भारतीय गुणवत्ता परिषद्
QUALITY COUNCIL® OF INDIA
Creating an Ecosystem for Quality

राष्ट्रीय अस्पताल और स्वास्थ्यचर्या-प्रदाता प्रत्यायन बोर्ड
National Accreditation Board For Hospitals and Healthcare Providers

2nd EDITION
EFFECTIVE 1ST APRIL, 2026

GUIDEBOOK TO CERTIFICATION STANDARDS FOR EMERGENCY DEPARTMENT IN HOSPITALS

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

National Accreditation Board for Hospitals & Healthcare Providers (NABH)

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

The period of Accreditation for this Organisation

June 2022 is from **June 2026** until

Prof Jeffrey Braithwaite, President

Ms Elaine O'Connor, Head of Operations

National Accreditation Board
for Hospitals and Healthcare Providers (NABH)

QUALITY : SAFETY : WELLNESS

Guidebook to Certification Standards for Emergency Department in Hospitals

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FOREWORD

17 September 2025

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) has been at the forefront of advancing quality and patient safety in India's healthcare system. Over the years, NABH has worked tirelessly to build a culture of excellence, ensuring that healthcare organisations are equipped to provide care that is safe, effective, and patient-centered.

It gives me immense pride to introduce the 2nd edition NABH Certification standards for Emergency Department in Hospitals. Emergency care forms the backbone of any healthcare delivery system, as it represents the first point of contact for patients in critical need. The performance of an emergency department often determines patient outcomes, satisfaction, and trust in the hospital. In this context, the certification standards have been thoughtfully designed to ensure that emergency departments function with the highest levels of preparedness, clinical excellence, and efficiency.

The NABH emergency department in hospitals standards hallmark methodology of eight chapters approach has been retained; There are a total of 276 objective elements, 47 standards and 12 Key Performance Indicators (KPI's).

These standards focus on key aspects such as timely triage and stabilization, effective communication, patient safety protocols, infection control, risk management, and continuous training of healthcare professionals etc. These standards emphasize structured workflows, evidence-based practices, and the use of technology to enhance responsiveness and coordination of care. Importantly, it also addresses the well-being of emergency care providers, acknowledging the challenging nature of their work and their critical role in saving lives.

This certification program aligns with NABH's broader mission of fostering a robust healthcare ecosystem that upholds international best practices while being sensitive to the unique needs of our nation. It is not merely a set of requirements but a roadmap for hospitals to strengthen their emergency care systems, elevate patient confidence, and contribute to the national vision of accessible and reliable healthcare for all.

I extend my sincere appreciation to the dedicated experts, clinicians, and healthcare providers who contributed to developing these standards. Their insights and experience have ensured that this program remains practical, comprehensive, and aspirational.

As hospitals adopt these standards, I am confident that emergency care delivery in India will be elevated to new benchmarks of excellence. This initiative reflects our collective commitment to ensuring that every patient who walks into an emergency department receives care that is timely, safe, and of the highest quality.

NABH remains steadfast in its mission of taking quality, safety, and wellness to every corner of the country.

Jai Hind

Dr. Atul Mohan Kochhar
CEO, NABH

ACKNOWLEDGEMENTS

17 September 2025

The conceptualization, development, and release of this document has been possible only due to the unwavering dedication, vision, and expertise of many distinguished individuals and organisations.

I extend my heartfelt gratitude to **Shri Jaxay Shah, Chairman of the Quality Council of India**, whose vision of taking quality to the grassroots and embedding it into the DNA of every Indian citizen has been a constant source of inspiration. His guidance has been instrumental in motivating us to pursue the highest levels of healthcare excellence.

I would like to express my sincere thanks to **Mr. Rizwan Koita, Chairman NABH**, for his pivotal role in advancing healthcare standards in our country. His invaluable insights, guidance, and commitment to patient safety and quality of care have been a guiding light in shaping this document.

I also convey my deepest appreciation to **Mr. Chakravarthy T. Kannan, Secretary General of Quality Council of India**, for his invaluable contributions and constant support in fostering excellence in healthcare standards across the nation.

My heartfelt thanks to the **NABH Technical Committee Members** for their valuable time, expertise, and suggestions were crucial in finalizing and enriching the standards.

I express my profound thanks to **Expert Group Members** and for their significant contributions. Their knowledge and vision have strengthened the overall framework of these standards.

I would also like to thank all **assessors, hospital management teams, clinicians, nurses, paramedics, and quality managers** who provided extensive feedback, ensuring that the standards reflect real-world applicability and are aligned with the evolving needs of the healthcare sector in emergency department.

Finally, I deeply appreciate the efforts of the **NABH Secretariat team**, who worked relentlessly to coordinate the process and ensure the timely completion of this edition.

This document stands as a testament to the collaborative spirit, hard work, and shared vision of a committed healthcare community. Together, we reaffirm our dedication to building a healthcare ecosystem that prioritizes **quality, safety, sustainability, and patient-centered care**.

With sincere appreciation and profound gratitude. Thank You

Jai Hind

Dr. Atul Mohan Kochhar
CEO, NABH

CONTENTS

About NABH

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

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

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

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

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

NABH Activities

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

NABH Certification Programmes: NABH offers certification to Medical Laboratory, Nursing Excellence, Emergency Department, Stroke Center, Dental Healthcare Service Providers, Entry Level for Hospitals Entry Level Ayush Hospitals and Entry Level Ayush Centres and HIS/ EMR standards

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

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

Training & Education: NABH conducts Education/Interactive Workshops, Awareness Programmes, and Programme on Implementation (POI).

Scope and Purpose of the Standards

Scope of the Standards

These standards are applicable for health care organisation willing for emergency department in hospitals program provided that health care organisation fulfils the following requirements:

Hospitals with a minimum of 25 operational beds, excluding emergency beds. The required number of emergency beds is based on the hospital's total bed strength

- Up to 50 Beds – 2 Emergency Beds
- 51–100 Beds – 4 Emergency Beds
- 101–200 Beds – 6 Emergency Beds
- 201–350 Beds – 8 Emergency Beds
- More than 350 Beds – 10 Emergency Beds

The hospital must commit to comply with NABH emergency department in hospitals certification standards and all applicable legal/ statutory/ regulatory requirements.

These standards apply to the entire organisation, not just the emergency department, and are applicable to both public and private hospitals

Purpose of the Standards

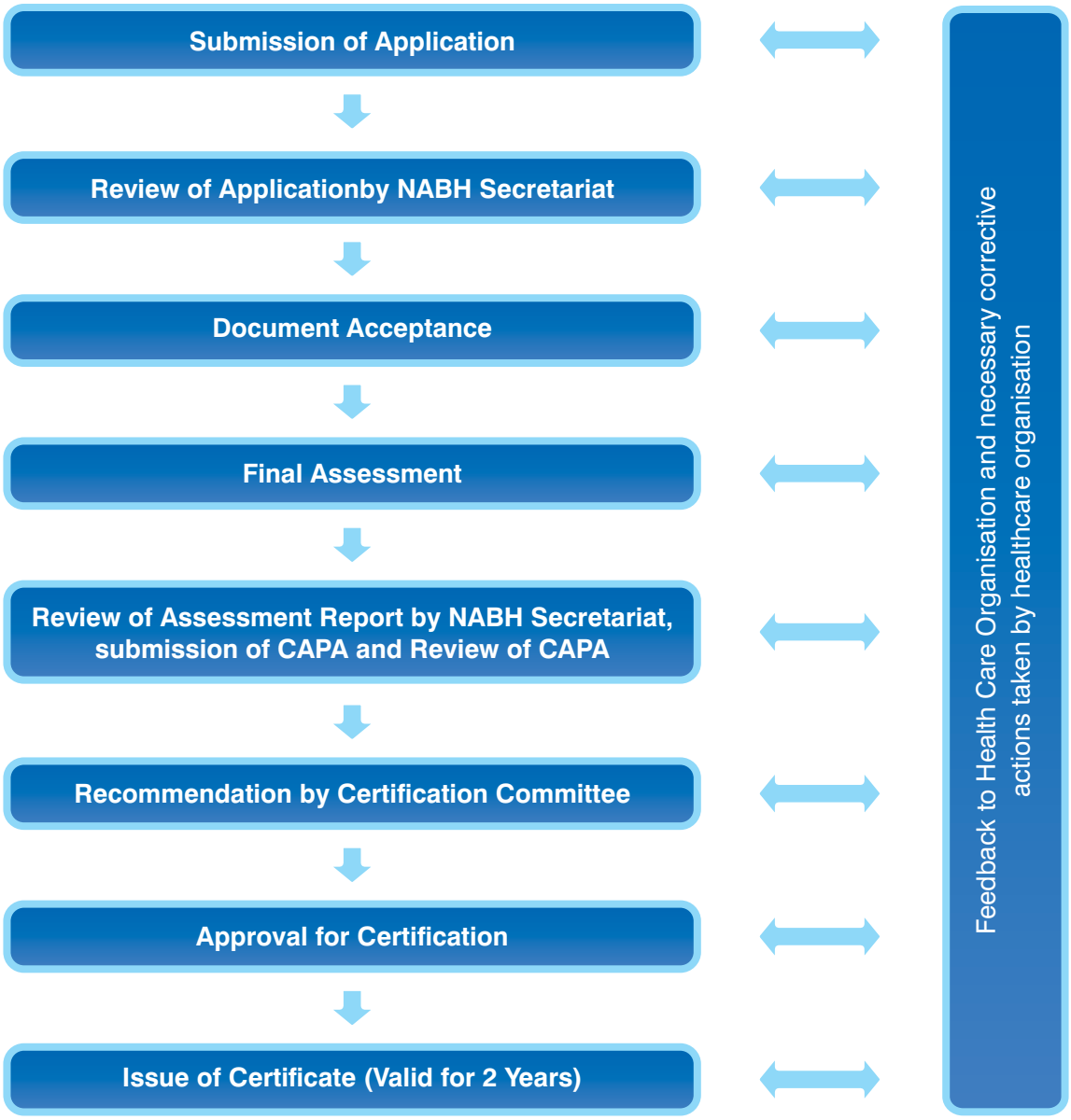
The aim of the standards is to achieve an acceptable level of performance with a view to:

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

In addition, these standards can also be used to:

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

Overview of the NABH Certification Process



* For Renewal Assessment, the certified hospital must apply six months prior to the expiry of the validity of certification

How to read the standard?

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

1. Access, Assessment and Information (AAI)
2. Patient Care and Rights (PCR)
3. Management of Medication (MOM)
4. Infection Prevention and Control (IPC)
5. Patient Safety and Quality Improvement (PSQ)
6. Responsibilities of Management (ROM)
7. Facility Management and Safety (FMS)
8. Human Resource Management (HRM)

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

What is a standard?

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

What is an Objective Element?

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

What is an Interpretation?

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

Other Sections Included in the Standard Book

- About NABH
- Scope and purpose of the standards
- Overview of the NABH accreditation process
- System Documentation
- Abbreviations
- Glossary

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

System Documentation

Introduction

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

Why do we need documentation?

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

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

Type of documents

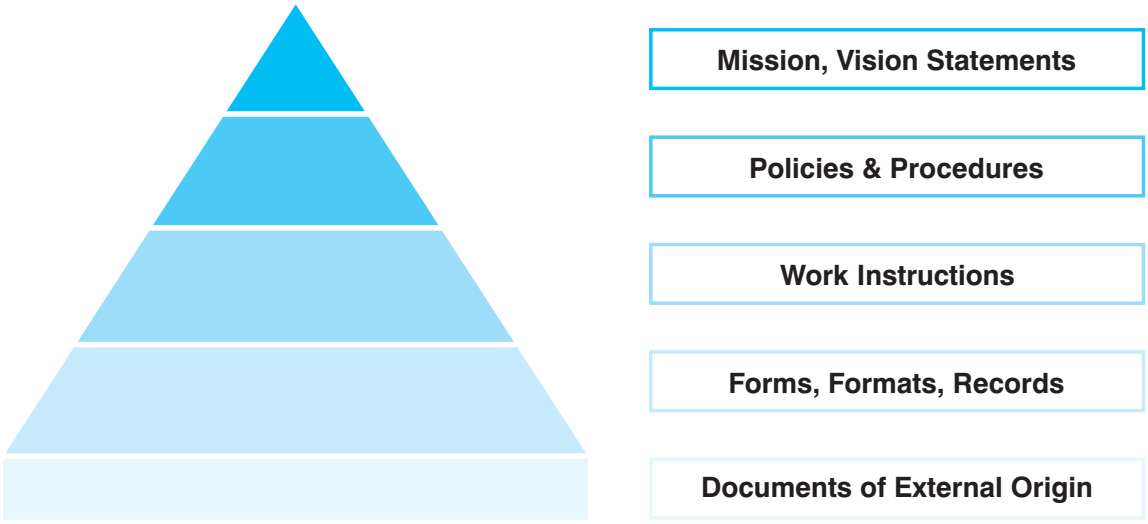
From the top level of planning to the level of maintaining records of activities, the documentation follows a general principle as below:

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

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

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

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



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

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

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

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

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

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

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

Documentation related to processes and procedures

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

Which processes should be documented?

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

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

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

How to develop documentation that is easy to follow?

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

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

Controlled Documents

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

Characteristics of controlled documents:

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

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

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

An example of the control box is given below:

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

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

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

Body of Document

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

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

- Name of the Document:
- Purpose of the Process that is documented
- Start point
- End Point
- Procedure:

  Step 1: XXXXXXXXXXXX

  Step 2: XXXXXXXXXXXX

  Step 3: XXXXXXXXXXXX

  Step n: XXXXXXXXXXXX
- Related Records
- Related documents

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

MANUALS

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

Summary of Chapters, Standards and Objective Elements

Chapters		No. of Standards	No. of Objective Elements
Chapter 1:	Access, Assessment and Information (AAI)	11	94
Chapter 2:	Patient Care and Rights (PCR)	10	59
Chapter 3:	Management of Medication (MOM)	7	43
Chapter 4:	Infection Prevention and Control (IPC)	3	13
Chapter 5:	Patient Safety and Quality Improvement (PSQ)	3	16
Chapter 6:	Responsibilities of Management (ROM)	3	13
Chapter 7:	Facility Management and Safety (FMS)	5	16
Chapter 8:	Human Resource Management (HRM)	5	22
Total		**47**	**276**

Summary of Changes

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
Access, Assessment and Information (AAI)		
AAI.1.a	AAI.1.a	Changes in the interpretation for better clarity
AAI.1.b	AAI.1.b	Changes in the interpretation for better clarity
AAI.1.c AAI.1.d	AAI.1.c	Merged for better clarity
AAI.1.e	AAI.1.d	Changes in the interpretation for better clarity
AAI.2.a AAI.2.b AAI.2.c	AAI.2.a	Merged for better clarity
AAI.2.d	AAI.2.b	Changes in the interpretation for better clarity
AAI.2.e	AAI.2.c	Changes in the interpretation for better clarity
AAI.2.f	AAI.2.d	Changes in the interpretation for better clarity
AAI.2.g	AAI.2.e	Changes in the interpretation for better clarity
AAI.2.h	AAI.2.f	Changes in the interpretation for better clarity
AAI.2.i	AAI.2.g	Changes in the interpretation for better clarity
AAI.3.a	AAI.3.a	Changes in the interpretation for better clarity
AAI.3.b	AAI.3.b	Changes in the interpretation for better clarity
AAI.3.c	AAI.3.c	Changes in the interpretation for better clarity
AAI.3.d AAI.3.e	AAI.3.d	Merged for better clarity
AAI.4.a	AAI.4.a	Changes in the interpretation for better clarity
	AAI.4.b	New Objective Element
AAI.4.b	AAI.4.c	Changes in the interpretation for better clarity
AAI.4.c PCR.3.b	AAI.4.d	Merged for better clarity
AAI.5.a	AAI.5.a	Changes in the interpretation for better clarity

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
AAI.5.b	AAI.5.b	Changes in the interpretation for better clarity
AAI.5.c	AAI.5.c	Changes in the interpretation for better clarity
AAI.5.d	AAI.5.d	Changes in the interpretation for better clarity
AAI.6.a	AAI.6.a	Changes in the interpretation for better clarity
AAI.6.b	AAI.6.b	Changes in the interpretation for better clarity
AAI.6.c AAI.6.d	AAI.6.c	Merged for better clarity
AAI.6.e	AAI.6.d	Changes in the interpretation for better clarity
AAI.6.f	AAI.6.e	Changes in the interpretation for better clarity
AAI.7.a	AAI.7.a	Changes in the interpretation for better clarity
AAI.7.b	AAI.7.b	Changes in the interpretation for better clarity
AAI.7.c	AAI.7.c	Changes in the interpretation for better clarity
AAI.8.a	AAI.8.a	Changes in the interpretation for better clarity
AAI.8.b	AAI.8.b	Changes in the interpretation for better clarity
AAI.8.c	AAI.8.c	Changes in the interpretation for better clarity
AAI.8.d	AAI.8.d	Changes in the interpretation for better clarity
AAI.9.a AAI.9.b	AAI.9.a	Merged for better clarity
AAI.9.c	AAI.9.b	Changes in the interpretation for better clarity
AAI.9.d	AAI.9.c	Changes in the interpretation for better clarity
AAI.9.e	AAI.9.d	Changes in the interpretation for better clarity
AAI.9.f	AAI.9.e	Changes in the interpretation for better clarity
AAI.9.g		Deleted
AAI.10.a	AAI.10.a	Changes in the interpretation for better clarity
AAI.10.b	AAI.10.b	Changes in the interpretation for better clarity
AAI.10.c	AAI.10.c	Changes in the interpretation for better clarity
AAI.10.d	AAI.10.d	Changes in the interpretation for better clarity

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
AAI.10.e	AAI.10.e	Changes in the interpretation for better clarity
AAI.11.a	AAI.11.a	Changes in the interpretation for better clarity
AAI.11.b	AAI.11.b	Changes in the interpretation for better clarity
AAI.11.c	AAI.11.c	Changes in the interpretation for better clarity
AAI.11.d	AAI.11.d	Changes in the interpretation for better clarity
Patient Care and Rights (PCR)		
	PCR.1.a	New Objective Element
PCR.1.a	PCR.1.b	Changes in the interpretation for better clarity
PCR.1.b PCR.1.c	PCR.1.c	Merged for better clarity
PCR.1.d	PCR.1.d	Changes in the interpretation for better clarity
PCR.1.e PCR.1.f PCR.1.g	PCR.1.e	Merged for better clarity
PCR.1.h	PCR.1.f	Changes in the interpretation for better clarity
	PCR.1.g	New Objective Element
PCR.2.a	PCR.2.a	Changes in the interpretation for better clarity
PCR.2.b PCR.2.d	PCR.2.b	Merged for better clarity
PCR.2.c	PCR.2.c	Changes in the interpretation for better clarity
PCR.2.e	PCR.2.d	Changes in the interpretation for better clarity
PCR.2.f		Deleted
PCR.3.a	PCR.3.a	Changes in the interpretation for better clarity
	PCR.3.b	New Objective Element
	PCR.3.c	New Objective Element
PCR.3.c	PCR.3.d	Changes in the interpretation for better clarity
PCR.3.d	PCR.3.e	Changes in the interpretation for better clarity
PCR.3.e	PCR.3.f	Changes in the interpretation for better clarity

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
PCR.4.a PCR.4.b	PCR.4.a	Merged for better clarity
PCR.4.c	PCR.4.b	Changes in the interpretation for better clarity
	PCR.4.c	New Objective Element
PCR.4.d PCR.4.e	PCR.4.d	Merged for better clarity
PCR.4.f	PCR.4.e	Changes in the interpretation for better clarity
PCR.4.g	PCR.4.f	Changes in the interpretation for better clarity
PCR.5.a	PCR.5.a	Changes in the interpretation for better clarity
	PCR.5.b	New Objective Element
PCR.5.b	PCR.5.c	Changes in the interpretation for better clarity
PCR.5.c	PCR.5.d	Changes in the interpretation for better clarity
PCR.5.d	PCR.5.e	Changes in the interpretation for better clarity
PCR.5.e		Deleted
PCR.5.f	PCR.5.f	Changes in the interpretation for better clarity
PCR.5.g	PCR.5.g	Changes in the interpretation for better clarity
PCR.5.h		Deleted
PCR.6.a	PCR.6.a	Changes in the interpretation for better clarity
PCR.6.b		Deleted
PCR.6.c		Deleted
PCR.6.d	PCR.6.b	Changes in the interpretation for better clarity
PCR.6.e	PCR.6.c	Changes in the interpretation for better clarity
PCR.6.f	PCR.6.d	Changes in the interpretation for better clarity
PCR.7.a	PCR.7.a	
	PCR.7.b	New Objective Element
PCR.7.b	PCR.7.c	
	PCR.7.d	New Objective Element

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
PCR.7.c	PCR.7.e	
	PCR.7.f	New Objective Element
	PCR.7.g	New Objective Element
PCR.7.j	PCR.7.h	Changes in the interpretation for better clarity
PCR.7.k	PCR.7.i	Changes in the interpretation for better clarity
PCR.7.d	PCR.7.j	Changes in the interpretation for better clarity
PCR.7.e		Deleted
PCR.7.f		Deleted
PCR.7.h	PCR.7.k	Changes in the interpretation for better clarity
PCR.7.g	PCR.7.l	Changes in the interpretation for better clarity
PCR.7.i		Deleted
	PCR.8.a	New Objective Element
	PCR.8.b	New Objective Element
PCR.8.a	PCR.8.c	Changes in the interpretation for better clarity
PCR.8.b	PCR.8.d	Changes in the interpretation for better clarity
PCR.8.c PCR.8.d	PCR.8.e	Merged for better clarity
PCR.9.a	PCR.9.a	Changes in the interpretation for better clarity
PCR.9.b	PCR.9.b	Changes in the interpretation for better clarity
PCR.9.c	PCR.9.c	Changes in the interpretation for better clarity
	PCR.10.a	New Objective Element
	PCR.10.b	New Objective Element
	PCR.10.c	New Objective Element
	PCR.10.d	New Objective Element
	PCR.10.e	New Objective Element
MANAGEMENT OF MEDICATION (MOM)		

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
MOM.1.a.	MOM.1.a.	Changes in the interpretation for better clarity
MOM.1.b.	MOM.1.b.	Changes in the interpretation for better clarity
MOM.1.c.	MOM.1.c.	Changes in the interpretation for better clarity
MOM.1.d.	MOM.1.d.	Changes in the interpretation for better clarity
MOM.1.e	MOM.1.e	Changes in the interpretation for better clarity
MOM.2.a. MOM.2.b.	MOM.2.a.	Merged for better clarity
MOM.2.c.	MOM.2.b.	Changes in the interpretation for better clarity
MOM.2.d.	MOM.2.c.	Changes in the interpretation for better clarity
MOM.2.e.	MOM.2.d.	Changes in the interpretation for better clarity
MOM.2.f MOM.2.g	MOM.2.e.	Merged for better clarity
MOM.3.a.	MOM.3.a.	Changes in the interpretation for better clarity
	MOM.3.b.	New Objective Element
MOM.3.b.	MOM.3.c.	Changes in the interpretation for better clarity
MOM.3.c.	MOM.3.d.	Changes in the interpretation for better clarity
MOM.3.d.	MOM.3.e.	Changes in the interpretation for better clarity
MOM.3.e.	MOM.3.f.	Changes in the interpretation for better clarity
MOM.3.f.	MOM.3.g.	Changes in the interpretation for better clarity
MOM.3.g.	MOM.3.h.	Changes in the interpretation for better clarity
MOM.3.h.	MOM.3.i.	Changes in the interpretation for better clarity
MOM.3.i.	MOM.3.j	Changes in the interpretation for better clarity
MOM.4.a.	MOM.4.a.	Changes in the interpretation for better clarity
MOM.4.b.	MOM.4.b.	Changes in the interpretation for better clarity
MOM.4.c.	MOM.4.c.	Changes in the interpretation for better clarity
MOM.4.d.	MOM.4.d.	Changes in the interpretation for better clarity
MOM.4.e.	MOM.4.e.	Changes in the interpretation for better clarity

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
MOM.4.f	MOM.4.f	Changes in the interpretation for better clarity
MOM.4.g.	MOM.4.g.	Changes in the interpretation for better clarity
MOM.4.h.	MOM.4.h.	Changes in the interpretation for better clarity
MOM.4.i.	MOM.4.i.	Changes in the interpretation for better clarity
MOM.4.j.	MOM.4.j.	Changes in the interpretation for better clarity
MOM.4.i.	MOM.4.k.	Changes in the interpretation for better clarity
MOM.4.m.	MOM.4.l.	Changes in the interpretation for better clarity
MOM.4.n.	MOM.4.m.	Changes in the interpretation for better clarity
MOM.4.k.		Deleted
MOM.5.a.	MOM.5.a.	Changes in the interpretation for better clarity
MOM.5.c.	MOM.5.b.	Changes in the interpretation for better clarity
MOM.5.d,	MOM.5.c.	Changes in the interpretation for better clarity
MOM.5.b.		Deleted
MOM.6.a.	MOM.6.a.	Changes in the interpretation for better clarity
MOM.6.b. MOM.6.c.	MOM.6.b.	Merged for better clarity
MOM.6.d.	MOM.6.c.	Changes in the interpretation for better clarity
MOM.6.e.	MOM.6.d.	Changes in the interpretation for better clarity
	MOM.7.a.	Changes in the interpretation for better clarity
	MOM.7.b.	Changes in the interpretation for better clarity
	MOM.7.c.	Changes in the interpretation for better clarity
MOM.7.d.		Deleted
Infection Prevention And Control (IPC)		
	IPC.1.a.	
HIC.2.a	IPC.1.b.	Changes in the interpretation for better clarity
HIC.2.b	IPC.1.c.	Changes in the interpretation for better clarity

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
HIC.2.c	IPC.1.d.	Changes in the interpretation for better clarity
	IPC.1.e.	New Objective Element
	IPC.1.f.	New Objective Element
HIC.2.d	IPC.1.g.	Changes in the interpretation for better clarity
	IPC.2.a.	New Objective Element
HIC.3.a HIC.3.b	IPC.2.c.	Merged for better clarity
HIC.1.a	IPC.3.a.	Changes in the interpretation for better clarity
HIC.1.b	IPC.3.b.	Changes in the interpretation for better clarity
HIC.1.c	IPC.3.c.	Changes in the interpretation for better clarity
Patient Safety and Quality Improvement (PSQ)		
	PSQ.1.a	New Objective Element
CQI.1.a	PSQ.1.b	Changes in the interpretation for better clarity
CQI.1.b	PSQ.1.c	Changes in the interpretation for better clarity
CQI.1.c	PSQ.1.d	Changes in the interpretation for better clarity
CQI.1.d	PSQ.1.e	Changes in the interpretation for better clarity
CQI.1.e	PSQ.1.f	Changes in the interpretation for better clarity
CQI.2.a	PSQ.2.a	Changes in the interpretation for better clarity
CQI.2.b	PSQ.2.b	Changes in the interpretation for better clarity
CQI.2.c	PSQ.2.c	Changes in the interpretation for better clarity
CQI.2.d	PSQ.2.d	Changes in the interpretation for better clarity
	PSQ.3.a	New Objective Element
	PSQ.3.b	New Objective Element
	PSQ.3.c	New Objective Element
	PSQ.3.d	New Objective Element
	PSQ.3.e	New Objective Element

