Threats), for example Organisation can have a strategic plan to become a market leader in the provision of cardiothoracic and vascular services. The resource allocation will have to follow the pattern to achieve the target. The process by which an organisation envisions its future and develops strategies, goals, objectives and action plans to achieve that future.
Surveillance	The continuous scrutiny of factors that determines the occurrence and distribution of diseases and other conditions of ill health. It implies watching over with great attention, authority and often with suspicion. It requires professional analysis and sophisticated interpretation of data leading to recommendations for control activities.
Table-top exercise	A table-top exercise is an activity in which key personnel assigned emergency management roles and responsibilities are gathered to discuss, in a non-threatening environment, various simulated emergency situations.
Telemedicine	The use of technology, such as video conferencing or remote monitoring, to provide medical care to patients from a distance.
Traceability	Traceability is the ability to trace the history, application, use and location of an item or its characteristics through recorded identification data.
Transfusion reaction	A transfusion reaction is a problem that occurs after a patient receives a transfusion of blood.
Transitions of care	The situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.
Transmission-based precautions	The extra work practices used in situations when standard precautions alone may not be enough to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions.

Term	Definition
Triage	Triage is a process of prioritising patients based on the severity of their condition so as to treat as many as possible when resources are insufficient for all to be treated immediately. The sorting of patients according to criteria which ensures that the most seriously ill or injured patient is treated before patients with less serious problems.
Turn-around-time	Turnaround time (TAT) means the amount of time taken to complete a process or fulfil a request.
Unstable patient	A patient whose vital parameters need external assistance for their maintenance.
Validated tool	A validated tool refers to a questionnaire/scale that has been developed to be administered among the intended respondents. The validation processes should have been completed using a representative sample, demonstrating adequate reliability (the ability of the instrument to produce consistent results) and validity (the ability of the instrument to produce true results).
Validation	Validation is verification, where the specified requirements are adequate for the intended use.
Values	The fundamental principles, beliefs or statements of philosophy that drive organisational behaviour and decision-making, and that may involve social or ethical issues. This refers to the guiding principles and behaviours that embody how an organisation and its people are expected to operate. Values reflect and reinforce the desired culture of an organisation.
Variation	A difference in healthcare processes or outcomes, compared to peers or to a standard such as an evidence-based guideline recommendation.
Verbal order	Verbal orders are those orders given by a physician with prescriptive authority to a licensed person who is authorised by the organisation.
Verification	Verification is the provision of objective evidence that a given item fulfils specified requirements.
Vision	An overarching statement of the way an organisation wants to be, an ideal state of being at a future point. This refers to the desired future state of an organisation. The vision describes where the organisation is headed, what it intends to be, or how it wishes to be perceived in the future.

Term	Definition
Vulnerable patient	Those patients who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status, for example infants, elderly, physically- and mentally-challenged, semiconscious/unconscious, those on immunosuppressive and/or chemotherapeutic agents.
Well-being	Well-being is a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions.
Workplace violence	A violent act (or acts) including physical assaults or threats of assaults directed towards a person at work or while on duty. Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.
Written guidance	A written document providing help, advice and direction for implementation of a policy and procedure. Written guidance has been used to guide implementation of NABH Standards.

Key Performance Indicators (KPI)

The concept of performance in health services represents an instrument for bringing quality, efficiency, and efficacy together. Performance represents the extent to which set objectives are accomplished. Performance is a multidimensional one, covering various aspects, such as evidence-based practice (EBP), continuity and integration in healthcare services, health promotion, and orientation towards the needs and expectations of patients.

Key Performance Indicators (KPIs) help to systematically monitor, evaluate, and continually improve service performance. By themselves, KPIs cannot improve performance. However, they do provide "signposts" that signal progress toward goals and objectives as well as opportunities for improvement.

Well-designed KPIs should help the organization to do a number of things, including:

- Establish baseline information, i.e., the current state of performance
- Set performance standards and targets to motivate continual improvement
- Measure and report improvements over time
- Compare performance across geographic locations
- Benchmark performance against regional and international peers or norms
- Allow stakeholders to independently judge health sector performance.

Healthcare organizations are encouraged to capture all data, which involves clinical and support services. The data needs to be analyzed, and risks, rates, and trends for all the indicators have to be demonstrated for appropriate action.

The intent of the NABH KPIs is to have comprehensive involvement of the scope of services for which an institution has applied for the accreditation program. Standardized definitions for each indicator along with numerator and denominator, have been explained. Each HCO can have the data set, analyze the data and appropriate correction, corrective, and preventive action can be formulated. Each institution can also design their own methodology of data collection, but a broad guidance note has been given to facilitate the organization's compliance. Guidance has also been provided to explain how the data could be captured from the system (HIS/EMR). In all instances where the system is unable to collate the numerator and/or denominator, at a minimum the system should have a provision for manual entry of the numerator and denominator to ensure that the indicator value is calculated automatically. Further, there are a few indicators for which it may not be possible for the system to collate the data. For such indicators, a specific note has been provided in the guidance.

