NATIONAL QUALITY ASSURANCE STANDARDS

FOR

Public Health Facilities

2024

Ministry of Health and Family Welfare
Government of India

सत्यमेव जयते

राष्ट्रीय स्वास्थ्य मिशन

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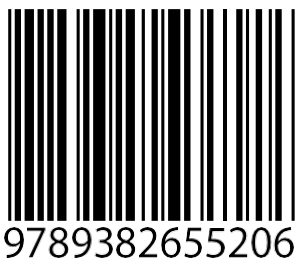

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Quality of care is a key thrust area for both Policy Makers and Public Health Practitioners as it is an instrument of optimal utilization of resources and improving health outcomes as well as client satisfaction. National Quality Assurance Standards have been developed keeping in mind the specific requirements for public health facilities as well global best practices. Standards are meant for providers to assess their own quality for improvement as well as facilities for certification.

Target Audience

National Quality Assurance Standards for Public Health care facilities are intended for policy makers, program officers, service providers, assessors and certification agencies who intend to support, assess and sustain quality of care in public health care system and working to bring up their facilities for quality certification. Standards could also be used as self- improvement tools by health care facilities without linking with formal certification process.

Type of Healthcare Facilities

This set of National Quality Assurance Standards (NQAS) is applicable in all secondary healthcare facilities operated by state or central health department in India i.e. District Hospitals/District Hospitals designated as teaching institutions, Sub-divisional hospitals, Thaluk hospitals, Area hospital, or any other equivalent health facility.

Range of Services

These standards are formulated to assess the quality of preventive, curative and promotive services provided by a secondary public hospitals. Range of services cover by these standards are:

- Out-patient department services
- Maternal, Newborn, Child and Adolescent health services
- In-patient departmental care
- Emergency care services
- Intensive care services
- Laboratory and radiology diagnostic services
- Blood bank services
- Surgical services
- Hemodialysis Services
- Hospital auxiliary and support services, etc.
- Disease control programs and public health functions

National Quality Assurance Standards for Public Health care facilities 2024 describes the intent of each standard as well as detailed measurement and assessment protocols. An assessment tool based on these standards has been defined and compiled in assessor's guidebook.

NATIONAL QUALITY ASSURANCE STANDARDS

INTRODUCTION TO NATIONAL QUALITY ASSURANCE STANDARDS

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

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

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

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

Following are salient features of the proposed quality system:

1. **Comprehensiveness –** The proposed system is all inclusive and captures all aspects of quality of care within the eight areas of concern. The departmental checklists transposed within Quality Standards, and commensurate measurable elements provide an exhaustive matrix to capture all aspects of quality of care at the Public Health Facilities.
2. **Contextual –** The proposed system has been developed primarily for meeting the requirements of the Public Health Facilities; since Public Hospitals have their own processes, responsibilities and peculiarities, which are very different from 'for-profit' sector. For instance, there are standards for providing free drugs, ensuring availability of clean linen, etc. which may not be relevant for other hospitals.
3. **Contemporary –** Contemporary Quality standards such as NABH, ISO and JCI, and Quality improvement tools such as Six Sigma, Lean and CQI have been consulted and their relevant practices have been incorporated.
4. **User Friendly –** The Public Health System requires a credible Quality system. It has been endeavour of the team to avoid complex language and jargon. So that the system remains user-friendly to enable easy understanding and implementation by the service providers. Checklists have been designed to be user-friendly with guidance for each checkpoint. Scoring system has been made simple with uniform scoring rules and weightage. Additionally, a formula fitted excel sheet tool has been provided for the convenience, and also to avoid calculation errors.
5. **Evidence based –** The Standards have been developed after consulting vast knowledge resource available on the quality. All respective operational and technical guidelines related to RMNCHA and National Health Programmes have been factored in.

6. **Objectivity –** Ensuring objectivity in measurement of the Quality has always been a challenge. Therefore in the proposed quality system, each Standard is accompanied with measurable elements & Checkpoints to measure compliance to the standards. Checklists have been developed for various departments, which also captures inter-departmental variability for the standards. At the end of assessment, there would be numeric scores, bringing out the quality of care in a snap-shot, which can be used for monitoring, as well as for inter-hospital/ inter-state(s) comparison.
7. **Flexibility –** The proposed system has been designed in such a way that states and Health Facilities can adapt the system according to their priorities and requirements. State or facilities may pick some of the departments or group of services in the initial phase for Quality improvement. As baseline differs from state to state, checkpoints may either be made essential or desirable, as per availability of resources. Desirable checkpoints will be counted in arriving at the score, but this may not withhold its certification, if compliance is still not there. In this way the proposed system provides flexibility, as well as 'road-map'.
8. **Balanced –** All three components of Quality – Structure, process & outcome, have been given due weightage.
9. **Transparency –** All efforts have been made to ensure that the measurement system remains transparent, so that the assessee and assessors have similar interpretation of each checkpoint.
10. **Enabler –** Though standards and checklists are primarily meant for the assessment, it can also be used as a 'road-map' for improvement.

NATIONAL QUALITY ASSURANCE STANDARDS

Area of Concern - A: Service Provision	
Standard A1	The facility provides curative services
Standard A2	The facility provides RMNCHA services
Standard A3	The facility provides diagnostic services
Standard A4	The facility provides services as mandated in National Health Programmes/State Scheme.
Standard A5	The facility provides support services
Standard A6	Health services provided at the facility are appropriate to community needs.
Area of Concern - B: Patient Rights	
Standard B1	The facility provides information to care seekers, attendants & community about the available services and their modalities.
Standard B2	Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barriers on account of physical economic, cultural or social reasons.
Standard B3	The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.
Standard B4	The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making.
Standard B5	The facility ensures that there are no financial barriers to access, and that there is financial protection given from the cost of hospital services.
Standard B6	The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities.
Area of Concern - C: Inputs	
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.
Standard C2	The facility ensures the physical safety of the infrastructure.
Standard C3	The facility has established Programme for fire safety and other disaster.
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.
Standard C5	The facility provides drugs and consumables required for assured list of services.
Standard C6	The facility has equipment & instruments required for assured list of services.
Standard C7	The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff

Area of Concern - D: Support Services	
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas.
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.
Standard D4	The facility has established Programme for maintenance and upkeep of the facility.
Standard D5	The facility ensures 24 X 7 water and power backup as per requirement of service delivery, and support services norms.
Standard D6	Dietary services are available as per service provision and nutritional requirement of the patients.
Standard D7	The facility ensures clean linen to the patients.
Standard D8	The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.
Standard D9	Hospital has defined and established procedures for Financial Management.
Standard D10	The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government.
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.
Standard D12	The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations.
Area of Concern - E: Clinical Services	
Standard E1	The facility has defined procedures for registration, consultation and admission of patients.
Standard E2	The facility has defined and established procedure for clinical assessment, reassessment and preparation of the treatment plan.
Standard E3	The facility has defined and established procedures for continuity of care of patient and referral.
Standard E4	The facility has defined and established procedures for nursing care.
Standard E5	The facility has a procedure to identify high risk and vulnerable patients.
Standard E6	Facility ensures rationale prescribing and use of medicines
Standard E7	The facility has defined procedures for safe drug administration.
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage.
Standard E9	The facility has defined and established procedures for discharge of patient.
Standard E10	The facility has defined and established procedures for intensive care.
Standard E11	The facility has defined and established procedures for Emergency Services and Disaster Management.
Standard E12	The facility has defined and established procedures of diagnostic services.
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.

Standard E14	The facility has established procedures for Anaesthetic Services.
Standard E15	The facility has defined and established procedures of Operation theatre services.
Standard E16	The facility has defined and established procedures for the management of death & bodies of deceased patients.
Maternal & Child Health Services	
Standard E17	The facility has established procedures for Antenatal care as per guidelines.
Standard E18	The facility has established procedures for Intranatal care as per guidelines.
Standard E19	The facility has established procedures for postnatal care as per guidelines.
Standard E20	The facility has established procedures for care of new born, infant and child as per guidelines.
Standard E21	The facility has established procedures for abortion and family planning as per government guidelines and law.
Standard E22	The facility provides Adolescent Reproductive and Sexual Health services as per guidelines.
National Health Programmes	
Standard E23	The facility provides National health Programme as per operational/Clinical Guidelines.
Standard E24	The facility has defined and established procedures for Haemodialysis services.
Area of Concern - F: Infection Control	
Standard F1	The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection.
Standard F2	The facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis.
Standard F3	The facility ensures standard practices and materials for Personal protection.
Standard F4	The facility has standard procedures for processing of equipment and instruments.
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention.
Standard F6	The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.
Area of Concern - G: Quality Management	
Standard G1	The facility has established organizational framework for quality improvement.
Standard G2	The facility has established system for patient and employee satisfaction.
Standard G3	The facility have established internal and external quality assurance programs whenever it is critical to quality.
Standard G4	The facility has established, documented implemented and maintained Standard Operating Procedures or all key processes and support services.
Standard G5	The facility maps its key processes and seeks to make them more efficient by reducing non-value adding activities and wastages.
Standard G6	The facility has defined mission, values, Quality policy & objectives & prepares a strategic plan to achieve them.
Standard G7	The facility seeks continually improvement by practicing Quality method and tools.
Standard G8	The facility has defined, approved and communicated Risk Management framework for existing and potential risks.

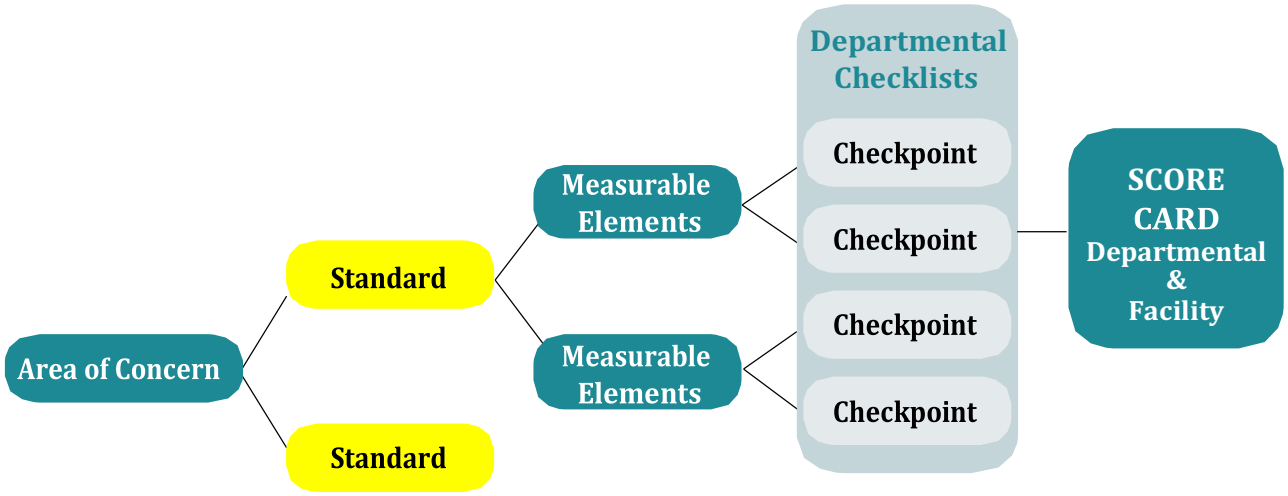
Standards G9	The facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan
Standard G10	The facility has established clinical Governance framework to improve the quality and safety of clinical care processes
Area of Concern - H: Outcome Indicator	
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks.
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark.
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark.
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark.

COMPONENTS OF QUALITY MEASUREMENT SYSTEM

The main pillars of Quality Measurement Systems are Quality Standards. These standards have been defined for various level of facilities. The Standards have been grouped within the eight Areas of Concern. Each Standard further has specific Measurable Elements. These standards and measurable elements are checked in each department of a health facility through department specific Checkpoints. All Checkpoints for a department are collated, and together they form assessment tool called 'Checklist'. Scored/ filled-in Checklists would generate scorecards.