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
	PSQ.3.f	New Objective Element
CQI.3.a		Deleted
CQI.3.b		Deleted
CQI.3.c		Deleted
CQI.3.d		Deleted
CQI.3.e		Deleted
CQI.3.f		Deleted
CQI.3.g		Deleted
CQI.4.a		Deleted
CQI.4.b		Deleted
CQI.4.c		Deleted
CQI.4.d		Deleted
Responsibilities of Management (ROM)		
ROM.1.a	ROM.1.a	Changes in the interpretation for better clarity
ROM.1.b	ROM.1.b	Changes in the interpretation for better clarity
ROM.2.a	ROM.2.a	Changes in the interpretation for better clarity
ROM.2.b	ROM.2.b	Changes in the interpretation for better clarity
ROM.2.c	ROM.2.c	Changes in the interpretation for better clarity
ROM.2.c	ROM.2.c	Changes in the interpretation for better clarity
ROM.2.e	ROM.2.e	Changes in the interpretation for better clarity
ROM.2.f	ROM.2.f	Changes in the interpretation for better clarity
ROM.2.g	ROM.2.g	Changes in the interpretation for better clarity
ROM.2.h	ROM.2.h	Changes in the interpretation for better clarity
ROM.3.a	ROM.3.a	Changes in the interpretation for better clarity
ROM.3.b	ROM.3.b	Changes in the interpretation for better clarity
ROM.3.c	ROM.3.c	Changes in the interpretation for better clarity

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
Facility Management and Safety (FMS)		
FMS.1.a	FMS.1.a	Changes in the interpretation for better clarity
FMS.1.b	FMS.1.b	Changes in the interpretation for better clarity
FMS.3.a FMS.3.b	FMS.1.c	Merged for better clarity
FMS.1.c	FMS.1.d	Changes in the interpretation for better clarity
FMS.1.d FMS.1.e	FMS.1.e	Merged for better clarity
FMS.1.f	FMS.1.f	Changes in the interpretation for better clarity
FMS.2.a FMS.2.g	FMS.2.a	Merged for better clarity
FMS.2.b		Deleted
FMS.2.c	FMS.2.b	Changes in the interpretation for better clarity
FMS.2.d	FMS.2.c	Changes in the interpretation for better clarity
FMS.2.e FMS.2.f	FMS.2.d	Merged for better clarity
FMS.4.a FMS.4.b	FMS.3.a	Merged for better clarity
FMS.4.c	FMS.3.b	Changes in the interpretation for better clarity
FMS.5.a	FMS.4.a	Changes in the interpretation for better clarity
FMS.5.b	FMS.4.b	Changes in the interpretation for better clarity
FMS.6.b	FMS.5.a	Changes in the interpretation for better clarity
FMS.6.c	FMS.5.b	Changes in the interpretation for better clarity
FMS.6.a		Deleted
FMS.6.d		Deleted
Human Resource Management (HRM)		
HRM.1.a	HRM.1.a	Changes in the interpretation for better clarity
	HRM.1.b	New Objective Element

1st Edition Emergency Department in Hospital	2nd Edition Emergency Department in Hospital	Remarks
HRM.1.b	HRM.1.c	Changes in the interpretation for better clarity
HRM.2.a HRM.2.b	HRM.2.a	Merged for better clarity
	HRM.2.b	New Objective Element
	HRM.2.c	New Objective Element
	HRM.2.d	New Objective Element
	HRM.2.e	New Objective Element
	HRM.2.f	New Objective Element
	HRM.2.g	New Objective Element
HRM.2.c		Deleted
HRM.2.d		Deleted
HRM.2.e		Deleted
HRM.2.f		Deleted
HRM.2.f		Deleted
HRM.3.a HRM.3.b	HRM.3.a	Merged for better clarity
HRM.3.c	HRM.3.b	Changes in the interpretation for better clarity
HRM.4.b	HRM.4.a	Changes in the interpretation for better clarity
HRM.4.a	HRM.4.b	Changes in the interpretation for better clarity
HRM.4.c	HRM.4.c	Changes in the interpretation for better clarity
HRM.4.d	HRM.4.d	Changes in the interpretation for better clarity
	HRM.4.e	New Objective Element
HRM.5.a	HRM.5.a	Changes in the interpretation for better clarity
HRM.5.b	HRM.5.b	Changes in the interpretation for better clarity
HRM.5.c	HRM.5.c	Changes in the interpretation for better clarity
HRM.5.d	HRM.5.d	Changes in the interpretation for better clarity
HRM.5.e	HRM.5.e	Changes in the interpretation for better clarity

CHAPTER 1

Access, Assessment and Information (AAI)

Intent of the chapter

The Emergency Department of organisation defines its scope of service provision and provides information to patients about the services available. This will facilitate appropriately matching patients with the Emergency Department's resources. Once the patient is in the Emergency Department, the patient is registered, assessed, and managed. The emergency care including laboratory and imaging services are provided by competent staff in a safe environment for both patients and staff.

A standardized approach is used for referring or transferring patients in case the services they need do not match with the services available in the Emergency Department of an organisation. Further, the chapter lays down key safety and process elements that the organisation should meet, in the continuum of the patient care within the hospital and till discharge.

The medical record is an essential patient care document which contains all the details of assessment and care that has been provided in a chronological manner.

SUMMARY OF STANDARDS

AAI.1	The organisation establishes the emergency department with an easy access and defines and displays the scope of services that it can provide.
AAI.2	Emergency care is provided in consonance with statutory requirements including medico-legal cases and as per written guidance. *
AAI.3	The Emergency Department has a documented registration, admission and transfer process.
AAI.4	Laboratory and Imaging services are provided as per the scope of services of the organisation.
AAI.5	There is an appropriate mechanism for transfer (in and out) or referral of patients.
AAI.6	Emergency patients cared for by the organisation undergo an established initial assessment.
AAI.7	Patients cared for by the organisation undergo a regular reassessment.
AAI.8	Patient care is continuous and multidisciplinary in nature.
AAI.9	The Emergency Department has a documented discharge process.
AAI.10	The Emergency Department has a complete and accurate medical record for every patient.
AAI.11	The medical record reflects continuity of care.

Standards and Objective Elements

Standard

AAI. 1 **The organisation establishes the emergency department with an easy access and defines and displays the scope of services that it can provide.**

Objective Elements

a. **The emergency department shall have an easy and direct access from the approach road / main gate.**

Interpretation: The organisation establishes the emergency department with an easy access to the department which includes structural and operational resources for easy and quick access. The identified area to treat emergency patients shall be easily accessible for the initiation of care. There shall be signage and directions in an understandable manner leading to the emergency area of the organisation.

b. **An alert mechanism is activated upon arrival of the patient to which staff respond promptly.**

Interpretation: Alert could be activated as soon as patients and their attendants arrive at emergency door/hospital entrance depending on layout of the hospital. Emergency department coordinator/reception/security may be utilized for the purpose. Ambulances bringing patients in shall pass the information through radio/mobile enroute to alert the emergency department.

c. **The services which are being provided are clearly defined.**

Interpretation: The services provided are defined by senior management and are in consonance with the requirements of the community. The scope could be by inclusion or exclusion in relation to the services practiced in the department. The department could have a brochure detailing the scope. The defined services are prominently displayed.

d. **Staff are oriented to these defined services.**

Interpretation: All clinical and diagnostic outsourced services shall be documented and information of the same shall be known to all the staff. This information could also be made available for patients by the staff through website, display, brochures etc. Training of staff and internal audit to check awareness on the subject shall be carried out periodically to improve services.

Standard

AAI. 2 **Emergency care is provided in consonance with statutory requirements including medico-legal cases and as per written guidance. ***

Objective Elements

a. Written guidance is available for emergency care and is documented and is in consonance with statutory requirements.

Interpretation: Written guidance shall include guidelines/SOPs/protocols to provide general emergency care as well as management of specific conditions, for example poisoning, road traffic accidents, patients with acute stroke and coronary disease, etc. It shall address both adult and paediatric patients. The procedure shall incorporate at a minimum identification, assessment and provision of care. In case, emergency services are out of the scope of the organisation, or the organisation does not have facilities for appropriate emergency care of a given clinical condition, at a minimum, such patients shall be provided with first aid before transferring them to another organisation. Processes shall be in place to ensure patient safety.

The organisation shall also define as to what constitutes a medico-legal case (MLC). The care provided, especially the documentation and intimation to appropriate authorities, shall be in accordance with statutory requirements. The organisation shall have policy on management of suspected sexual assault and guidance on storage of samples of MLC patients. The patients receive care in consonance with the policies.

b. The organisation has systems in place for the management of patients found dead on arrival and patients who die within a few minutes of arrival.

Interpretation: There is written guidance for managing situations where a patient is either found dead on arrival or dies within a few minutes of arrival (after a failed attempt at resuscitation). The written guidance shall conform to the relevant local laws.

The written guidance in case of a patient found dead on arrival (brought in dead) to the emergency department address:

- Maintaining a logbook of patients found dead on arrival.
- The decision on whether to perform a post-mortem.
- The decision regarding the issue of medical certificate of cause of death.
- The temporary storage of the body in appropriate conditions.
- What to do in case of unclaimed/unaccompanied bodies.

In case of death of a patient within a few minutes after arrival (after a failed attempt at resuscitation), the written guidance shall address:

- Process of registration of such patients and recording the entire resuscitation events.
- The decision on whether to perform a post-mortem.
- The temporary storage of the body in appropriate conditions.
- Issue of medical certificate of cause of death and handing over of the body.

c. Documented policies and procedures guide the triage of patients and initiation of appropriate care.

Interpretation: Triage shall be done only by qualified/trained personnel. Written guidance based on evidence/sound clinical practices shall guide these activities. The triage shall be part of the routine day-to-day functioning of the emergency department and not from the perspective of managing a large number of patients during a disaster. The criteria could be separate for trauma and non-trauma patients and adults and children, for example, paediatric assessment triangle (PAT) / paediatric observation priority score (POPS). If several clients are waiting to be triaged, a visual triage assessment may be conducted.

d. Staff is familiar with the policies and trained on the procedures for care of emergency patients.

Interpretation: Staff is familiar with the policies, processes and protocols which govern the provision of emergency care at their institution. They shall be aware of codes pertaining to emergency department as protocolized at their organisation like code stroke, code PAMI, code trauma etc.

e. There are documented standard clinical guidelines available for common and critical conditions which are framed using evidence based medicine.

Interpretation: Clinical practice guidelines brought out by national and international professional organisations may be used. Standard treatment guidelines (STGs) brought out by the government of India are a good starting point. In the absence of evidence-based clinical practice guidelines or where adapting the clinical practice guidelines are not feasible, sound clinical practices shall guide the delivery of care.

f. Admission or discharge to home or transfer to another organisation is documented.

Interpretation: The organisation shall maintain documentation to indicate if a patient who came to the emergency was sent home after providing initial care/was admitted for further care in the organisation/admitted in an emergency department for a short stay and then discharged/transferred to another organisation. The staff shall have a clear understanding of the scope of the activities of the organisation and the procedure of referral and transfer to an appropriate another centre, of patients who cannot be cared for in-house, after administering the due first-aid/emergency care. Written guidance exist for handover between doctors and staff during the above to maintain continuum of care.

g. In case of discharge to home or transfer to another organisation a discharge note shall be given to the patient.

Interpretation: The discharge/transfer note shall contain salient clinical findings, investigations done, treatment given, and condition at discharge/transfer. The reasons for discharge or transfer shall be documented.

Standard

AAI. 3 **The Emergency Department has a documented registration, admission and transfer process.**

Objective Elements

a. The organisation uses written guidance for registering and admitting patients. *

Interpretation: The Organisation shall prepare a document(s) detailing the mechanism for registration and admission of patients, which shall also include unidentified patients. All patients who are assessed in the hospital shall be registered. Any regulation from the government shall be adhered. The process of registration and admission shall be so designed to avoid duplication in documentation, for example, information once generated in the system shall be available to all the departments within HCO. The organisation could consider mechanisms to verify the identity of the patient during registration. All admissions must be authorised by a doctor. Additional documentation as required shall be included for foreign nationals and unidentified patients coming in emergency.

The written guidance addresses emergency patients. The patients and/or family are informed of the salient steps for registration/admission. This could be done through appropriate displays/information on the website.

General consent for treatment is obtained when the patient enters the organisation and its scope is explained. The organisation shall define as to what is the scope of the general consent and the same shall be communicated to the patient and/or his family members. This cannot include consent for invasive procedures or other procedures for which a specific consent is required as per this standard.

b. A unique identification number is generated at the end of the registration.

Interpretation: The organisation shall ensure that every patient gets a unique number which is generated at the end of registration of the first interaction that the patient has with the organisation. This number shall be used for identification of the patient across the organisation and to ensure continuity of care across the organisation. All hospital records of the patient shall have this number.

"Unique" implies that this is a one-time affair. Please note that a patient can have only one unique number. However, in the case of multiple visits (OP/IP), a different number could be generated in addition to the above-mentioned unique number. These numbers shall be linked to the unique number to ensure continuity of care.

c. Access to the healthcare services in the organisation is prioritised according to the clinical needs of the patient.*

Interpretation: Patients with a clinical problem which warrant an earlier response are identified and prioritised in care settings (outpatient, and diagnostic services). For example, a patient waiting in the OPD who complains of giddiness is seen as soon as possible; a vulnerable patient coming for a diagnostic test is fast-tracked. All the staff handling these activities shall be oriented to the applicable guidelines. It is preferable that the organisation develop a mechanism which would help all concerned in identifying such patients. One such mechanism that the organisation could consider is having a visual aid in the form of a sticker placed on the file or on the patient's clothing to help identify such patients.

d. The written guidance also addresses managing patients during non-availability of beds. *

Interpretation: The organisation is aware of the availability of alternate organisations where the patients may be directed in case of non-availability of beds. In case the organisation admits these patients in a temporary holding area, it shall ensure that there is adequate infrastructure to take care of these patients. Further, the organisation shall define as to how long patients are kept on temporary beds before a decision to transfer out is taken. The guidance also addresses managing patients when the bed is not available in the desired bed category or unit, and the financial implications of the same explained to the patient of the same. Staff is aware of these processes.

Standard

AAI. 4 **Laboratory and Imaging services are provided as per the scope of services of the organisation.**

Objective Elements

a. **Documented policies and procedures are in place for ordering and reporting of laboratory and radiological investigations which have been requested from the emergency department.**

Interpretation: Scope of the laboratory and imaging services is commensurate to the services provided by the organisation. The organisation shall ensure availability of laboratory and imaging services, commensurate with the healthcare services it offers. For example, a cardiac care organisation must necessarily have facilities for cardiac enzymes. Point of testing equipment for emergency tests like ABG, cardiac enzymes, blood glucose etc. and ultrasound examination to screen for injuries and other abnormalities could preferably be made available to improve efficiency of the emergency department. Quality assurance monitoring of POCT equipment like ABG, cardiac enzyme machine etc shall be ensured. The organisation shall ensure that these services are available round the clock, and patient care is not disrupted. Test results required for emergency management must be available within its premises. Reports shall not get delayed due to lack of adequate equipment.

b. **Critical results are intimated to the person concerned at the earliest. ***

Interpretation: The laboratory shall establish and document critical limits for tests which require immediate attention for patient management, and the same shall be documented. If it is not practical to establish the biological reference interval for a particular analysis, the laboratory shall carefully evaluate the published data for its reference intervals. Critical results of outsourced investigations are also included. The organisation shall define and document the critical results of imaging which require immediate attention for patient management and the same shall be documented, for example ectopic pregnancy. The critical results must be documented for each modality of imaging. Critical results of outsourced investigations shall also be intimated.

Laboratory in-charge identifies suitable personnel from emergency department to report critical results. The critical test results shall be communicated to the person concerned from the treating team (treating doctor/doctor member of treating team/ER nurse on duty) at the earliest, but not later than one hour of completion of test/report being ready.

The intimation includes the name of the patient; Unique ID; date and time of sample collection; test name, result, measure unit and reference range; operator identity of who has communicated the value; the identity of the recipient; read-back and date and time of acknowledgement. The intimation shall be documented.

In the case of electronic health systems, system-generated critical result reporting can supplement the physical reporting of critical results.

c. **Written guidance is available to guide the movement of patients from the emergency department for investigations (within or outside the hospital) or transfer to another organisation in a safe manner.**

Interpretation: Patients needing transfer include those who have come to the emergency but need to be transferred to another organisation or those already admitted but who now require care in another organisation. It also includes patients being shifted for diagnostic tests. The transfer shall be done in a safe manner which includes pre-transfer stabilisation where appropriate, choosing the mode/vehicle for transport, equipment and monitoring required during the transfer.

d. Staff is aware and trained on these processes.

Interpretation: The staff accompanying shall at least be a trained trauma technologist/emergency technologist/nurse. The staff shall have undergone training in basic or advanced cardiopulmonary resuscitation as appropriate. Further, the staff identified shall be aware of the transfer procedure. A doctor shall accompany an unstable admitted patient who is being transferred out or being shifted for diagnostic purposes.

Standard

AAI. 5 **There is an appropriate mechanism for transfer (in and out) or referral of patients.**

Objective Elements

a. Written guidance is available for the transfer in of patients into the organisation.

Interpretation: This shall address both planned and unplanned transfers. For unplanned transfers and in case of suspected unstable patients, the organisation could send a suitably trained person with the ambulance. However, this shall be guided by the information received by the organisation. It is a good practice to provide feedback to the referral organisation/doctor on patient's clinical status for transfer in cases.

b. Written guidance is available for the transfer-out/referral of stable and unstable patients to another facility in an appropriate manner.

Interpretation: Patients needing transfer include those who have come to the emergency but need to be transferred to another organisation or those already admitted but who now require care in another organisation. It also includes patients being shifted for diagnostic tests. The transfer shall be done in a safe manner which includes pre-transfer stabilisation where appropriate, choosing the mode/vehicle for transport, equipment and monitoring required during the transfer. In case the organisation is unable to meet some of the stated requirements, the reasons for the same shall be documented.

c. Written guidance identifies staff who are responsible for the patient during transfer/referral.

Interpretation: The staff accompanying shall at least be a trained trauma technologist/emergency technologist/nurse. The staff shall have undergone training in basic or advanced cardiopulmonary resuscitation as appropriate. Further, the staff identified shall be aware of the transfer procedure. A doctor shall accompany an unstable admitted patient who is being transferred out or being shifted for diagnostic purposes.

d. The organisation gives a summary of patient's condition and the treatment which was given.

Interpretation: The organisation gives a transfer summary mentioning the significant findings and treatment given to all patients who are being transferred from the emergency ward/or patients being transferred for diagnostic and therapeutic purposes. In case of a patient being discharged from the organisation and transferred out, a discharge summary is given to such patients, including those patients going against medical advice. A copy of the same shall be retained by the organisation.

Standard

AAI. 6 **Emergency patients cared for by the organisation undergo an established initial assessment.**

Objective Elements

a. The organisation defines and documents the content of the initial assessment for emergency patients.

Interpretation: The organisation shall have a standardised format for initial assessment of patients in the emergency area. The format shall be designed to ensure that the laid-down parameters are captured. The initial assessment could be standardised across the hospital, or it could be modified depending on the need of the department. In the emergency, this shall include recording the vital parameters.

For in-patients getting admitted from emergency, this shall cover history, examination, including vital signs and documentation of any drug allergies. It shall mention the provisional diagnosis. If a detailed assessment has been done earlier (emergency on the same day), it need not be written in detail again. However, there shall be a comment linking the assessment to the earlier assessment, and the findings of all such assessments shall be reviewed and/or verified. Initial assessment shall include reconciliation of medications for IP patients.

b. The organisation determines who can perform the initial assessment.

Interpretation: The organisation determines who can do what assessment. Various categories of staff could do the assessment. Caregivers perform initial assessment within their scope of practice, registration and applicable laws and regulations. Psychological, spiritual, cultural, social and economic aspects of initial assessment for in- patients could be done by various healthcare professionals. The organisation defines the process by which contents of the assessment (initial assessment and diagnostic) performed by a qualified and privileged healthcare professional associated with the hospital is accepted in to the system of patient care. For example, patients referred by visiting consultant.

c. The organisation defines the time frame within which the initial assessment is completed based on the patient's needs.

Interpretation: The organisation shall define and document the time frame within which the initial assessment is to be completed concerning emergency department; and the same shall be implemented. In the case of emergency, the time frame shall be from the time the patient arrives in emergency department until the initial assessment is completed. The maximum time frame within which

the initial assessment is completed in emergency is within one hour. Patients may be assessed earlier depending upon clinical need. The initial assessment for emergency patients is documented as per the patient's condition and as defined in the triage policy.

d. Initial assessment also includes nursing assessment which is done at the time of admission and this is documented.

Interpretation: The initial assessment shall identify the nursing needs and also help identify any special needs of the patient. It shall be completed within a defined time frame. A checklist or template could be used for the same. Abridged nursing documentation may be used

e. The initial assessment results in a documented working diagnosis, work-up plan and management plan which is signed by the emergency doctor.

Interpretation: The care plan shall be documented by the treating doctor or by a doctor member of the treating team in the patient record and followed. The care plan is prepared and documented based on initial assessment and result of diagnostic tests if available. It shall include a provisional diagnosis/differential diagnosis, relevant diagnostic investigations when required; initial treatment suggested and specific instructions if any. The care plan shall be subject to modifications or changes at reassessments. The care plan reflects the desired results of the treatment, care and service.

Standard

AAI. 7 **Patients cared for by the organisation undergo a regular reassessment.**

Objective Elements

a. Patients are reassessed at appropriate intervals.

Interpretation: After the initial assessment, the patient is reassessed periodically, and this is documented in the case sheet. Re- assessment shall be done for all care givers as applicable. The frequency may be different for different patients based on the setting of emergency department, and the patient's condition, for example patients in emergency department need to be reassessed more frequently compared to a patient in the ward. Reassessments shall also be done in response to significant changes in patients' condition. Every patient shall be reassessed at least twice during their stay in Emergency department by the emergency team doctor or a doctor from the treating team. Caregivers perform reassessment within their scope of practice, registration and applicable laws and regulations.

b. Staff involved in direct clinical care, documents reassessments.

Interpretation: Actions taken under reassessment are documented. The staff shall be the treating doctor of emergency or any member of the team as per their domain of responsibility of care. At a minimum, the documentation shall include vitals, systemic examination findings and medication orders. The nursing staff can document a patient's vitals. Only phrases like “patient well”; “condition better” shall not be acceptable.

c. **Patients are reassessed to determine their response to treatment and to plan further treatment or discharge from the emergency department.**

Interpretation: The care plan is monitored to assess its effectiveness in achieving the desired results of the treatment, care or service. The care plan shall be dynamic and modified where necessary according to the patient's condition by the treating doctor or a doctor member of the emergency department. The change in the care plan is documented in the medical record. Different sections of the medical record, such as progress notes, doctor's orders or medication charts, could show evidence of the change in the care plan. Discharge from emergency shall be planned accordingly.

Standard

AAI. 8 **Patient care is continuous and multidisciplinary in nature.**

Objective Elements

a. **During all phases of care, there is a qualified medical professional responsible for patient's care.**

Interpretation: For all patients cared for by the emergency department, there is a qualified doctor identified as responsible for care. Although a team may provide care, the hospital record shall identify a doctor as being responsible for patient care. Written guidance exists for contingency situation such as on call doctors not responding to the call for various reasons.

b. **Information is exchanged and documented during each staffing shift, between shifts and during transfers to units/departments./other medical facilities.**

Interpretation: Change of shift and change of unit handover by doctors, and nurses involved in direct patient care shall be standardised and documented. Information shared shall consist of the patient's current condition, recent changes in condition, ongoing treatment and possible changes or complications. Situational briefing techniques such as the SBAR (Situation, Background, Assessment and Recommendation) process can provide a standard framework for handovers. Read-back, multidisciplinary rounds, teach-back, involving patients and families in the process of care are other modalities to ensure and streamline handover communication.

c. **Transfers between departments/units are done in a safe manner.**

Interpretation: The organisation shall ensure that intra-organisation transfers are done adhering to safe practices. The patients shall be transported safely,and a proper handover and takeover shall be documented. Patients are transported in a safe and timely manner to and from the imaging services. The system shall be in place to ensure that the conduct of imaging tests is not delayed due to delay in transportation. This shall also address the transfer of unstable patients.

d. **Written guidance is available to guide the referral of patients to other departments/ specialties.**

Interpretation: Referral could be for opinion, co-management or takeover. The referral note shall mention the reason for the referral. It could be graded into immediate, urgent, priority or routine category. All referrals shall be based on clinical significance and for a better outcome. All referrals shall be seen

within a defined timeframe. The timeframe could be different based on the urgency of referral. The organisation has written guidance for the referral of patients to other departments or specialities.

Standard

AAI. 9 **The Emergency Department has a documented discharge process.**

Objective Elements

a. **The patient's discharge process is discussed with the patient and/or family.**

Interpretation: The patient's treating doctor determines the readiness for discharge/ admission to definitive department/ward during regular reassessments. The same is discussed with the patient and family. Patients are informed of their next follow up where appropriate. Instructions are provided in the language the patient can understand and documentation is done.

b. **Written guidance exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).**

Interpretation: The discharge procedures are documented to ensure coordination amongst various departments, including accounts so that the discharge papers are completed well within time. For medicolegal cases (MLC) and absconded cases, the organisation shall ensure that the police are informed about the discharge.

c. **Written guidance is in place for patients leaving against medical advice and patients being discharged on request.**

Interpretation: The treating doctor shall explain the consequences of this action to the patient/attendant. The written guidance could address the reasons for leaving against medical advice (LAMA) for any possible corrective and/or preventive action by the organisation with standardized documentation forms available for this eventuality.

d. **A discharge summary is given to all the patients leaving the hospital from the emergency department (including patients leaving against medical advice and on request).**

Interpretation: The organisation hands over the discharge summary and reports to the patient/attendant in all cases, and a copy is retained in the medical record. In LAMA cases,the patient's right to refuse treatment and his/her request to leave the organisation is respected, the declaration of the patient/attendant is to be recorded in a proper format, and a discharge summary and all reports are handed over as usual. The terminology used to refer to such patients may differ, but the intent of issuing the discharge summary with reports remains the same. In case of death, a death summary is given to the next of kin/relatives.

e. **The organisation defines the content of the discharge summary.**

Interpretation: Discharge summary shall have following minimum content:

- Patient's name

- Unique identification number
- Name of the treating doctor
- Date of admission and date of discharge
- Reasons for admission
- Significant findings, diagnosis and the patient's condition at the time of discharge
- Information regarding investigation results
- Any procedure performed
- Medication administered
- Any other treatment given.