The Department Specific Key Performance Indicators are to be captured from in-patients except where the indicator specifically mandates that all patients need to be included.

The suggested minimum sample size to be taken for various audits and KPIs as applicable has been specified.

Key Performance Indicators (KPI)

The Key performance indicators expected to be monitored by the healthcare organization

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
1	PSQ 3a	Time for initial assessment of indoor patients	The time shall begin from the time that the patient has arrived at the bed of the ward until the time that the initial assessment has been completed and documented by a doctor.	Sum of time taken for the assessment (in minutes)		Minutes	Monthly	This shall be captured either through the HIS or through an audit. In case of an audit, the sample size shall be as specified in the sample size calculation table. Daycare patients are not included. Sampling: Yes Sampling methodology: Stratified random For data captured through HIS- Sampling: No The system should track the number of records for which the initial assessment time could not be captured due to incomplete data.	The system generates a time stamp for the start time (time of the arrival of patient at the bed of the ward) and the end time (completion and documentation of initial assessment by doctor). The initial assessment is deemed to be completed when the data pertaining to chief complaint, history, examination findings, and provisional/ final diagnosis is captured. Any edits done subsequently to any of these fields shall not result in the alteration of the time stamp of the endpoint of the initial assessment.
				Total number of admissions					The denominator shall include all admissions except daycare.
2	PSQ 3a	Number of reporting errors/1000 investigations		Number of reporting errors	X1000	/1000 tests	Monthly	This includes reporting errors picked up after dispatch. This shall be captured in the laboratory and radiology. Reporting errors include transcription errors. For better analysis, the organization could capture the data separately for different laboratory departments (For example, Biochemistry/ Microbiology/Pathology) and imaging modalities (for example, X- Ray/USG/CT/MRI).	The numerator shall include any amendment or revision carried out after the report has been signed, and approved by the authorized signatory and the system has released the same.
				Number of tests performed					The denominator shall include the total number of tests performed until midnight of the last day of the calendar month

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
								If a report has more than one error in it, the total number of errors should be counted. For example, 10 tests were performed, one report was generated for these 10 tests and if the results of two tests are revised, the value of the numerator shall be two and denominator shall be 10. Further, the organization could consider capturing data pertaining to reporting errors that were identified and rectified before the dispatch of the reports. This would enable the organization to improve its process. Although the indicator is collated on a monthly basis, immediate correction is to be initiated when such instances happen. Sampling: No	
3	PSQ 3a	Percentage of adherence to safety precautions by staff working in diagnostics.		Number of staff adhering to safety precautions Number of staff audited	X100	Percent age	Monthly	This shall be captured in the laboratory and radiology. This shall be captured by doing an audit on a monthly basis. The audit should be done by an individual outside of the department being audited. Even if the staff is not adhering to any one of the organization's/statutory safety requirements, it shall be considered as non- adherence. Sampling: Yes Sampling methodology: Stratified random	Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
4	PSQ 3a	Incidence of medication errors	A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. (Ref: NCC- MERP).	Total number of medication errors Total number of opportunities	X100	Percentage	Monthly	The methodology for capture shall be as stated in NABH's document on medication errors. The indicator shall be captured for admitted patients. Sampling: Yes Sampling methodology: Stratified random	It is preferred that the data is captured through the system for all the sub-components of medication errors. Wherever there is a limitation in capturing the information through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
5	PSQ 3a	Percentage of in- patients developing adverse drug reaction(s).	Adverse Drug reaction is a response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function.	Number of adverse drug reactions Number of inpatients	X100	Percentage	Monthly	The organization needs to have a mechanism in place to ensure that all adverse drug reactions are captured and reported. Sampling: No	The organization can use or download PvPI software (Vigi Fow) to document and analyze adverse drug reactions. The numerator shall be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system). The denominator shall include the total number of inpatients until midnight of the last day of the calendar month.
6	PSQ 3a	Percentage of unplanned return to OT	Unplanned return to the OT is defined as any secondary procedure required for a	Number of unplanned returns to OT	X100	Percentage	Monthly	The data shall be captured with a delay of 30 days. This ensures that the organization has adequate time to capture complications that require an unplanned return to the OT.	The system shall count the total number of unplanned surgeries done within 30 days. Wherever there is a limitation in capturing the information through the