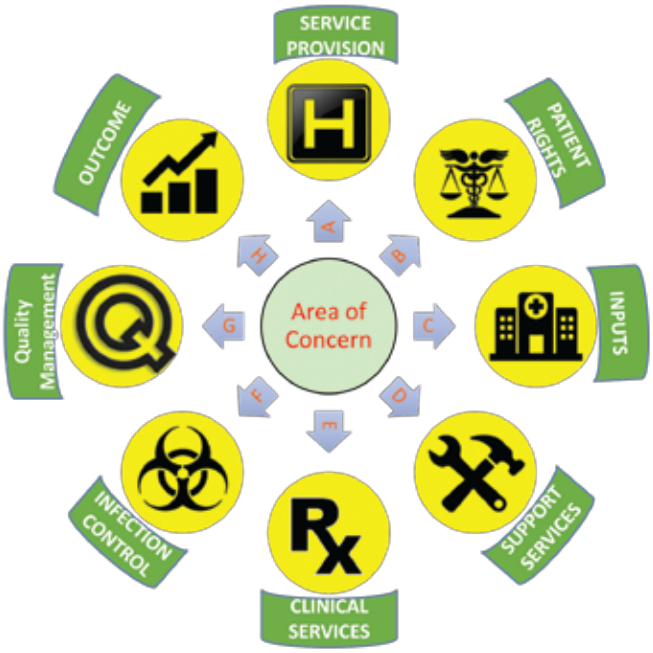
Functional relationship between quality standards, measurable elements, check-points and check-list is shown in Figure1.

Figure 1: Functional Relationship between Components of Quality Measurement System



Following are the areas of concern in a health facility:

A. Service Provision
B. Patient Rights
C. Inputs
D. Support Services
E. Clinical Services
F. Infection Control
G. Quality Management
H. Outcome



ASSESSMENT PROTOCOL

A. General Principles

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

1. **Integrity –** Assessors and persons managing assessment programmes should
   - Perform their work with honesty, diligence and responsibility
   - Demonstrate their competence while performing assessment
   - Performance assessment in an impartial manner
   - Remain fair and unbiased in their findings

2. **Fair Presentation -** Assessment findings should represent the assessment activities truthfully and accurately. Any unresolved diverging opinion should between assessors and assesses should be reported.

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

4. **Independence-** Assessors should be independent to the activity that they are assessing and should act in a manner that is free from bias and conflict of interest. For internal assessment, the assessor should not assess his or her own department and process. After the assessment, assessor should handhold to guide the service providers for closing the gap and improving the services.

5. **Evidence based approach –** Conclusions should be arrived based on evidences, which are objective, verifiable and reproducible.

B. Planning Assessment Activities

Following assessment activities are undertaken at different level -

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

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

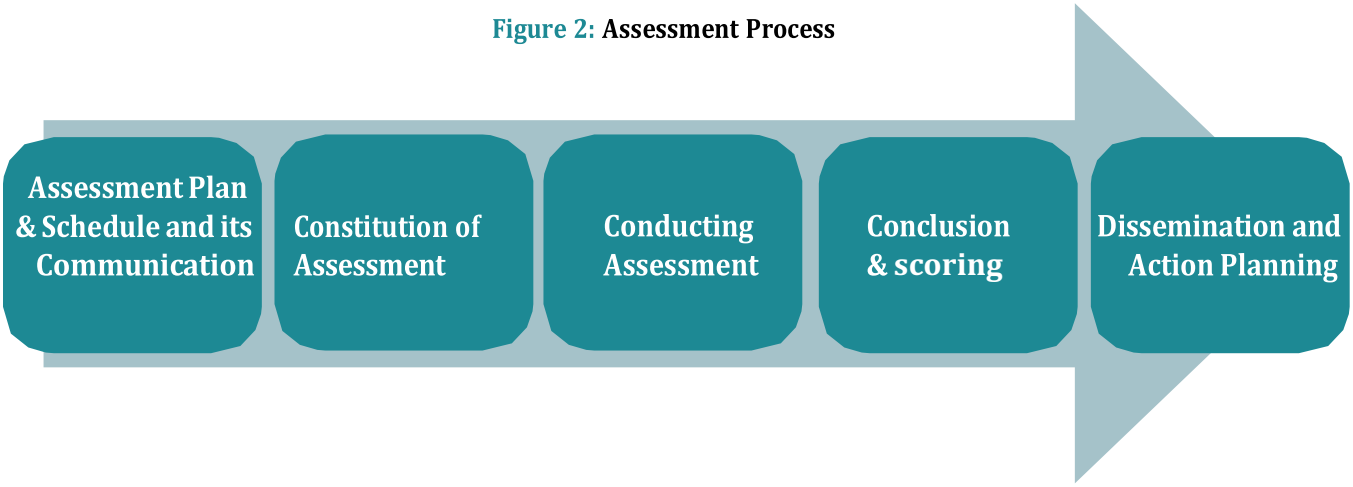
For internal assessment, the Hospital Quality Team should appoint a coordinator, preferably the hospital manager or quality manager, whose main responsibilities are given below -

1. Preparing assessment plan and schedule
2. Constitute an assessment team for internal assessment
3. Arrange stationary (forms & formats) for internal assessment
4. Maintenance of assessment records
5. Communicating and coordinating with departments

6. Monitor & review the internal assessment programme
7. Disseminate the findings of internal assessment
8. Preparation of action plan in coordination with quality team and respective departments.

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

Figure 2: Assessment Process



C. Constituting assessment team

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

D. Preparing assessment schedule

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

E. Performing Assessment

i. Pre-assessment preparation – Team leader of the assessment team should ensure that assessment schedule has been communicated to respective departments. Team leader should assign the area of responsibility to each team member, according to the schedule and competency of the members.
ii. Opening meeting – A short opening meeting with the assessee's department or hospital should be conducted for introduction, aims & objective of the assessment and role clarity.
iii. Reviewing documents – The available records and documents such as SOPs, BHT, Registers, etc should be reviewed.

F. Communication during assessment

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

G. Using checklists

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

Figure 3: Sample checklist*

Checklist for Accident & Emergency						
Reference	Measurable Element	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1.	Facility Provides Curative Services					
ME A1.1.	The facility provides General Medicine services	ailability of Emergency Medical Procedures	0/1/2	SI/OB	Poisoning, Snake Bite, CVA, Acute MI, ARF, Hypovolemic Shock , yspnoea, Unconscious Patients	
ME A1.2.	The facility provides General Surgery services	Availability of Emergency Surgical Procedures		SI/OB	Appendicitis, Rupture spleen, Intestinal Obstruction, Assault Injuries, perforation, Burns	
ME A1.4.	The facility provides paediatrics services	Availability of emergency Paediatric procedures		SI/OB	ARI, Diarrhoeal diseases, Hypothermia, PEM, resuscitation	
ME A1.5.	The facility provides Ophthalmology Services	Availability of Emergency Ophthalmology procedures		SI/OB	Foreign body and injuries	

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

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

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

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

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

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

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

g) Right next to Checkpoint is a blank column for noting the findings of assessment, in term of Compliance – Full, Partial or and Non Compliance.

h) Next to compliance column is the assessment method column. This denotes the 'HOW' to gather the information. Generally, there are four primary methods for assessment - SI means staff interview, OB means observation, RR means record review & PI - Patient Interview.

i) Column next to assessment method contains means of verification. It denotes what to see at a Checkpoint. It may be list of equipment or procedures to be observed, or question you have to ask or some benchmark, which could be used for comparison, or reference to some other guideline or legal document. It has been left blank, as the check point is self-explanatory.

Assessor should gather information and evidence to assess compliance to the requirement of measurable element and checkpoints at Health Facility being assessed. Information can be gathered by following four methods

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

a) Enumeration of articles like equipment, drugs, etc

b) Displays of signages, work instructions, important information

c) Facilities - patient amenities, ramps, complaint-box, etc.

d) Environment – cleanliness, loose-wires, seepage, overcrowding, temperature control, drains, etc

e) Procedures like measuring BP, counselling, segregation of biomedical waste,

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

a) Review of clinical records - delivery note, anaesthesia note, maintenance of treatment chart, operation notes, etc.
b) Review of department registers like admission registers, handover registers, expenditure registers, etc.
c) Review of licenses, formats for legal compliances like Blood bank license and Form 'F' for PNDT
d) Review of SOPs for adequacy and process
e) Review of monitoring records – TPR chart, Input/output chart, culture surveillance report, calibration records, etc
f) Review of department data and indicators

iii. **Staff interview –**Interaction with the staff helps in assessing the knowledge and skill level, required for performing job functions. Examples -

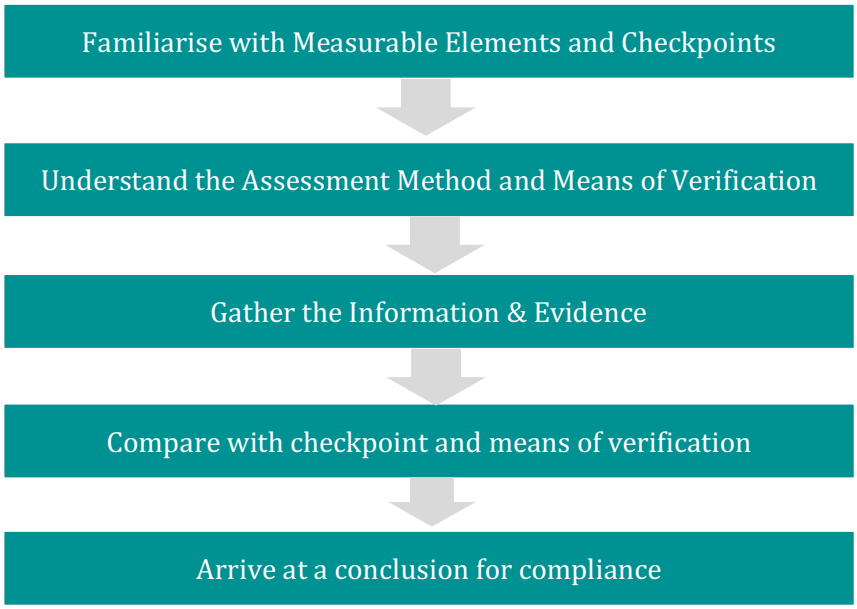
a) Competency testing – Quizzing the staff on knowledge related to their job
b) Demonstration – Asking staff to demonstrate certain activities like hand-washing technique, new born resuscitation, etc.
c) Awareness - Asking staff about awareness off patients' right, quality policy, handling of high alerts drugs, etc.
d) Attitude about patient's dignity and gender issues.
e) Feedback about adequacy of supplies, problems in performing work, safety issues, etc.

iv. **Patient / Client Interview–** Interaction with patients/clients may be useful in getting information about quality of services and their experience in the hospital. It gives us users' perspective. It should include -

a) Feedback on quality of services staff behavior, food quality, waiting times, etc.
b) Out of pocket expenditure incurred during the hospitalisation
c) Effective of communication like counselling services and self drug administration

Assessor may use one these method to assess certain measurable element. Suggestive methods have been given in the Assessment method column against each checkpoint Means of verification has been given against each checkpoint. Normal flow of gathering information assessment would be as given in Figure 4 -

Figure 4: Flow of Information



H. Assessment conclusion

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

After arriving on conclusion, assessor should mark 'C' for compliance, 'P' for partial compliance and 'N' for non-compliance in Compliance column.

INTENT OF STANDARDS & MEASURABLE ELEMENTS

INTENT OF STANDARDS AND MEASURABLE ELEMENTS

AREA OF CONCERN - A: SERVICE PROVISION

Overview

Apart from the curative services that district hospitals provide, Public hospitals are also mandated to provide preventive and promotive services. Reproductive and Child Health services are now grouped as RMNCHA, which are major chunk of the services. These services are also priority for the government, so as to have direct impact on the key indicators such as MMR and IMR.

This area of concern measures availability of services. "Availability" of functional services means service is available to end-users because mere availability of infrastructure or human resources does not always ensure availability of the services. For example, a facility may have functional OT, Blood Bank, and availability of Obstetrician and Anaesthetist, but it may not be providing CEmONC services on 24x7 basis. The facility may have functional Dental Clinic, but if there are hardly any procedures undertaken at the clinic, it may be assumed that the services are either not available or non-accessible to users. Compliance to these standards and measurable elements should be checked, preferably by observing delivery of the services, review of records and checking utilisation of the services.