In addition to the name of the treating doctor, it could also have the name of the other consultants involved in the treatment.

Standard

AAI. 10 **The Emergency Department has a complete and accurate medical record for every patient.**

Objective Elements

a. Every medical record has a unique identifier.

Interpretation: The medical record shall have a unique identifier number. Every sheet in the medical record shall have this unique identifier This shall also apply to records on digital media. In case of electronic records, all entries for one unique identifier shall be available in one place, and/ or traceable to the number

b. Organisation policy identifies those authorized to make entries in medical record.

Interpretation: The organisation shall have written guidance for authorising who can make entries and the content of entries. This could be a different category of staff for different entries, but it shall be uniform across the organisation. For example, medication orders by doctors, medication administration chart by nurses and nutritional assessment by dieticians.

c. Entry in the medical record is named, signed, dated and timed.

Interpretation: All entries shall be documented immediately but no later than one hour of completion of the assessment/procedure. For records on electronic media, it is preferable that the date and time are automatically generated by the system.

d. The author of the entry can be identified.

Interpretation: This could be by writing the full name or by mentioning the employee code number, or with the help of a stamp, etc. In case of electronic-based records, provision for authorised e-signatures, as per statutory requirements, must be kept.The identity of the person who has made the entry shall be traceable. This could be done by either writing the name against every entry or by having a 'master signature list' in the medical record which has the name of the person against the signature or by stating the employee code number against every entry

e. **The record provides a complete and chronological account of patient care.**

Interpretation: The medical record has all the identified sheets filed in sequential order. Entries in the components of the record are filed in chronological order. It shall be ensured that all medico-legal case records have mandatory information. In case a sheet is missing a note to that effect would be put in the medical record. It is preferable that the pages in the medical record are numbered. Standardized Forms exists to make the process smother when it comes to Triage, HPI Ordering of Test, Treatments Admission, Transfer, AMA, Death, Discharge.

Standard

AAI. 11 **The medical record reflects continuity of care.**

Objective Elements

a. **When a patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital where applicable.**

Interpretation: The medical record shall contain the date of transfer, the reason for transfer and the name of the receiving organisation. It is mandatory to mention the clinical condition of the patient before transfer. If the patient has been transferred at his/her request, a note may be added to that effect. In such instances, the name of the receiving organisation could be the name the patient desires to go. In such instances, the name of the receiving organisation could be recorded accordingly.

b. **The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.**

Interpretation: The discharge summary shall be signed by a doctor member of the treating team. The electronically signed out medical records are acceptable.

c. **In case of death, the medical record contains a copy of the death certificate.**

Interpretation: This shall mention the cause date and time of death. Medical certificate of the cause of death as per the international classification of the cause of the death (WHO), shall be a part of medical record. Cardiac and respiratory arrest is an event of death and not the cause of death. The form shall be filled following the guidance specified in 'Physicians' Manual on medical certification of cause of death issued by Government of India.

Refer Annexure on NABH standards on recording cause of death at health facility

d. **Care providers have access to current and past medical record.**

Interpretation: The organisation shall provide access to medical records to designated healthcare providers (those involved in the care of that patient). For electronic medical record system, identified care providers shall have a user ID and a password. A provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care. In case of physical records, when the MRD is not open, there shall be a system in place by which authorised personnel can access the MRD and retrieve the record. For all existing hospital patients coming to the emergency room, medical records shall be retrievable.

CHAPTER 2

Patient Care and Rights (PCR)

Intent of the chapter

Patients in the Emergency Department are provided urgent care in consonance with their clinical requirements and in accordance to the statutes of the land. Policies and procedures guide the activities in the Emergency Department including the ambulance services. Standard protocols are uniformly followed for cardio-pulmonary resuscitation and provision of resources and trained manpower is available for satisfactory resuscitation efforts.

There are also policies and procedures to guide the nursing practices for the patients in the Emergency Departments. Patients may need to undergo surgical or other clinical procedures in the Emergency Department and there are safeguards in place to prevent any adverse events. Situations needing special attention such as sedation, restraints, end of life care and pain management and recognized and attended to according to laid down policy and procedure.

The rights and responsibilities of the patient and family are outlined. The staff is aware of these and is trained to protect patient rights. Patients are informed of their rights and educated about their responsibilities at the time of admission. Regardless of paying capacity of patient, emergency care should be provided to all patients attending the Emergency Department. A documented process for obtaining patient and/or families consent exists for informed decision making about their care.

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

SUMMARY OF STANDARDS

PCR.1	The ambulance services are commensurate with the scope of the services provided by the organisation.
PCR.2	The emergency department plans for handling community emergencies, epidemics, mass casualty incidents and other disasters.
PCR.3	The care of patients requiring cardio-pulmonary resuscitation is guided by evidence based written guidance document.
PCR.4	Nursing care to patients is provided in accordance with written guidance document.
PCR.5	Clinical procedures are performed in a safe manner.
PCR.6	Documented policies and procedures guide the care of patients under special conditions such as restraints (physical and/or chemical), pain management.

PCR.7	Patient and family rights support individual beliefs, values and involve the patient and family in the decision making processes.
PCR.8	A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.
PCR.9	The emergency department has a system for effective communication with patients and /or families.
PCR 10	The care of critically ill and injured patients is guided by an appropriate written guidance.

Standards and Objective Elements

Standard

PCR.1 **The ambulance services are commensurate with the scope of the services provided by the organisation.**

Objective Elements

a. **The organisation has access to ambulance services commensurate with the scope of the services provided by it.**

Interpretation: Commensurate to its scope of services, the organisation may provide in-house or use out-sourced ambulance service for safe patient transport with appropriate care. Turn around time for outsourced and in house ambulance should be recorded for quality monitoring purposes.

The organisation shall decide the appropriate level of an ambulance to be provided based on the National Ambulance Code AIS-125.

b. **There are adequate access and space for the ambulance(s).**

Interpretation: The organisation shall demarcate a proper space for the ambulance(s). The demarcation shall be done keeping in mind easy accessibility for receiving patients and enabling the ambulance(s) to exit quickly. Adequate and prominent signage shall exist to guide the ambulance drivers to the ambulance entry and route to the emergency department. It is preferable that the organisation has an ambulance parking bay.

c. **The ambulance(s) is fit for purpose and is appropriately equipped.**

Interpretation: The vehicle used as an ambulance shall adhere to statutory requirement for example registration as an ambulance under the Motor Vehicle Act, valid fitness certificate, pollution control certificate, and insurance of the vehicle.

An ambulance shall have at least basic life support equipment, for both adult and paediatric patients. Based on the organisation's scope, additional equipment, for example monitoring and resuscitative equipment, shall be available in the ambulance.

Refer to National Ambulance code AIS-125.

d. **The ambulance(s) is operated by trained personnel.**

Interpretation: The ambulance shall be operated by a driver with a valid driving licence Additionally, technician/nurse and/or doctor may be there depending on the situation and scope of the ambulance. Personnel in the ambulance shall have training in basic life support and be trained in basic cardiopulmonary resuscitation.

e. **The ambulance(s) is checked daily for functioning status, medical equipment, emergency medications and consumables.**

Interpretation: The check shall indicate the functioning status of the ambulance like lights, siren, beacon lights, fuel, tyres etc.

The checks shall indicate the functioning status of the medical equipment based on a documented checklist.

Emergency medications are available in the ambulance during patient transport. Based on a checklist, a daily check is done to ensure availability and expiry dates of emergency medications and documented. After the return from every trip, medications used shall be topped up if used and the same verified and documented. The medications shall be stored in a safe environment as per policy of the organisation. In case the organisation follows a system of sealing the emergency medication kit, then the check shall be carried out after each use of the kit.

f. The ambulance(s) has a proper communication system.*

Interpretation: The ambulance shall be connected with the organisation/control room by wireless/mobile phones. The communication system shall encompass the whole process of patient transport. There shall be written guidance by the organisation as to how a call for patient transport is received, who are the people expected to respond and organise the transport. The communication ensures that the ambulance leaves the hospital within a predefined timeframe based upon the patient's needs.

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

Interpretation: From the time of first communication with the patient/ patient's attendant, a file is created to record appropriate information, attempts are made to gather important clinical information (patient's age, weight, provisional diagnosis and ongoing treatment at the referring organisation). This information is used by the ambulance personnel of the receiving organisation to be better prepared to assess, initiate emergency care/interventions during transit and transport the patient safely. The organisation shall ensure to focus on pre-hospital emergency care for seriously ill or injured patients before they reach hospital, and during emergency transfer to organisation or between organisations.

During the transit, when required, there is an exchange of information between the ambulance personnel and the medical professional at the receiving organisation. The information will help the doctor at the receiving organisation guide the ambulance personnel to facilitate the management during the transit.

When the patient is being shifted by an external agency, wherever possible, an attempt is made by the doctor of the receiving organisation to communicate with the ambulance personnel of the external agency to ascertain the clinical situation and make appropriate suggestions. However, the medical professional in the ambulance would be responsible for decision-making regarding the care/interventions during the transit.

Standard

PCR.2 **The Emergency Department plans for handling community emergencies, epidemics, mass casualty incidents and other disasters**

Objective Elements

a. The organisation identifies potential community emergencies, epidemics and other disasters.*

Interpretation: The organisation shall identify potential community emergencies, epidemics and other disasters likely to cause a sudden rush of victims. Some examples include earthquake, floods, train accident, civil unrest outside the organisation's premises, major fire and outbreak of disease/epidemics.

These shall be identified based on geographical location and the community served by the organisation. For example, an organisation in an industrial town shall identify the industrial hazards that may occur in its vicinity.

b. The organisation manages community emergencies, epidemics and other disasters as per a documented plan.*

Interpretation: The disaster, community emergency and epidemic plan must incorporate essential elements of alert code, information and communication, action cards for each of the staff, availability and earmarking of resources including adequacy of medical supplies, equipment, materials, trained personnel, establishment of command nucleus, training and mock drills, and managing clinical activities during the event. The emergency room could follow triage policy according to the National Disaster Management Authority (NDMA) guidelines.

It shall also include aspects like activating and deactivating plan; receive, identify and triage casualties; defined areas for reception and treatment for casualties; transportation aids; communication aids; manage visitors, and control the movement of individuals and vehicles, relocate/discharge admitted patients wherever needed.

The plans shall conform to the relevant local laws and national plans on disaster management. A good reference is NDMA guidelines.

c. Provision is made for availability of medical supplies, equipment and materials during such emergencies.

Interpretation: Resource availability shall be according to threat perception. The number of resources, i.e. medical consumables, equipment, etc. to be commensurate with the expected workload.

d. The plan is tested at least twice a year.

Interpretation: Testing twice a year is only the minimum frequency, and this may be increased. In case the organisation has different plans for different disasters, each of the plans shall be tested at least twice a year.

The plan can be tested using a table-top exercise, or a mock drill. At a minimum, at least one mock drill shall be held once in 12 months. This shall test all the components of the plan and not just awareness. In the case of a mock drill, simulated patients (not real) shall be used. After every table-top exercise/mock drill, the variations are identified, the reason for the same is analysed, debriefing conducted and where appropriate the necessary corrective and/or preventive actions are taken.

Standard

PCR.3	**The care of patients requiring cardio-pulmonary resuscitation is guided by evidence based written guidance document**

Objective Elements

a. Cardio-pulmonary resuscitation services are available and provided to patients at all times.

Interpretation: The organisation shall document the procedure for cardio-pulmonary resuscitation (CPR) for adults across all areas in the organisation. This shall be in consonance with accepted practices. Where appropriate, it shall also address obstetric, paediatric and neonatal patients. The organisation shall ensure that medical equipment for resuscitation and medications for basic and advanced life support are provided in standardised manner. Basic life support shall be initiated as soon as a condition requiring CPR is identified. This shall be implemented in all areas of the organisation. The protocols could be displayed prominently in emergency, and all crash carts etc.

b. During cardio-pulmonary resuscitation, assigned roles and responsibilities are complied with.

Interpretation: The CPR team members have a clear understanding of their roles and responsibilities during the resuscitation to effectively function as a team.

c. Medical equipment and medications for use during cardio-pulmonary resuscitation are available in the organisation.

Interpretation: At a minimum, emergency medications and equipment for intubation based on the needs of the patients served shall be available in patient care areas. Other equipment like defibrillator shall be easily accessible to ensure that there is no delay in cardio-pulmonary resuscitation. It is preferable that the minimum emergency medication is standardised across the organisation.

d. The events during cardio-pulmonary resuscitation are recorded.

Interpretation: In the actual event of cardio-pulmonary resuscitation, or a mock drill of the same, all the activities along with the personnel attended shall be recorded. At the minimum, it will include timeliness of response, availability of human resources, equipment, drugs, and barriers if any. The recording could be done using the pre-defined procedural checklist and by monitoring whether the prescribed activity has been performed properly and in the right sequence.

It is a good practice to debrief team members regarding the necessary immediate corrective and preventive action.

e. A multi-disciplinary committee does a post-event analysis of cardio-pulmonary resuscitations

Interpretation: The frequency of the committee meeting shall be at least once a quarter. The analysis shall focus on the initiation of CPR, time of arrival of the team, availability of required resources, recording of the sequence of events during CPR (including technique) and the overall coordination. The organisation shall monitor outcome of CPR and identifies areas for improvement. The multidisciplinary committee shall be independent and include at least one physician/cardiologist, anaesthesiologist, one member from the code blue team and nurse. The analysis shall be completed within a defined time frame.

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

Interpretation: Corrective and preventive measures shall be completed within a defined time frame. The findings of the post-event analysis are communicated to the personnel participated in the CPR. Any lapses shall be discussed, with the view to improve the outcomes in future. During subsequent resuscitations, it is preferable that implementation of these actions is noted and training be modified, if necessary.

Standard

PCR.4 **Nursing care to patients is provided in accordance with written guidance document.**

Objective Elements

a. Nursing care is provided to patients in accordance with written guidance.*

Interpretation: The written guidance could be in the form of a nursing manual/SOPs incorporating various basic nursing practices and procedures. Examples of these are monitoring vital parameters, administration of medications, basic hygiene needs of the patient, etc.

Care of patients in specific clinical situations shall be guided by nursing clinical practice guidelines based on best clinical practices. The nursing clinical care guidelines/pathways shall be reviewed annually at the minimum, and revised as appropriate.

Examples of nursing clinical practice guidelines include prevention of fall, prevention of development of pressure ulcers in an in-patient, and deep venous thrombosis risk assessment and prevention.

b. Assignment of patient care is done as per good clinical / nursing practice.

Interpretation: Assignment shall be based on the patient's clinical requirements, the competence of the nursing staff, and shall align with the guidelines laid down by regulatory and professional bodies in this regard.

c. The organisation implements acuity-based staffing to improve patient outcomes.

Interpretation: Patient outcomes are linked to acuity-based staffing of nursing personnel, in terms of numbers and competence. Examples of outcomes include incidence of pressure sores, falls, medication administration errors, ventilator-associated pneumonia, etc.

d. Nursing care is aligned and integrated with overall patient care which is documented.*

Interpretation: Care shall be provided as per the nursing care plan, which is individualised as per the clinical needs of the patient. Wherever a patient care plan has been developed, the nursing care plan shall be aligned with the same. Uniformity and continuity of care shall be practised.

Components of the nursing care plan include:

- Assessment
- Plan of care
- Implementation of care
- Evaluation
- Modification of plan of care as may be required

The documentation includes all nursing-related care and not just monitoring of vitals and documentation of medication administration. The nursing progress shall be documentedin a timely manner for the individual patient.

e. Nurses are provided with the appropriate and adequate equipment for providing safe and efficient nursing care.

Interpretation: There shall be an adequate number of nebuliser machines, glucometers, sphygmomanometers, thermometers, weighing scale(s), and other basic equipment/gadgets necessary for functioning in the designated area. Further, the equipment shall be appropriate for the area. For example, the BP cuffs in the Paediatric area shall be of appropriate size.

f. Nurses are empowered to make patient care decisions within their scope of practice.

Interpretation: The organisation shall define the patient care decisions that come under the scope of nursing practice. Nurses shall be aware of the same and be able to make appropriate nursing-related decisions in a timely manner.

Standard

PCR.5 **Clinical procedures are performed in a safe manner.**

Objective Elements

a. Clinical procedures are performed based on the clinical needs of the patient.

Interpretation: The decision to perform a procedure shall be based on the clinical needs of the patient, in consonance with standard treatment guidelines and/or sound clinical practice for the given condition/procedure. A qualified medical practitioner decides if the procedure is indicated. When multiple procedure options exist, the decision shall be based on which option is likely to provide the best outcome, and also taking into consideration, the patient wishes and safety. The organisation could conduct a clinical audit of various procedures to achieve the best possible outcomes.

b. Performance of various clinical procedures is based on written guidance and done in a safe manner. *

Interpretation: The written guidance is a broad guideline applicable to all procedures - diagnostic, therapeutic, and supportive. The written guidance shall incorporate as to who will do the procedure, the pre-procedure instructions where applicable, the conduct of the procedure and post-procedure instructions and care, where applicable.

The organisation shall establish and implement safe use of equipment used for performing procedures and treatments. A brief assessment, including at least patient's vitals is done prior to performing the procedure.

c. Qualified personnel order, plan, perform and assist in performing procedures.

Interpretation: The personnel performing or assisting a procedure shall be privileged for the same.

d. Care is taken to prevent adverse events like a wrong patient, wrong procedure and wrong site. *

Interpretation: The organisation shall use a documented check-list to prevent adverse events like a wrong patient, wrong procedure and wrong site. This could be based on the WHO safety check-list or its modification. At least two identifiers shall be used to identify the patient out of which one shall be the unique identification number. Besides, the organisation shall have a procedure to identify the site of the

procedure, where appropriate. The organisation identifies those invasive procedures within its scope where a pre-procedure checklist could be used to mitigate the risk of wrong-site/side, wrong patient and wrong procedure.

The responsibility for ensuring the correct site and side where applicable/patient/procedure verification rests with all team members. However, the person performing the procedure carries ultimate responsibility. In case the procedure is being performed by a person in training, the supervising clinician carries ultimate responsibility.

In emergencies, all attempts shall still be made to identify the correct site (including side where applicable)/patient/procedure according to the laid down guidance, although it may not be possible or appropriate to complete all the checks. Any exceptions to the full protocol shall be documented in the medical record.

Patient and/or relatives shall be involved during site marking in ensuring correct patient, correct procedure and correct site whenever possible.

e. Informed consent is taken by the personnel performing the procedure, where applicable.

Interpretation: The informed consent shall be taken by the person performing the procedure or a doctor from the treating team. In case the procedure is being done by a person in training, it shall specify the same, and shall be supervised by the treating doctor.

f. Patients are appropriately monitored during and after the procedure.

Interpretation: At a minimum, for invasive procedures, this shall include pulse, blood pressure and respiratory rate and any other parameter as clinically required. The extent and duration of monitoring may be tailored to the need based on the complexity of the procedure and the co-morbidities of the patient.

g. Procedures are documented accurately in the patient record.

Interpretation: The documentation shall mention the name of the procedure, the person who performed the procedure, salient steps of the procedure, key findings and the post-procedure care. All documentation shall have name, date, time and signature.

Standard

PCR.6 **Documented policies and procedures guide the care of patients under special conditions such as restraints (physical and/or chemical), pain management.**

Objective Elements

a. Written guidance is provide the care of vulnerable patients and special requirements.

Interpretation: Written guidance for Identification and management of vulnerable patients is developed in consonance with statutory requirements, national and international guidelines.

It shall include (but not limited to) elderly, children, differently-abled and/or mentally challenged, patient

with risk of suicide, self-harm, comatose, critically ill, patients under sedation and anaesthesia, pregnant women, patients on dialysis, patients receiving chemotherapy, immunosuppressed patients, etc. The guidance shall state who is responsible for identifying these patients, risk management in these patients and monitoring of these patients (at least twice a day).

The guidance shall include how informed consent is obtained from a vulnerable patient, and from the family or legal representative of a patient incapable of making an independent decision.

The care is organised and delivered in accordance with written guidance.

Refer to the glossary for a definition of "vulnerable patient".

b. Patients on restraints are monitored appropriately.

Interpretation: Restraints include physical and chemical restraints. Written guidance is used to identify patients who need restraints and provide care to them. The written guidance shall incorporate the suggested situations where restraints could be used. It shall also specify as to who can authorise the use of restraints, the frequency of monitoring these patients and the validity of restraint orders. The need for restraints is regularly reassessed, and the least invasive restraint is selected if required. The rationale for using restraints is explained to the family, and consent is obtained where appropriate (as directed by statutory requirements). These patients shall be monitored more frequently for the complications that the restraints may cause. For example, neurovascular deficit. When restraints are used, the following shall be documented in the medical record: the reason for using restraints and the time frame during which restraints were used.

c. Patients receiving sedation are monitored appropriately.

Interpretation: Written guidance based on standard treatment guidelines/sound clinical practices govern the administration of procedural sedation. At a minimum, this shall include identification of areas in the organisation where procedural sedation is administered and procedures are performed. Written guidance also includes the mechanism for writing orders, the pre-procedure assessment, monitoring during and after the procedure and the discharge/transfer out criteria after the procedure. A pre-sedation assessment shall be performed and documented to evalu¬ate risk and appropriateness of procedural sedation for the patient. The scope and content of this assessment shall be based on professional guidelines and are defined in written guidance.

d. The organisation respects and supports management of pain and patient and family are educated about the same.

Interpretation: Written guidance based on sound clinical practices govern the care of patients in pain. The patients in pain receive care according to pain management guidelines and according to patient goals for pain management. It shall include as to how patients are screened for pain, the mechanism to ensure that a detailed pain assessment is done (when necessary), pain mitigation techniques and monitoring. Patients and their families are educated on this aspect.

Standard

PCR.7 **Patient and family rights support individual beliefs, values and involve the patient and family in the decision making processes.**

Objective Elements

a. **Patients and family rights include respecting values and beliefs, any special preferences, cultural needs, and responding to requests for spiritual needs.**

Interpretation: This could include how they wish to be addressed, dietary preferences and worship requirements. This may also include any specific requirement following death.

b. **Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.**

Interpretation: During all stages of patient care, be it in the examination or carrying out a procedure, hospital staff shall ensure that the patient's privacy and dignity are maintained. The organisation shall develop the necessary guidelines for the same. During procedures, the organisation shall ensure that the patient is exposed just before the actual procedure. With regards to photographs/recording procedures, the organisation shall ensure that explicit informed consent is taken and that the patient's identity is not revealed.

c. **Patient and family rights include protection from neglect or abuse.**

Interpretation: Examples of this include falling from the bed/trolley due to negligence, assault, repeated internal examinations (unwarranted), manhandling, etc. Special precautions shall be taken, especially concerning vulnerable patients, for example elderly, neonates, physically and mentally challenged patients, comatose patients, patients under anaesthesia etc.

d. **Patient and family rights include treating patient information as confidential.**

Interpretation: The organisation and the treating team shall take effective measures to maintain the confidentiality of all patient-related information. Staff shall avoid having patient-related discussions in public places. Statutory requirements regarding privileged communication shall be followed at all times (refer the glossary for a definition of privileged communication). Confidential information, including HIV status, shall not be revealed without the patient's permission. It shall not be explicitly written/pasted on the cover of the medical record, nor shall it be displayed in a manner that is easily understandable by the public at large.

e. **Patient and family rights include the refusal of treatment.**

Interpretation: The treating doctor shall discuss all the available options and allow the patient to make an informed choice. In case of refusal, the treating doctor shall explain the consequences of the refusal of treatment and document the same. After explanation of consequences, if the patient still refuses treatment, the same must be respected.

f. **Patient and family rights include a right to seek an additional opinion regarding clinical care.**

Interpretation: There is a mechanism for patient and family to seek a second opinion if they wish, from within or outside the organisation. The organisation shall respect the decision of the patient and family and facilitate access to all relevant information or clinical evaluation. Request for additional information on a particular physician in terms of qualifications and experience may be provided.

g. **Patient and family rights include informed consent before the transfusion of blood and blood components, anaesthesia, surgery, initiation of any research protocol and any other invasive / high-risk procedures / treatment.**

Interpretation: Informed consent shall be obtained by treating doctor or a doctor member of the treating team.

h. **Patient and family rights include a right to complain and information on how to voice a complaint.**

Interpretation: The displayed patient rights shall include the right to make a complaint and also mention the methodology to voice the same. Complaint mechanism must be accessible, and redressal of complaint must be fair and transparent.

i. **Patient and family rights include information on the expected cost of the treatment.**

Interpretation: Patients and families are explained about the expected costs of treatment in a transparent manner. This includes consultations, procedures and investigations. It may involve giving written estimates or making the concerned tariff available.

j. **Patient and family rights include access to their clinical records.**

Interpretation: The organisation shall ensure that every patient has access to his/her record. This shall be in consonance with the Code of Medical Ethics laid down by the Medical Council of India and statutory requirements.

k. **Patient and family rights include information on the name of the treating doctor, care plan, progress and information on their health care needs.**

Interpretation: Information on the name of the treating doctor, care plan, the progress of the patient and the healthcare needs are discussed with patient and family.

l. **Patient rights include determining what information regarding their care would be provided to self and family.**

Interpretation: The organisation needs to evolve a mechanism to provide sensitive and/or confidential information to the patient and the next of kin if desired by the patient. In the case of minors, it will be provided to at least one of the parents / guardian.

Standard

PCR.8 **A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.**

Objective Elements

a. **The organisation obtains informed consent from the patient or family for situations where informed consent is required. ***

Interpretation: A list of procedures shall be made for which informed consent is required. This shall be prepared to keep in mind the requirements of this standard and statutory requirement. For example, some statutory requirements are MTP Act, PC-PNDT Act and The Transplantation of Human Organs Act. The policy for HIV testing shall follow HIV and AIDS (prevention and control) act 2017 and the national policy on HIV testing laid down by National AIDS Control Organisation (NACO). The organisation shall

have written guidance explaining the various steps involved in the informed consent process and the person responsible. The staff are made aware of the same.

b. Informed consent process adheres to statutory norms.

Interpretation: This includes (but is not limited to):

i. Taking consent before the procedure;

ii. At least one witness signing the consent form.

The witness shall be a person who was present for the entire duration of the communication between the doctor and the patient.