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
			complication resulting directly from the index operation during the same admission. For example, post-operative bleeding, debridement, secondary suturing, embolectomy, evaluation under anesthesia etc.					For example, the data which is collated in early January (assuming that the December data is being reported) would include surgeries done in the month of November. This also includes unplanned re-exploration. This shall not include surgeries under LA. However, if any such patient requires an unplanned return to the OT, the same shall be captured in the incident form. Sampling: No	system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
				Number of patients who underwent surgeries in the OT					The system shall count the total number of patients who underwent surgeries in the OT.
7	PSQ 3a	Percentage of surgeries where the organization's procedure to prevent adverse events like the wrong site, wrong patient, and wrong surgery have been adhered to.		Number of surgeries where the WHO safe surgery checklist was followed	X100	Percentage	Monthly	This should be done by a prospective audit. The audit shall be done when the surgery is being performed. A person(s) working in the OT complex could be entrusted with this responsibility. It is preferable that the identity of the person auditing is anonymized from the operating team. Sampling: Yes Sampling methodology: Stratified random (distributed across various days and operating surgeons).	Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
				Number of surgeries that were audited					
8	PSQ 3a	Percentage of transfusion reactions	Any adverse reaction to the transfusion of blood or blood components shall be considered as transfusion reaction. It may	Number of transfusion reactions	X100	Percentage	Monthly	The number of units includes whole blood and components. The denominator is the number of units transfused and not the number of units issued from the blood bank. Sampling: No	The numerator shall be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
			range from a mild allergic reaction (including chills/rigors) to a life-threatening complication like TRALI and Graft Versus Host Disease.	Number of units transfused					The denominator shall include the total number of units transfused until midnight of the last day of the calendar month.
9	PSQ 3a	Standardized Mortality Ratio for ICU		Actual deaths in ICU		Ratio	Monthly	Predicted death shall be calculated from models such as APACHE, SOFA, SAPS, MPM etc. Sampling: No	The system shall calculate the total number of deaths in all its ICUs until midnight of the last day of the calendar month.
				Predicted deaths in ICU					The denominator shall be captured through the system. Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data
10	PSQ 3a	Return to ICU within 48 hours		Number of returns to ICU within 48 hours	X100	Percentage	Monthly	This shall include data from all ICUs within the organization, excluding HDUs. Sampling: No	The system shall calculate the total number of returns in all ICUs within 48 hours until midnight of the last day of the calendar month.
				Number of discharges/transfers from the ICU					The system shall calculate the total number of discharges/transfers from all the ICUs until midnight of the last day of the calendar month.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
11	PSQ 3a	Return to the emergency department within 72 hours with similar presenting complaints		Number of returns to emergency within 72 hours with similar presenting complaints	X100	Percent age	Monthly	To capture this indicator, it may be a good practice to capture during the initial assessment itself if the patient had come within 72 hours for similar complaints. Sampling: No	The system shall calculate the total number of returns to an emergency within 72 hours with similar presenting complaints until midnight of the last day of the calendar month.
				Number of patients who have come to the emergency					The system shall calculate the total number of patients who have come to the emergency until midnight of the last day of the calendar month.
12	PSQ 3a	Incidence of hospital-associated pressure ulcers after admission	A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.	Number of patients who develop new/ worsening of pressure ulcer	X1000	/1000 Patient days	Monthly	The organization shall use The European and US National Pressure Ulcer Advisory Panels (EPUAP and NPUAP) staging system to look for worsening pressure ulcers. Sampling: No	The numerator can be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).
				Total number of inpatient days					The denominator shall include the total number of in-patient days until midnight of the last day of the calendar month. To calculate the number of in-patient days only patients admitted in the wards and ICUs shall be included. Day care patients including patients undergoing dialysis, and emergency shall not be a part of this count.
13	PSQ 3b	Catheter-associated Urinary tract infection rate	As per the latest CDC/NHSN definition	Number of urinary catheter-associated UTIs in a month	X1000	/1000 urinary catheter - days	Monthly	Sampling: No	The numerator can be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
				Number of urinary catheter days in that month					There should be endeavors to capture the denominator data through the system.
14	PSQ 3b	Ventilator-associated Pneumonia rate	As per the latest CDC/NHSN definition	Number of "Ventilator-Associated Pneumonia" in a month	X1000	/1000 ventilato r- days	Monthly	Sampling: No	The numerator can be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).
				Number of ventilator days in that month					There should be endeavors to capture the denominator data through the system.
15	PSQ 3b	Central line-associated bloodstream infection rate	As per the latest CDC/NHSN definition	Number of central line-associated bloodstream infections in a month	X1000	/1000 central line days	Monthly	Sampling: No	The numerator can be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).
				Number of central line days in that month					There should be endeavors to capture the denominator data through the system.
16	PSQ 3a	Surgical site infection rate	As per the latest CDC/NHSN definition	Number of surgical site infections in a given month	X100	/100 procedu res	Monthly	Keeping in mind the definition of SSI, the numbers would have to be updated on a continual basis until such time that the monitoring period is over. For example, in January, the data for December would be reported. The denominator would be the number of surgeries performed in December, and that would not change. With respect to the numerator, there would be some data but it would not be complete data. Hence, whatever value the organization gets at	The numerator shall be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).
				Number of surgeries performed in that month					The system shall calculate the total number of surgeries performed until midnight on the last day of the calendar month.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
								this stage would at best be a preliminary value. The organization will continue to monitor the patients and by the end of January, will have complete data with respect to procedures which have a 30-day surveillance period. At this point in time, based on the data that the organization has collated the numerator may change and hence, the SSI rate. However, this again would not be the final data. The organization will continue to monitor procedures that have a 90-day surveillance period, and if there are new SSIs, it would get added to the numerator and thus the rate would change. The surveillance period for surgeries which are done in December and have a 90-day surveillance period would end on March 30th (give or take a few days). It is only at this point in time that the organization can have the final SSI rate for December. Sampling: No	
17	PSQ 3b	Compliance to hand hygiene practices		Total number of actions performed Total number of hand hygiene opportunities	X100	Percent-age	Monthly	Observation involves directly watching and recording the hand hygiene behavior of healthcare workers and the physical environment. A good reference is the WHO hand hygiene compliance monitoring tool. Please refer: http://www.who.int/gpsc/5may/tools/en/	Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
								http://www.who.int/entity/gpsc/5may/Observation_Form.doc?ua=1 Sampling: Yes Sampling methodology: Stratified random. However, the organization should try to ensure that all staff relevant categories of staff are covered at least once in a quarter.	
18	PSQ 3b	Percentage of cases who receive appropriate prophylactic antibiotics within the specified time frame		Number of patients who did receive appropriate prophylactic antibiotic(s) Number of patients who underwent surgeries	X100	Percentage	Monthly	The appropriate prophylactic antibiotic should be according to hospital policy. The numerator shall include patients who received the appropriate drug (and dose) within the appropriate time. A patient who was not given prophylactic antibiotic because it was not indicated (for example clean surgery) shall be included in the numerator. A patient who is given a prophylactic antibiotic even though it was not indicated, shall be considered as having received it inappropriately. Sampling: No	The system shall calculate the number of patients who did receive appropriate prophylactic antibiotic(s)until midnight of the last day of the calendar month. The system shall calculate the total number of patients who underwent surgeries until midnight of the last day of the calendar month.
19	PSQ 3c	Percentage of rescheduling of surgeries	Re-scheduling of surgeries includes cancellation and postponement (beyond 4 hours) of the surgery.	Number of cases re-scheduled	X100	Percentage	Monthly	Any case included in the OT list (including tentative/provisional) but rescheduled/canceled shall be included in the numerator. The start time for calculation of any delay shall be the first booked time for that particular case. Sampling: No	The system shall calculate the number of patients whose surgery was canceled or delayed beyond 4 hours from the planned time as per OT list.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
				Number of surgeries planned					The system shall calculate the total number of patients for whom the surgeries were planned until midnight of the last day of the calendar month. However, for the purpose of calculation, the system shall not include any planned surgeries of the subsequent month.
20	PSQ 3c	Turnaround time for the issue of blood and blood components	Time taken is to be calculated from the time the request is received in the blood bank till the blood is cross-matched/reserved and available for transfusion.	Sum of time taken (in minutes)		Minutes	Monthly	This will include blood outsourced from other Blood Banks, for those organizations not having in-house Blood Bank. Sampling: No	The system shall calculate the sum of time taken for the issue of all blood and blood components.
				Total number of blood and blood components cross-matched/reserved					The denominator shall include the total number of blood and blood components cross-matched/reserved until midnight of the last day of the calendar month.
21	PSQ 3c	Nurse-patient ratio for ICUs and wards		Number of nursing staff		Ratio	Continuous	The HCOs should calculate the staffing patterns separately for ICUs and the wards. The in-charge/supervisor of the area shall not be included for calculating the number of staff. It is preferable that in the case of ICU, the organization captures the ratio for ventilated and non-ventilated patients separately. To be calculated for each shift separately. Sampling: No	The system shall calculate the number of nursing staff in each location, each shift, each day. This data shall be used to calculate the average for a particular category (ward beds/ ICU ventilated/ICU non-ventilated) for each shift and day. The final step of the calculation involves capturing the average of all the categories of beds for all shifts.