Compliance to following standards ensures that the health facility is addressing this area of concern:

STANDARD A1 THE FACILITY PROVIDES CURATIVE SERVICES	The standard would include availability of OPD consultation, Indoor services and Surgical procedures, Intensive care, Emergency Care and dialysis services under different specialties e.g. Medicine, Surgery, Orthopaedics, Paediatrics etc. Each measurable element under this standard measures one speciality across the departments. For Example, ME A1.2 measures availability of emergency surgical procedures in Accident & Emergency department, availability of General surgery clinic at OPD, Availability of surgical procedures in Operation theatre and availability of indoors services for surgery patients in wards.
STANDARD A2 THE FACILITY PROVIDES RMNCHA SERVICES	These standard measures availability of Reproductive, Maternal, Newborn, Child and Adolescent services in different departments of the hospital. Each aspect of RMNCHA services is covered by one measurable element of this standard.
STANDARD A3 THE FACILITY PROVIDES DIAGNOSTIC SERVICES	It covers availability of Laboratory, Radiology and other diagnostics services viz ultrasound in the respective departments.
STANDARD A4 THE FACILITY PROVIDES SERVICES AS MANDATED IN NATIONAL HEALTH PROGRAMMES/ STATE SCHEME	This standard measures availability of the services at health facility under different National Health Programmes such as NTEP, NVBDCP, PMNDP, Viral Hepatitis, National programme for palliative care, Sickle cell Anaemia Elimination Programme etc. One Measurable element has been assigned to each National Health Programme.
STANDARD A5 THE FACILITY PROVIDES SUPPORT SERVICES	The standard measures availability of support services like dietary, laundry and housekeeping services at the facility.
STANDARD A6 HEALTH SERVICES PROVIDED AT THE FACILITY ARE APPROPRIATE TO COMMUNITY NEEDS	The standard mandates availability of the services according to specific local health needs. Different geographical area may have certain health problems, which are prevalent locally.

Measurable Elements

Area of Concern - A: Measurable Elements Service Provision	
Standard A1	**The facility provides Curative Services**
ME A1.1	The facility provides General Medicine services
ME A1.2	The facility provides General Surgery services
ME A1.3	The facility provides Obstetrics & Gynaecology Services
ME A1.4	The facility provides Paediatric Services
ME A1.5	The facility provides Ophthalmology Services
ME A1.6	The facility provides ENT Services
ME A1.7	The facility provides Orthopaedics Services
ME A1.8	The facility provides Skin & VD Services
ME A1.9	The facility provides Psychiatry Services
ME A1.10	The facility provides Dental Treatment Services
ME A1.11	The facility provides AYUSH Services
ME A1.12	The facility provides Physiotherapy Services
ME A1.13	The facility provides services for OPD procedures
ME A1.14	Services are available for the time period as mandated
ME A1.15	The facility provides services for Super specialties, as mandated
ME A1.16	The facility provides Accident & Emergency Services
ME A1.17	The facility provides Intensive care Services
ME A1.18	The facility provides Blood bank & transfusion services
ME A1.19	The facility provides dialysis services
Standard A2	**The facility provides RMNCHA Services**
ME A2.1	The facility provides Reproductive health Services
ME A2.2	The facility provides Maternal health Services
ME A2.3	The facility provides Newborn health Services
ME A2.4	The facility provides Child health Services
ME A2.5	The facility provides Adolescent health Services
Standard A3	**The facility provides diagnostic Services**
ME A3.1	The facility provides Radiology Services
ME A3.2	The facility provides Laboratory Services
ME A3.3	The facility provides other diagnostic services, as mandated
Standard A4	**The facility provides services as mandated in National Health Programmes/State Scheme**
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines
ME A4.2	The facility provides services under National TB elimination Programme as per guidelines
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines

ME A4.5	The facility provides services under National Programme for control of Blindness as per guidelines
ME A4.6	The facility provides services under Mental Health Programme as per guidelines
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines
ME A4.8	The facility provides services under National Programme for Non-Communicable Diseases as per guidelines
ME A4.9	The facility provides services under Integrated Disease Surveillance Programme as per Guidelines
ME A4.10	The facility provides services under National health Programme for deafness
ME A4.11	The facility provides services as per State specific health programmes
ME A4.12	The facility provides services as per Rashtriya Bal Swasthya Karykram
ME A4.13	The facility provides services as per Pradhan Mantri National Dialysis Programme (PMNDP)
ME A4.14	The facility provides services as per National Viral Hepatitis Programme
ME A4.15	The facility provides services as per National Programme for Palliative Care
ME A4.16	The facility provides services under Anaemia Mukt Bharat including Sickle Cell Anaemia Elimination Programme.
Standard A5	**The facility provides support services**
ME A5.1	The facility provides dietary services
ME A5.2	The facility provides laundry services
ME A5.3	The facility provides security services
ME A5.4	The facility provides housekeeping services
ME A5.5	The facility ensures maintenance services
ME A5.6	The facility provides pharmacy services
ME A5.7	The facility has services of medical record department
ME A5.8	The facility provides mortuary services
Standard A6	**Health services provided at the facility are appropriate to community needs**
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.
ME A6.2	There is a process for consulting community/or their representatives when planning or revising scope of services of the facility.

AREA OF CONCERN - B: PATIENT RIGHTS

Overview

Mere availability of services does not serve the purpose until the services are accessible to the users, and are provided with dignity and confidentiality. Access includes Physical access as well as financial access. The Government has launched many schemes, such as JSSK, RBSK and PMJAY, for ensuring that the service packages are available cashless to different targeted groups. There are evidences to suggest that patients' experience and outcome improves, when they are involved in the care. So availability of information is critical for access as well as enhancing patients' satisfaction. Patients' rights also include that health services give due consideration to patients' cultural and religious preferences.

Brief description of the standards under this area of concern are given below:

STANDARD B1 THE FACILITY PROVIDES THE INFORMATION TO CARE SEEKERS, ATTENDANTS & COMMUNITY ABOUT THE AVAILABLE SERVICES AND THEIR MODALITIES	Standard B1 measures availability of the information about services and their modalities to patients and visitors. Measurable elements under this standard check for availability of user-friendly signages, display of services available and user charges, citizen charter, enquiry desk and access to clinical records.
STANDARD B2 SERVICES ARE DELIVERED IN A MANNER THAT IS SENSITIVE TO GENDER, RELIGIOUS AND CULTURAL NEEDS, AND THERE ARE NO BARRIERS ON ACCOUNT OF PHYSICAL ECONOMIC, CULTURAL OR SOCIAL REASONS.	Standard B2 ensures that the services are sensitive to gender, cultural and religious needs. This standard also measures the physical access, and specially-abled friendliness of the services, such as availability of ramps and specially-abled friendly toilets. The standard mandates provision for affirmative action for vulnerable and marginalized patients like orphans, destitute, terminally ill patients, victims of rape and domestic violence and ensure everyone can avail health care services with dignity and confidence at public hospitals.
STANDARD B3 THE FACILITY MAINTAINS PRIVACY, CONFIDENTIALITY & DIGNITY OF PATIENT, AND HAS A SYSTEM FOR GUARDING PATIENT RELATED INFORMATION	Standard B3, This standard measures the patient friendliness of the services in terms of privacy, confidentiality and dignity. Measurable elements under this standard check for provisions of screens and curtains, confidentiality of patients' clinical information, behaviour of service providers, and also ensuring specific precautions to be taken, while providing care to patients with HIV infection, abortion, teenage pregnancy, etc.
STANDARD B4 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR INFORMING PATIENTS ABOUT THE THEM IN TREATMENT PLANNING, AND FACILITATES INFORMED DECISION MAKING	Standard B4, This standard mandates that health facility has procedures of informing patients about their rights, and actively involves them in the decision-making about their treatment. Measurable elements in this standard look for practices such as informed consent, dissemination of patient rights and communication to patients about their clinical conditions and options available. Standard also focuses on grievance redressal and its compliance that can be checked through review of records for consent, interviewing staff about their awareness of patients' rights, interviewing patients whether they had been informed of the treatment plan, available options and its prognosis.
STANDARD B5 THE FACILITY ENSURES THAT THERE IS NO FINANCIAL BARRIER TO ACCESS, AND THAT THERE IS FINANCIAL PROTECTION GIVEN FROM THE COST OF HOSPITAL SERVICES	Standard B5, This standard majorly checks that there are no financial barriers to the services. Measurable elements under this standard check for availability of free drugs, diagnostics, consultation, procedure and transport under different schemes, and timely payment of the entitlements under JSY and Family planning incentives. This standard also ensures the implementation of health insurance scheme like PMJAY.

STANDARD B6
FACILITY HAS DEFINED FRAMEWORK FOR ETHICAL MANAGEMENT INCLUDING DILEMMAS CONFRONTED DURING DELIVERY OF SERVICES AT PUBLIC HEALTH FACILITIES

Public Health facilities have been instituted for providing health care services for the larger good and welfare of community. Apart from providing health care services, the public health facilities have a statutory obligation to conduct medico-legal examinations, post-mortems, facilitate justice dispensation as required by the law, issuing medical certificates and implement government health policies. It is of utmost importance that public health facilities portray highest standards for ethical practices in clinical care and governance.

This standard requires the facility to adhere to Ethical norms, and a pre-defined code of conduct is followed by its staff. The standard ensures the identification, reporting & resolution of ethical dilemmas faced by health professionals while delivering the service. The standard mandates compliance with code of conduct by health professionals. Preferably code of conducts should be communicated to the staff in form of written instructions. This may include do's and don't while performing their duties. These norms should broadly encompass provider's duty to sick, doing 'no-harm', keeping privacy, confidentiality and autonomy of patients, non-discrimination and equity. Ethical norms should be in consonance with Code of Medical Ethics and Code of Nursing ethics released by the Indian Medical Council and Indian Nursing Council respectively.

While providing the services, the providers may confront ethical dilemmas. These may arise from patient's refusal to receive treatment, withdrawal of life support, prescribing drugs that doctor found more effective but are not part of essential drug list, entertaining representatives of pharmaceutical companies at workplace, sharing data with research purposes where consent has not been taken from patients, etc. to address these ethical dilemmas effectively and within the legal parameters, the health facility should develop and implement a framework to address ethical dilemmas.

The facility need mechanism in place to identify the situations, where ethical dilemma usually arise or have potential to arise. Further, the facility should appoint a person or group that will address such issues of ethical dilemma, and will endeavour to timely resolve it. The formal mechanism of referral of such issues to appointed person on group. All the decisions pertaining to dilemmas are effectively communicated to concerned staff. These standards are targeted for secondary and public hospital; those are usually not involved research activities. However, if any health care facility is involved in clinical or public health research activity (like DNB courses, MPH and other students degree or professions), should have mechanism to take formal approval for ethics committee.

Area of Concern - B: Measurable Elements Patient Rights	
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities.**
ME B1.1	The facility has uniform and user-friendly signage system.
ME B1.2	The facility displays the services and entitlements available in its departments.
ME B1.3	The facility has established citizen charter, which is followed at all levels.
ME B1.4	User charges are displayed and communicated to patients effectively.
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC/BCC approaches.
ME B1.6	Information is available in local language and easy to understand.
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel.
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barriers on account of physical economic, cultural or social reasons.**
ME B2.1	Services are provided in manner that are sensitive to gender.
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services.
ME B2.3	Access to facility is provided without any physical barrier & friendly to people with disability.
ME B2.4	There is no discrimination on basis of social & economic status of patients.
ME B2.5	There is affirmative action to ensure that vulnerable sections can access services.
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**
ME B3.1	Adequate visual privacy is provided at every point of care.
ME B3.2	Confidentiality of patients records and clinical information is maintained.
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services.
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups.
Standard B4	**The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making.**
ME B4.1	There is established procedures for taking informed consent before treatment and procedures.
ME B4.2	Patient is informed about his/her rights and responsibilities.
ME B4.3	Staff are aware of Patients rights responsibilities.
ME B4.4	Information about the treatment is shared with patients or attendants, regularly.
ME B4.5	The facility has defined and established grievance redressal system in place.
Standard B5	**The facility ensures that there is no financial barrier to access, and that there is financial protection given from the cost of hospital services.**
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes.
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards.

ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility.
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles.
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients.
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme.
Standard B6	**The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities.**
ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.
ME B6.2	The facility staff is aware of code of conduct established.
ME B6.3	The facility has an established procedure for entertaining representatives of drug companies and suppliers.
ME B6.4	The facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions.
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization.
ME B6.6	There is an established procedure for 'end-of-life' care.
ME B6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific treatment.
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research.
ME B6.9	There is an established procedure to issue of medical certificates and other certificates.
ME B6.10	There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services.
ME B6.11	An updated copy of code of ethics under National Medical Commission is available with the facility.
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dilemmas' in a time-bound manner through ethical committee

AREA OF CONCERN - C: INPUT

Overview

This area of concern predominantly covers the structural part of the facility. Indian Public Health Standards (IPHS) defines infrastructure, human resources, drugs and equipment requirements for different level of health facilities. Quality standards given in this area of concern take into cognizance of the IPHS requirement. However, focus of the standards is to ensure compliance to minimum level of inputs, which are required for ensuring delivery of committed level of the services. The words like 'adequate' and 'as per load' has been given in the requirements of standards & measurable elements, as it would be hard to set structural norms for every level of the facility that commensurate with patient load. For example, a 100-bedded hospital having 40% bed occupancy may not have same requirements as the similar hospital having 100% occupancy. So structural requirement should be based more on the utilization, than fixing the criteria like beds available. Assessor should use his/her discretion to arrive at a decision, whether available structural component is adequate for committed service delivery or not.

Following are the standards under this area of concern:

STANDARD C1 THE FACILITY HAS INFRASTRUCTURE FOR DELIVERY OF ASSURED SERVICES, AND AVAILABLE INFRASTRUCTURE MEETS THE PREVALENT NORMS	Standard C1 measures adequacy of infrastructure in terms of space, layouts, circulation area, communication facilities, service counters, patient amenities, communication facilities, etc. It also looks into the functional aspect of the structure whether it commensurate with the process flow of the facility or not. Minimum requirement for space, layout and patient amenities are given in some of departments, but assessors should use his discretion to see whether space available is adequate for the given work load. Compliance to most of the measurable elements can be assessed by direct observation except for checking functional adequacy, where discussion with staff and hospital administration may be required to know the process flow between the departments, and also within a department.
STANDARD C2 THE FACILITY ENSURES THE PHYSICAL SAFETY OF THE INFRASTRUCTURE.	Standard C2 deals with Physical safety of the infrastructure. It includes seismic safety, safety of lifts, electrical safety, and physical condition of hospital infrastructure.
STANDARD C3 THE FACILITY HAS ESTABLISHED PROGRAMME FOR FIRE SAFETY AND OTHER DISASTER	Standard C3 is concerned with fire safety of the facility. Measurable elements in this standard look for implementation of fire prevention, availability of adequate number of firefighting equipment and preparedness of the facility for fire and other disaster in terms of mock drill and staff awareness and training.
STANDARD C4 THE FACILITY HAS ADEQUATE QUALIFIED AND TRAINED STAFF, REQUIRED FOR PROVIDING THE ASSURED SERVICES TO THE CURRENT CASE LOAD	Standard C4 measures the numerical adequacy and skill sets of the staff. It includes availability of doctors, nurses, paramedics and support staff. There are two components while assessing the staff adequacy-first is the numeric adequacy, which can be checked by interaction with hospital administration and review of records. Second is the availability of human resources within the department. For instance, a hospital may have 20 security guards, but if none of them is posted at the labour room, then the intent of standard is not being complied with. The facility also establishes procedures for credentialing and privileging patient care staff.
STANDARD C5 THE FACILITY PROVIDES DRUGS AND CONSUMABLES REQUIRED FOR ASSURED SERVICES	Standard C5 measures availability of drugs and consumables in user departments. Assessor may check availability of drugs under the broad group such as antibiotics, analytic IV fluids, dressing material, and make an assessment that majority of normal patients and critically ill patients are getting treated at the health facility.

STANDARD C6 THE FACILITY HAS EQUIPMENT & INSTRUMENTS REQUIRED FOR ASSURED LIST OF SERVICES	Standard C6 is also concerned with availability of equipment & instruments in various departments and service delivery points. Equipment and instruments have been categorized into sub groups as per their use, and measurable elements have been assigned to each sub group, such as examination and monitoring, clinical procedures, diagnostic equipment, resuscitation equipment, storage equipment and equipment used for non clinical support services. Some representative equipment could be used as tracers and checked in each category.
STANDARD C7 FACILITY HAS A DEFINED AND ESTABLISHED PROCEDURE FOR EFFECTIVE UTILIZATION, EVALUATION AND AUGMENTATION OF COMPETENCE AND PERFORMANCE OF STAFF	Human resources are the most critical asset of a healthcare organization. Public health facilities serve volumes of patients and sometime feel constrained by limited human resources. For being a facility providing quality and safe healthcare services, it is indispensable to ensure that the staff engaged in patient care and auxiliary activities have requisite knowledge and skills to accomplish their task in the expected manner. It is also important to ensure that workforce is working at optimal level and their performance is evaluated periodically. This standard and related measurable elements require that public health facility should have defined staff's competency and have a system for assessing it periodically at pre-defined interval, and takes actions for maintaining it. These criteria should be based on job description as defined in Standard D-11. These defined criteria can be converted into simple checklist that can work as tools for the competency assessment e. g. Checklist for competency assessment of Labour room nurse, Lab technician, Security guard, Hospital manager, etc. The Ministry of Health & Family Welfare, Government of India also has prepared checklist for competence assessment (Eg: OSCE is available for the competence assessment for labour room, etc). In addition there are explicit requirement spelled by the professional bodies such as National Medical Commission, Nursing Council of India, Dental Council of India, etc. These requirements can be used to ensure that the staff have been trained as per their job description and responsibilities. These can also be used after local customization. This standard also requires that performance evaluation criteria should also be defined for each cadre of staff. These criteria may have some indicators measuring productivity and efficiency of the staff as well. Based on these defined criteria, the competence and performance of staff should be evaluated at least once in a year though it may be more frequent ongoing activity. Competence assessment program and performance evaluation program should include contractual staff, staff working in hospital premises through outsourced agencies, empanelled doctors providing services for specific duration. Based on these assessment and evaluation, the training needs of each staff are identified and training plan is prepared. Staff should be trained according to the training plan. Facility should also ensure that skills gained through training are retained and utilized and feedback is given to individual staff on their competence and performance.

Area of Concern - C: Measurable Elements Inputs	
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.**
ME C1.1	Departments have adequate space as per patient or work load.
ME C1.2	Patient amenities are provided as per patient load.
ME C1.3	Departments have layout and demarcated areas as per functions.
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law.
ME C1.5	The facility has infrastructure for intramural and extramural communication.
ME C1.6	Service counters are available as per patient load.
ME C1.7	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital).
Standard C2	**The facility ensures the physical safety of the infrastructure.**
ME C2.1	The facility ensures the seismic safety of the infrastructure.
ME C2.2	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/ board.
ME C2.3	The facility ensures safety of electrical establishment.
ME C2.4	Physical condition of buildings are safe for providing patient care.
Standard C3	**The facility has established Programme for fire safety and other disaster.**
ME C3.1	The facility has plan for prevention of fire.
ME C3.2	The facility has adequate fire fighting Equipment.
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation.
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.**
ME C4.1	The facility has adequate specialist doctors as per service provision.
ME C4.2	The facility has adequate general duty doctors as per service provision and work load.
ME C4.3	The facility has adequate nursing staff as per service provision and work load.
ME C4.4	The facility has adequate technicians/paramedics as per requirement.
ME C4.5	The facility has adequate support/general staff.
ME C4.6	The facility has established procedure for credentialing & privileging patient care staff.
Standard C5	**The facility provides drugs and consumables required for assured services.**
ME C5.1	The departments have availability of adequate drugs at point of use.
ME C5.2	The departments have adequate consumables at point of use.
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed.
Standard C6	**The facility has equipment & instruments required for assured list of services.**
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients.
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility.
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility.
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients.

ME C6.5	Availability of Equipment for Storage.
ME C6.6	Availability of functional equipment and instruments for support services.
ME C6.7	Departments have patient furniture and fixtures as per load and service provision.
Standard C7	**The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year.
ME C7.3	Criteria for performance evaluation clinical and para clinical staff are defined.
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year
ME C7.5	Criteria for performance evaluation of support and administrative staff are defined.
ME C7.6	Performance evaluation of support and administration staff is done on predefined criteria at least once in a year.
ME C7.7	Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff.
ME C7.8	Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan.
ME C7.9	The Staff is provided training as per defined core competencies and training plan.
ME C7.10	There is established procedure for utilization of skills gained through trainings by on - job supportive supervision.
ME C7.11	Feedback is provided to the staff on their competence assessment and performance evaluation.

AREA OF CONCERN - D: SUPPORT SERVICES

Overview

Support services are backbone of every health care facility. The expected clinical outcome cannot be envisaged in absence of sturdy support services. This area of concern includes equipment maintenance, calibration, drug storage and inventory management, security, facility management, water supply, power backup, dietary services and laundry. Administrative processes like RKS, Financial management, legal compliances, staff deputation and contract management have also been included in this area of concern.

Brief description of the standards under this area of concern are given below:

STANDARD D1 THE FACILITY HAS ESTABLISHED PROGRAMME FOR INSPECTION, TESTING AND MAINTENANCE AND CALIBRATION OF EQUIPMENT	Standard D1 is concerned with equipment maintenance processes, such as AMC, daily and breakdown maintenance processes, calibration and availability of operating instructions. Equipment records should be reviewed to ensure that valid AMC is available for critical equipment and preventive / corrective maintenance is done timely. Calibration records and label of measuring equipment should be reviewed to confirm that the calibration has been done. Operating instructions should be displayed or should readily available with the users.
STANDARD D2 THE FACILITY HAS DEFINED PROCEDURES FOR STORAGE, INVENTORY MANAGEMENT AND DISPENSING OF MEDICINES IN PHARMACY AND PATIENT CARE AREAS	Standard D2 is concerned with safe storage of drugs and scientific management of the inventory, so drugs and consumables are available in adequate quantity in patient care area. Measurable elements of this standard look into processes of indenting, procurement, storage, expired medicbines management, inventory management, stock management at patient care areas, including storage at optimum temperature. While assessing drug management system, these practices should be looked into each clinical department, especially at the nursing stations and its complementary process at drug stores/Pharmacy.
STANDARD D3 THE FACILITY PROVIDES SAFE, SECURE AND COMFORTABLE ENVIRONMENT TO STAFF, PATIENTS AND VISITORS	Standard D3 is concerned with providing safe, secure and comfortable environment to patients as well as to service providers. The measurable elements under this standard have two aspects, - provision of comfortable work environment in terms of illumination & temperature control in patient care areas and work stations, and arrangement for security of patients & staff. Availability of environment control arrangements should be looked into. Security arrangements at patient area should be observed for restriction of visitors and crowd management.
STANDARD D4 THE FACILITY HAS ESTABLISHED PROGRAMME FOR MAINTENANCE AND UPKEEP OF THE FACILITY	Standard D4 is concerned with adequacy of facility management processes. This includes appearance of facility, cleaning processes, infrastructure maintenance, removal of junk and condemned items and control of stray animals and pests at the facility.
STANDARD D5 THE FACILITY ENSURES 24X7 WATER AND POWER BACKUP AS PER REQUIREMENT OF SERVICE DELIVERY, AND SUPPORT SERVICES NORMS	Standard D5 covers processes to ensure water supply (quantity & quality), power back-up and medical gas supply. All departments should be assessed for availability of water and power back-up. Some critical area like OT and ICU may require two-tire power backup in terms of UPS. Availability of central oxygen and vacuum supply should especially be assessed in critical area OT, ICU & IPD.
STANDARD D6 DIETARY SERVICES ARE AVAILABLE AS PER SERVICE PROVISION AND NUTRITIONAL REQUIREMENT OF THE PATIENTS	Standard D6 is concerned with processes ensuring timely and hygienic diet to the patient as per their nutritional requirement. It includes nutritional assessment of patients, availability of different types of diets as per the disease condition. It also includes procedures for preparation and distribution of food, including hygiene & sanitation in the kitchen. Patients/staff may be interacted for knowing their perception about quality and quantity of the food.