In case the patient has to undergo a procedure repeatedly for a long time (for example dialysis),informed consent is taken at the first instance. Such consent shall have a defined validity period but not more than six months. The patient endorses the consent at each repeat treatment. However, if there is a change in the treatment modality or an addition of another modality, then fresh consent shall be obtained.

c. Informed consent includes information regarding the procedure; it's risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.

Interpretation: The consent shall have the name of the doctor performing the procedure. In case a procedure requires more than one doctor from different specialities, then the same will have to be explained to the patient and consent shall include the name of the principal surgeon from each speciality who is performing the procedure. Each doctor will have to explain his role and address all aspects required for informed consent. for example, if the surgery involves the requirement of a neurosurgeon, ENT surgeon and an Ophthalmologist, the consent shall reflect the same. It shall have the names of the principal surgeons of the three specialities. It is the responsibility of each of the surgeons/team to explain their role and the benefits/risks and alternatives of the procedures they are performing on the patient.

If it is a “doctor under training” the same shall be specified. However, the name of the qualified doctor supervising the procedure shall also be mentioned.

The consent form shall at a minimum be bilingual. When consent is taken in a language other than what the patient understands, there shall be clear documentation detailing the language in which the patient has been counselled and if any interpreter has been used.

It shall have the risks, benefits and alternatives of the procedure as a part of the documentation. The focus is on informed consent as a process of effective communication between a doctor and patient and not a signature on a form.

d. The organisation describes who can give consent when a patient is incapable of independent decision making and implements the same. *

Interpretation: The consent shall be taken from the patient in all cases when the patient is capable of giving consent and above the legal age for giving consent. No one can consent on behalf of a competent adult. The organisation shall take into consideration the statutory norms when the patient is incapable of independent decision making. This would include next of kin/legal guardian. The order of preference of next of kin/legal guardian is spouse, son/daughter/parents/brothers/sister. For life-threatening situations when a patient is incapable and next of kin is not available, in the interest of the patient, the treating doctor and another clinician can decide to safeguard the patients' life.

e. **Informed consent is taken by the person performing the procedure.**

Interpretation: The person performing shall be responsible for the entire consent process, including providing explanation and taking the signature. For example, it is not acceptable if the person performing the procedure only explains, and the written consent is taken by the nurse.

A doctor member of the team can take consent on behalf of the person performing the procedure.

Standard

PCR.9 **The Emergency Department has a system for effective communication with patients and /or families.**

Objective Elements

a. **Documented policies and procedures guide the effective communication with the patients and/or families.**

Interpretation: Communication is considered to be effective if it serves the purpose. The principles of effective communication are complied. For example, the seven C's namely clear, correct, complete, concrete, concise, considerate and courteous.The organisation has plans to identify and overcome potential communication barriers. For example, the language barrier could be overcome by having interpreters. The organisation could adopt any model of effective communication..

b. **The organisation shall identify special situations where enhanced communication would be required .**

Interpretation: Some of these situations could include communication during challenging situations like breaking bad news, handling adverse events, handling an aggressive patient/family, talking to a family of a patient who has expired, counselling for a complicated intervention etc.

c. **The organisation also defines what constitutes an unacceptable communication. and sensitizes, trains the staff about the same.**

Interpretation: The organisation shall not allow unacceptable communication. For example, abusing patients, hurting the religious or cultural sentiments, communicating with disrespect, etc. the staff is trained on this subject.

Standard

PCR.10 **The care of critically ill and injured patients is guided by an appropriate written guidance.**

Objective Elements

a. **The management of critically ill and injured including time sensitive conditions affecting patients in Emergency Department is guided by written guidance**

Interpretation: Management of critically ill and injured patients will be done according to an evidence-based protocol which is documented and is available to all the doctors and nurses and paramedical staff to follow triage system to guide the management of critically ill and injured patients in Emergency Department shall be well established.

b. **Written guidance shall be well established for resuscitation in the management of critically ill and injured patients in Emergency Department.**

Interpretation: Resuscitation and treatment of critically ill patients and injured patients shall be as per established protocol and a clear clinical pathway shall be available for the doctors and staff for guidance.

c. **Appropriate Referral and follow up process shall be well established for doctors and staff to follow for the management of critically ill and injured patients in Emergency Department.**

Interpretation: Appropriate referral to a sub specialty/ specialty shall be based on a written guidance. For example trauma, snake bite, metabolic syndrome etc.

d. **Doctors and staff involved in direct patient care shall be trained and periodically updated in management of critically ill and injured patients in Emergency Department.**

Interpretation: For example ACLS,ATLS,NALS,PALS training and periodic updates. Training in various codes for critically ill patients like code stroke, code PAMI, code trauma etc.

e. **Management of critically ill and injured shall be monitored by periodic audit and clinical indicators and corrective and preventive action based on the same.**

Interpretation: Performance clinical indicators like door to needle time and door to ballon time and time taken for triage are some of the examples of monitoring of outcomes for critically ill patients. Reference: Annexure on performance indicators. CAPA based on analysis, benchmark and threshold values shall be done.

CHAPTER 3

Management of Medication (MOM)

Intent of the chapter

The Emergency Department has a safe and organized medication process. The process includes policies and procedures that guide the availability, safe storage, prescription, dispensing and administration of medications.

The availability of emergency medication is stressed upon. The organisation should have a mechanism to ensure that the emergency medications are standardized, readily available and replenished in a timely manner. There should be a monitoring mechanism to ensure that the required medications are always stocked and well within expiry dates.

The process also includes monitoring of patients after administration and procedures for reporting and analyzing adverse drug events, which include errors and events.

SUMMARY OF STANDARDS

MOM.1	The organisation develops, updates and implements a hospital formulary and known to the emergency department staff.
MOM.2	Documented policies processes and protocols guide the requisition storage and replacement of emergency medications.
MOM.3	Medications are prescribed safely and rationally.
MOM.4	There are Policies, Processes and Protocols for reconstitution of emergency medications before administration.
MOM.5	There are Policies, Processes and Protocols to report and analyze near misses, medication errors and adverse drug events.
MOM.6	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used in a safe manner.
MOM.7	Medical supplies and consumables are stored appropriately and are available where required.

Standards and Objective Elements

Standard

MOM. 1 — **The organisation develops, updates and implements a hospital formulary and known to the emergency department staff.**

Objective Elements

a. **A list of medication appropriate for the patients and emergency department's resources is developed collaboratively by the multi-disciplinary committee.**

Interpretation: The multidisciplinary committee shall prepare the organisation's formulary. The formulary shall include medications necessary to meet the organisation's mission, patient needs and scope of services. The formulary could be prepared keeping in view the "National List of Essential Medicines" and "WHO Model List of Essential Medicines". It could also take into consideration the harm potential of the medication, interactions with other medications and likelihood of patient safety incidents. The organisation could look at the possibility of having system-wise/speciality wise formulary.

At a minimum, the formulary shall include the name of the molecule, formulation and strength(s). The organisation shall endeavour to limit the number of drug concentrations of a particular drug in the formulary.

Implants and devices are included in drugs and shall be included in the formulary

b. **The formulary is available for clinicians to refer and adhere to.**

Interpretation: The current formulary shall be made available to all treating doctors of the organisation. The organisation needs to ensure that clinicians have access to the current version of the formulary. The formulary could be made available in either physical or electronic form.

c. **The organisation adheres to the procedure for the acquisition of formulary medications.**

Interpretation: The procedure shall address the issues of vendor selection, vendor evaluation, reorder levels, indenting process, generation of the purchase order, and receipt of goods. The procedure also addresses managing stock-outs due to various reasons.

d. **The organisation adheres to the procedure to obtain medications not listed In the formulary.**

Interpretation: Local purchase/hotline, which takes care of the immediate requirement are examples of the procedure to obtain medications not listed in the formulary. Whenever there is the local purchase of a medication that is not listed in the formulary, the organisation shall have a process of evaluation, authorisation and ratification and decision-making on its subsequent inclusion in the formulary if necessary.

e. **There is a procedure to obtain medications when the pharmacy is closed or in case of stock outs.**

Interpretation: When the pharmacy is closed or in case of stock outs there shall be a standard operating procedure to procure the drugs. It is preferable that the organisation has a 24-hour pharmacy.

Standard

MOM. 2 **Documented policies processes and protocols guide the requisition storage and replacement of emergency medications.**

Objective Elements

a. Medications are stored in a clean, safe and secure environment while incorporating the manufacturer's recommendation(s).

Interpretation: The medication storage space shall be clean, safe and secure. The organisation shall adhere to the storage requirements of drugs as specified by the manufacturer. In the absence of manufacturer's instructions, the organisation shall develop and implement storage requirements. Storage requirements shall apply to all areas where medications are stored, including clinical areas.

Medications shall be protected from loss or theft throughout the organisation. Some of the ways of ensuring this is to limit access to medication storage areas to authorised team members, locking medication carts and never leaving them unattended, or storing medications in an area that is continuously staffed. It is preferable that the medication storage area is organised. Overall cleanliness of the storage area shall be maintained.

Vaccines shall be stored at the required temperature as per manufacturers recommendations. Where appropriate, temperature monitoring of the room, the cold storage area/refrigerator shall be done at least once a day. In case of areas which are not open all days, it shall be done on all working days.

Beyond expiry date drugs (before disposal), shall be stored separately and away from drugs which are intended for patient use.

b. Sound inventory control practices guide storage of the medications.

Interpretation: The Organisation shall follow inventory control practices like ABC, VED, FSN, First Expiry First Out, lead time analysis, etc. or a combination of these. The medicines could be stored in an alphabetical order of generic name.

To check for loss or theft, the organisation could conduct stock verification audits at regular intervals (as defined by the organisation) to verify the inventory and detect instances of loss or theft.

The organisation also has a mechanism for handling medications which are not part of the regular inventory. For example, not for sale medications including physician's samples.

c. High-risk medications including look-alike, sound-alike medications and different concentrations of the same medication are stored physically apart from each other. *

Interpretation: Many drugs in ampoules, vials or tablets may look-alike or sound-alike. These are identified periodically, and the Look-alike Sound-alike medications (LASA) list shall be made available in all units where drugs are stored. Different concentrations of the same drug need to be identified. The list shall be developed from the hospital formulary. The list will have to be revised at regular intervals depending on the changes in the formulary and changes in the packaging (in case of look-alike).

A good practice is to store the two identified look-alike/sound-alike drugs and/or different concentrations of the same drugs as far apart physically as is possible.. This is in addition to regular storage practices. In addition to the pharmacy, these storage practices shall be followed in patient care areas.

d. The list of emergency medications is defined and is stored uniformly. *

Interpretation: The list of emergency medications shall be prepared in consonance with sound clinical practices and documented. The list of drugs could be modified according to the needs of the clinical department for example emergency, ICU, physiotherapy, CATH lab etc. A crash cart would help the organisation to store these medications, i.e. the rows and drawers have defined medicines.

No other drug shall be kept stored with emergency medications.

e. Emergency medications are available all the time and are replenished promptly when used.

Interpretation: Adequate quantity of emergency medicines shall be stocked at all times. An inventory check shall be done at least daily to ensure this. In case the organisation follows a system of sealing the emergency cart, then the check shall be carried out after each use of the cart/once every month.

Standard

MOM. 3 **Medications are prescribed safely and rationally.**

Objective Elements

a. Medication prescription is in consonance with good practices / guidelines for rational prescription of medications.*

Interpretation: This shall address both outpatient and in-patient prescription.

The organisation shall ensure that clinicians are trained/sensitised on the rational prescription of medications.

WHO states: "Rational use of medicines requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community."

Code of Medical Ethics-2002" published by Medical Council of India shall be followed.

b. The organisation adheres to the determined minimum requirements of a prescription. *

Interpretation: Prescriptions generated within the organisation (IPD, OPD and emergency) shall be in accordance with national/international guidelines and regulatory bodies. At a minimum, the prescription shall have the name of the patient; unique hospital number; name of the drug (generic composition is mandatory except in the case of combinations of vitamins and/or minerals), strength, dosage instruction, duration and total quantity of the medicine; name, signature and registration number of the prescribing doctor. Error-prone abbreviations shall not be used. All prescriptions shall be written in capital letters. It is preferable to use digital prescription system to reduce errors.

Prescription errors or illegible prescriptions will be initialled after a single strikethrough and rewritten.

Good references are the Drugs and Cosmetics Act and the Code of Medical Ethics and Institution for Safe Medication Practices guidelines.

c. Drug allergies and previous adverse drug reactions are ascertained before prescribing.

Interpretation: Dug allergy and previous adverse drug reaction shall be ascertained during the initial consultation, before prescribing or at any point of time during care. It is a good practice to document drug allergies prominently in the medical record, both in OP and IP.

d. The organisation ensures that only authorised personnel write orders. *

Interpretation: Medication orders shall be written by a doctor who at a minimum, holds an MBBS qualification. In case there is any other category of staff authorised to write medication orders, the same shall be backed by a legislation or government order. The medication order card in the IP shall have the orders written by a doctor, even if it is the case of transcribing orders of the treating consultant from an OP record or an admission note. In facilities which use Electronic Medical Record (EMR), the doctor shall directly enter the prescription in the Hospital Information System (HIS) using his or her unique login. In case the HIS entry is made by an assistant, the same shall be verified and authorised by the doctor.

e. Medication orders are written in a uniform location in the medical records, which also include the patient's name and unique identification number.

Interpretation: All the orders for medicines shall be recorded on a uniform location of the medical record. Only medications written in this location shall be administered to the patient. It is imperative that medication orders that are written in any other location of the medical record be moved to this location, electronic orders, when typed, shall again follow the same principles. It is preferable that the prescription and the administration record is on the same sheet. This would help minimise medication errors. A drug 'Kardex' could be used for this purpose. The treatment orders are written daily or authorised daily in a 'Kardex' like format. Phrases like "CST"/" continue same treatment"/"repeat all"/"repeat 1,4,5,8" shall not be accepted.

Whenever there is a modification in the medication order in the existing order for a particular drug, a fresh order will have to be written for that drug for example, Tab. Paracetamol 500 mg QID changed to Tab. Paracetamol 500 mg BD - this shall warrant the first order to be discontinued and a fresh medication order to be written. A strike-through or over-writing of the previous order is not acceptable.

f. Medication orders are clear, legible, dated, timed, named and signed.

Interpretation: All hand-written medication orders shall be written in capital letters. In case abbreviations are used, a list of approved standardised abbreviations for medication orders shall be used throughout the organisation. Error-prone abbreviations shall not be used. A good reference is the Institution for Safe Medication Practices guidelines.

The identity of the person who has written the medication order shall be traceable. This could be done by either writing the name against every order or by having a 'master signature list' in the medical record which has the name of the person against the signature or by stating the employee code number against every medication order.

g. Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.

Interpretation: In case of medication orders which have two or more drugs (tablet/capsule/injection) the strength of all the individual drugs shall be written. This may not be applicable for preparations having a combination of vitamins and/or minerals. Medication orders shall be recorded separately if the strength differs for each time of administration.

There shall be a mechanism for taking action when medications orders are incomplete with respect to any of the above parameters.

h. Verbal orders are implemented by ensuring safe medication management practices. *

Interpretation: The organisation shall ensure safe medication management practices through written guidance and implementation of the same. The written guidance shall mention who can give a verbal order, when can it be given and how the order will be authenticated. Verbal orders shall be limited to urgent situations where immediate written or electronic communication is not practical. To the extent possible, their usage shall be limited. The organisation shall have an approved list of formulary drugs which can be ordered verbally. This list can be defined either by inclusion or exclusion.

i. The organisation defines and updates its list of high-risk medication(s). *

Interpretation: The organisation shall define and update its list of high risk medications periodically. High risk/high alert medications carry a heightened risk for adverse outcomes and catastrophic harm whenever there is an error. High-risk medications/high alert medications include medicines with low therapeutic window, controlled substances, psychotherapeutic medications, look-alike and sound-alike medications, and concentrated electrolytes. The list shall be available in the pharmacy and all clinical areas where high-risk medications are stored.

j. Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications and corrective and/or preventive action (s) is taken based on the analysis where appropriate.

Interpretation: The scope of the audit shall include:

- legibility, use of capitals in written orders;
- the appropriateness of the drug, dose, frequency, and route of administration, the presence of therapeutic duplication;
- the possibility of drug interaction and measures taken to avoid the same;
- the possibility of food-drug interaction and measures taken to avoid the same.
- scope for dosage adjustment in renal and hepatic impairment.
- the possibility of intravenous incompatibility.
- presence of inappropriate dilutions and duration of medications Infusions.

This shall be done at least once a month using a representative sample size.

It could preferably be done by a clinical pharmacologist/clinical pharmacist. In case there is no clinical pharmacologist/clinical pharmacist, it could be done by a multidisciplinary committee/team, who is trained in audit of medication orders/prescriptions. It is preferable that this is done for all prescriptions as 'live audit before the medicines are dispensed.

Where appropriate, a corrective and/or preventive action(s) is taken based on the root-cause analysis. The records of the same shall be maintained.

Standard

MOM. 4 **There are Policies, Processes and Protocols for reconstitution of emergency medications before administration.**

Objective Elements

a. Medications are administered by those who are permitted by law to do so.

Interpretation: Only a registered nurse or doctor with a minimum of MBBS qualification shall administer medication. In case there is any other category of staff authorised to administer medication, a legislation or government order shall back the same.

b. Prepared medication is labeled before preparation of a second drug.

Interpretation: Labelling is required when more than one drug is prepared and loaded. Examples of these are anaesthetic drug preparation in OTS. chemotherapy drugs etc.

c. Patient is identified prior to administration.

Interpretation: At a minimum, two identifiers shall be used for patient identification, with one of them being the unique identification number (for example hospital number/IP number, etc.) and full name of the patient.

d. Medication is verified from the medication order and physically inspected before administration.

Interpretation: Staff administering medications shall verify the medication order and ensure that medications are administered appropriately. The general appearance of the medication (for example melting, clumping, etc.) and the expiry dates shall be checked before administration. If any of the parameters concerning an order, such as name, strength, route or frequency or time are missing/incomplete, the medication administration shall be deferred, pending early verification by the treating team. In case the confirmation is obtained verbally, it shall be considered a verbal order and the procedure for verbal orders shall be adhered to.

In case of high-risk medication(s), the verification shall be done by at least two staff (nurse-nurse or nurse-doctor), independently and documented.

The nurses shall be knowledgeable regarding high-risk medications and shall be empowered to highlight prescription errors noted while verifying the orders.

e. Strength is verified from the order before administration.

Interpretation: The person administering the drug shall verify the strength from the medication order before administration. In case of discrepancy, medication administration shall be deferred.

f. The route is verified from the order before administration.

Interpretation: Where applicable, the site/ route of administration shall also be verified. Refer to MOM.4.d

g. Timing is verified from the order before administration.

Interpretation: The organisation shall have documentation to support the time of administration of drugs for which the time has not been written. For example, 1-1. 1, BD etc. The suggested timings for these medicines have to be adhered, "ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications" provide guidance on scheduling medications and classifies them into time-critical and non-time-critical. The organisation could adopt/adapt the same,

h. Medication administration is documented.

Interpretation: The organisation shall ensure that documentation of medication administration is done in a uniform location. It shall include the name of the medication, strength, route of administration, timing and the name/employee ID number and signature of the person who has administered the medication. Medicines administered shall be documented each time for each dose of the same medication separately. The records shall reflect the actual administration. For example, if brand Y was given in place of brand X (same generically), the documentation shall be of brand Y. Similarly, if the order was for a tablet of 250 mg. but the administration was ½ a tablet of 500 mg, the latter shall be documented. In the case of infusions, it shall capture the start time, the rate/volume of infusion and end time. In case of continuous infusion, the drop rate/volume shall be documented and the total volume infused shall be calculated for each shift.

i. Measures to govern patient's self-administration of medications are Implemented. *

Interpretation: At the outset, the organisation could define if it would permit the self-administration of medications. In case the organisation permits the same, the written guidance shall define the medications which the patient can self-administer. It is preferable that the organisation also incorporates a method for assisting self-administration of medications. The organisation shall ensure that the patient is reminded to take the medication (before every dose) and document the same. For example, self-administration of insulin.

j. Measures to govern patient's medications brought from outside the organisation shall be implemented. *

Interpretation: At the outset, the organisation could define if it would permit the patient getting his/her medications. In case of the organisation permitting the same, written guidance shall include the pre-requisites for such a medication (for example, clear label with mention of the name, strength, expiry date, batch number etc.).

k. Near-expiry medications are handled effectively. *

Interpretation: The organisation could define as to what constitutes "near expiry" medications, for example, three months before the expiry date. The organisation's mechanism shall ensure that near expiry medications are withdrawn and that no beyond expiry date medication is available.

l. High-risk medication orders are verified before dispensing.

Interpretation: High-risk medications shall be given only after written orders, and it shall be verified by the staff before dispensing. This shall adhere to statutory requirements, where applicable.

m. Patients shall be monitored after medication administration. *

Interpretation: Relevant monitoring shall be done collaboratively to verify that the medicine is having its intended effect. It could also include monitoring the effects of medications (beneficial or adverse) through laboratory results. Besides, this shall help identify near misses, medication errors and adverse drug reactions.

The organisation shall define those situations and medications where more frequent monitoring is required. For example, administration of high-risk medicines. The effect of medication in high risk patients like those on dialysis, in the ICU and elderly group shall be monitored on a regular basis.

Standard

MOM. 5 **There are Policies, Processes and Protocols to report and analyze near misses, medication errors and adverse drug events.**

Objective Elements

a. **The organisation shall capture near misses, medication errors and adverse drug reactions.**

Interpretation: Near misses, medication errors and adverse drug reactions shall be defined. This shall be in consonance with best practices. The organisation shall have a written guidance on the process to capture near misses, medication errors and adverse drug reactions. This shall incorporate identifying, documenting, reporting, analysing and action taken regarding near misses, medication errors and adverse drug reactions.

Refer to the glossary for "near miss", "medication error" and "adverse drug reaction".

b. **Near misses, medication errors and adverse drug reactions shall be reported within a specified time frame. ***

Interpretation: The organisation shall define the timeframe for reporting once any of this has occurred and adhere to the same.

c. **Corrective and/or preventive action(s) are taken based on the analysis.**

Interpretation: Where appropriate, corrective and/or preventive action are taken. The records of the same shall be maintained. It is preferable that corrective and/or preventive action(s) be taken based on the root-cause analysis.

Standard

MOM. 6 **Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used in a safe manner.**

Objective Elements

a. **Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals are used safely. ***

Interpretation: Written guidance, developed in consonance with local and national regulations/guidelines shall be implemented. The written guidance could address all the objective elements of this standard. Examples of regulations/guidelines are Narcotic Drugs and Psychotropic Substances Act and AERB guidelines.

b. **Narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals drugs shall be stored securely.**

Interpretation: Narcotic drugs shall be stored securely in consonance with statutory requirements. The security measures shall ensure that these medications are not diverted and abused.

Chemotherapeutic agents shall be accessible only to authorised personnel.

Radiopharmaceuticals shall be labelled and stored as per AERB guidelines.

It is preferable that these medications are stored separately from other medications.

c. **A proper record shall be kept of the usage, administration and disposal of narcotic drugs and psychotropic substances, chemotherapeutic agents and radio-pharmaceuticals.**

Interpretation: A strict inventory control shall be kept for narcotic drugs and psychotropic substances, chemotherapeutic agents and radiopharmaceuticals. Record of usage, administration, wastage and disposal of narcotic drugs shall be kept following statutory requirements. These shall be disposed off according to existing statutory requirements (including Narcotic Drugs and Psychotropic Substances Act, AERB rules and Biomedical waste management rules) and the manufacturer's recommendation (where applicable).

d. **Chemotherapy and radio-pharmaceuticals shall be prepared properly and safely and administered by qualified personnel.**

Interpretation: It is required that qualified personnel have received special training in the preparation and administration of chemotherapeutic drugs.

A bio-safety cabinet of class II (preferably IIA) with appropriate personal protective equipment shall be used for preparing/mixing chemotherapeutic drugs.

Radio-pharmaceuticals shall be prepared and administered by an authorised caregiver.

Standard

MOM. 7 **Medical supplies and consumables are stored appropriately and are available where required.**

Objective Elements

a. **The organisation adheres to the defined process for the acquisition of medical supplies and consumables. ***

Interpretation: In this context, medication supplies and consumables refer to items which are used in patient care excluding medications and implants. The process shall address the issues of vendor selection, vendor evaluation indenting process, generation of the purchase order and receipt of goods.

b. **Medical supplies and consumables are used in a safe manner, where appropriate.**

Interpretation: The items shall be opened and used using relevant precautions to maintain sterility and integrity.

c. **Medical supplies and consumables are stored in a clean, safe and secure environment, and incorporating manufacturer's recommendation(s).**

Interpretation: The organisation shall ensure that the storage requirements specified by the manufacturer are adhered to. This shall apply to all areas where these are stored, including wards. They shall be protected from loss or theft. Overall cleanliness of the storage area shall be maintained. Hazardous materials shall be identified and kept safely.

CHAPTER 4

Infection Prevention and Control (IPC)

Intent of the chapter

The standards guide the provision of an effective infection control program in the Emergency Department. The program is documented and aims at reducing/eliminating infection risks to patients, visitors and providers of care.

The organisation proactively monitors adherence to infection control practices such as standard precautions, cleaning disinfection and sterilization. Adequate facilities for the protection of staff are available. Bio Medical Waste is managed as per policies and procedures and in accordance to legal requirements.

SUMMARY OF STANDARDS

IPC.1	The emergency department promotes adherence to standard precautions and implements infection and control processes in clinical services
IPC.2	The emergency department implements infection and control processes in support services
IPC.3	The emergency department performs surveillance activities to prevent and control infections.

Standards and Objective Elements

Standard

IPC.1 **The Emergency department promotes adherence to standard precautions and implements infection and control processes in clinical services**

Objective Elements

a. The organisation adheres to standard precautions at all times.

Interpretation: The components of standard precautions include hand hygiene, appropriate use of personal protective equipment, respiratory etiquettes, safe injection practices, sterile instruments and devices, clean and dis-infected environmental surfaces cleaning and disinfection of equipment, and needle-stick and sharps injury prevention. Appropriate preparation of body parts before a procedure and the use of disinfected/sterilised instruments is ensured.

b. Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.

Interpretation: Personal protective equipment includes:

- Gloves
- Protective eyewear (goggles)
- Mask
- Gown
- Boots/shoe covers and
- Cap/hair cover

The staff use PPE appropriate to the risks involved and guidance available. The PPE is removed as soon as the purpose is served.

c. Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.

Interpretation: The organisation provides at least one easily accessible washbasin with running water in every patient care area in the department for health care providers. Hand rubs shall be available in every patient care area.

d. Isolation/ Barrier nursing facilities are available and implemented.