S. No.	Standard	Indicator	Definition	Formula	Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
				Number of occupied beds				The system shall calculate the total number of occupied beds in each location, each shift each day. This data shall be used to calculate the average for a particular category (ward beds/ ICU ventilated/ICU non-ventilated) for each shift and day. The final step of the calculation involves capturing the average of all the categories of beds for all shifts.
22	PSQ 3c	Waiting time for outpatient consultation	Waiting time is the length of time which one must wait in order for a specific action to occur after that action is requested or mandated. Waiting time for outpatient consultation is the time from which the patient has come to the concerned outpatient department (it may or may not be the same time as registration) till the time that the concerned consultant (not the junior doctor/resident) begins the assessment.	Sum total time (in minutes) for consultation Total Number of outpatients	Minutes	Monthly	In the case of appointment patients, the time shall begin with the scheduled appointment time and end when the concerned consultant (not the junior doctor/resident) begins the assessment. In cases where the patient has been seen ahead of the appointment time, the waiting time shall be taken as zero minutes. Sampling: No	The system shall calculate the sum of the total waiting time of all Outpatient consultations. The denominator shall include the total number of out-patient days until midnight of the last day of the calendar month.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
23	PSQ 3c	Waiting time for diagnostics	Waiting time for diagnostics is the time from which the patient has come to the diagnostic service (the requisition form has been presented to the counter) until the time that the test is initiated.	Sum total time (in minutes) Number of out-patients reported in Diagnostics		Minute	Monthly	Waiting time for diagnostics is applicable only for outpatients and for laboratory and imaging. In the case of appointment patients, the time shall begin with the scheduled appointment time and end when the diagnostic procedure begins. In cases where the patient's diagnostic test commences ahead of the appointment time, the waiting time shall be taken as zero minutes. Sampling: No	The system shall calculate the sum of total waiting time for patients for laboratory and imaging services. The denominator shall include the total number of out-patients who reported in laboratory and imaging until midnight of the last day of the calendar month.
24	PSQ 3c	Time taken for discharge	The discharge process is deemed to have started when the consultant formally approves discharge and ends with the patient leaving the clinical unit	Sum of time taken for discharge (in minutes) Number of patients discharged		Minute	Monthly	In case patients request additional time to leave the clinical unit that shall not be added. The discharge is deemed to have been completed when the formalities for the same have been completed. Day care patients are not included. Sampling: No	The system shall calculate the sum of the time taken for all the discharges. The denominator shall include the total number of patients discharged until midnight of the last day of the calendar month.
25	PSQ 3c	Percentage of medical records having incomplete and/or improper consent	Informed consent is a type of consent in which the health care provider has a duty to inform his/her patient about the procedure, its potential risk and benefits, alternative procedures with their risk and	Number of medical records having incomplete and/ or improper consent	X100	Percent age	Monthly	If any of the essential elements/requirements of consent is missing, it shall be considered incomplete. If any consent obtained is invalid/void (consent obtained from the wrong person/consent obtained by the wrong person, etc.), it is considered improper. Sampling: No	Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula	Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
			benefits so as to enable the patient to make an informed decision of his/her health care	Number of discharges and deaths				The denominator shall include the total number of patients discharged until midnight of the last day of the calendar month.
26	PSQ 3c	Number of stock-outs of emergency medications	A stock-out is an event that occurs when an item listed as an emergency medication by the organization is not available in the organization.	Number of stock-outs of emergency drugs	Number	Monthly	To capture this, the organization should maintain a register in the pharmacy and stores (and also, if necessary, in the wards) wherein all such events are captured. The organization shall capture the number of instances. In one instance, it is possible that there was a stock-out of more than one emergency drug. For example, if on the 7th there was an instance of stock out of two emergency drugs and on 24th there was an instance of stock out of one emergency drug, the value of the indicator would be two. Sampling: No	The system shall calculate the number of stock outs of emergency medications. In case the system does not capture this value, there should be a provision for entering the manually collected data
27	PSQ 3d	Number of variations observed in mock drills	A mock drill is a simulation exercise of preparedness for any type of event. It could be an event or disaster. This is basically a dry run or preparedness drill. For example, Fire -mock drill, disaster drill, Code Blue Drill.	Total number of variations in a mock drill	Number	Monthly	To capture the variation, it is suggested that every organization develop a checklist to capture the events during a mock drill. This shall also include tabletop exercises. Sampling: No	Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
28	PSQ 3d	Incidence of patient falls	The US Department of Veteran Affairs National Centre for Patient Safety defines fall as "Loss of upright position that results in landing on the floor ground or an object or furniture or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair." It is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.	Number of patient falls Total number of inpatient days	X1000	/1000 patient days	Monthly	Falls may be: • at different levels – i.e., from one level to ground level, for example from beds, wheelchairs or downstairs • on the same level as a result of slipping, tripping, or stumbling, or from a collision, pushing, or shoving, by or with another person • below ground level, i.e. into a hole or other opening in the surface All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons. Assisted falls (when another person attempts to minimize the impact of the fall by assisting the patient's descent to the floor) should be included. (NDNQI, 2005). Sampling: No	The numerator shall be captured through an incident reporting module/software (stand-alone or integrated with HIS). The denominator shall include the total number of in-patient days until midnight of the last day of the calendar month. To calculate the number of in-patient days only patients admitted in the wards and ICUs shall be included. Daycare patients including patients undergoing dialysis, and emergency shall not be a part of this count
29	PSQ 3d	Percentage of near misses	A near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorized as near misses.	Number of near misses reported Number of incidents reported	X100	Percent-age	Monthly	A key to any near miss report is the "lesson learned". Near miss reporters can describe what they observed at the beginning of the event, and the factors that prevented loss from occurring. Sampling: No	The number of near misses can be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system). The number of incidents reported can be captured through an incident reporting module/software (stand-alone or integrated with HIS/EMR system).