STANDARD D7 THE FACILITY ENSURES CLEAN LINEN TO THE PATIENTS	Standard D7 is concerned with the laundry processes. It includes availability of adequate quantity of clean & usable linen, process of providing and changing bed sheets in patient care area and process of collection, washing and distributing the linen. Besides direct observation, staff interaction may help in knowing availability of adequate linen and work practices. An assessment of segregation and disinfection of soiled laundry should be undertaken. Observation should be recorded if laundry is being washed at some public water body like pond or river.
STANDARD D8 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR PROMOTING PUBLIC PARTICIPATION IN MANAGEMENT OF HOSPITAL TRANSPARENCY AND ACCOUNTABILITY	Standard D8 measures processes related to functioning of Rogi Kalyan Samiti (RKS; equivalent to Hospital Management Society) and community participation in Hospital Management. RKS records should be reviewed to assess frequency of the meetings, and issues discussed in RKS meeting. Participation of non-official members like community/ NGO representatives in such meetings should be checked.
STANDARD D9 HOSPITAL HAS DEFINED AND ESTABLISHED PROCEDURES FOR FINANCIAL MANAGEMENT	Standard D9 is concerned with the financial management of the funds/grants, received from different sources including NHM. Assessment of financial management processes by no means should be equated with financial or accounts audit. Hospital administration and accounts department can be interacted to know process of utilization of funds, timely payment of salaries, entitlements and incentives to different stakeholders and process of receiving funds and submitting utilization certificates. An assessment of resource utilisation and prioritisation should be undertaken.
STANDARD D10 THE FACILITY IS COMPLIANT WITH ALL STATUTORY AND REGULATORY REQUIREMENT IMPOSED BY LOCAL, STATE OR CENTRAL GOVERNMENT	Standard D10 is concerned with compliances to statutary and regulatory requirements. It includes availability of requisite licenses, updated copies of acts and rules, and adherence to the legal requirements as applicable to Public Health Facilities.
STANDARD D11 ROLES & RESPONSIBILITIES OF ADMINISTRATIVE AND CLINICAL STAFF ARE DETERMINED AS PER GOVT. REGULATIONS AND STANDARDS OPERATING PROCEDURES	Standard D11 is concerned with processes regarding staff management and their deployment in the departments of a facility. This includes availability of Job descriptions for different cadre, processes regarding preparation of duty rosters and staff discipline. The staff can be interviewed to assess about awareness own job description. It should be assessed by observation and review of the records. Adherence to dress-code should be observed during the assessment.
STANDARD D12 THE FACILITY HAS ESTABLISHED PROCEDURE FOR MONITORING THE QUALITY OF OUTSOURCED SERVICES AND ADHERES TO CONTRACTUAL OBLIGATIONS	Standard D12 This standard measures the processes related to outsourcing and contract management. This includes monitoring of outsourced services, adequacy of contract documents and tendering system, timely payment for the availed services and provision for action in case of inadequate/poor quality of services. Assessor should review the contract records related to outsourced services, and interview hospital administration about the management of outsourced services.

Area of Concern - D: Measurable Elements Support Services	
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**
ME D1.1	The facility has established system for maintenance of critical Equipment.
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment.
ME D1.3	Operating and maintenance instructions are available with the users of equipment.
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.**
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables.
ME D2.2	The facility has established procedure for procurement of drugs.
ME D2.3	The facility ensures proper storage of drugs and consumables.
ME D2.4	The facility ensures management of expiry and near expiry drugs.
ME D2.5	The facility has established procedure for inventory management techniques.
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas.
ME D2.7	There is a process for storage of vaccines and other drugs, requiring controlled temperature.
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs.
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**
ME D3.1	The facility provides adequate illumination at patient care areas.
ME D3.2	The facility has provision of restriction of visitors in patient areas.
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers.
ME D3.4	The facility has security system in place in patient care areas.
ME D3.5	The facility has established measure for safety and security of female staff.
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility.**
ME D4.1	Exterior and interior of the facility building is maintained appropriately
ME D4.2	Patient care areas are clean and hygienic.
ME D4.3	Hospital infrastructure is adequately maintained.
ME D4.4	Hospital maintains open areas and landscaping of them.
ME D4.5	The facility has policy of removal of condemned junk material.
ME D4.6	The facility has established procedures for pest, rodent and animal control.
Standard D5	**The facility ensures 24 × 7 water and power backup as per requirement of service delivery, and support services norms.**
ME D5.1	The facility has adequate arrangement storage & supply for potable water in all functional areas.
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load.
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply.
ME D 5.4	The facility has adequate arrangement for uninterrupted supply of RO water for dialysis unit

Standard D6	**Dietary services are available as per service provision and nutritional requirement of the patients.**
ME D6.1	The facility has provision of nutritional assessment of the patients.
ME D6.2	The facility provides diets according to nutritional requirements of the patients.
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients.
Standard D7	**The facility ensures clean linen to the patients.**
ME D7.1	The facility has adequate availability of linen for meeting its need.
ME D7.2	The facility has established procedures for changing of linen in patient care areas
ME D7.3	The facility has standard procedures for handling, collection, transportation and washing of linen.
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**
ME D8.1	The facility has established a procedure for management of activities of Rogi Kalyan Samiti.
ME D8.2	The facility has established procedures for community based monitoring of its services.
Standard D9	**Hospital has defined and established procedures for Financial Management.**
ME D9.1	The facility ensures proper utilization of the fund provided to it.
ME D9.2	The facility ensures proper planning and requisition of resources based on its need.
Standard D10	**The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government.**
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities.
ME D10.2	Updated copies of relevant laws, regulations and government orders are available at the facility.
ME D10.3	The facility ensures relevant processes are in compliance with the statutory requirements.
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**
ME D11.1	The facility has established job description as per govt guidelines.
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments.
ME D11.3	The facility ensures adherence to dress code as mandated by the administration/ the health department.
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations.**
ME D12.1	There is established system of contract management for the outsourced services.
ME D12.2	There is a system of periodic review of quality of outsourced services.

AREA OF CONCERN - E: CLINICAL CARE

Overview

The ultimate purpose of the existence of a hospital is to provide clinical care. Therefore, clinical processes are the most critical and important in hospitals. These are the processes that define directly the outcome of services and quality of care. The Standards under this area of concern could be grouped into three categories. First, nine standards (E1-E9) are concerned with those clinical processes that ensure adequate care to the patients. It includes processes such as registration, admission, consultation, clinical assessment, continuity of care, nursing care, identification of high-risk and vulnerable patients, prescription practices, safe drug administration, maintenance of clinical records and discharge from the hospital.

Second set of the next seven standards (E10-E16) is concerned with specific clinical and therapeutic processes including intensive care, emergency care, diagnostic services, transfusion services, anaesthesia, surgical services handling of death, conduct of post-mortem etc.

The third set of eight standards (E17- E24) are concerned with specific clinical processes for Maternal, Newborn, Child, Adolescent & Family Planning services, National Health Programmes and specific schemes like PMNDP. These standards are based on the technical guidelines published by the Government of India on respective programmes and processes.

It may be difficult to assess clinical processes, as direct observation of clinical procedures may not always be possible at time of assessment. Therefore, assessment of these standards would largely depend upon review of the clinical records and interaction with the staff to know their skill level and how they practice clinical care (Competence testing) would also be helpful. Assessment of this standard would require thorough domain knowledge.

Following is the brief description of standards under this area of concern:

STANDARD E1 THE FACILITY HAS DEFINED PROCEDURES FOR REGISTRATION, CONSULTATION AND ADMISSION OF PATIENTS	Standard E1, This standard is concerned with the registration and admission processes in hospitals. It also covers OPD consultation processes. The assessor should review the records to verify that details of patients have been recorded, and patients have been given unique identification number. OPD consultation may be directly observed, followed by review of OPD tickets to ensure that patient history, examination details, provisional & confirmed diagnosis etc. have been recorded on the OPD ticket. Staff should be interviewed to know, whether there is any fixed admission criteria especially in critical care department.
STANDARD E2 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURE FOR CLINICAL ASSESSMENT, REASSESSMENTS AND TREATMENT PLAN PREPARATION	Standard E2, This standard pertains to clinical assessment of the patients. It includes initial assessment and reassessment of admitted patients at defined interval depending on the disease condition. Care planning is done for individual case as per assessment and investigation findings (Wherever applicable). It also ensures that care or treatment is provided as per standard treatment guidelines/available clinical evidences
STANDARD E3 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR CONTINUITY OF CARE OF PATIENT AND REFERRAL	Standard E3 is concerned with continuity of care for the patient's ailment. It includes process of inter-departmental transfer, referral to another facility, and linkages with higher institutions. Staff should be interviewed to know the referral linkages, how they inform the referral hospital about the referred patients and arrangement for the vehicles and follow-up care. Records should be reviewed for confirming that referral slips have been provided to the referred patients.
STANDARD E4 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR NURSING CARE	Standard E4 measures adequacy and quality of nursing care for the patients. It includes processes for identification of patients, timely and accurate implementation of treatment plan, nurses' handover processes, maintenance of nursing records and monitoring of the patients. Staff should be interviewed and patients' records to be reviewed for assessing how drugs distribution/ administration endorsement and other procedures like sample collection and dressing have been done on time as

	per treatment plan. Handing-over of patients is a critical process and should be assessed adequately. Review BHT for patient monitoring & nursing notes should be done.
STANDARD E5 THE FACILITY HAS A PROCEDURE TO IDENTIFY HIGH RISK AND VULNERABLE PATIENTS	Standard E5 is concerned with identification of vulnerable and High-risk patients. Review of records and staff interaction would be helpful in assessing how High-risk patients are given due attention and treatment.
STANDARD E6 FACILITY ENSURES RATIONALE PRESCRIBING AND USE OF MEDICINES	Standard E6 is concerned with assessing that patients are prescribed drugs according to standard treatment guidelines and protocols. Patient records are assessed to ascertain that prescriptions are written in generic name only. Hospital drug formulary is available and followed. For all cases, medicine review and optimization are done.
STANDARD E7 THE FACILITY HAS DEFINED PROCEDURES FOR SAFE DRUG ADMINISTRATION	Standard E7 concerns with the safety of drug administration. It includes administration of high alert medicines, legibility of medical orders, process for checking medicines before administration and processes related to self-drug administration. Patient's records should be reviewed for legibility of the writing and recording of date and time of orders. Safe injection practices like use of separate needle for multi-dose vial should be observed.
STANDARD E8 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR MAINTAINING, UPDATING OF PATIENTS' CLINICAL RECORDS AND THEIR STORAGE	Standard E8 is concerned with the processes of maintaining clinical records systematically and adequately. Compliance to this standard can be assessed by comprehensive review of the patients' records. If the records are maintained in e-version, the security & safety of clinical standards need to be ensured.
STANDARD E9 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR DISCHARGE OF PATIENT.	Standard E9 measures adequacy of the discharge process. It includes pre-discharge assessment, adequacy of discharge summary, pre-discharge counselling and adherence to standard procedures, if a patient is found absconding. Patients' record should be reviewed for adequacy of the discharge summary.
STANDARD E10 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR INTENSIVE CARE.	Standard E10 is concerned with processes related to intensive care treatment of patients, availability and adherence to protocols related to pain management, sedation, intubation, newborn resuscitation, ETAT etc.
STANDARD E11 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR EMERGENCY SERVICES AND DISASTER MANAGEMENT	Standard E11 is concerned with emergency clinical processes and procedures. It includes triage, adherence to emergency clinical protocols, disaster management, processes related to ambulance services, handling of medico-legal cases, etc. Availability of the buffer stock for medicines and other supplies for disaster and mass casualty needs to be found out. Interaction with staff and hospital administration should be done to asses overall disaster preparedness of the health facility.
STANDARD E12 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES OF DIAGNOSTIC SERVICES	Standard E12 deals with the procedures related to diagnostic services. The standard is majorly applicable for laboratory and radiology services, services, ultrasound and other diagnostic services if provoided by the facility. It includes pre-testing, testing and post- testing procedures. It needs to be observed that samples in the laboratory are properly labelled, and instructions for handling sample are available. The process for storage and transportation of samples needs to be ensured. Availability & use of critical values and biological references should also be checked.