Interpretation: The organisation shall define the conditions where isolation is required, and the conditions wherein barrier nursing or both are required. Patients requiring isolation shall be placed in isolation room with negative pressure and appropriate signage.

e. Appropriate antimicrobial usage policy is established and implemented.

Interpretation: The organisation shall identify clinical conditions in which antimicrobial agents [antimicrobial (including anti-tubercular agents), anti-fungal agents, anti-viral agents and anti-parasitic

agents] shall be used in terms of the type of the antimicrobial agent, monotherapy vs combination therapy, escalation and de-escalation of therapy, dose and duration of antimicrobial therapy, and shall implement the same.

f. **The Emergency department is geared to manage high patient volumes during community outbreaks, epidemics and pandemics.**

Interpretation: Strategic measures are taken during community outbreaks, epidemics and pandemic situations through anticipating surges in ED patient visits, maintaining structured workflow and careful departmental geographic planning, maintaining high quality and high efficiency care, with emphasis on patient and provider safety, and developing new infection control protocols when necessary.

Specific interventions include triaging patients to the most appropriate care setting, standardizing ED admission criteria, screening patients and staff through clinical features and rapid diagnostics and point of care testing, cohorting patients to a designated specific area of the department, establishing a static staff assignment model, limiting patient-to-provider spread and provider-to-patient spread, use of telephonic/video interactions, staff reinforcements, and upscaling/upstocking of medicines, supplies and equipment.

g. **Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.**

Interpretation: At a minimum, Hepatitis B vaccination shall be provided to staff involved in direct patient care. Other relevant immunisation is provided as per the risk from time to time and in accordance with applicable statutory requirements. The organisation provides post-exposure prophylaxis for hepatitis B and HIV exposure. This shall align with National and/or international guidelines.

Standard

IPC.2 **The Emergency department implements infection and control processes in support services**

Objective Elements

a. **The emergency department has appropriate engineering controls to prevent infections.**

Interpretation: This shall include the design of the department (optimum spacing between beds is one-two metres), emergency operating room including zoning of OT, air quality and water supply.

b. **The Emergency department adheres to housekeeping procedures.**

Interpretation: Housekeeping shall be addressed in all areas including toilets, corridors. Regular cleaning to remove visible dirt and dust is mandatory. This includes the environment, fixtures, fomites, furniture, furnishings, equipment, etc., as applicable.

c. **Biomedical waste (BMW) is handled appropriately and safely.**

Interpretation: Proper segregation and collection of biomedical waste in different colour-coded bags and containers as per statutory provisions is implemented. Biomedical waste shall be handled in the proper manner using appropriate personal protective equipment.

Standard

IPC.3 **The Emergency Department performs surveillance activities to prevent and control infections.**

Objective Elements

a. **Surveillance activities are appropriately directed towards the activities in the Emergency Department.**

Interpretation: The department shall define the frequency and mode of surveillance and must be able to provide evidence of conducting periodic surveillance in its identified high-risk activities.

b. **Surveillance activities also include monitoring the compliance with hand hygiene guidelines.**

Interpretation: The monitoring shall be done at a minimum once every month. An appropriate sample size shall be chosen and all categories of staff (involved in direct patient care) shall be monitored. The compliance levels shall be shared with the relevant staff. A good tool is the WHO's "Observation Form".

c. **Surveillance activities include monitoring the effectiveness of housekeeping services.**

Interpretation: To capture effectiveness, the organisation shall identify desired outcome parameters for housekeeping activities. For example, cleanliness of department, patient feedback on housekeeping services, staff feedback on housekeeping services. The data could be captured using a checklist.

CHAPTER 5

Patient Safety and Quality (PSQ)

Intent of the chapter

The standards encourage an environment of continual quality improvement. The quality and safety program should be documented and involve all aspects of the functioning in the Emergency Department. Processes should be in place to ensure the patient safety. The Emergency Department should collect data on key performance indicators as part of its quality improvement program. The collected data should be collated, analysed and used for further improvements in emergency care. The improvements should be sustained. Quality improvement is a continuous process, so after initial incorporation into processes of the department, new areas for improvement are identified.

The organisation should define its sentinel events and intensively investigate when such events occur.

The quality program should be supported by the management.

SUMMARY OF STANDARDS

PSQ.1	The department has a designated individual and well-designed, comprehensive and multidisciplinary committee to co-ordinate all quality and safety activities of the emergency department.
PSQ.2	There is a structured patient safety program in the emergency department.
PSQ.3	The organisation identifies key indicators to monitor structures, processes and outcomes which are used as tools for continual improvement.

Standards and Objective Elements

Standard

IPC.1	**The department has a designated individual and well-designed, comprehensive and multidisciplinary committee to co-ordinate all quality and safety activities of the emergency department.**

Objective Elements

a. **There is a designated individual for coordinating and implementing the quality improvement and safety programme in the department.**

Interpretation: The individual (doctor/nurse) shall be a person having a good knowledge of patient and general safety, of NABH Standards and of statutory requirements, hospital quality improvement principles and evaluation methodologies. The role and responsibilities of the individual shall be defined and documented.

b. **The multidisciplinary committee co-ordinates all activities and provides oversight to the functioning of the Emergency Department.**

Interpretation: The committee is multidisciplinary including physicians and nurses in the Emergency department, quality manager and hospital administrator, The Committee interacts with all levels of personnels working in the department to review patient care processes and meets at least once in three months

c. **Scope of activities also includes oversight of emergency services and data review.**

Interpretation: The Committee covers all aspects of emergency department's operations including resource allocation (manpower, equipment and supplies), and quality improvement. The committee ensures a system for accurate measurement and collection of data.

d. **The quality improvement program is reviewed at predefined intervals and opportunities for improvement are identified.**

Interpretation: The review shall be done at least every three months and shall be based on newer literature on quality improvement, on audit findings, on feedback mechanisms etc, and shall identify opportunities for improvement.

In case the annual review does not identify any opportunities for improvement, the same shall be documented in the minutes of the quality improvement committee meeting.

e. **Audits are conducted at regular intervals as a means of continuous monitoring.**

Interpretation: The internal audit, which will be conducted at least once in six months by identified and trained staff, shall include all the applicable standards and objective elements of NABH certification standards for Emergency department. At the end of the audit, there shall be a formal meeting to summarize the findings and corrective and preventive measures shall be taken and documented.

f. **There is an established process in the organisation to monitor and improve quality of patient care.**

Interpretation: Monitoring shall be done through performance audits to review clinical performance against agreed standards. This could also be in the form of a competency evaluation by written questionnaire or witnessed demonstration of key procedures

Standard

IPC.2 **There is a structured patient safety program in the emergency department.**

Objective Elements

a. **The patient safety program is comprehensive and covers all the major elements related to patient safety and risk management.**

Interpretation: The patient safety programme shall address all elements of safety for clinical and support services.

b. **The scope of the program is defined to include adverse events ranging from "no harm" to "sentinel events".**

Interpretation: The department shall clearly define as to what constitutes no harm and sentinel events with regards to the patient. The Emergency department shall focus on reducing medical errors, preventing infections (including cross-infections from other patients and healthcare workers) and ensuring a safe environment for patients. Reporting of near misses and adverse events shall be encouraged. Simulation-based trainings can also help in improving patient safety

c. **The patient safety program identifies opportunities for improvement based on review at pre-defined intervals.**

Interpretation: The patient safety programme identifies opportunities for improvement based on the review at pre-defined intervals but at least once in three months. The review shall be done by safety committee and at a minimum shall include report of facility inspection rounds, patient safety incidents, risk management and analysis of key-safety indicators. The minutes of the review meetings shall be recorded and maintained.

d. **The Emergency Department adapts and implements national/international patient safety goals/solutions.**

Interpretation: At a minimum, the department shall adhere to the current national patient-safety framework, WHO patient-safety solutions and/or international patient safety goals.

Standard

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

Objective Elements

a. **The department identifies and monitors key indicators to oversee the clinical structures, processes and outcomes.**

Interpretation: Some of the indicators that could be monitored pertain to appropriate patient assessment, medication management, unplanned return to Emergency Department, mortality rates etc.

b. **The department identifies and monitors key indicators to oversee the infection prevention and control activities.**

Interpretation: Some of the indicators that could be monitored pertain to thrombophlebitis, compliance to hand hygiene etc

c. **The department identifies and monitors key indicators to oversee the managerial structures, processes and outcomes.**

Interpretation: Some of the indicators that could be monitored pertain to utilisation of space, manpower and equipment, staff training sessions, patient satisfaction etc.

d. **The organisation identifies and monitors key indicators to oversee patient safety activities.**

Interpretation: Some of the indicators that could be monitored pertain to patient safety goals and risk management.

e. **There is a mechanism for analysis of data which results in identifying opportunities for improvement.**

Interpretation: The data is analysed and based on this corrective and preventive actions are taken, where necessary. The department could also consider developing benchmarks/acceptable quality levels based on national/international norms.

f. **The improvements are implemented and evaluated.**

Interpretation: The improvement activities carried out by the department shall have an evaluable outcome. The same shall be documented.

CHAPTER 6

Responsibilities of Management (ROM)

Intent of the chapter

The standards encourage the governance of the organisation in a professional and ethical manner. The responsibilities of the management are defined. The services provided by each department are documented.

Leaders ensure that patient-safety and risk-management issues are an integral part of patient care and hospital management.

SUMMARY OF STANDARDS

ROM.1	The organisation is aware and implements applicable legislations and regulations required to operate the emergency department in the health care organisation.
ROM.2	The services provided by emergency department are documented.
ROM.3	Management ensures that patient safety aspects and risk management issues are an integral part of patient care and emergency department management.

Standards and Objective Elements

Standard

ROM.1 **The organisation is aware and implements applicable legislations and regulations required to operate the emergency department in the health care organisation.**

Objective Elements

a. The leadership of emergency department is conversant with the laws and regulations and knows their applicability to the organisation.

Interpretation: The leader is conversant with the different statutory requirements as per the scope of services and takes measures to adhere to the same. The organisation conducts its functioning as a duly permitted legal entity under the relevant registering authority(s). Applications to update statutory documents must be made in accordance with the timelines set out in the relevant laws/registration authority requirements to ensure continuity of statutory compliances. Research, including clinical trials, shall be conducted in accordance with statutory norms.

b. The Leadership ensures implementation of these requirements and gives an undertaking accordingly.

Interpretation: The leader could develop a mechanism which ensures implementation of various requirements stated in the laws and regulations. There shall be a mechanism to regularly update any amendments in the prevailing laws of the land. A tracker sheet could be developed for this purpose

Standard

ROM.2 **The services provided by emergency department are documented.**

Objective Elements

a. The scope of services of the emergency department is defined.

Interpretation: Scope of emergency services shall align with scope of the organisation. For example if organisation is not providing burns services. Emergency services should be clearly displaying its scope and its limitations for example only superficial burns less than 20% etc. shall be accepted. Scope of diagnostic services shall be displayed too.

b. Administrative policies and procedures for the Emergency Department are maintained.

Interpretation: Written guidance shall include guidelines/SOPs/protocols to provide general emergency care as well as management of specific conditions, for example poisoning, road traffic accidents, patients with acute stroke and coronary disease, etc. It shall address both adult and

paediatric patients. The procedure shall incorporate at a minimum identification, assessment and provision of care. In case, emergency services are out of the scope of the organisation, or the organisation does not have facilities for appropriate emergency care of a given clinical condition, at a minimum, such patients shall be provided with first aid before transferring them to another organisation. Processes shall be in place to ensure patient safety. The organisation shall also define as to what constitutes a medico-legal case (MLC). The care provided, especially the documentation and intimation to appropriate authorities, shall be in accordance with statutory requirements. The organisation shall have policy on management of suspected sexual assault and guidance on storage of samples of MLC patients. Policies and procedures on Management of crowd and violent patients shall be made and implemented

c. The organisation is managed by the leaders in an ethical manner.

Interpretation: The organisation shall function ethically. Transparency in its actions shall be one of its guiding principles. Handling of complaints, grievances, clinical care delivery and research shall be some of the areas to address. The framework includes codes of conduct. A good reference guide for minimum code of conduct for doctors is "Code of medical ethics, 2002" published by Medical Council of India

d. The organisation accurately bills for its services based upon a standard billing tariff.

Interpretation: Emergency services shall have standard tariff list available for procedures being done in emergency as well as in the organisation as many of the patients will get admitted to the hospital through emergency services. Billing personnel shall be available to maintain transparency in billing and correct explanation of charges applicable for illness.

e. The person heading the emergency department has requisite and appropriate qualification or experience.

Interpretation: Head of the department should possess minimum MBBS qualification from recognised university. He/she should be trained in emergency medicine. Preferably qualified as DNB emergency medicine/fellowship in emergency medicinev(NMC recognised/NBE recognised degree/diploma). Training in ACLS, BLS, ATLS is mandatory. NALS/PALS is desirable.

f. The organisation allocates adequate resources for effective functioning of the Emergency Department.

Interpretation: emergency department shall have an annual budget for operational expenses and capital expenditure as applicable. Annual budget of the organisation may separately mention about ER budget.

g. The organisation documents employee rights and responsibilities.

Interpretation: The organisation shall define employee rights and responsibilities. it could be in the form of service rules.

h. The organisation has a formal documented agreement for all outsourced services applicable to Emergency Department and has a mechanism to monitor the same.

Interpretation: MOU for outsourced services shall mention service standards required to be implemented alongwith monitoring mechanism to be followed by the stated agency.

Standard

ROM.3 **Management ensures that patient safety aspects and risk management issues are an integral part of patient care and Emergency Department management.**

Objective Elements

a. The management ensures proactive risk management across the Emergency Department.

Interpretation: Risk management shall include clinical and non-clinical (strategic, financial, operational and hazard) risks. It shall include risk identification at every level of the organisation, analysis, prioritisation and risk alleviation. The same shall be documented. At a minimum, analysis of potential risks must include the likelihood of its occurrence and the potential severity of the impact or consequences. The identified risks shall be documented in a risk register, which shall be updated at regular intervals.

This shall be documented as a "risk management plan". It shall include the various risks identified, the action taken for risk alleviation of each of these risks and the mechanism for informing staff regarding the same. Other components of the risk management plan include contingency plans and education and training of staff.

Further, the risk management plan shall be monitored and reviewed for continued effectiveness at least annually. The results of the review shall be communicated to the relevant stakeholders in the organisation. This could be done using a matrix.

Clinical-risk assessment could include:

- Medication management, covering issues such as patient/service-user allergies, antimicrobial resistance, use of cytotoxic drugs and narcotics and controlled drugs management.
- Equipment risks - fire/injury risks from the use of LASER, and cautery Use of ionising radiation, radioactive isotopes and nuclear medicine are some of the examples.
- Risks resulting from long-term conditions.
- Patient falls
- Infections s
- Risks related with a vulnerable patient like Deep Venous Thrombosis
- Risk associated with clinical alarms.

b. The management ensures implementation of systems for internal and external reporting of system and process failures.

Interpretation: The organisation has a system in place for internal and external reporting of system and process failures. The contingency plan shall be in place to deal with the situation of system and process failure anticipated within the organisation. In case the MRI machine of the organisation breaks down, internal reporting is to be done to head of the organisation and external reporting to be done to the patients. In case of fire incidents, strong internal and external reporting systems are required. The system for reporting shall be documented. The plan shall ensure that critical systems and services do not fail or that failures are recovered within minimum time frames. The plan shall be tested at regular interval.

c. The management ensures that appropriate corrective and preventive action is taken to address safety related incidents.

Interpretation: Root cause analysis of all safety related incidents whether clinical or non-clinical shall be carried out based on which corrective and preventive lessons are drawn and implemented.

CHAPTER 7

Facility Management and Safety (FMS)

Intent of the chapter

The standards guide the provision of a safe and secure environment for patients, their families, staff and visitors. To ensure this, the organisation conducts regular facility inspection rounds and takes the appropriate action to ensure safety.

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

The organisation plans for emergencies within the facilities and the community.

SUMMARY OF STANDARDS

FMS.1	The emergency's environment and facilities operate to ensure safety of patients, their families, staff and visitors.
FMS.2	The emergency department has a program for bio-medical equipment management.
FMS.3	The emergency department has a system for provision of program for medical gases, vacuum & compressed air.
FMS.4	The emergency department has plans for fire & non-fire emergencies.
FMS.5	The emergency department has a plan for management of hazardous materials

Standards and Objective Elements

Standard

FMS.1 **The Emergency's environment and facilities operate to ensure safety of patients, their families, staff and visitors.**

Objective Elements

a. **Patient-safety devices are installed across the Emergency Department and inspected periodically.**

Interpretation: For example, grab bars, bed rails, sign posting, safety belts on stretchers and wheelchairs, alarms both visual and auditory where applicable, warning signs like radiation or biohazard, call bells, fire-safety devices, etc.

b. **There is internal and external sign postings in the emergency in a language understood by the patient, families and community.**

Interpretation: Manner implies language and/or pictorial signs. Signage could be bilingual and shall meet statutory requirements

c. **Adequate number of voice and data points shall be provided.**

Interpretation: Adequate UPS points and data points shall be provided in emergency department so that they do not have to depend on extension points.

d. **The provision of space shall be in accordance with the available literature on good practices (Indian or international standards) and directives from government agencies.**

Interpretation: The basis of the appropriateness of facilities and space provisions shall be as per the national/international guidelines. For example, IPHS guidelines for district hospitals. The organisation endeavours to upgrade its physical infrastructure to meet national and international guidelines.The infrastructure and equipment shall be upgraded, commensurate with the scope and complexities of functioning.

e. **Potable water and electricity are available round the clock and maintained and evaluated appropriately.**

Interpretation: The organisation shall ensure that there is sufficient water supply to meet the requirements. Alternate sources for electricity and water are provided as backup in case of any failure/shortage The electric load shall be appropriate to the requirements of the organisation and adhere to the regulatory requirements. Alternate sources for water and electricity shall be made available all the times. A good reference for estimating the water requirement is the National Building Code. Alternate electric supply could be from DG sets, solar energy, UPS and any other suitable source. Alternate source of water can be bore/open well, supply through water tanker or extra storage tanks.

f. **Maintenance staff is contactable round the clock for emergency repairs.**

Interpretation: Essential staff like plumber, electrician , biomedical technician etc are available in the night/ off duty hours.

Standard

FMS.2 **The emergency department has a program for bio-medical equipment management.**

Objective Elements

a. **The Emergency Department plans for equipment in accordance with its services. Department follows documented procedure for equipment replacement and disposal.**

Interpretation: This shall also take into consideration future requirements. The medical equipment shall be appropriate to its scope of services. A good reference for minimum medical equipment is the IPHS guideline. The organisation shall plan for equipment replacement keeping in mind the strategic plans, upgrade/update path and the equipment log. The organisation shall condemn (dispose of) equipment in a systematic manner.

b. **Medical equipment in the Emergency Department is inventoried and proper logs are maintained as required.**

Interpretation: A unique identifier is provided for each equipment. This includes equipment on a rental basis and equipment kept for demonstration purpose. The relevant quality conformance certificates/marks along with manufacturer factory test certificate need to be retained as part of the documentation for all equipment.

c. **Qualified and trained personnel operate and maintain the medical equipment.**

Interpretation: The operator of the medical equipment is trained to use medical equipment safely and effectively. For example Nurse trained to use Blood gas analyser, ECG machine and syringe pump etc. Maintenance of medical equipment shall be done by a bio-medical engineer/technologist or instrumentation engineer/technologist with relevant training and experience.

d. **Medical Equipments are periodically inspected and calibrated for their proper functioning.**

Interpretation: The organisation has weekly/monthly/annual schedules of inspection and calibration of equipment, which involve measurement, appropriately. The organisation either calibrates the equipment in-house or outsources, maintaining traceability to national or international or manufacturer's guidelines / standards. The organisation shall ensure that calibration and conformance testing of the equipment has been done before commissioning. Medical equipment is re-calibrated after its repairs/breakdown. There is a documented operational and maintenance (preventive and breakdown) plan.

Standard

FMS.3 **The Emergency Department has a system for provision of program for medical gases, vacuum & compressed air.**

Objective Elements

a. **Adequate oxygen, air & vacuum medical gas terminal are provided on each emergency bed. Alternate sources for medical gases, vacuum and compressed air are provided for in case of failure.**

Interpretation: Standardised colour coding of the cylinders and pipelines shall be maintained. The procedures for medical gases address the safety issues at all levels from the point of storage/source area, gas supply lines and the end-user area. Appropriate safety measures shall be developed and implemented for all levels. This shall include alarm units and valve boxes installation at various locations and 24X7 monitoring of plant alarm unit for gas pressure going beyond the set limit, pin-indexed medical gas outlets, auto-change over from one source to an alternate source. For medical gases alternate source, could be standby gas manifold/bulk cylinders.

b. **There is an operational and maintenance (preventive and breakdown) plan for piped medical gas, compressed air and vacuum installation.**

Interpretation: This shall adhere to the manufacturer's recommendations. Compressed air purity shall be checked (at the level of the terminal outlet) once in a year at least in one terminal from minor OT and ER ICU if applicable.

Standard

FMS.4 **The emergency has plans for fire & non-fire emergencies.**

Objective Elements

a. **The Emergency Department has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.**

Interpretation: The organisation shall:

- have a fire plan and non fire emergency plan covering fire arising out of burning of inflammable items, explosion, electric short-circuiting or acts of negligence or due to the incompetence of the staff on duty;
- deploy adequate and qualified personnel for this;
- follow current NABH minimum fire safety guidelines;
- have safety measures in place to minimise the effect of smoke during the fire;
- have adequate training plans;
- have schedules for the conduct of mock fire drills including table top exercise;
- document and maintain mock drill records;
- display exit plans prominently;
- have evacuation plans for patient, staff and visitors
- have a dedicated emergency illumination system, which comes into effect in case of fire.

The organisation shall take care of fire and non fire emergencies by identifying them and by deciding the appropriate course of action. The organisation shall establish liaison with civil and police authorities and fire brigade as required by law for enlisting their help and support in case of an emergency.

b. The emergency has a documented safe-exit plan in case of fire and non-fire emergencies.

Interpretation: Exit plan shall be displayed in emergency, particularly close to the lifts and inside all enclosed areas like individual rooms and laboratories. Exit doors shall remain open or have push bars on them. Fire signage shall follow the norms laid down by respective statutory body (for example, fire service) and/or National Building Code. Signage and maintenance of refuge area as applicable shall be done.

Standard

FMS.5 **The emergency department has a plan for management of hazardous materials.**

Objective Elements

a. The Emergency Department implements processes for sorting, labeling, handling, storage, transporting and disposal of hazardous material.

Interpretation: The organisation shall identify and document the hazardous materials and have a documented procedure for their sorting, storage, handling, transportation and disposal. In addition to chemicals, biological materials like blood, body fluids and microbiological cultures, mercury, nuclear isotopes, medical gases, LPG gas, steam, ETO, etc. are some of the other common hazardous materials. The organisation could develop its procedures based on Material Safety Data Sheets (MSDS). Applicable statutory requirements shall be complied.

b. There is a plan for managing spills of hazardous materials.

Interpretation: The plan shall be developed based on information provided in MSDS. The key elements shall be summarized in a manner that is easy to understand (if necessary, translated in local language) and available for staff to refer to wherever such materials are stored. Personnel who handle such material are accordingly trained. The organisation has a HAZMAT kit(s) for handling spills of hazardous materials. Emergency staff is educated and trained for handling such materials.

CHAPTER 8

Human Resource Management (HRM)

Intent of the chapter

The most important resource of an Emergency Department is the human resource. Human resources are an asset for effective and efficient functioning of an Emergency Department. Without an equally effective human resource management system, all other inputs like technology, infrastructure and finances come to naught. Human resource management is concerned with the “people” dimension in management.

The goal of human resource management is to acquire, provide, retain and maintain competent people in right numbers to meet the needs of the patients and community served by the organisation. This is based on the organisation's mission, objectives, goals and scope of services. Effective human resource management involves the following processes and activities:-

(a) Acquisition of Human Resources which involves human resource planning, recruiting and socialization of the new employees.

(b) Training and development relates to the performance in the present and future anticipated jobs. The employees are provided with opportunities to advance personally as well as professionally.

(c) Motivation relates to job design, performance appraisal and discipline.

(d) Maintenance relates to safety and health of the employees.

SUMMARY OF STANDARDS

HRM.1	Emergency department has a documented system of human resource planning.
HRM.2	There is a program for training and development of staff in the emergency department.
HRM.3	An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.
HRM.4	The emergency department addresses the health needs of the employees.
HRM.5	There is documented personal information for each staff member.

Standards and Objective Elements

Standard

HRM.1 **Emergency department has a documented system of human resource planning.**

Objective Elements

a. **Human resource planning supports the Emergency Department's current and future requirements to meet the care, treatment and service needs of the patient.**

Interpretation: Human resource planning shall be done in a structured manner for all categories of staff keeping in mind the volume and mix of patients, services, and medical technology. The emergency department staff typically includes emergency physicians, nurses (including triage nurses and charge nurses), paramedics, respiratory therapists, social workers, and various other support staff.

b. **The organisation has contingency plans to manage long- and short-term workforce shortages in the Emergency department, including unplanned shortages.**

Interpretation: Staff shortages can be managed using a contingency plan, which may include strategies such as reprioritising tasks, allocating tasks to different staff members, and relying on a pool of filler staff

c. **The job specification and job description are well defined for each category of staff in Emergency Department.**

Interpretation: The content of each job shall be defined and the qualifications, skills and experience required for performing the job shall be laid down. The job description shall be commensurate with the qualification

Standard

HRM.2 **There is a program for training and development of staff in the emergency department.**

Objective Elements

a. **All staff joining the Emergency Department undergo training on the department's policies and procedures including emergency protocols and triaging.**

Interpretation: The training encompasses clinical protocols, life safety procedures, emergency response plans, and the use of specific equipment relevant to the department The training also focuses on triaging of patients including quickly assessing patients upon arrival, categorizing them based on the severity of their condition, and prioritizing treatment according to their needs. Proctoring i.e. monitoring and evaluating the performance of medical professionals to ensure competency and maintain quality of

care is done when a staff member is new, has a specific skill gap, or is returning to work after a break. The departmental induction shall be in addition to the organisation level general induction.

b. There is a policy for on-going training and development of Emergency department staff.

Interpretation: A training and development policy incorporating the procedure for identification of training needs, the training methodology, documentation of training, training assessment, the impact of training and the training calendar shall be prepared. The policy includes assessing requirement for continuing education requirements of staff and implementing the same. Training also occurs when job responsibilities change/new equipment is introduced.

c. Staff involved in direct patient care are provided training on cardio-pulmonary resuscitation periodically.