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
30	PSQ 3d	Rate of needlestick injuries	Needlestick injury is a penetrating stab wound from a needle (or other sharp objects) that may result in exposure to blood or other body fluids. Needlestick injuries are wounds caused by needles that accidentally puncture the skin. (Canadian Centre for Occupational Health and Safety)	Number of needlestick injuries Average occupied beds	X1000	Rate	Monthly on a cumulative basis	The denominator is the average of the sum of the daily figures for the number of beds occupied by patients. The rate will be monitored on a monthly basis but reported cumulatively i.e. in the form of year to date. For example, in January it would be January data but in February it would be January + February data, in July it would be data from January to July, and so on so that by the end of the year the annual rate is obtained. Sampling: No	The number of needle stick injuries shall be captured through an incident reporting module/software (stand alone or integrated with HIS/EMR system). The system shall calculate the average occupied beds.
31	PSQ 3d	Appropriate handovers during shift change		Total number of handovers done appropriately Total number of handover opportunities	X100	Percent-age	Monthly	Handover is an important communication tool used by healthcare workers. The data can be collated together but it has to be captured separately for doctors and nurses. Handover documentation by each shift can be used as a guide to capturing the information. The handover information shared shall consist of the patient's current condition, recent changes in condition, ongoing treatment, and possible changes or complications. If the organization is using a standardized handover template (for example SBAR), for the handover to be deemed appropriate, all the components need to be filled. Though the organization shall use all or none	The system shall calculate the total number of handovers done appropriately. Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data. The system shall calculate the total number of handover opportunities based on the staff ROTA.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
								principle to report the numerator, organizations are encouraged to analyze the components and identify specific opportunities for improvement. Sampling: No	
32	PSQ 3d	Percentage of safe and rational prescriptions	Rational use of medicines requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community.	Total number of safe and rational prescriptions Total number of prescriptions audited	X100	Percent age	Monthly	This includes only prescriptions for out-patients. This indicator shall be captured through the prescription audit. The methodology for audit shall be as stated in NABH's document on prescription audit. Sampling: Yes Sampling methodology: Stratified random	There should be endeavors to capture data through the system. Wherever there is a limitation in capturing the information through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