STANDARD E13 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR BLOOD BANK/STORAGE MANAGEMENT AND TRANSFUSION	Standard E13 is concerned with functioning of blood bank and transfusion services. The measurable elements under this standard are processes for donor selection, collection of blood, testing procedures, preparation of blood components, labelling and storage of blood bags, compatibility testing, issuing, transfusion and monitoring of transfusion reaction. The assessor should observe the functioning, and interact with the staff to know regarding adherence to standard procedures for blood collection and testing, including preparation of blood components, storage practices, as per National guidelines. Record of temperature maintained in different storage units should be checked. The staff should also be interacted to know how they manage if certain blood is not available at the blood bank. Records should be reviewed for assessing processes of monitoring transfusion reactions and ensures the availability of services.
STANDARD E14 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ANAESTHETIC SERVICES	Standard E14 is concerned with the processes related with safe anaesthesia practices. It includes pre-anaesthesia, monitoring and post-anaesthesia processes. Records should be reviewed to assess how Pre-anaesthesia check-up is done and records are maintained. Interact with Anaesthetists and OT technician/Nurse for adherence to protocols in respect of anaesthesia safety, monitoring, recording & reporting of adverse events, maintenance of anaesthesia notes, etc.
STANDARD E15 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES OF OPERATION THEATRE SERVICES	Standard E15 is concerned with processes related with Operation Theatre. It includes processes for OT scheduling, pre-operative, Post-operative practices of surgical safety. Interaction with the surgeon(s) and OT staff should be done to assess processes - preoperative medication, part preparation and evaluation of patient before surgery, identification of surgical site, etc. Review of records for usage of surgical safety checklist & protocol for instrument count, suture material, etc may be undertaken.
STANDARD E16 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR END OF LIFE CARE AND DEATH	Standard E16 concerned with management of death. Records should be reviewed for knowing adequacy of the notes. Interact with the facility staff to know how news of death is communicated to relatives, and kind of support available to family members. This standard also covers procedures for post-mortem, its recording and handing over body to relatives/kin. etc.
STANDARD E17 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ANTENATAL CARE AS PER GUIDELINES	Standard E17 is concerned with processes ensuring that adequate and quality antenatal care is provided at the facility. It includes measurable elements for ANC registration, processes during check-up, identification of High Risk pregnancy, management of severe anaemia and counselling services. Staff at ANC clinic should be interviewed and records should be reviewed for maintenance of MCP cards and registration of pregnant women. For assessing quality and adequacy of ANC check- up, direct observation may be undertaken after obtaining requisite permission. ANC records can be reviewed to see findings of examination and diagnostic tests are recorded. Review the line listing of anaemia cases and how they are followed. Client and staff can be interacted for counselling on the nutrition, birth preparedness, family planning, as per National guidelines etc.
STANDARD E18 THE FACILITY HAS ESTABLISHED PROCEDURES FOR INTRANATAL CARE AS PER GUIDELINES	Standard E18 measures the quality of intra-natal care. It includes clinical process for normal delivery as well as management of complications and C-Section surgeries. Staff can be interviewed to know their skill and practices regarding management of different stages of labour, especially Active Management of Third stage of labour. Staff may be interacted for demonstration of resuscitation and essential newborn care. Competency of the staff for managing obstetric emergencies, interpretation of partograph, should also be assessed The standard is applicable to Labour Room and Maternity Operation Theatre in LaQshya.

STANDARD E19 THE FACILITY HAS ESTABLISHED PROCEDURES FOR POSTNATAL CARE AS PER GUIDELINES	Standard E19 is concerned with adherence to post-natal care of mother and newborn within the hospital. Observe that postnatal protocols of prevention of hypothermia and breastfeeding are adhered to. Mother may be interviewed to know that proper counselling has been provided to manage the post-natal complications of mother & newborn.
STANDARD E20 THE FACILITY HAS ESTABLISHED PROCEDURES FOR CARE OF NEW BORN, INFANT AND CHILD AS PER GUIDELINES	Standards E20 is concerned with adherence to clinical protocols for newborn and child health. It covers immunization, emergency triage, management of newborn and childhood illnesses like neonatal asphyxia, low birth weight, neo-natal jaundice, sepsis, malnutrition and diarrhoea. Immunization services are majorly assessed at immunization clinic. Staff interview and observation should be done to assess availability of diluents, adherence to protocols of reconstitution of vaccine, storage of VVM labels and shake test. Adherence to clinical protocols for management of different illnesses in newborn and child should be done through interaction with the doctors and nursing staff.
STANDARD E21 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ABORTION AND FAMILY PLANNING AS PER GOVERNMENT GUIDELINES AND LAW	Standard 21 is concerned with providing safe and quality family planning and abortion services. This includes standard practices and procedures for Family palling counselling, spacing methods, family planning surgeries and counselling and procedures for abortion. Quality and adequacy of counselling services can be assessed by exit interview with the clients. Staff at family planning clinic may be interacted to assess adherence to the protocols for IUD insertion, precaution & contraindication for oral pills, use of injectable, family planning surgery, etc.
STANDARD E22 THE FACILITY PROVIDES ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH SERVICES AS PER GUIDELINE	Standard E22 is concerned with services related to Adolescent Friendly Health Clinics service (AFHCS) guidelines. It includes promotive, preventive, curative and referral services under the AFHCS. Staff should be interviewed, and records should be reviewed.
STANDARD E23 THE FACILITY PROVIDES NATIONAL HEALTH PROGRAMME AS PER OPERATIONAL/CLINICAL GUIDELINES	Standard E23 pertains to adherence for clinical guidelines under the National Health Programmes. For each national health programme, quality of curative & followup services as per respective National guidelines should be assessed.
STANDARD E24 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURE FOR HAEMODIALYSIS SERVICES	Standards E24 is concerned with procedures related to Haemodialysis Services. It includes processes for pre-haemodialysis assessment like complete patient assessment performed before dialysis, predialysis testing, etc. It also includes processes during and after haemodialysis, post- dialysis samples is being taken and observations are recorded. It includes the management of the Quality of services provided in Haemodialysis Unit.

Area of Concern - E: Measurable Elements Clinical Services	
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**
ME E1.1	The facility has established procedure for registration of patients.
ME E1.2	The facility has a established procedure for OPD consultation.
ME E1.3	There is established procedure for admission of patients.
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility.
Standard E2	**The facility has defined and established procedure for clinical assessment, reassessment and treatment plan preparation.**
ME E2.1	There is established procedure for initial assessment of patients.
ME E2.2	There is established procedure for follow-up/ reassessment of Patients.
ME E2.3	There is an established procedure to plan and deliver appropriate treatment or care to individuals as per the needs to achieve best possible results.
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral.**
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer.
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/ higher facilities to assure the continuity of care.
ME E3.3	A person is identified for care during all steps of care.
ME E3.4	The facility is connected to medical colleges through telemedicine services.
Standard E4	**The facility has defined and established procedures for nursing care.**
ME E4.1	Procedure for identification of patients is established at the facility.
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility.
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens.
ME E4.4	Nursing records are maintained.
ME E4.5	There is procedure for periodic monitoring of patients.
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**
ME E5.1	The facility identifies vulnerable patients and ensure their safe care.
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need.
Standard E6	**Facility ensures rationale prescribing and use of medicines**
ME E6.1	The facility ensured that drugs are prescribed in generic name only.
ME E6.2	There is procedure of rational use of drugs.
ME E6.3	There are procedures defined for medication review and optimization
Standard E7	**The facility has defined procedures for safe drug administration.**
ME E7.1	There is process for identifying and cautious administration of high alert drugs.
ME E7.2	Medication orders are written legibly and adequately.
ME E7.3	There is a procedure to check drug before administration/dispensing.

ME E7.4	There is a system to ensure right medicine is given to right patient.
ME E7.5	Patient is counselled for self drug administration.
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage.**
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated.
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.
ME E8.3	Care provided to each patient is recorded in the patient records.
ME E8.4	Procedures performed are written on patients records.
ME E8.5	Adequate form and formats are available at point of use.
ME E8.6	Register/records are maintained as per guidelines.
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records.
Standard E9	**The facility has defined and established procedures for discharge of patient.**
ME E9.1	Discharge is done after assessing patient readiness.
ME E9.2	Case summary and follow-up instructions are provided at the discharge.
ME E9.3	Counselling services are provided as during discharges wherever required.
Standard E10	**The facility has defined and established procedures for intensive care.**
ME E10.1	The facility has established procedure for shifting the patient to step-down/ward based on explicit assessment criteria.
ME E10.2	The facility has defined and established procedure for intensive care.
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubation, and care of patients on ventilation and subsequently on its removal.
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management.**
ME E11.1	There is procedure for Receiving and triage of patients.
ME E11.2	Emergency protocols are defined and implemented.
ME E11.3	The facility has disaster management plan in place.
ME E11.4	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement.
ME E11.5	There is procedure for handling medico legal cases.
Standard E12	**The facility has defined and established procedures of diagnostic services.**
ME E12.1	There are established procedures for Pre-testing Activities.
ME E12.2	There are established procedures for testing Activities.
ME E12.3	There are established procedures for Post-testing Activities.
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**
ME E13.1	Blood bank has defined and implemented donor selection criteria.
ME E13.2	There is established procedure for the collection of blood.
ME E13.3	There is established procedure for the testing of blood.
ME E13.4	There is established procedure for preparation of blood component.

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

ME E18.6	The facility staff adheres to standard protocols for identification and management of PPH.
ME E18.7	The facility staff adheres to standard protocols for Management of HIV in Pregnant Woman & Newborn
ME E18.8	The facility staff adheres to standard protocol for identification and management of preterm delivery.
ME E18.9	Staff identifies and manages infection in pregnant woman
ME E18.10	There is Established protocol for newborn resuscitation is followed at the facility.
ME E18.11	The facility ensures Physical and emotional support to the pregnant women means of birth companion of her choice
Standard E19	**The facility has established procedures for postnatal care as per guidelines**
ME E19.1	The facility staff adheres to protocol for assessments of condition of mother and baby and providing adequate postpartum care
ME E19.2	The facility staff adheres to protocol for counseling on danger signs, post-partum family planning and exclusive breast feeding
ME E19.3	The facility staff adheres to protocol for ensuring care of newborns with small size at birth
ME E19.4	The facility has established procedures for stabilization/treatment/referral of post natal complications
ME E19.5	The facility ensures adequate stay of mother and newborn in a safe environment as per standard Protocols
ME E19.6	There is established procedure for discharge and follow up of mother and newborn
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**
ME E20.1	The facility provides immunization services as per guidelines
ME E20.2	Triage, Assessment & Management of newborns, infant & children having emergency signs are done as per guidelines
ME E20.3	Management of Low birth weight newborns is done as per guidelines
ME E20.4	Management of neonatal asphyxia is done as per guidelines
ME E20.5	Management of neonatal sepsis is done as per guidelines
ME E20.6	Management of children with Jaundice is done as per guidelines.
ME E20.7	Management of children presenting with fever, cough/ breathlessness is done as per guidelines
ME E20.8	Management of children with severe Acute Malnutrition is done as per guidelines
ME E20.9	Management of children presenting diarrhoea is done per guidelines
ME E20.10	The facility ensures optimal breast-feeding practices for new born & infants as per guidelines
ME E20.11	The facility provide services under Rashtriya Bal Swasthya Karyakram (RBSK).
Standard E21	**The facility has established procedures for abortion and family planning as per government guidelines and law.**
ME E21.1	Family planning counselling services provided as per guidelines.
ME E21.2	The facility provides spacing method of family planning as per guideline.
ME E21.3	The facility provides limiting method of family planning as per guideline.
ME E21.4	The facility provide counselling services for abortion as per guideline.
ME E21.5	The facility provide abortion services for 1st trimester as per guideline.
ME E21.6	The facility provide abortion services for 2nd trimester as per guideline.