Interpretation: All doctors and nurses working in the emergency department shall undergo appropriate training. For example, advanced cardiac life support (ACLS), advanced trauma life support (ATLS), paediatric advanced life support (PALS), and neonatal resuscitation program (NRP) or any other equivalent/similar programme. The training could be imparted by trainers from within or outside the organisation using updated evidence-based protocols.

d. Staff are provided training on infection prevention and control.

Interpretation: Staff in the Emergency department are trained on standard and transmission-based precautions, case definitions for infections especially during outbreaks, epidemics and pandemics, suspected patient triage procedures and infection control measures while undertaking prehospital rescue operations

e. All staff is trained on the safety aspects including fire and non-fire emergencies , risks within the hospital environment and incident management.

Interpretation: In case of fire, training shall include the various classes of fires, information and demonstration on how to use fire extinguishers, evacuation plans and other procedures to be followed in case of fire. Staff in the organisation shall be trained on identified non-fire emergencies. They are also trained on their specific role in such emergencies. The training shall include the various elements of the disaster management plan. Staff are also trained in their specific role during management of external / internal disaster.

The staff shall be able to identify such risks that shall include patient, visitors and staff-related risks and can practically demonstrate actions for the same like taking care of blood spills, handling hazardous materials etc

The staff shall be able to intimate the sequence of events that they will undertake in the eventuality of occurrence of any incident.

f. Staff are trained in the organisation's and departmental quality improvement programme.

Interpretation: Staff is made aware of the structure of the quality improvement programme of the organisation. Staff are trained on the quality assurance programme of the emergency department.

g. Staff are trained in healthcare communication techniques.

Interpretation: The staff shall be trained to handle challenging situations as well as good practices in health care communication.

Standard

HRM.3 **An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.**

Objective Elements

a. **Performance is evaluated based on the performance expectations described in the job description.**

Interpretation: Criteria for evaluation shall be based on key performance indicators/key result areas which are derived from the job description. The appraisal includes a mechanism of ongoing professional practice evaluation (OPPE) to assess the performance and competency of staff. It identifies areas where staff may need improvement and ensures they are meeting required standards and maintaining necessary skills. Ongoing practice evaluation is done at least once a year.

b. **The policies and procedures regarding disciplinary and grievance handling are implemented and are known to all categories of staff of the Emergency Department.**

Interpretation: Written guidance governs disciplinary and grievance handling mechanisms which is in consonance with the prevailing laws and includes prevention of sexual harassment. All staff in the department shall be aware of the disciplinary procedure and the process to be followed in case they feel aggrieved. The organisation shall support the staff (second victim) involved in unanticipated adverse events, medical error or patients related injury

Standard

HRM.4 **The emergency department addresses the health needs of the employees.**

Objective Elements

a. **Health problems of the employees are taken care of in accordance with the organisation's policy.**

Interpretation: The department has a written guidance on staff health and safety programme that addresses staff physical and mental health and safe working conditions.

b. **A pre-employment medical examination is conducted on all the employees**

Interpretation: The purpose of this examination is to ensure that the staff is fit to provide safe care to patients. Performance of diagnostic tests could be guided by the nature of the job of the staff in the department.

c. **Regular physical and medical checks are done for the staff at-least once a year and the findings/ results are documented.**

Interpretation: The results of examination, investigations (if any) and outcome of the evaluation shall be documented in the personal file. The staff member shall not be charged for this health check. The department could do health checks more frequently if required.

d. **Occupational health hazards are adequately addressed, and stress reduction strategies are implemented.**

Interpretation: Streamlined workflows, efficient resource allocation, and supportive systems can minimize stress among emergency department staff and maximize their ability to provide effective patient care. Measures such as well-designed physical spaces with adequate lighting and ergonomic furniture, user-friendly technology, and robust staffing models, suitable working hours, and facilities for refreshments can prevent burnout and promote teamwork.

e. **The organisation has measures in place for prevention and handling workplace violence.**

Interpretation: Mitigation strategies to reduce risk of safety threat should be put in place. These could include training of staff on conflict resolution, adequate security staffing, weapon detection systems, controlling access and entry, and establishing clear communication channels and protocols for handling potentially violent situations. Intervention measures include early recognition of signs of agitation and potential violence, de-escalation, safety measures, physical restraint and Law Enforcement especially in cases of serious threats or assaults, and post-Incident reporting and briefing.

Standard

HRM.5 **There is documented personal information for each staff member.**

Objective Elements

a. **Personal files are maintained in respect of all employees.**

Interpretation: Each file must be current, updated and could be in the electronic format.

b. **The personal files contain personal information regarding the employees' qualification, disciplinary background and health status.**

Interpretation: The personal file shall contain these records.

c. **All records of in-service training and education and evaluations are contained in the personal files for all staff.**

Interpretation: Evaluations would include performance appraisals, training assessment and outcome of health checks. The personal file would include records of achievement/ appreciation/complaint/warning/memo etc.

d. **There is a process for credentialing and privileging of medical professionals.**

Interpretation: The organisation identifies the individuals who have the required qualification(s), training and experience to provide patient care in consonance with the law. The education, registration, training and experience of the identified medical professionals are verified, documented and updated periodically. Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.

e. There is a process for credentialing and privileging of nursing professionals.

Interpretation: The organisation identifies the individuals who have the required qualification(s), training and experience to provide patient care in consonance with the law. The education, registration, training and experience of the identified nursing professionals are verified, documented and updated periodically. Nursing professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.

Glossary

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

Term	Definition
Accreditation	Accreditation is self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to improve the health care system continuously.
Accreditation assessment	The evaluation process for assessing the compliance of an organisation with the applicable standards for determining its accreditation status.
Advance life support	Emergency medical care for sustaining life, including defibrillation, airway management, and drugs and medications.
Adverse drug reaction	A response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function.
Adverse event	An injury related to medical management, in contrast to complications of the disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable. (WHO Draft Guidelines for Adverse Event Reporting and Learning Systems)
Anaesthesia Death	It is defined as death occurring within 24 hours of administration of anaesthesia due to cases related to anaesthesia. However, death may occur even afterwards due to the complications.
Assessment	All activities including history taking, physical examination, laboratory investigations that contribute towards determining the prevailing clinical status of the patient.
Barrier nursing	The nursing of patients with infectious diseases in isolation to prevent the spread of infection. As the name implies, the aim is to erect a barrier to the passage of infectious pathogenic organisms between the contagious patient and other patients and staff in the hospital, and thence to the outside world. The nurses wear gowns, masks, and gloves, and they observe strict rules that minimise the risk of passing on infectious agents.
Basic life support	Basic life support (BLS) is the level of medical care which is used for patients with life-threatening illnesses or injuries until the patient can be given full medical care.

Term	Definition
Breakdown maintenance	Activities which are associated with the repair and servicing of site infrastructure, buildings, plant or equipment within the site's agreed building capacity allocation which have become inoperable or unusable because of the failure of component parts.
Byelaws	A rule governing the internal management of an organisation. It can supplement or complement the government law but cannot countermand it, e.g. municipal by-laws for construction of hospitals/nursing homes, for disposal of hazardous and/or infectious waste
Calibration	Set of operations that establish, under specified conditions, the relationship between values of quantities indicated by a measuring instrument or measuring system, or values represented by a material measure or a reference material, and the corresponding values realised by standards.
Care Plan	A plan that identifies patient care needs, lists the strategy to meet those needs, documents treatment goals and objectives, outlines the criteria for ending interventions, and documents the individual's progress in meeting specified goals and objectives. The format of the plan may be guided by specific policies and procedures, protocols, practice guidelines or a combination of these. It includes preventive, promotive, curative and rehabilitative aspects of care.
Citizen's charter	Citizen's Charter is a document which represents a systematic effort to focus on the commitment of the organisation towards its citizens in respects of standard of services, information, choice and consultation, non-discrimination and accessibility, grievance redress, courtesy and value for money. (Reference: https://goicharters.nic.in/faq.htm)
Clinical autopsy	It is a surgical procedure that consists of an examination of a corpse by dissection to identify the cause, mode and manner of death or to evaluate any disease or injury that may be present for research or educational purposes.
Clinical practice guidelines	Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.
Competence	Demonstrated ability to apply knowledge and skills (para 3.9.2 of ISO 9000: 2015). Knowledge is the understanding of facts and procedures. Skill is the ability to perform a specific action.
Confidentiality	Restricted access to information to individuals who have a need, a reason and permission for such access. It also includes an individual's right to personal privacy as well as the privacy of information related to his/her healthcare records.

Term	Definition
Consent	1. The willingness of a party to undergo examination/procedure/ treatment by a healthcare provider. It may be implied (e.g. patient registering in OPD), expressed which may be written or verbal. Informed consent is a type of consent in which the healthcare provider has a duty to inform his/her patient about the procedure, its potential risk and benefits, alternative procedure with their risk and benefits so as to enable the patient to make an informed decision of his/her health care. 2. In law, it means active acquiescence or silent compliance by a person legally capable of consenting. In India, the legal age of consent is 18 years. It may be evidenced by words or acts or by silence when silence implies concurrence. Actual or implied consent is necessarily an element in every contract and every agreement.
Control Charts	The statistical tool used in quality control to (1) analyse and understand process variables, (2) determine process capabilities, and to (3) monitor effects of the variables on the difference between target and actual performance. Control charts indicate upper and lower control limits, and often include a central (average) line, to help detect the trend of plotted values. If all data points are within the control limits, variations in the values may be due to a common cause and process is said to be 'in control'. If data points fall outside the control limits, variations may be due to a special cause, and the process is said to be out of control.
Correction	Action to eliminate the detected non-conformity (Reference: ISO 9000:2015)
Corrective action	Action to eliminate the cause of a non-conformity and to prevent recurrence. (Reference: ISO 9000:2015)
Credentialing	The process of obtaining, verifying and assessing the qualification of a healthcare provider.
Data	Data is a record of the event.
Discharge summary	A part of a patient record that summarises the reasons for admission, significant clinical findings, procedures performed, treatment rendered, patient's condition on discharge and any specific instructions given to the patient or family (for example follow-up medications).
Disciplinary procedure	A sequence of activities to be carried out when staff does not conform to the laid-down norms, rules and regulations of the healthcare organisation.
Drug dispensing	The preparation, packaging, labelling, record keeping, and transfer of a prescription drug to a patient or an intermediary, who is responsible for the administration of the drug. (Reference: Mosby's Medical Dictionary, 9th edition, 2009, Elsevier.)

Term	Definition
Drug Administration	The giving of a therapeutic agent to a patient, e.g. by infusion, inhalation, injection, paste, pessary, suppository or tablet.
Effective communication	Effective Communication is a communication between two or more persons wherein the intended message is successfully delivered, received and understood. The effective communication also includes several other skills such as non-verbal communication, engaged listening, ability to speak assertively, etc.
Employees	All members of the healthcare organisation who are employed full time and are paid suitable remuneration for their services as per the laid-down policy.
Enhanced communication	Enhanced communication is using the methods of communication to ensure meaning and understanding through the recognition of the limitations of others. The intent is to ensure purposeful, timely and reliable communication. The communication must be sensitive, empathetic and inclusive.
Ethics	Moral principles that govern a person's or group's behaviour.
Evidence-based medicine	Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.
Family	The person(s) with a significant role in the patient's life. It mainly includes spouse, children and parents. It may also include a person not legally related to the patient but can make healthcare decisions for a patient if the patient loses decision-making ability.
Failure Mode and Effect Analysis (FMEA)	A method used to prospectively identify error risks within a particular process.
Formulary	An approved list of drugs. Drugs contained in the formulary are generally those that are determined to be cost-effective and medically effective.
Goal	A broad statement describing a desired future condition or achievement without being specific about how much and when. (Reference: American Society for Quality) The term “goals” refers to a future condition or performance level that one intends to attain. Goals can be both short- and longer-term. Goals are ends that guide actions. (Reference: Malcolm Baldridge National Quality Award)
Grievance-handling procedures	The sequence of activities carried out to address the grievances of patients, visitors, relatives and staff.

Term	Definition
Hazardous materials	Substances dangerous to human and other living organisms. They include radioactive or chemical materials.
Hazardous waste	Waste materials dangerous to living organisms. Such materials require special precautions for disposal. They include the biologic waste that can transmit disease (for example, blood, tissues) radioactive materials, and toxic chemicals. Other examples are infectious waste such as used needles, used bandages and fluid soaked items.
Healthcare-associated infection	Healthcare-associated infection (HAI), also referred to as "nosocomial" or "hospital" infection, is an infection occurring in a patient during the process of care in a hospital or other health care facility which was not present or incubating at the time of admission. (Reference: World Health Organization)
Healthcare organisation	The generic term is used to describe the various types of organisation that provide healthcare services. This includes ambulatory care centres, hospitals, laboratories, etc.
High-dependency unit	A high-dependency unit (HDU) is an area for patients who require more intensive observation, treatment and nursing care than are usually provided for in a ward. It is a standard of care between the ward and full intensive care.
High Risk/High Alert Medications	High-risk/high-alert medications are medications involved in a high percentage of medication errors or sentinel events and medications that carry a high risk for abuse, error, or other adverse outcomes. Examples include medications with a low therapeutic index, controlled substances, psychotherapeutic medications, and look-alike and sound-alike medications.
Incident reporting	It is defined as written or verbal reporting of any event in the process of patient care, that is inconsistent with the deserved patient outcome or routine operations of the healthcare facility.
In-service education/training	Organised education/training usually provided in the workplace for enhancing the skills of staff members or for teaching them new skills relevant to their jobs/tasks.
Indicator	A statistical measure of the performance of functions, systems or processes over time. For example, hospital acquired infection rate, mortality rate, caesarean section rate, absence rate, etc.
Information	Processed data which lends meaning to the raw data.
Intent	A brief explanation of the rationale, meaning and significance of the standards laid down in a particular chapter.

Term	Definition
Inventory control	The method of supervising the intake, use and disposal of various goods in hands. It relates to supervision of the supply, storage and accessibility of items in order to ensure an adequate supply without stock-outs/excessive storage. It is also the process of balancing ordering costs against carrying costs of the inventory so as to minimise total costs.
Isolation	Separation of an ill person who has a communicable disease (e.g.,measles, chickenpox, mumps, SARS) from those who are healthy. Isolation prevents transmission of infection to others and also allows the focused delivery of specialised health care to ill patients. The period of isolation varies from disease-to-disease. Isolation facilities can also be extended to patients for fulfilling their individual, unique needs.
Job description	1. It entails an explanation pertaining to duties, responsibilities and conditions required to perform a job. 2. A summary of the most important features of a job, including the general nature of the work performed (duties and responsibilities) and level (i.e., skill, effort, responsibility and working conditions) of the work performed. It typically includes job specifications that include employee characteristics required for competent performance of the job. A job description should describe and focus on the job itself and not on any specific individual who might fill the job.
Job specification	1. The qualifications/physical requirements, experience and skills required to perform a particular job/task. 2. A statement of the minimum acceptable qualifications that an incumbent must possess to perform a given job successfully.
Maintenance	The combination of all technical and administrative actions, including supervision actions, intended to retain an item in, or restore it to, a state in which it can perform a required function. (Reference: British Standard 3811:1993)
Medical equipment	Any fixed or portable non-drug item or apparatus used for diagnosis, treatment, monitoring and direct care of a patient.
Medication error	A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labelling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. (Reference: The National Coordinating Council for Medication Error Reporting and Prevention)

Term	Definition
Medication Order	A written order by a physician, dentist, or other designated health professionals for a medication to be dispensed by a pharmacy for administration to a patient. (Reference: Mosby's Medical Dictionary, 10th edition, Elsevier)
Mission	An organisation's purpose. This refers to the overall function of an organisation. The mission answers the question, "What is this organisation attempting to accomplish?" The mission might define patients, stakeholders, or markets served, distinctive or core competencies or technologies used.
Monitoring	The performance and analysis of routine measurements aimed at identifying and detecting changes in the health status or the environment, e.g. monitoring of growth and nutritional status, air quality in operation theatre. It requires careful planning and use of standardised procedures and methods of data collection.
Multidisciplinary	A generic term which includes representatives from various disciplines, professions or service areas.
Near-miss	A near-miss is an unplanned event that did not result in injury, illness, or damage--but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorised as near-misses.
No harm	This is used synonymously with a near miss. However, some authors draw a distinction between these two phrases. A near-miss is defined when an error is realised just in the nick of time, and abortive action is instituted to cut short its translation. In no harm scenario, the error is not recognised, and the deed is done, but fortunately for the healthcare professional, the expected adverse event does not occur. The distinction between the two is important and is best exemplified by reactions to administered drugs in allergic patients. A prophylactic injection of cephalosporin may be stopped in time because it suddenly transpires that the patient is known to be allergic to penicillin (near-miss). If this vital piece of information is overlooked, and the cephalosporin administered, the patient may fortunately not develop an anaphylactic reaction (no harm event).
Notifiable disease	Certain specified diseases, which are required by law to be notified to the public health authorities. Under the international health regulation (WHO's International Health Regulations 2005), the following diseases are always notifiable to WHO: (a) Smallpox (b) Poliomyelitis due to wild-type poliovirus (c) Human influenza caused by a new subtype (d) Severe acute respiratory syndrome (SARS).

Term	Definition
Notifiable disease	In India, the following is an indicative list of diseases which are also notifiable, but may vary from state to state: (a) Polio (b) Influenza (c) Malaria (d) Rabies (e) HIV/AIDS (f) Louse-borne typhus (g) Tuberculosis (h) Leprosy (i) Leptospirosis (j) Viral hepatitis (k) Dengue fever
Objective	A specific statement of a desired short-term condition or achievement includes measurable end-results to be accomplished by specific teams or individuals within time limits. (Reference: American Society for Quality)
Objective element	It is that component of standard which can be measured objectively on a rating scale. Acceptable compliance with the measurable elements will determine the overall compliance with the standard.
Occupational health hazard	The hazards to which an individual is exposed during the course of the performance of his job. These include physical, chemical, biological, mechanical and psychosocial hazards.
Operational plan	The operational plan is the part of your strategic plan. It defines how you will operate in practice to implement your action and monitoring plans - what your capacity needs are, how you will engage resources, how you will deal with risks, and how you will ensure the sustainability of the organisation's achievements.
Organogram	A graphic representation of the reporting relationship in an organisation.
Outsourcing	Hiring of services and facilities from other organisation based upon one's own requirement in areas where such facilities are either not available or else are not cost-effective. For example, outsourcing of house-keeping, security, laboratory/certain special diagnostic facilities. When an activity is outsourced to other institutions, there should be a memorandum of understanding that clearly lays down the obligations of both organisations: the one which is outsourcing and the one who is providing the outsourced facility. It also addresses the quality-related aspects.

Term	Definition
Patient-care setting	The location where a patient is provided health care as per his needs, e.g. ICU, speciality ward, private ward and general ward.
Patient record/ medical record/ clinical record	A document which contains the chronological sequence of events that a patient undergoes during his stay in the healthcare organisation. It includes demographic data of the patient, assessment findings, diagnosis, consultations, procedures undergone, progress notes and discharge summary.
Patient Satisfaction and	Patient satisfaction is a measure of the extent to which a patient is content with the health care which they received from their health care provider. Patient satisfaction is thus a proxy but a very effective indicator to measure the success of Health care providers.
Patient Experience	Patient Experience is the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care. It is a holistic perception that the patient forms about the healthcare provider based on the overall interactions/ care touchpoints.
Performance appraisal	It is the process of evaluating the performance of staff during a defined period of time with the aim of ascertaining their suitability for the job, the potential for growth as well as determining training needs.
Point of care equipment	Medical Equipment that is used to deliver care/intervene at or near the site of patient care. These are primarily Point-of-care testing (POCT), or bedside testing equipment that helps in reducing turn-around times. POCT Machine examples; Glucometer, ABG Analyser, Stat Lab at ICU/ER, portable USG etc.
Policies	They are the guidelines for decision-making,e.g. admission, discharge policies, antibiotic policy,etc.
Preventive action	Action to eliminate the cause of a potential non-conformity. (Reference ISO 9000:2015)
Preventive maintenance	It is a set of activities that are performed on plant equipment, machinery, and systems before the occurrence of a failure in order to protect them and to prevent or eliminate any degradation in their operating conditions. The maintenance carried out at predetermined intervals or according to prescribed criteria and intended to reduce the probability of failure or the degradation of the functioning of an item.
Prescription	A prescription is a document given by a physician or other healthcare practitioner in the form of instructions that govern the care plan for an individual patient. Legally, it is a written directive, for compounding or dispensing and administration of drugs, or for other service to a particular patient. (Reference: Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition, Saunders)

Term	Definition
Privileging	It is the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications and skills.
Privileged communication	Confidential information furnished (to facilitate diagnosis and treatment) by the patient to a professional authorised by law to provide care and treatment.
Procedural sedation	Procedural sedation is a technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function. Procedural sedation and analgesia (PSA) is intended to result in a depressed level of consciousness that allows the patient to maintain oxygenation and airway control independently. (Reference: The American College of Emergency Physicians)
Procedure	1. A specified way to carry out an activity or a process (Para 3.4.5 of ISO 9000: 2015). 2. A series of activities for carrying out work which when observed by all help to ensure the maximum use of resources and efforts to achieve the desired output.
Process	A set of interrelated or interacting activities which transforms inputs into outputs (Para 3.4.1 of ISO 9000: 2015).
Programme	A sequence of activities designed to implement policies and accomplish objectives.
Protocol	A plan or a set of steps to be followed in a study, an investigation or an intervention.
Quality	1. Degree to which a set of inherent characteristics fulfil requirements (Para 3.1.1 of ISO 9000: 2015). Characteristics imply a distinguishing feature (Para 3.5.1 of ISO 9000: 2015). Requirements are a need or expectation that is stated, generally implied or obligatory (Para 3.1.2 of ISO 9000:2015). 2. Degree of adherence to pre-established criteria or standards.
Quality assurance	Part of quality management focussed on providing confidence that quality requirements will be fulfilled (Para 3.2.11 of ISO 9000:2015).
Quality improvement	Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers/patients.

Term	Definition
Radiation Safety	Radiation safety refers to safety issues and protection from radiation hazards arising from the handling of radioactive materials or chemicals and exposure to Ionizing and Non-Ionizing Radiation. This is implemented by taking steps to ensure that people will not receive excessive doses of radiation and by monitoring all sources of radiation to which they may be exposed.(Reference: McGraw-Hill Dictionary of Scientific & Technical Terms) In a Healthcare setting, this commonly refers to X-ray machines, CT/PET CT Scans, Electron microscopes, Particle accelerators, Cyclotron etc. Radioactive substances and radioactive waste are also potential Hazards. Imaging Safety includes safety measures to be taken while performing an MRI, Radiological interventions, Sedation, Anaesthesia, Transfer of patients, Monitoring patients during imaging procedure etc.
Re-assessment	It implies a continuous and ongoing assessment of the patient, which is recorded in the medical records as progress notes.
Reconciliation of medications	Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital. (Reference: Institute for Healthcare Improvement)
Resources	It implies all inputs in terms of men, material, money, machines, minutes (time), methods, metres (space), skills, knowledge and information that are needed for the efficient and effective functioning of an organisation.
Risk abatement	Risk abatement means minimising the risk or minimising the impact of that risk.
Risk assessment	Risk assessment is the determination of the quantitative or qualitative value of risk related to a concrete situation and a recognised threat (also called hazard). Risk assessment is a step in a risk management procedure.
Risk management	Clinical and administrative activities to identify, evaluate and reduce the risk of injury.
Risk mitigation	Risk mitigation is a strategy to prepare for and lessen the effects of threats and disasters. Risk mitigation takes steps to reduce the negative effects of threats and disasters.

Term	Definition
Risk reduction	The conceptual framework of elements considered with the possibilities to minimise vulnerabilities and disaster risks throughout society to avoid (prevention) or to limit (mitigation and preparedness) the adverse impacts of hazards, within the broad context of sustainable development. It is the decrease in the risk of a healthcare facility, given activity, and treatment process with respect to patient, staff, visitors and community.
Root Cause Analysis (RCA)	Root Cause Analysis (RCA) is a structured process that uncovers the physical, human, and latent causes of any undesirable event in the workplace. Root cause analysis (RCA) is a method of problem-solving that tries to identify the root causes of faults or problems that cause operating events. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing correction on root causes, problem recurrence can be prevented. The process involves data collection; cause charting, root cause identification and recommendation generation and implementation.
Safety	The degree to which the risk of an intervention/procedure, in the care environment is reduced for a patient, visitors and healthcare providers.
Safety programme	A programme focused on patient, staff and visitor safety.
Scope of services	Range of clinical and supportive activities that are provided by a healthcare organisation.
Security	Protection from loss, destruction, tampering, and unauthorised access or use.
Sedation	The administration to an individual, in any setting for any purpose, by any route, moderate or deep sedation. There are three levels of sedation: Minimal sedation (anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are not affected. Moderate sedation/analgesia (conscious sedation) - A drug-induced depression of consciousness during which patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation. No interventions are needed to maintain a patent airway. Deep sedation/analgesia - A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. Patients may need help in maintaining a patent airway.

Term	Definition
Sentinel events	A relatively infrequent, unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of healthcare services. Major and enduring loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.
Social responsibility	A balanced approach for an organisation to address economic, social and environmental issues in a way that aims to benefit people, communities and society,e.g. adoption of villages for providing health care, holding of medical camps and proper disposal of hospital wastes.
Sound clinical practice	Practitioner decisions based on available knowledge, principles and practices for specific clinical situations.
Special Educational needs of the patient	In addition to routine carried by the healthcare professionals, patients and family have special educational needs depending on the situation. For example, a post-surgical patient who has to take care of his wound, nasogastric tube feeding, patient on tracheostomy getting discharged who has to be taken care of by the family etc. The special educational needs are also greatly influenced by the literacy, educational level, language, emotional barriers and physical and cognitive limitations. Hence it is important for the staff to determine the special educational needs and the challenges influencing the effective education.
Staff	All personnel working in the organisation including employees, “fee-for-service” medical professionals, part-time workers, contractual personnel and volunteers.
Standard precautions	1. A method of infection control in which all human blood and other bodily fluids are considered infectious for HIV, HBV and other blood-borne pathogens, regardless of patient history. It encompasses a variety of practices to prevent occupational exposure, such as the use of personal protective equipment (PPE), disposal of sharps and safe housekeeping 2. A set of guidelines protecting first aiders or healthcare professionals from pathogens. The main message is: "Don't touch or use anything that has the victim's body fluid on it without a barrier." It also assumes that all body fluid of a patient is infectious, and must be treated accordingly. Standard Precautions apply to blood, all body fluids, secretions, and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin and mucous membranes
Standards	A statement of expectation that defines the structures and process that must be substantially in place in an organisation to enhance the quality of care.