Department Specific Key Performance Indicators								
S. No.	**Standard**	**Indicator**	**Definition**	**Formula**	**Unit**	**Frequency of data collation/ Monitoring**	**Remarks**	**HIS/EMR System Guide**
Cardiology								
1	PSQ 3a	Percentage of Beta-blocker prescription with a diagnosis of CHF with reduced EF	Proportion of patients with Congestive Heart Failure for whom it is indicated beta blocker prescription at the time of discharge	Number of patients discharged with a diagnosis of CHF with reduced EF and prescribed a beta blocker at discharge / Number of patients discharged with a diagnosis of CHF	X100	Percentage	Monthly	Mandatory if specialty is in the scope and this is applicable only for admitted patients. The data has to be captured from the discharge summary. The 2022 AHA/ ACC/ HFSA Guidance for the Management of Heart Failure. 1. ACE/ ARB 2. Beta Blocker 3. Mineralocorticoid (MRA) receptor antagonist. 4. SGLT Inhibitor Step Ladder therapy guidelines	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
2	PSQ 3a	Percentage of patients with myocardial infarction for whom Door to balloon time of 90 minutes is achieved		Number of acute myocardial infarction (AMI) patients undergoing primary angioplasty for whom Door to balloon time of 90 minutes is achieved / Total number of AMI patients undergoing primary angioplasty	X100	Percentage	Monthly	Mandatory if specialty is in the scope. The start time shall be when the patient is diagnosed with AMI (STEMI at first ECG after arrival at the hospital) and the clinician decides to perform primary angioplasty as the first choice of treatment. The end time shall be the time of the first device activation. Reference: AHA Cardiac outcome assessment program (COAP)	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
Endocrinology									
3	PSQ 3a	Percentage of Hospitalized patients with hypoglycemia who achieved targeted blood glucose level.	The definitions provided by the American diabetes association (ADA) from time to time shall be used to define hypoglycemia. The blood glucose level is detected by POCT as well as continuous glucose monitoring.	Number of patients with hypoglycemic events where the target glucose level was achieved post-treatment.	Number of patients with Hypoglycemic events	X100	Percentage	Monthly	Mandatory if the specialty is in the scope. As per the current ADA definition, the blood glucose level below 54 mg/dl requires immediate action. Hence for the purpose of this indicator only admitted patients experiencing an episode of blood glucose level below 54 mg/dl shall be included. The target glucose level is resolution of hypoglycemia namely glucose level greater than or equal to 70 mg/dl.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Obstetrics									
4	PSQ 3a	Spontaneous Perineal Tear Rate	A Perineal tear (Perineal laceration) is a tear in the tissue (skin and muscle) around the patient's vagina and perineum	Number of cases where a spontaneous perineal tear occurs	Total number of Vaginal deliveries	X100	Rate (per hundred vaginal deliveries)	Monthly	Mandatory if the specialty is in the scope. All four degrees of perineal tear should be included. An episiotomy may help to prevent a severe perineum tear during childbirth.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
Ophthalmology									
5	PSQ 3a	Postoperative Endophthalmitis rate	Postoperative endophthalmitis is an inflammatory condition of the eye, presumed to be due to an infectious process from bacteria, fungi, or, on rare occasions, parasites that enter the eye during the perioperative period	Number of cases of postoperative endophthalmitis Total no of Ophthalmic surgeries	X100	Rate (per hundred ophthalmic surgeries	Monthly	Mandatory if the specialty is in the scope	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data
Gastroenterology									
6	PSQ 3a	Percentage of patients undergoing Colonoscopy who are sedated	**Minimal Sedation (Anxiolysis) -** A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. **Moderate sedation (Analgesia) -** Indicates a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.	No. of patients sedated for the colonoscopy procedure Total number of patients undergoing Colonoscopy	X100	Percentage	Monthly	Optional Implementing sedation in GI Endoscopy will be considered good practice, However, the indicator pertains to Colonoscopy only as advised by the American Association of Gastroenterology. This includes all patients including out-patient and daycare.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula	Unit	Frequency of data collation/ Monitoring	Remarks	HIS/EMR System Guide
Gastroenterology								
			No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. **Deep sedation/ Analgesia -** A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation is inadequate. Cardiovascular function is usually maintained. **General Anaesthesia -** A drug induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug induced depression or neuromuscular function. Cardiovascular function may be impaired.						