Standard E22	The facility provides Adolescent Reproductive and Sexual Health services as per guidelines.
ME E22.1	The facility provides Promotive ARSH Services.
ME E22.2	The facility provides Preventive ARSH Services.
ME E22.3	The facility provides Curative ARSH Services.
ME E22.4	The facility provides Referral Services for ARSH.
National Health Programmes	
Standard E23	**The facility provides National health Programme as per operational/Clinical Guidelines.**
ME E23.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines.
ME E23.2	The facility provides services under National TB elimination Programme as per guidelines
ME E23.3	The facility provides services under National Leprosy Eradication Programme as per guidelines.
ME E23.4	The facility provides services under National AIDS Control Programme as per guidelines.
ME E23.5	The facility provides services under National Programme for control of Blindness as per guidelines .
ME E23.6	The facility provides services under Mental Health Programme as per guidelines .
ME E23.7	The facility provides services under National Programme for the health care of the elderly as per guidelines .
ME E23.8	The facility provides service under National Programme for Non-communicable diseases as per guidelines.
ME E23.9	The facility provide service for Integrated disease surveillance Programme.
ME E23.10	The facility provide services under National Programme for prevention and control of deafness.
ME E23.11	The facility provide services National viral Hepatitis Control Programme
ME E23.12	The facility provide services under National Programme for Palliative care.
ME E23.13	The facility provide services under Anaemia Mukt Bharat including Sickle Cell Anaemia Elimination Programme
Standard E24	**The facility has defined and established procedure for Haemodialysis services.**
ME E24.1	The facility has defined and established procedure for Pre Haemodialysis assessment
ME E24.2	The facility has defined and established procedure for care during Haemodialysis
ME E24.3	The facility has defined and established procedure for care after completion of Haemodialysis

AREA OF CONCERN - F: INFECTION CONTROL

Overview

The first principle of health care is "to do no harm". As Public Hospitals usually have high occupancy, the Infection control practices become more critical to avoid cross-infection and its spread. This area of concern covers Infection control practices, hand-hygiene, antisepsis, Personal Protection, processing of equipment, environment control, and Biomedical Waste Management.

Following is the brief description of the Standards within this area of concern:

STANDARD F1 THE FACILITY HAS INFECTION CONTROL PROGRAMME AND PROCEDURES IN PLACE FOR PREVENTION AND MEASUREMENT OF HOSPITAL ASSOCIATED INFECTION	Standard F1 is concerned with the implementation of Infection control programme at the facility. It includes existence of functional infection control committee, microbiological surveillance, measurement of hospital acquired infection rates, periodic medical check-up and immunization of staff and monitoring of Infection control Practices. Hospital administration should be interacted to assess the functioning of infection control committee. Records should be reviewed for confirming the culture surveillance practices, monitoring of Hospital acquired infection, status of staff immunization, etc. Implementation of antibiotic policy can be assessed through staff interview, perusal of patient record and usage pattern of antibiotic.
STANDARD F2 THE FACILITY HAS DEFINED AND IMPLEMENTED PROCEDURES FOR ENSURING HAND HYGIENE PRACTICES AND ANTISEPSIS	Standard F2 is concerned with practices of hand-washing and antisepsis. Availability of Hand washing facilities with soap and running water should be observed at the point of use. Technique of hand-washing for assessing the practices, and effectiveness of training may be observed.
STANDARD F3 THE FACILITY ENSURES STANDARD PRACTICES AND MATERIALS FOR PERSONAL PROTECTION	Standard F3 is concerned with usage of Personal Protection Equipment (PPE) such as gloves, mask, apron, etc. Interaction with staff may reveal the adequacy of supply of PPE.
STANDARD F4 THE FACILITY HAS STANDARD PROCEDURES FOR PROCESSING OF EQUIPMENT AND INSTRUMENTS	Standard F4 is concerned with standard procedures, related to processing of equipment and instruments. It includes adequate decontamination, cleaning, disinfection and sterilization of equipment and instruments. These practices should be observed and staff should be interviewed for compliance to certain standard procedures.
STANDARD F5 PHYSICAL LAYOUT AND ENVIRONMENTAL CONTROL OF THE PATIENT CARE AREAS ENSURES INFECTION PREVENTION	Standard F5 pertains to environment cleaning. It assesses whether lay out and arrangement of processes are conducive for the infection control or not. Environment cleaning processes like mopping, especially in critical areas like OT and ICU should be observed for the adequacy and technique.
STANDARD F6 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR SEGREGATION, COLLECTION, TREATMENT AND DISPOSAL OF BIO MEDICAL AND HAZARDOUS WASTE	Standard F6 is concerned with of Biomedical waste management including its segregation, transportation, disposal and management of sharps. Availability of equipment and practices of segregation can be directly observed. Staff should be interviewed about the procedure for management of the needle stick injuries. Storage and transportation of waste should be observed and records are verified.

Area of Concern - F: Measurable Elements Infection Control	
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection.**
ME F1.1	The facility has functional infection control committee.
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas.
ME F1.3	The facility measures hospital associated infection rates.
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff.
ME F1.5	The facility has established procedures for regular monitoring of infection control practices.
ME F1.6	The facility has defined and established antibiotic policy.
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis.**
ME F2.1	Hand washing facilities are provided at point of use.
ME F2.2	Staff is trained and adhere to standard handwashing practices
ME F2.3	The facility ensures standard practices and materials for antisepsis.
Standard F3	**The facility ensures standard practices and materials for Personal protection.**
ME F3.1	The facility ensures adequate personal protection equipment as per requirements.
ME F3.2	The facility staff adheres to standard personal protection practices.
Standard F4	**The facility has standard procedures for processing of equipment and instruments.**
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedure areas.
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment.
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention.**
ME F5.1	Layout of the department is conducive for the infection control practices.
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas.
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas.
ME F5.4	The facility ensures segregation of infectious patients.
ME F5.5	The facility ensures air quality of high risk area.
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**
ME F6.1	The facility ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines.
ME F6.2	The facility ensures management of sharps as per guidelines.
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines.

AREA OF CONCERN - G: QUALITY MANAGEMENT

Overview

Quality management requires a set of interrelated activities that assure quality of services according to set standards and strive to improve upon it through a systematic planning, implementation, checking and acting upon the compliances. The standards in this area of concern are the opportunities for improvement to enhance quality of services and patient satisfaction by using various Quality tools & methods. These standards are in synchronization with facility based quality improvement activities given in 'Operational Guidelines'.

Following are the Standards under this area of Concern:

STANDARD G1 THE FACILITY HAS ESTABLISHED ORGANIZATIONAL FRAMEWORK FOR QUALITY IMPROVEMENT	Standard G1 is concerned with creating a Quality Team at the facility and making it functional. Assessor may review the document and interact with Quality team members to know how frequently they meet and responsibilities have been delegated to them. Quality team meeting records may be reviewed at periodic intervals. At department level eg: labour room and maternity operation theatre small quality circle may be constituted to coordinate & continuously improve the system. As quality circles are the informal teams.The quality circle at each department is supposed to interlink their activity with the overall hospital's quality objectives & quality team.
STANDARD G2 THE FACILITY HAS ESTABLISHED SYSTEM FOR PATIENT AND EMPLOYEE SATISFACTION WHEREVER IT IS CRITICAL TO QUALITY	Standard G2 is concerned with having a system of measurement of patient and employee satisfaction. This includes periodic patients' satisfaction survey, analysis of the feedback and preparing action plan. Assessors should review the records pertaining to patient satisfaction and employee satisfaction survey to ascertain that Patient feedback is taken at prescribed intervals and adequate sample size is adequate.
STANDARD G3 FACILITY HAVE ESTABLISHED INTERNAL AND EXTERNAL QUALITY ASSURANCE PROGRAMS	Standard G3 is concerned with implementation of internal and external assessments, quality assurance programmes within departments such as EQAS of diagnostic services, daily round and use of departmental checklists etc. Interview with hospital staff, Matron, Hospital Managers etc may give information about how they conduct internal assessments, daily round of departments, usage of checklists etc at a defined periodicity. Review of Internal assessment records may reveal their adequacy and periodicity.
STANDARD G4 THE FACILITY HAS ESTABLISHED, DOCUMENTED IMPLEMENTED AND MAINTAINED STANDARD OPERATING PROCEDURES FOR ALL KEY PROCESSES AND SUPPORT SERVICES.	Standard G4 is concerned with availability and adequacy of Standard operating procedures and work instructions with the respective process owners. Display of work instructions and clinical protocols should be observed during the assessment.
STANDARD G5 THE FACILITY MAPS ITS KEY PROCESSES AND SEEKS TO MAKE THEM MORE EFFICIENT BY REDUCING NON VALUE ADDING ACTIVITIES AND WASTAGES	Standard G5 concerns the efforts' made for the mapping and improving processes. Records should be checked to ensure that the critical processes have been mapped, wastes have been identified and efforts are made to remove them to make processes more efficient.

STANDARD G6 THE FACILITY HAS DEFINED MISSION, VALUES, QUALITY POLICY & OBJECTIVES & PREPARES A STRATEGIC PLAN TO ACHIEVE THEM	Every organization has a purpose for its existence and what it wants to be achieve in future. Public health facilities have been created not only to provide curative services, but also support health promotion in their target community and disease prevention. Therefore, public hospitals not only cater needs of sick and those in need of medical care, but also provide holistic care, which includes preventive & promotive care. With this positioning it is very important that health facilities should clearly articulate their mission statement in consultation with internal and external stakeholders and disseminate it effectively amongst staff, visitors& community. The Mission statement may incorporate 'what is the purpose of existence',' who are our users' and 'what do we intend to do by operating this facility'. Mission statement should be pragmatic and simple so it can be easily understood by target audiences, and they can relate it with their work. As the public health facility is part of larger public health system governed by State Health Department, it is recommended that the facility's mission statement should be in congruence with mission of the State's Health department. Mission statement should be approved and endorsed by administration of facility and effectively communicated in local language through display. Caution should also be taken to keep the language simple and easily understandable. This standard also requires health facilities to define core value that should be part of all policies & procedures and are always considered while realizing the services to the patients and community. Being public hospital, facility should have core values of Honesty, transparency, Non–discrimination, ethical practices, Competence, empathy and goodwill towards community. It is also of utmost importance that how hospital administration plan and promote that these values amongst its staff so it becomes part of their attitude and work culture. Quality policy is overall intension and direction of an organization related to quality as formally expressed by hospital administration. Hospital should define what they intend to achieve in terms of quality, safety and patient satisfaction. Quality Policy should be aligned with the mission statement to achieve overall aim of the facility. To achieve the mission and quality policy, the facility should define commensurate objectives. Objectives are more tangible and short-term goals, with each objective targeting one specific issue or aspiration of organization. Objectives should be Specific, Measurable, Attainable, Relevant/realistic and Time-bound (SMART). Though Mission and Quality Policy are framed at the organizational level, objectives can be at departmental or activity level. Quality Policy and objectives should also be disseminated effectively to staff and other relevant stakeholders. It is equally important that hospital administration prepares a time bound plan to achieve these objectives and provide adequate resources to achieve them. Assessment of this standard and related measurable elements can be done by reviewing the records pertaining to mission, quality policy and objectives. Assessors may also interview some of the staff about their awareness of Mission, Values, Quality Policy and objectives.
STANDARD G7 THE FACILITY SEEKS CONTINUALLY IMPROVEMENT BY PRACTICING QUALITY METHOD AND TOOLS.	Standard G7 is concerned with the practice of using Quality tools and methods like control charts, 5-'S', etc. The Assessor should look for any specific methods and tools practiced for quality improvement.

STANDARD G8 THE FACILITY HAS DEFINED, APPROVED AND COMMUNICATED RISK MANAGEMENT FRAMEWORK FOR EXISTING AND POTENTIAL RISKS.	Healthcare facilities of all level are exposed to risks from Internal and External sources, which may put attainment of Quality objective at a risk. In Public hospitals these risks may be patients' safety issues, shortage of supplies, fall in allocation of resources, man-made or natural disaster, failure to comply with statutary & legal requirements, Violence towards service providers or even risk of getting outdated or becoming obsolete. Hospitals are complex organizations and just reacting on occurred threats may not be helpful alone. This standard requires healthcare facilities to develop, implement and continuously improve a risk management framework considering both internal and external threats. Risk Management framework should not be isolated exercise. It should be integrated with facility's objectives and intended Quality Management System (QMS). In this direction, the initial step is to define scope of risk management and objectives of the framework keeping in mind the context and environment. The hospital administration should prepare a comprehensive list of current and perceived risks. It is also important to define the responsibility and process of reporting and managing risks. Facility should also have provision for training of staff on risk management framework. Assessors may verify documents that defines facilities risk management system. Assessors should verify that potential risks has been identified in framework keeping in accordance to context of. Assessors can also interview hospital administration and staff for their knowledge and practice of risk management framework.
STANDARDS G9 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ASSESSING, REPORTING, EVALUATING AND MANAGING RISK AS PER RISK MANAGEMENT PLAN	To implement risk management framework facility should prepare a risk management plan. The Plan will delineate responsibilities and timelines for risk management activities such as assessment and risk treatment. All staff and external stakeholders should be made aware of the plan in general and their roles &responsibilities in particular. Facility should define the criteria for identifying the risk and finalise its assessment tools. These tools may be a simple checklist, reporting format or work instruction for identifying risks. It may be checklist for fire safety preparedness, infection control audit, electrical safety audit or even an open ended questionnaire for staff on what potential threats they feel on their security at workplace. Once risks are identified, they should be analysed and evaluated for their impact. Based on their impact the risk should be graded - severe, moderate and low. Accordingly actions are taken to mitigate prevent or eliminate the risks. Actions may need to be prioritized in term of potential impact a rick may have. Facility should also establish a risk register. This register will record the identified or reported risk, their severity and actions to be taken. Assessors should review relevant records for verify availability of a valid plan for risk management and whether risk management activities have been conducted as per plan. Assessors should also review risk register to see how facility has graded their risks and prioritized them for action.