Term	Definition
Sterilisation	It is the process of killing or removing microorganisms including their spores by thermal, chemical or irradiation means.
Strategic plan	Strategic planning is an organisation's process of defining its strategy or direction and making decisions on allocating its resources to pursue this strategy, including its capital and people. Various business analysis techniques can be used in strategic planning, including SWOT analysis (Strengths, Weaknesses, Opportunities and Threats), e.g. Organisation can have a strategic plan to become a market leader in the provision of cardiothoracic and vascular services. The resource allocation will have to follow the pattern to achieve the target. The process by which an organisation envisions its future and develops strategies, goals, objectives and action plans to achieve that future.
Surveillance	The continuous scrutiny of factors that determines the occurrence and distribution of diseases and other conditions of ill health. It implies watching over with great attention, authority and often with suspicion. It requires professional analysis and sophisticated interpretation of data leading to recommendations for control activities.
Table-top exercise	A table-top exercise is an activity in which key personnel assigned emergency management roles and responsibilities are gathered to discuss, in a non-threatening environment, various simulated emergency situations. (Reference: https://uwpd.wisc.edu/content/uploads/2014/01/ What_is_a_tabletop_exercise.pdf)
Traceability	Traceability is the ability to trace the history, application, use and location of an item or its characteristics through recorded identification data. (Reference: ISO 9000:2015)
Transfusion reaction	A transfusion reaction is a problem that occurs after a patient receives a transfusion of blood.
Triage	Triage is a process of prioritising patients based on the severity of their condition so as to treat as many as possible when resources are insufficient for all to be treated immediately.
Turn-around-time	Turnaround Ttime (TAT) means the amount of time taken to complete a process or fulfil a request.
Unstable patient	A patient whose vital parameters need external assistance for their maintenance.
Validated tool	A validated tool refers to a questionnaire/scale that has been developed to be administered among the intended respondents. The validation processes should have been completed using a representative sample, demonstrating adequate reliability (the ability of the instrument to produce consistent results) and validity (the ability of the instrument to produce true results).

Term	Definition
Validation	Validation is verification, where the specified requirements are adequate for the intended use.
Values	The fundamental beliefs that drive organisational behaviour and decision-making. This refers to the guiding principles and behaviours that embody how an organisation and its people are expected to operate. Values reflect and reinforce the desired culture of an organisation.
Verbal order	Verbal orders are those orders given by a physician with prescriptive authority to a licensed person who is authorised by the organisation.
Verification	Verification is the provision of objective evidence that a given item fulfils specified requirements.
Vision	An overarching statement of the way an organisation wants to be, an ideal state of being at a future point. This refers to the desired future state of an organisation. The vision describes where the organisation is headed, what it intends to be, or how it wishes to be perceived in the future.
Vulnerable patient	Those patients who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status,e.g. infants, elderly, physically- and mentally-challenged, semiconscious/unconscious, those on immunosuppressive and/or chemotherapeutic agents.
Workplace violence	Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health. (Adapted from European Commission)

ANNEXURE-1 : NABH Key Performance Indicators

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

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

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

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

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

The intent of the NABH KPIs is to have comprehensive involvement of scope of services for which a HCO has applied for the accreditation program. Standardised definitions for each indicator along with numerator and denominator have been explained. Each HCO can have the data set measure, analyse the aggregated data and appropriate correction, corrective and preventive action can be formulated. Each HCO can also design their own methodology of data collection but a broad guidance note has been given to facilitate organisation's compliance.

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

NABH Key Performance Indicators

The Key performance indicators expected to be monitored by healthcare organisation:

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
1	PSQ 3a	Time for initial assessment of emergency department patients	The time shall begin from the time that the patient has arrived at the bed of the emergency ward until the time that the initial assessment has been completed and documented by a doctor.	Sum of time taken for the assessment (in minutes)		Minutes	Monthly	This shall be captured either through the HIS or through an audit. In case of an audit, the sample size shall be as specified in the sample size calculation table. Daycare patients are not included. Sampling: Yes Sampling methodology: Stratified random For data captured through HIS- Sampling: No The system should track the number of records for which the initial assessment time could not be captured due to incomplete data.	The system generates a time stamp for the start time (time of the arrival of patient at the bed of the ward) and the end time (completion and documentation of initial assessment by doctor). The initial assessment is deemed to be completed when the data pertaining to chief complaint, history, examination findings, and provisional/ final diagnosis is captured. Any edits done subsequently to any of these fields shall not result in the alteration of the time stamp of the endpoint of the initial assessment.
				Total number of admissions					The denominator shall include all admissions except daycare.
2	PSQ 3a	Incidence of medication errors	A medication error is any preventable event that may cause or lead to	Total number of medication errors	X100	Percent age	Monthly	The methodology for capture shall be as stated in NABH's document on medication errors. The	It is preferred that the data is captured through the system for all the sub-components of medication errors. Wherever

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
2	PSQ 3a	Incidence of medication errors	inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. (Ref: NCC- MERP).	Total number of opportunities				indicator shall be captured for admitted patients. Sampling: Yes Sampling methodology: Stratified random	there is a limitation in capturing the information through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
3	PSQ 3a	Standardized Mortality Ratio for Emergency Department		Actual deaths in Emergency Department Predicted deaths in Emergency Department		Ratio	Monthly	Predicted death shall be calculated from models such as APACHE, SOFA, SAPS, MPM etc. Sampling: No	The system shall calculate the total number of deaths in its emergency department until midnight of the last day of the calendar month The denominator shall be captured through the system. Considering the challenges of data capture for this indicator through the system there should be a provision for entering the manual/ electronically collected (app/ online forms) data
4	PSQ 3a	Return to the emergency department within 72 hours with similar presenting complaints		Number of returns to emergency within 72 hours with similar presenting complaints	X100	Percent age	Monthly	To capture this indicator, it may be a good practice to capture during the initial assessment itself if the patient had come within 72 hours for similar complaints. Sampling: No	The system shall calculate the total number of returns to an emergency within 72 hours with similar presenting complaints until midnight of the last day of the calendar month.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
				Number of patients who have come to the emergency					The system shall calculate the total number of patients who have come to the emergency until midnight of the last day of the calendar month.
5	PSQ 3b	Compliance to hand hygiene practices		Total number of actions performed Total number of hand hygiene opportunities	X100	Percent- age	Monthly	Observation involves directly watching and recording the hand hygiene behavior of healthcare workers and the physical environment. A good reference is the WHO hand hygiene compliance monitoring tool. Please refer: http://www.who.int/gpsc/5may/tools/en/http://www.who.int/entity/gpsc/5may/Observation_Form.doc?ua=1 Sampling: Yes Sampling methodology: Stratified random. However, the organisation should try to ensure that all staff relevant categories of staff are covered at least once in a quarter.	Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
6	PSQ 3c	Waiting time for emergency department consultation	Waiting time is the length of time which one must wait in order for a specific action to occur after that action is requested or mandated. Waiting time for emergency consultation is the time from which the patient has come to the concerned emergency department (it may or may not be the same time as registration) till the time that the concerned consultant (not the junior doctor/resident) begins the assessment.	Sum total time (in minutes) for consultation		Minutes	Monthly		The system shall calculate the sum of the total waiting time of all emergency consultations.
				Total Number of emergency patients					The denominator shall include the total number of emergency-patient days until midnight of the last day of the calendar month.
7	PSQ 3d	Rate of needlestick injuries	Needlestick injury is a penetrating stab wound from a needle (or other sharp objects) that may result in exposure to blood or other body fluids. Needlestick	Number of needlestick injuries	X1000	Rate	Monthly on a cumulative basis	The denominator is the average of the sum of the daily figures for the number of beds occupied by patients. The rate will be monitored on a monthly basis but reported cumulatively i.e. in the form of year to date. For example, in January it	The number of needle stick injuries shall be captured through an incident reporting module/ software (stand alone or integrated with HIS/ EMR system).

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
			injuries are wounds caused by needles that accidentally puncture the skin. (Canadian Centre for Occupational Health and Safety	Average occupied beds				would be January data but in February it would be January + February data, in July it would be data from January to July, and so on so that by the end of the year the annual rate is obtained. Sampling: No	The system shall calculate the average occupied beds.
8	PSQ 3d	Appropriate handovers during shift change		Total number of handovers done appropriately	X100	Percent age	Monthly	Handover is an important communication tool used by healthcare workers. The data can be collated together but it has to be captured separately for doctors and nurses. Handover documentation by each shift can be used as a guide to capturing the information. The handover information shared shall consist of the patient's current condition, recent changes in condition, ongoing treatment, and possible changes or complications. If the organisation is using a standardized handover template (for example	The system shall calculate the total number of handovers done appropriately. Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
				Total number of handover opportunities				SBAR), for the handover to be deemed appropriate, all the components need to be filled. Though the organisation shall use all or none principle to report the numerator, organizations are encouraged to analyze the components and identify specific opportunities for improvement. Sampling: No	The system shall calculate the total number of handover opportunities based on the staff ROTA.
9	PSQ 3a	Percentage of POCT results which led to a clinical intervention.	Point of care testing is defined as laboratory testing conducted close to the site of patient care typically by non-lab personnel e.g. nurses, e.g. blood gases, electrolytes, troponin, and blood glucose	Number of POCT tests which resulted in a clinical intervention where indicated. Number of POCT tests where clinical intervention was deemed necessary	X100	Percentage	Monthly	Optional The organisation should have a mechanism to ensure that all POCT results are documented. Based on these results, it is preferable that the organisation identifies results which require clinical intervention and documents the same.	If it is possible to retrieve data form HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/ online forms) data.
10	PSQ 3a	Percentage of sepsis patients who receive care as per the Hour-1 sepsis bundle.	Sepsis is a life-threatening organ dysfunction caused by a dysregulated host response to infection	Number of sepsis patients who receive care as per the Hour-1 sepsis bundle.	X100	Percentage	Monthly	The start time of the timeframe of one hour is when the patient reaches ER or ICU. In case the patient is shifted to the ICU from	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, Considering the challenges of data capture for this indicator through the system, there should be a provision

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
								the ER, the start time is when the patient arrives at the ER. The components of the Hour-1 bundle include measuring lactate obtaining blood culture before administering antibiotics, administering broad-spectrum antibiotics, beginning rapid administration of appropriate fluid, and applying vasopressors where appropriate. For the patient to be included in the numerator all the 5 components have to be met. Only if the organisation does not have capabilities to measure the lactate level the same could be excluded. However, in all such instances the diagnosis of sepsis should be clinically proven.	for entering the manual/ electronically collected (app/ online forms) data.
11	PSQ 3a	Time taken for triage	Triage is a process of prioritizing patients based on the severity of their condition so as to treat as	Sum of time taken (in minutes) for triage		Minutes	Monthly	Mandatory The start time is when the patient arrives at the emergency and the end time is when the triage is completed.	The system generated a time stamp for the start time (time of the arrival of patient at the emergency) and the end time (completion of triage)

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	HIS/ EMR System Guide
			many as possible when resources are insufficient for all to be treated immediately. The sorting of patients according to criteria which ensures that the most seriously ill or injured patient is treated before patients with less serious problems.	Number of stroke patients who receive thrombolytic therapy.					The denominator shall include all patients coming to the emergency
12	PSQ 3a	Percentage of stroke patients in whom the Door-to-Needle Time (DTN) of 60 minutes is achieved.	Door-to-needle time is the time it takes for the stroke patient to receive thrombolytic	Number of Stroke patients in whom the Door to needle time of 60 minutes is achieved. / Number of stroke patients who receive thrombolytic therapy.	X100	Percentage	Monthly	Mandatory if the specialty is in the scope. The start time shall be when the patient arrives at the emergency and the end time is initiation of thrombolytic therapy.	If it is possible to retrieve data from HIS/EMR, the data shall be captured through the system. However, considering the challenges of data capture for this indicator through the system, there should be a provision for entering the manual/ electronically collected (app/online forms) data.

Sample size calculation (Monthly)

Solvent formula

n=N/(1+Ne2)

(Where n=Number of samples, N = Total population and e=Error tolerance)

Using 95% confidence interval (margin of error 95%), the values are calculated as follows:

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

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

*It is preferred to take samples on Stratified random basis where indicated to eliminate the bias that can occur due to convenient sampling.

No sampling means that all the occurrence in the numerator shall be recorded irrespective of rate of occurrence.

Annexure-2 : Guidance on Monitoring Medication Errors

Definition

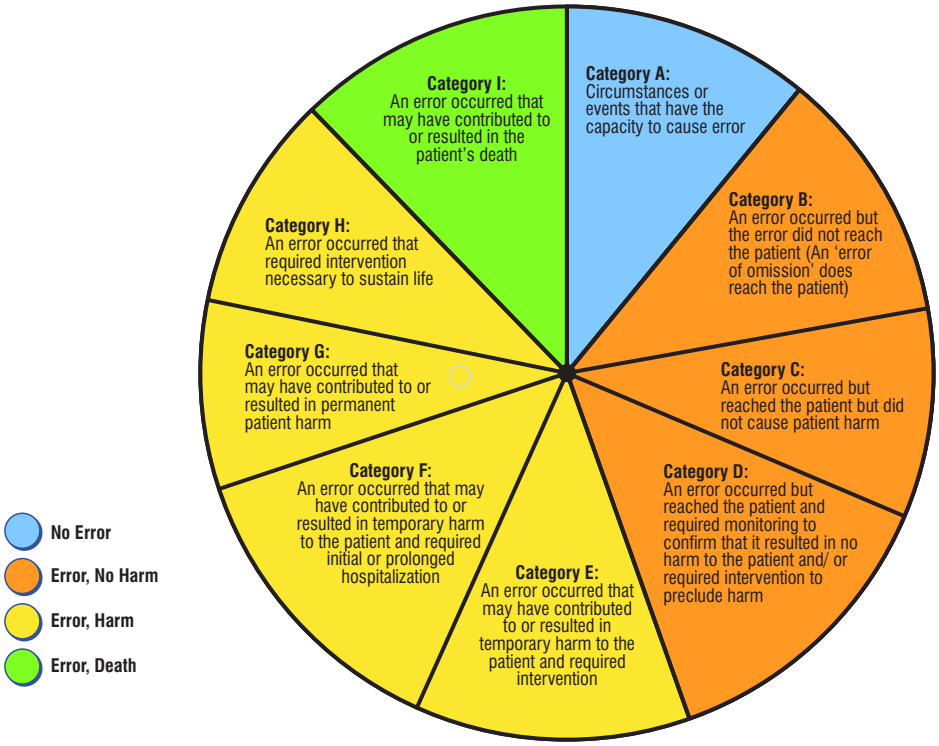
NCC-MERP (National Coordinating Council for Medication Error Reporting and Prevention) defines medication error as

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use."

Categories of Medication Error

Level of Harm	Category of Error	Explanation of events/ error
NO ERROR	Category A	Circumstances or events that have the capacity to cause error
ERROR, NO HARM	Category B	An error occurred, but the error did not reach the patient (An “error of omission” does reach the patient.)
	Category C	An error occurred that reached the patient but did not cause patient harm.
	Category D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm
ERROR, HARM	Category E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
	Category F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
	Category G	An error occurred that may have contributed to or resulted in permanent patient harm
	Category H	An error occurred that required intervention necessary to sustain life
ERROR , DEATH	Category I	An error occurred that may have contributed to or resulted in the patient's death.

NCC MERP Index for Categorizing Medication Errors



Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

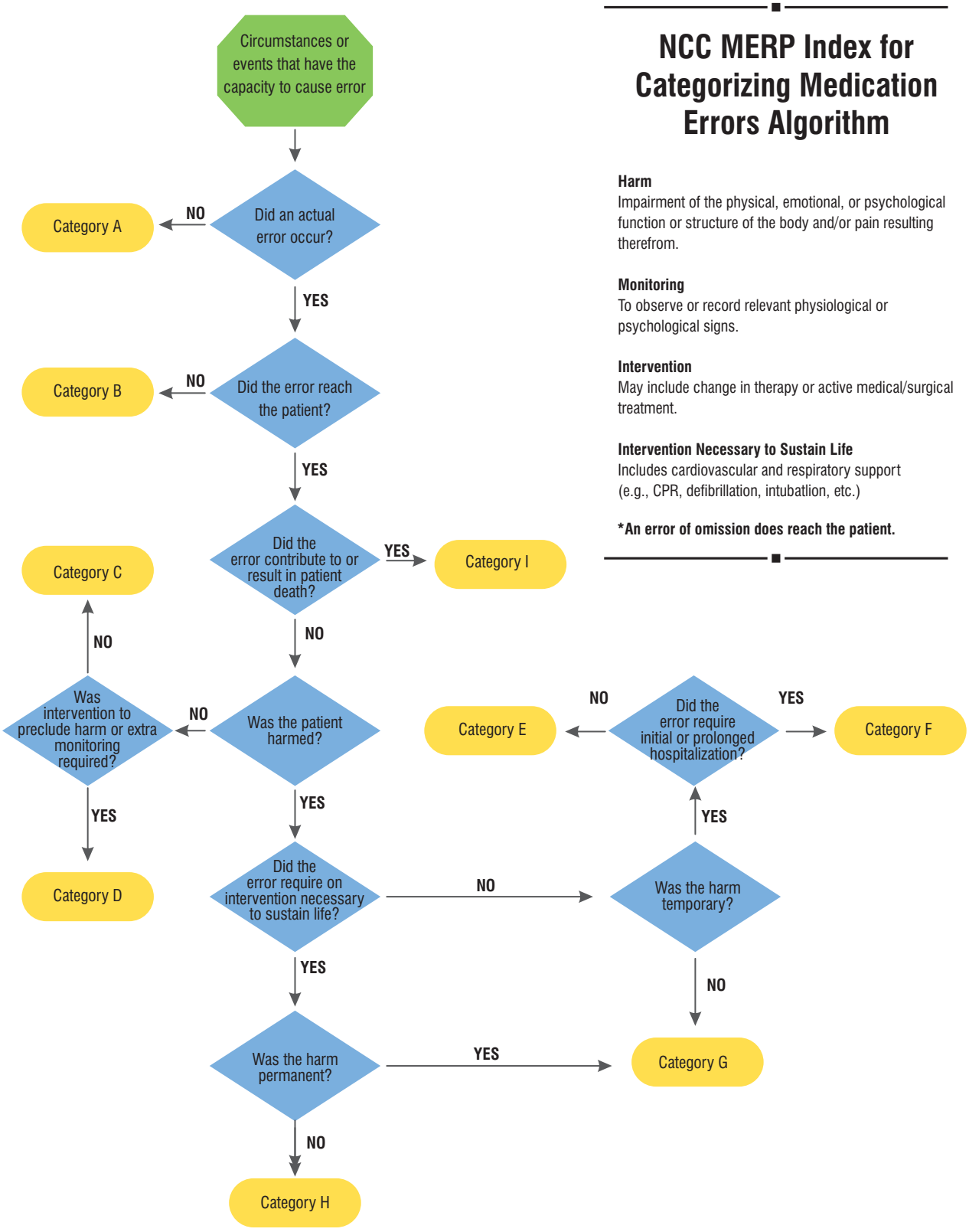
Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention
Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubatlion, etc.)

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) index for categorizing medication errors. © 2001 National Coordinating Council for Medication Error Reporting and Prevention.

NCC MERP Index for Categorizing Medication Errors Algorithm



Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubatlion, etc.)

***An error of omission does reach the patient.**

Algorithm developed by the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) for applying the NCC MERP index for categorizing medication errors. © 2001, National Coordinating Council for Medication Error Reporting and Prevention.

Methodology

Chart Review, Audit and Self Reporting of Medication Errors are preferred methods in case medication charts are documented manually in the HCO. Software programmes can be used where prescriptions are generated online.

The format for capturing medication errors by routine chart review is provided in Annexure.

The idea of trying to identify personnel involved in errors is to ensure that the organisation does a proper root cause analysis and takes appropriate corrective and/or preventive action. It is not meant for punitive action. Process improvements are a must to reduce errors.

Formula

Total number of errors identified	X 100
Total number of opportunities	

Note:
Self-reported medication errors, medication errors identified during audits or medication errors identified by any other methodology shall be added to the numerator i.e. the total number of errors identified.

Sample size

Adhere to the formula stated by NABH in its document on indicators for sample size calculation. The 'population' would be calculated from the running average of the previous three months of admissions.

Care needs to be taken to ensure that files from all clinical specialities are included. Stratified sampling will help the organisation achieve this.

Correction

Pending analysis, it is imperative that the organisation do a correction to mitigate the effect(s) of the error. An example of how correction could be done is provided below.

For category A and B	Administer the drug within a reasonable time frame
For Category C and D	Consult the clinician and follow orders accordingly

Analysis

The first step in the analysis is the collation of data. This would help identify

- Categories of error
- Personnel involved in error

The data could be collated as per the table below.

	A	B	C	D	E	F	G	H	I	TOTAL
DOCTORS										
NURSES										
PHARMACISTS										
TOTAL										

The organisation should identify the proper root cause to ensure that effective corrective and/ or preventive action are taken. It is suggested that appropriate tools are used for the same.

Some of the possible causes of medications errors are provided in the table below.

People	Environment	Equipment	Process
Casual Attitude	Pharmacy- poor drug storage- poor ventilation, lighting, humidity	Defective syringe pumps	'Ten' rights not observed
Inexperienced/ New staff	Pharmacy space constraint for storage		Wrong stocking
Untrained staff	Pharmacy manpower constraint for dispensing		Wrong labelling
Shift change time/ in a hurry			Inappropriate syringe/ diluent
Emotionally unfit			No cross-checking
Physically unfit			Stock-outs

People	Environment	Equipment	Process
Casual Attitude	Pharmacy- poor drug storage- poor ventilation, lighting, humidity	Defective syringe pumps	'Ten' rights not observed
Inexperienced/ New staff	Pharmacy space constraint for storage		Wrong stocking
Untrained staff	Pharmacy manpower constraint for dispensing		Wrong labelling
Shift change time/ in a hurry			Inappropriate syringe/ diluent
Emotionally unfit			No cross-checking
Physically unfit			Stock-outs
Wrong indent/ receiving			Unauthorized replacement of the drug
Patient identification error			LASA medicine error
Wrong dispensing pharmacy			
Wrong distribution GDA			
Illegible handwriting of doctors			

Some of the common corrective actions include

- Training
- Manpower recruitment
- Pharmacy stock rectification
- Equipment replacement/ rectification

Suggested Reading

1. www.nccmerp.org. National Coordinating Council for Medication Error Reporting and Prevention
2. American Society of Health-System Pharmacists. ASHP guidelines on pre- venting medication errors in hospitals. Am J Health-Syst Pharm. 2018; 75:1493–1517.
3. Nrupal Patel, Mira Desai, Samdih Shah et al. A study of medication errors in a tertiary care hospital. Perspect Clin Res. 2016 Oct-Dec; 7(4): 168–173.
4. Khandelwal AK. Getting it Right. Healthcare Radius 2014; March: 32-34

Annexure-3 : Medication Chart Review Checklist

Auditor: Date of Audit: Location:
UHID:

Date of Admission: Primary Consultant: Drug allergies documented: Yes/No

	Error Perpetuation (Write Category of error from A to I)# In case of no error, kindly write 0; if a particular parameter is not applicable, kindly write NA (Multiple errors can be there and documented for each row and column)									
	Drug 1	Drug 2	Drug 3	Drug 4	Drug 5	Drug 6	Drug 7	Drug 8	Drug 9	Drug 10
Doctors										
1. Incorrect drug selection										
2. No/wrong dose										
3. No/wrong unit of measurement										
4. No/wrong frequency										
5. No/wrong route										
6. No/wrong concentration										
7. No/wrong rate of administration										
8. Illegible handwriting										
9. Non-approved abbreviations used										
10. Non-usage of capital letters for drug names										
11. Non-usage of generic names										
12. Non-modification of drug dose keeping in mind drug-drug interaction										
13. Non-modification of time of drug administration/ dose/drug keeping in mind food-drug interaction										

	Error Perpetuation (Write Category of error from A to I)# In case of no error, kindly write 0; if a particular parameter is not applicable, kindly write NA (Multiple errors can be there and documented for each row and column)									
	Drug 1	Drug 2	Drug 3	Drug 4	Drug 5	Drug 6	Drug 7	Drug 8	Drug 9	Drug 10
Doctor and/or Nurse										
14. Wrong formulation transcribed/indented										
15. Wrong drug transcribed/indented										
16. Wrong strength transcribed/indented										
Pharmacist										
17. Wrong drug dispensed										
18. Wrong dose dispensed										
19. Wrong formulation dispensed										
20. Expired/Near-expiry drugs dispensed										
21. No/wrong labelling										
22. Delay in dispense > defined time										
23. Generic or class substitute done without consultation with the prescribing doctor										
Nurses										
24. Wrong Patient										
25. Dose Omission										
26. Improper Dose										
27. Wrong Drug										
28. Wrong Formulation Administered										

	Error Perpetuation (Write Category of error from A to I)# In case of no error, kindly write 0; if a particular parameter is not applicable, kindly write NA (Multiple errors can be there and documented for each row and column)									
	Drug 1	Drug 2	Drug 3	Drug 4	Drug 5	Drug 6	Drug 7	Drug 8	Drug 9	Drug 10
29. Wrong Route of Administration										
30. Wrong Rate										
31. Wrong Duration										
32. Wrong Time*										
33. No documentation of drug administration										
34. Incomplete/Improper documentation by nursing staff **										
35. Documentation without administration										
Others										

Number of errors (Number of cells having a value between A to I) =

For example, if drug 1 has an error of category C for doctors and an error of category B for Pharmacists and drug 4 has an error of category C for nurses; numerator will be 3.

Number of opportunities {Number of cells having a value of either 0 or a value between A to I (excluding NA)} =

For example, if the case sheet had ten drugs and all the cells had values, then the number would be 350. However, if there were six drugs and there were 24 cells with a value of 'NA' the number of opportunities would be 186{(35 X 6)-24}.

#Select only one of the medication error categories or subcategories, whichever best fits the error that is being reported. In selecting the patient outcome category, select the highest level severity that applies during the course of the event. For example, if a patient suffers a severe anaphylactic reaction (Category H) and requires treatment (Category F) but eventually recovers completely, the event should be coded as Category H.

* Deviation from the organisation's defined timeframe for the administration of drugs for which the time has not been written. The basis for stating 'wrong time' should be evidence-based. The organisation could adopt/adapt the ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications.

**Incomplete documentation includes the missing date, time, signature. Improper documentation includes writing the wrong dose like instead of stating ½ tablet of 500 mg is administered, stating that 1 tablet of 250 mg was administered (based on how the medication order was written) or not stating the actual brand that was administered in cases of brand substitution.

Annexure-3 : Quality tools

Quality Tools: QI data should be analysed using statistical/quality tools to assess compliance with the targets and identify areas for improvement.

Root cause analysis (RCA): RCA a very commonly used tool and is carried out for establishing causality when adverse trends are noted for any parameter or in the case of errors/incidents. RCA is a systematic, extensive and in-depth analysis of a problem with the view to get to the bottom of the problem. RCA is carried out by using either the 5 Why's Tool or the Cause and Effect Diagram.