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Surgery									
7	PSQ 3a	Bile Duct injury rate requiring operative intervention during Laparoscopic Cholecystect-omy	Bile duct injury during a Laparoscopic Cholecystectomy is an unintentional injury to the biliary tree that occurs during the operation.	Number of cases where bile duct injuries occurred during laparoscopic cholecystectomy and required subsequent operative intervention to repair the injury	Laparoscopic cholecystectomies performed	X100	Rate	Monthly	Optional. The injury may be detected intra-operative or in the postoperative period. All injuries requiring operative intervention shall be included for calculation of the indicator irrespective of the severity.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Biochemistry									
8	PSQ 3a	Percentage of POCT results which led to a clinical intervention.	Point of care testing is defined as laboratory testing conducted close to the site of patient care typically by non-lab personnel e.g. nurses, e.g. blood gases, electrolytes, troponin, and blood glucose.	Number of POCT tests which resulted in a clinical intervention where indicated.	Number of POCT tests where clinical intervention was deemed necessary.	X100	Percentage	Monthly	Optional The organization should have a mechanism to ensure that all POCT results are documented. Based on these results, it is preferable that the organization identifies results which require clinical intervention and documents the same.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

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Rehabilitation Medicine									
9	PSQ 3a	Functional gain following rehabilitation	Functional gain implies improvement in physical quality and activity.	The sum of the functional gain achieved before the discharge in patients undergoing neurorehabilitation.	Total number of patients undergoing neurorehabilitation	X100	Rate (per hundred neurorehabilitation patients)	Monthly	Optional. This is applicable only to admitted patients undergoing neurorehabilitation (For example Stroke, Trauma, Spinal injuries, post-neurosurgery etc.). The organization shall use the Functional Independence Measure (FIM) scale. This assesses physical and cognitive disability. Ranges from 18 to 126. Higher scores indicate more freedom for patients. Further, this is a measure of disability for a variety of populations and is not specific to any diagnosis.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Sepsis Management									
10	PSQ 3a	Percentage of sepsis patients who receive care as per the Hour-1 sepsis bundle.	Sepsis is a life-threatening organ dysfunction caused by a dysregulated host response to infection	Number of sepsis patients who receive care as per the Hour-1 sepsis bundle.	Total number of sepsis cases	X100	Percentage	Monthly	Mandatory if specialty (ICU) is in the scope The start time of the timeframe of one hour is when the patient reaches ER or ICU. In case the patient is shifted to the ICU from the ER, the start time is when the patient arrives at the ER.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for