STANDARD G10

THE FACILITY HAS ESTABLISHED CLINICAL GOVERNANCE FRAMEWORK TO IMPROVE THE QUALITY AND SAFETY OF CLINICAL CARE PROCESSES

Clinical Governance has broad 7 elements viz. Education & training, clinical audits, clinical effectiveness, research and development, openness, information management and risk management. Under NQAS structure, most of the elements are covered in their respective area of concerns.

This Standard requires healthcare facilities to develop, implement and improve clinical Governance framework. Framework should cover policy formulation, constitution of Apex Committee for clinical governance, defined roles and responsibilities of its members and ensuring regular discussions & monitoring on clinical cases.

In this direction, the first step should be reviewing the functioning of existing clinical committee viz. Drug and therapeutic committee, Medical, death and prescription audit committee etc by the Apex committee.

Committee should ensure the use of evidence-based practices and Standard treatment guideline for all the clinical treatment provided to the patient.

Assessor will verify the clinical governance policy, ensuring apex committee is meeting at regular intervals, data or information is analysed pertaining to clinical and administrative process and presented during the meeting. The steps are taken to improve the processes further using PDCA approach. Assessor may verify the transparency in the processes while respecting the confidentiality of patient and service providers.

Area of Concern - G : Measurable Elements Quality Management	
Standard G1	**The facility has established organizational framework for quality improvement.**
ME G1.1	The facility has a quality team in place.
ME G1.2	The facility reviews quality of its services at periodic intervals.
Standard G2	**The facility has established system for patient and employee satisfaction.**
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals.
ME G2.2	The facility analyses the patient feedback, and do root-cause analysis.
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients.
Standard G3	**Facility have established internal and external quality assurance programs wherever it is c ritical to quality.**
ME G3.1	The facility has established internal quality assurance programme at relevant departments.
ME G3.2	The facility has established external assurance programmes at relevant departments.
ME G3.3	The facility has established system for use of check lists in different departments and services.
ME G3.4	Actions are planned to address gaps observed during quality assurance process
ME G3.5	Planned actions are implemented through Quality improvement cycles(PDCA)
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**
ME G4.1	Departmental standard operating procedures are available.
ME G4.2	Standard Operating Procedures adequately describes process and procedures.
ME G4.3	Staff is trained and aware of the procedures written in SOPs.
ME G4.4	The facility ensures documented policies and procedures are appropriately approved and controlled.
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages.**
ME G5.1	The facility maps its critical processes.
ME G5.2	The facility identifies non value adding activities/waste/redundant activities.
ME G5.3	The facility takes corrective action to improve the processes.
Standard G6	**The facility has defined Mission, Values, Quality policy and Objectives, and prepares a strategic plan to achieve them.**
ME G6.1	The facility has defined mission statement.
ME G6.2	The facility has defined core values of the organization.
ME G6.3	The facility has defined Quality policy, which is in congruency with the mission of facility.
ME G6.4	The facility has defined quality objectives to achieve mission and quality policy.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services.
ME G6.6	The facility prepares strategic plan to achieve mission, quality policy and objectives.
ME G6.7	The facility periodically reviews the progress of strategic plan towards mission, policy and objectives.
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**
ME G7.1	The facility uses method for quality improvement in services.
ME G7.2	The facility uses tools for quality improvement in services.

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

AREA OF CONCERN - H: OUTCOME

Overview

Measurement of the quality is critical to improvement of processes and outcomes. This area of concern has four standard measures for quality - Productivity, Efficiency, Clinical Care & safety and Service quality in terms of measurable indicators. Every standard under this area has two aspects – Firstly, there is a system of measurement of indicators at the health facility; and secondly, how the hospital meets the benchmark. It is realised that at the beginning many indicators given in these standards may not be getting measured across all facilities, and therefore it would be difficult to set benchmark beforehand. However, the state can set their benchmarks, and evaluate performance of health facilities against benchmarks. In LaQshya (LR & MOT) and MusQan (SNCU/NBSU, Paed. OPD, Paed. ward & NRC, the benchmarks/targets for achievment is given in Annexure 'C' & Annexure 'A' respectively.

Following is the brief description of the Standards in this area of concern:

STANDARD H1 THE FACILITY MEASURES PRODUCTIVITY INDICATORS AND ENSURES COMPLIANCE WITH STATE/NATIONAL BENCHMARKS	Standard H1 is concerned with the measurement of Productivity indicators and meeting the benchmarks. This includes utilization indicators like bed occupancy rate and C-Section rate. Assessor should review these records to ensure that these indicators are getting measured at the health facility.
STANDARD H2 THE FACILITY MEASURES EFFICIENCY INDICATORS AND ENSURE TO REACH STATE/ NATIONAL BENCHMARK	Standard H2 pertains to measurement of efficiency indicators and meeting benchmark. This standard contains indicators that measure efficiency of processes, such as turnaround time, and efficiency of human resource like surgery per surgeon, lab tests done per technician. Review of records should be done to assess that these indicators have been measured correctly.
STANDARD H3 THE FACILITY MEASURES CLINICAL CARE & SAFETY INDICATORS AND TRIES TO REACH STATE/NATIONAL BENCHMARK	Standard H3 is concerned with the indicators of clinical quality & safety, such as average length of stay, death rates, HAI rates etc. Record review should be done to see the measurement of these indicators.
STANDARD H4 THE FACILITY MEASURES SERVICE QUALITY INDICATORS AND ENDEAVOURS TO REACH STATE/ NATIONAL BENCHMARK	Standard H4 is concerned with indicators measuring service quality, Patient satisfaction scores and waiting time and LAMA rates.

Area of Concern - H: Measurable Elements Outcomes	
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National Benchmarks.**
ME H1.1	The facility measures productivity Indicators on monthly basis
ME H1.2	The facility endeavours to improve its productivity indicators to meet benchmarks
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark.**
ME H2.1	The facility measures efficiency Indicators on monthly basis
ME H2.2	The facility endeavours to improve its efficiency indicators to meet benchmarks
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**
ME H3.1	The facility measures Clinical Care & Safety Indicators on monthly basis
ME H3.2	The facility endeavours to improve its clincal & safety indicators to meet benchmarks
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**
ME H4.1	The facility measures Service Quality Indicators on monthly basis
ME H4.2	The facility endeavours to improve its service Quality indicators to meet benchmarks

AMENDMENTS MADE UNDER NATIONAL QUALITYASSURANCE STANDARDS

List of Amendments done (2016)		
Added		
Reference No	Standards (2016)	Measurable Elements (2016)
1	B6	ME B6.1 – ME B6.11
2	C7	ME C7.1 – ME C7.11
3	G9	ME G9.1 – ME G9.6
4	G10	ME G10.1 – ME G10.10
Deleted		
1	C4	ME C4.6 & ME C4.7
2	E9	ME E9.4
3	E16	ME E16.3
Rephrased		
1	G7	ME G7.1 – ME G7.4 to ME G7.1 – ME G7.7
List of Amendments done (2018)		
Added		
Reference No	**Standards (2018)**	**Measurable Elements (2018)**
1	A4	ME A4.12
2	E18	ME E18.1, 18.2, 18.3, 18.5, 18.6, 18.7, 18.8, 18.9, 18.11
3	E19	ME E19.3
4	E20	ME E20.5, ME E20.6, ME E20.10
Deleted		
1	E18	ME E18.1, ME E18.3
2	H1	ME H1.3
Rephrased		
1	G6	ME G6.5
2	E18	ME E18.10
3	E19	ME E19.1, ME E19.3
4	E20	ME E20.4

List of amendments done (2020)		
Added		
Reference No	**Standards**	**Measurable Elements**
1	B6	ME B6.12
2	E2	ME E2.3
3	E6	ME E6.3
4	G3	ME G3.4 & ME 3.5
5	G10	ME G10.1, 10.2, 10.3, 10.4, 10.5, 10.6 & 10.7
Rephrased		
1	G4	ME G4.4
2	E23	ME E23.2
3	E2	Standard Statement
4	E6	Standard Statement
5	G3	Standard Statement
Deleted		
1	G6	ME G6.1, 6.2, 6.3, 6.4, 6,4 & 6.5

List of amendments done (2024)		
Added		
Reference No	**Standards**	**Measurable Elements**
1	A1	ME A1.19
2	A4	ME A4.13, A4.16
3	C4	ME C4.6
4	D5	ME D5.4
5	E23	ME E23.13
6	E24	ME E24.1, E24.2, E24.3
Rephrased		
1	A4	ME A4.8
2	E16	Standard Statement
3	E23	ME E23.8
4	F2	ME F2.2
5	F5	MEF5.1

INTENT FOR REVISED STANDARDS AND MEASURABLE ELEMENTS

Revised Standards & Measurable Elements for NQAS

Standards/ME no.	Statement	Intent
Standard A1	**The facility provides Curative services**	
ME A1.19	The facility provides dialysis services	ME ensures the availability of haemodialysis services to patients with a dedicated setup.
Standard A4	**The facility provides services as mandated in National Health Programmes/State Scheme**	
ME A4.13	The facility provides services such as Pradhan Mantri National Dialysis Programme (PMNDP)	ME ensures the availability of Haemodialysis services free of cost for those Below the poverty line and economically weaker Sections (EWS).
ME A4.16	The facility provides services under Anaemia Mukt Bharat, including Sickle Cell Anaemia Elimination Programme	ME ensures the identification, diagnosis & treatment of anaemia due to nutritional & non-nutritional cases in endemic areas like malaria, especially SCD, fluorosis, etc .
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.**	
ME C4.6	The facility has established procedure for credentialing & privileging patient care staff.	ME ensures professional qualification of cadre which is defined as per state norms, pre service screening, credentialing and privileging of MO, specialist and nursing staff done at defined intervals.
Standard D5	**The facility ensures 24 X 7 water and power backup as per requirement of service delivery, and support services norms.**	
ME D5.4	The facility has adequate arrangements for uninterrupted supply of RO water for dialysis unit	This section ensures a sufficient supply of RO water for dialysis to eliminate contaminants and endotoxins that interfere with the dialysis process.

Standards/ME no.	Statement	Intent
Standard E23	**Facility provides National Health Programme as per operational/ clinical guidelines**	
ME E23.13	The facility provide services under Anaemia Mukt Bharat including Sickle Cell Anaemia Elimination Programme	ME covers the screening, treatment and management of anemia and Sickle cell disease as per clinical indication.
Standard E24	**The facility has defined and established procedure for Hemodialysis Services**	
ME E 24.1	The facility has defined and established procedure for Pre-Haemodialysis assessment	ME ensures re dialysis observation & assessment is performed, recorded prior to dialysis session. Dialysis plan is made based on patient assessment, previous dialysis history, funding of baseline assessment & pre dialysis testing etc.
ME E 24.2	The facility has defined and established procedure for care during Haemodialysis	ME covers the safety of patient, regular assessment, recording & monitoring during dialysis
ME E 24.3	The facility has defined and established procedure for care after completion of Haemodialysis	ME covers testing, observation, assessment, and recording of status post-dialysis. It also includes counselling of patients for self-care.

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6	Ambulances	ME 11.4
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8	Anaesthetic Services	Standard 14
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10	Antenatal Care	Standard E 17
11	Antibiotic Policy	ME F1.5
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14	Below Poverty Lime	ME B 5.3
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17	Both Companion of Choice	ME E18.11
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23	Cleanliness	ME D4.2
24	Clinical Indicators	Standard H3
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