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Sepsis Management								
							The components of the Hour-1 bundle include measuring lactate obtaining blood culture before administering antibiotics, administering broad-spectrum antibiotics, beginning rapid administration of appropriate fluid, and applying vasopressors where appropriate. For the patient to be included in the numerator all the 5 components have to be met. Only if the organization does not have capabilities to measure the lactate level the same could be excluded. However, in all such instances the diagnosis of sepsis should be clinically proven.	entering the manual/ electronically collected (app/ online forms) data.
Respiratory Medicine/Pulmonary Medicine								
11	PSQ 3a	Percentage of COPD patients receiving COPD Action plan at the time of discharge	An action is a simple guide that helps patients to take care of their COPD.	Number of COPD patients provided with a COPD action plan at the time of discharge / Number of COPD patients discharged.	X100	Percentage	Monthly	Mandatory if specialty is in the scope. As recommended by GOLD standards. Some of the components of the action plan could include medications, advice regarding	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this

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Respiratory Medicine/Pulmonary Medicine									
								smoking cessation and vaccination where appropriate.	indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Neurology									
12	PSQ 3a	Percentage of stroke patients in whom the Door-to-Needle Time (DTN) of 60 minutes is achieved.	Door-to-needle time is the time it takes for the stroke patient to receive thrombolytic.	Number of Stroke patients in whom the Door to needle time of 60 minutes is achieved. Number of stroke patients who receive thrombolytic therapy.	X100	Percentage	Monthly	Mandatory if the specialty is in the scope. The start time shall be when the patient arrives at the emergency and the end time is initiation of thrombolytic therapy.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Paediatrics									
13	PSQ 3a	Percentage of bronchiolitis patients treated inappropriately	In patients with bronchiolitis steroids, bronchodilators, and antimicrobials are not recommended and hence would constitute inappropriate treatment.	Number of patients treated inappropriately. Total number of patients with bronchiolitis	X100	Percentage	Monthly	Mandatory if specialty is in the scope American Academy of Pediatrics. This would be applicable mostly to children less than 24 months.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for

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Paediatrics								
								Entering the manual/ electronically collected (app/ online forms) data.
Oncology								
14	PSQ 3a	Percentage of oncology patients who had treatment initiated following Multidisciplina-ry meeting (Tumour board)	A tumor board is a multidisciplinary team including a group of specialists and other medical professionals who meet on a regular basis. The objective is to collectively choose the most effective course of treatment for a patient	Number of new oncology patients who had treatment initiated following multidisciplinary meeting (tumour board) Number of new oncology cases (all disciplines) treated in the month	X100	Percentage	Monthly	Mandatory if specialty is in the scope	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Nuclear medicine								
15	PSQ 3a	Percentage of adverse reaction to radio-pharmaceutical	In general, the most common adverse reactions to radiopharmaceuticals are the following: nausea, dyspnea, bronchospasm, decrease in blood pressure, itching, flushing, hives, chills, cough, bradycardia, muscle cramps, and dizziness.	Total number of patients who developed adverse reaction(s) to radiopharmaceutical Total number of patients receiving the radiopharmaceutical	X100	Percentage	Monthly	Mandatory if specialty is in the scope	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

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Radiology									
16	PSQ 3a	Percentage of Intravenous Contrast Media Extravasation	Contrast extravasation is a problem that occurs when contrast dye leaks into the tissue around the vein where the IV is placed.	Number of Contrast extravasation Number of patients receiving contrast	X100	Percentage	Monthly	Mandatory if CT and/or MRI is in the scope. All patients undergoing intravenous contrast administration during CT or MRI are included in the calculation of this indicator	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
Emergency Medicine									
17	PSQ 3a	Time taken for triage	Triage is a process of prioritizing patients based on the severity of their condition so as to treat as many as possible when resources are insufficient for all to be treated immediately. The sorting of patients according to criteria which ensures that the most seriously ill or injured patient is treated before patients with less serious problems.	Sum of time taken (in minutes) for triage Total number of patients coming to the emergency		Minutes	Monthly	Mandatory The start time is when the patient arrives at the emergency and the end time is when the triage is completed.	The system generates a time stamp for the start time (time of the arrival of patient at the emergency) and the end time (completion of triage). The denominator shall include all patients coming to the emergency.

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Nephrology								
18	PSQ 3a	Percentage of patients undergoing dialysis who are able to achieve target hemoglobin levels		Number of patients undergoing dialysis who are able to achieve target hemoglobin levels / Total number of patients undergoing dialysis	X100	Percentage	Monthly	Mandatory if dialysis is in the scope. The target hemoglobin level in patients undergoing dialysis shall be between 11-12 gm/dl.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data

Sample size calculation (Monthly)

Screening Population#	Sample Size*
50	44
100	79
150	108
200	132
500	217
1000	278
2000	322
5000	357
10000	370
20000	377

#Screening population is the 'base' from which the samples would be selected. The 'base' shall be the average of the previous three months. For example, in the case of time for initial assessment of patients, this would be the average number of patients admitted per month in the preceding three months. Assuming that the average is 200, this would constitute the screening population and the organization would have to sample 132 patients over the entire month.

*For the recommended sample size, all the samples should be taken on a continuous basis.

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