5 Whys' tool (Taiichi Ohno), helps teams look beyond obvious and initial symptoms by asking "Why?" five times, sequentially in response to the first answer, till one reaches the root cause. As a result the focus(blame) shifts from individuals to the process. There may be multiple root causes of a problem; different people who see different parts of the system may answer the questions differently. The 5 whys has come under criticism for overly simplifying the problem on hand. The cause(s) of a problem and how to address them are likely to be understood more effectively by using multiple 5 Whys in conjunction with a Cause and Effect Diagram.

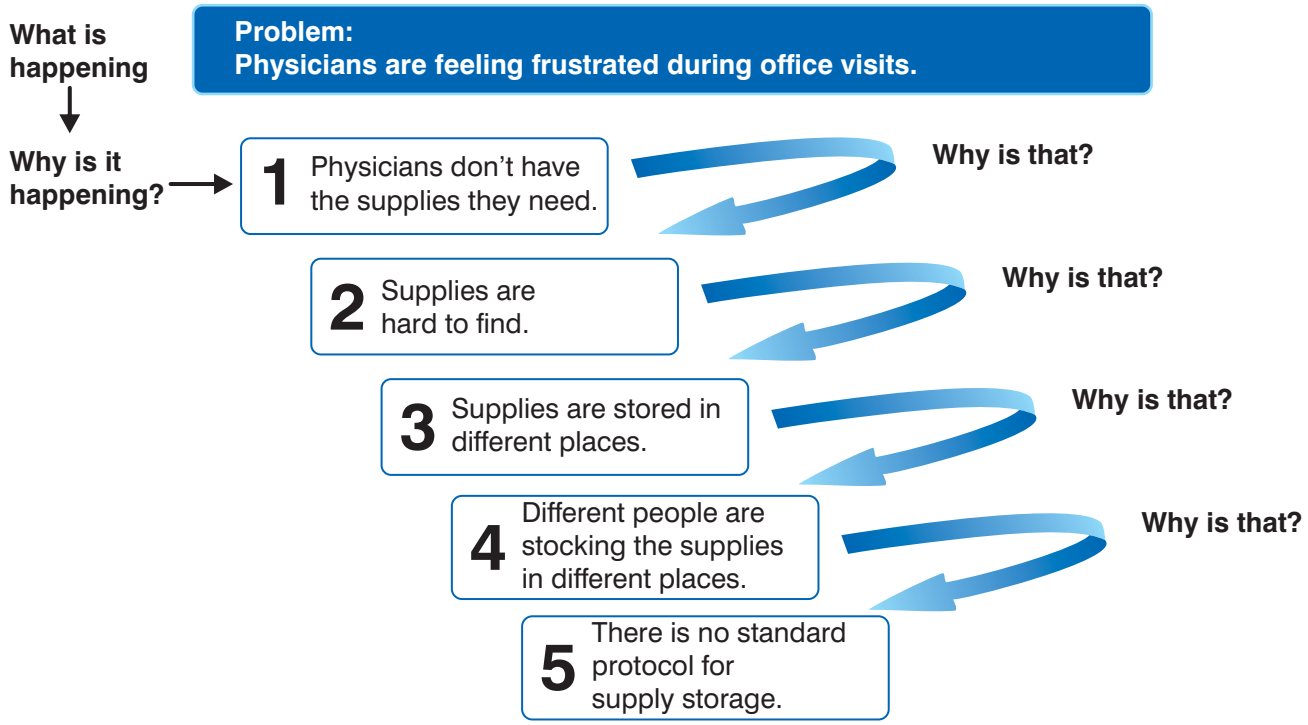


Figure 1: Illustration of 5-Why's Approach for carrying out a root cause analysis. (https://www.aafp.org/fpm/2007/0500/p30.html accessed on April 30, 2022)

Cause and Effect Diagram: Also known as Ishikawa or fishbone diagram, graphically displays the relationship of the many causes to the effect, and to each other; helping teams identify areas for improvement. A line runs horizontally from the tail to the head of the fish, where the effect is written. Causes are grouped under the categories of Materials, Methods, Equipment, Environment, and People or as required.

The tool is used extensively to reach the root cause of deviations from any policy, procedure or protocol and outliers for indicator data and for detailed analysis of incidents and adverse events.

For e.g. Fish bone/cause and effects diagrams can be used to identify the causes of underuse of the electronic health records in a hospital setting by the doctors and nurses.

Affinity Diagram: These diagrams serve the same purpose as the Ishikawa charts but the visual presentation differs..

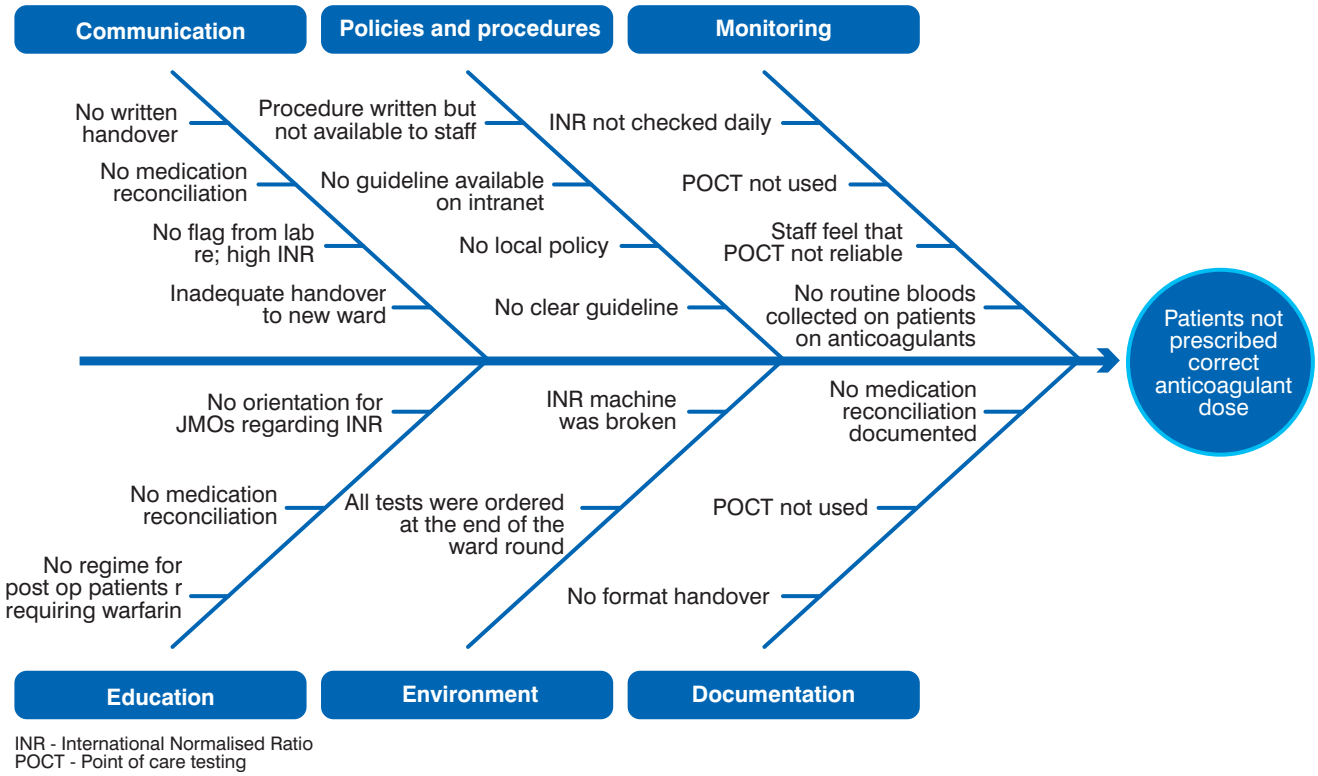


Figure 2 : Example of a Cause & Effect Diagram by Clinical Excellence Commission. Reasons why patients are not on a standardised anticoagulation pathway (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/cause-and-effect-diagrams)

Histogram: A histogram is a bar chart used to display variation in continuous data like time, weight, size, or temperature. It helps to recognize and analyse patterns not apparent by looking at data tables, or by finding the average or median and will effectively highlight the interval that is most frequently occurring.

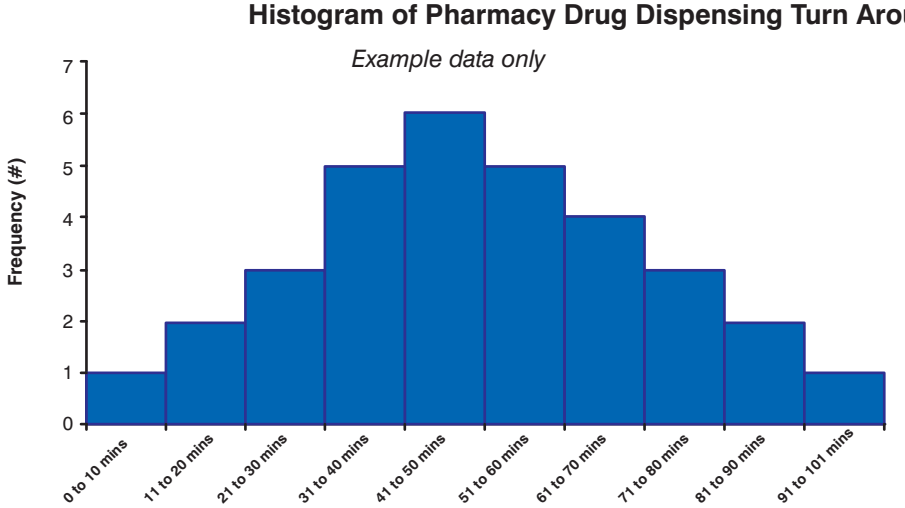


Figure 3: Histogram on Turnaround time for dispensing of the drug (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/histogram accessed on April 30, 2022)

Failure Modes and Effects Analysis(FMEA): FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur and prevent it by correcting the processes proactively, rather than reacting to adverse events after failures have occurred. The FMEA tool prompts teams to review, evaluate, and record the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences(severity and frequency) of each failure?)
- How can the failure be prevented?

The tool forms the core of risk assessment and risk mitigation. FMEA is particularly useful in

evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

Step in the process	Failure Mode	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity (1-10)	Risk Profile Number (RPN)	Action to Reduce Occurrence of Failure
1								
2								
3								

Figure 4 : Institute of Healthcare Improvement's format for Failure Mode Effect Analysis
(http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx accessed on April 30, 2022)

Flowchart (process map): Flow charts help understand a process in depth through visual representation of its steps; and should be prepared in early phase of improvement work. It is a road map of where things are happening, the order in which things happen and the relationships between parts of a process. A Flow Chart is recommended as the first step in almost any study. Often a Flow Chart may reveal that a process does not operate the way management or the operators in the process actually think it does. A high level flow is chart is prepared first to give a helicopter's view of the process followed by a detailed flow chart. Flow charts help identify gaps in the process, its bottlenecks, wasteful/unnecessary processes, delays, duplication, breakdowns in communication, and also how to improve the process. Improvement work can be focussed on these steps. An example of the same is given below-

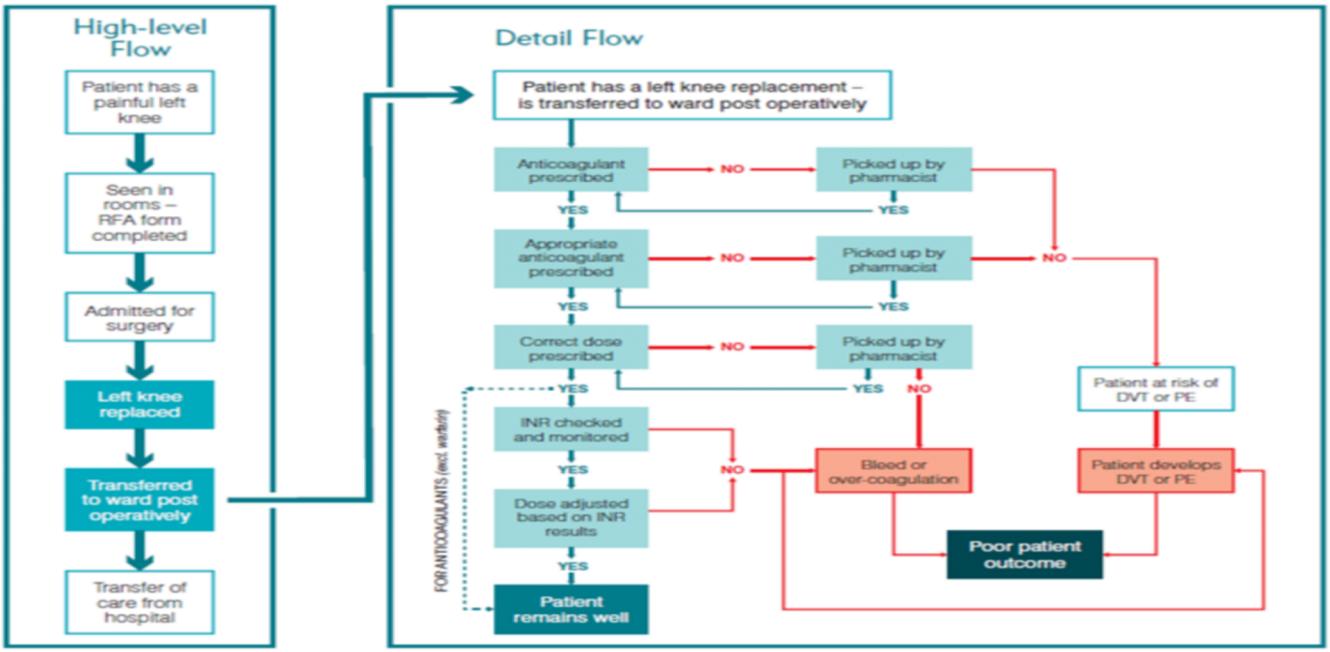


Figure 5: Flow chart of a patient's journey within the hospital(https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/flow-charts accessed on April 30, 2022)

Pareto Chart: The "Pareto Principle" is the "80/20 rule" and works on the theory that roughly 80% of the effect comes from 20% ("the vital few") of the causes. The "vital few" are easily distinguished from the "useful many" by plotting them as a bar diagram. Teams can prioritize and focus improvement efforts on the vital few. The example given below shows a Pareto Chart of types of medication errors. An audit of 430 medication errors was conducted to determine the categories (types) of errors and their frequency. The results were collected initially in a Tally Sheet (a simple sheet which collects data real time and indicates the frequency of occurrence of events) then the data was placed in descending order of frequency in a Pareto Chart Template in Excel. The types of errors that fall under the 80% cut off line indicate the 'vital few' types of medication error that should be addressed as a priority as they contribute most to the problem i. e.:

- Dose missed
- Wrong time
- Wrong drug
- Over dose

The types of medication errors that fall above the 80% cut off line are known as the 'trivial many' and are generally seen as not a high priority to address when compared to the 'vital few' factors.

A Pareto chart can also be used to study the occurrence of incidents/care management events (medication errors, pressure ulcers, IV complications etc.). Data for a Pareto Chart can also be collected after a braining storming session by putting together the number of votes cast for the proposed reasons for incidents, adverse trends of indicator data etc.

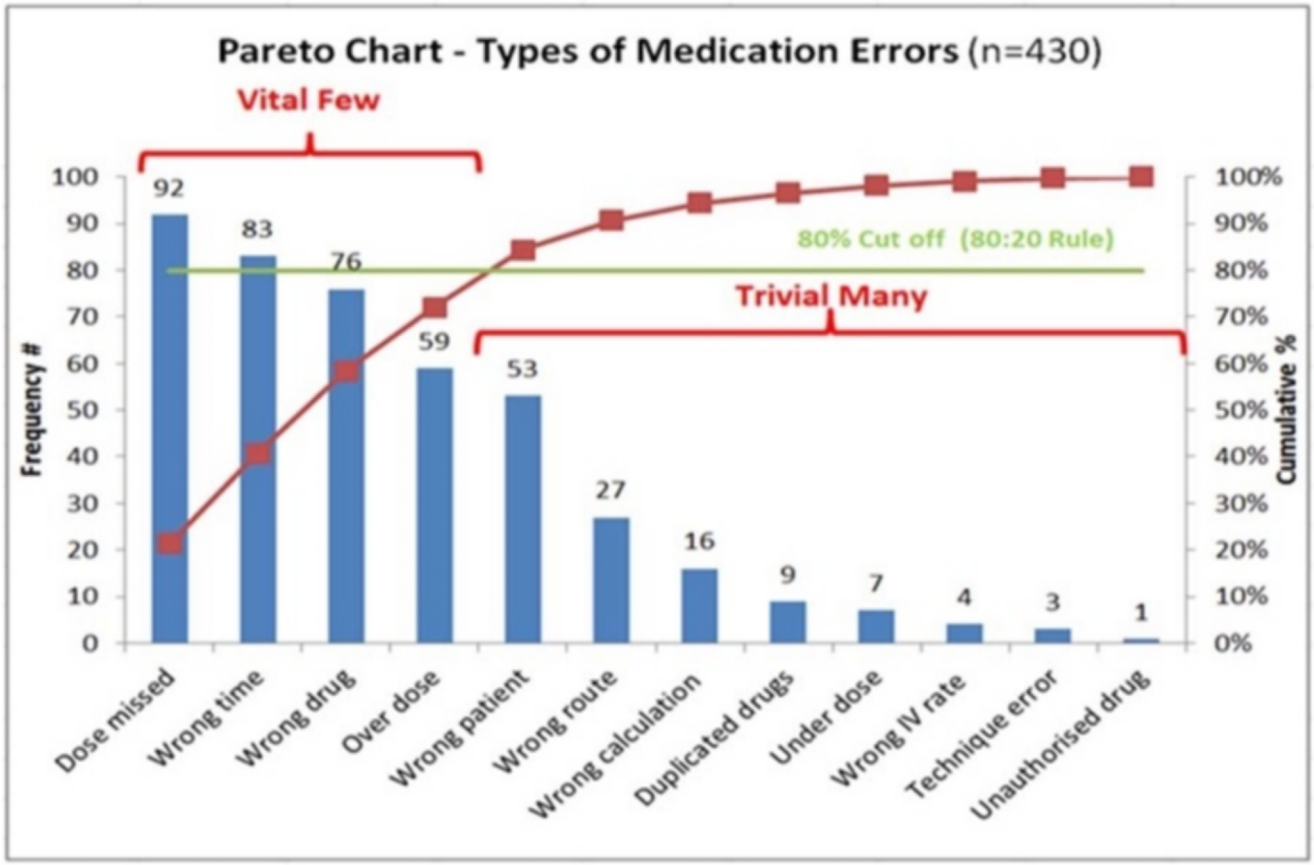


Figure 6: Pareto Analysis of Medication Error in a hospital

Run Chart & Control Chart: A run chart is a graph of data over time and assess variations in performance over a period of time and indicate trends. A control chart, with an upper (UCL) and a lower control limit (LCL), distinguishes between common and special causes of variation within a process.

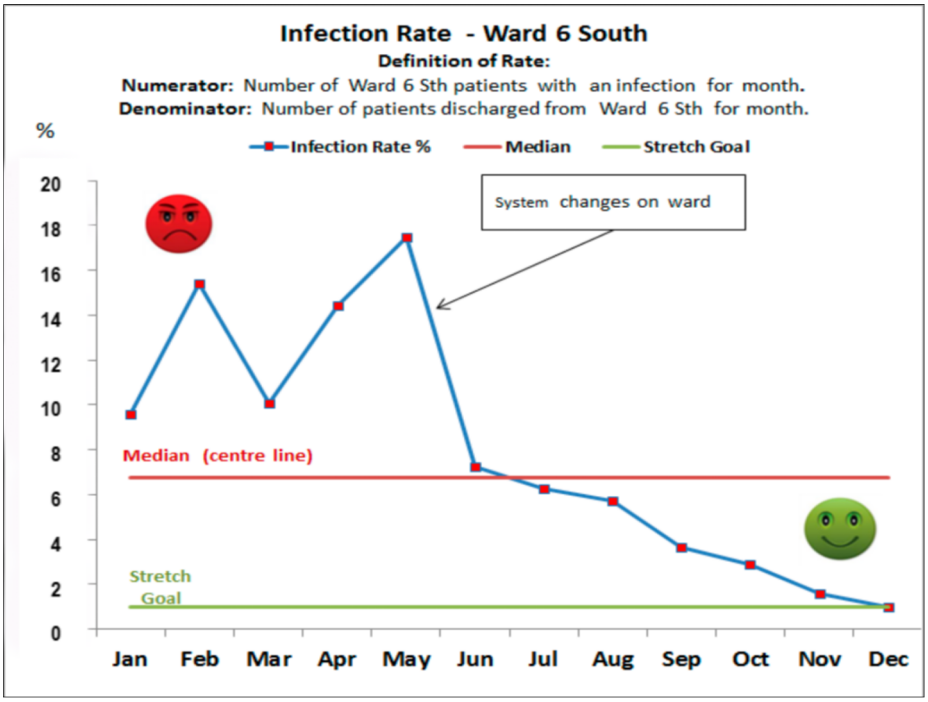


Figure 7: . Simple Annotated Run chart with UCL and LCL of an infection rate over time (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/run-charts accessed on April 30, 2022)

Driver Diagram: A driver diagram is a visual display of what "drives," or contributes to, the achievement of a project aim. driver diagram organises information on proposed activities so the relationships between the aim of the improvement project and the changes to be tested and implemented are made clear. The primary drivers (sometimes called "key drivers") contribute directly to achieving the aim. The secondary drivers are components of the primary drivers, and specific change ideas to test for each secondary driver.

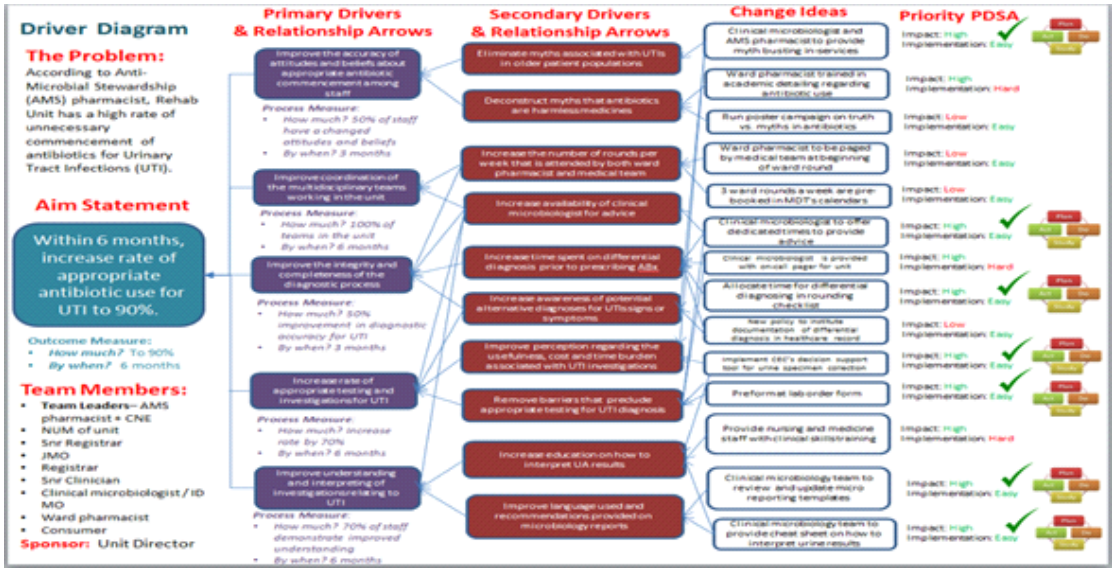


Figure 8: Driver Diagram (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/driver-diagrams accessed on April 30, 2022)

Scatter Diagram/Plot: Scatter diagrams are used to identify cause-and-effect relationships between two variables. A scatter diagram does not prove causation.

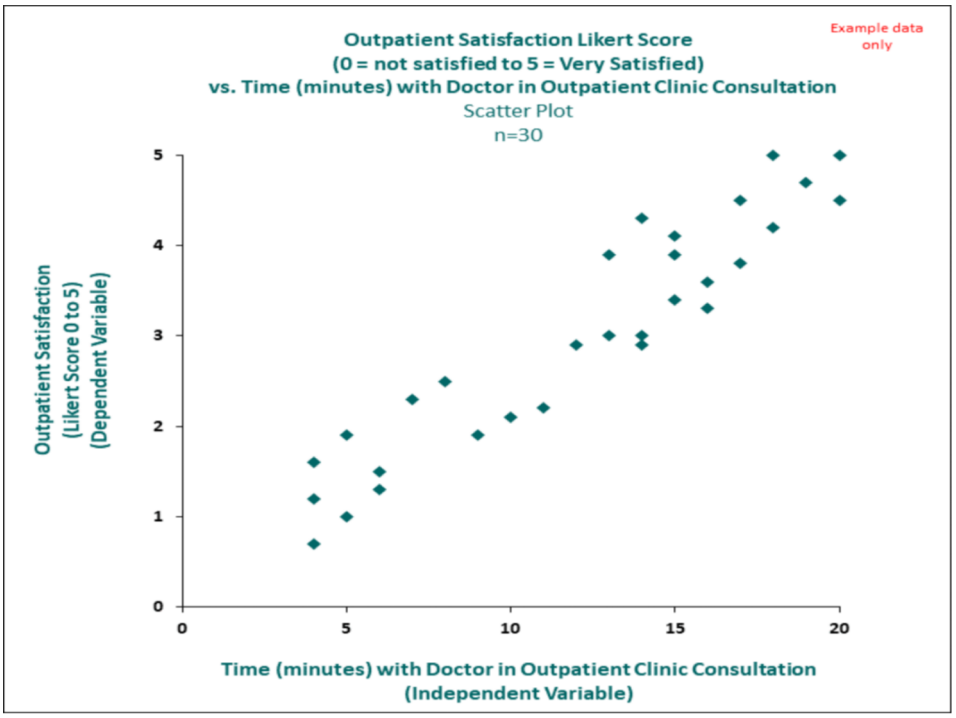


Figure 9: Scatter diagram showing patient satisfaction using likert's score v/s time with doctor consultation (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/scatter-plot accessed on April 30, 2022)

Project Planning Form: This tool helps teams think systematically about their improvement project. It tracks various elements like Plan-Do-Study-Act (PDSA) cycles.

Quality improvement technique/tool	Decisions	Describe problem	Cause analysis	Develop action plan	Monitor progress
Histogram		Yes		Yes	Yes
Pareto Chart	Yes	Yes		Yes	Yes
Driver Diagram	Yes	Yes		Yes	
Flow chart/					
Process Map		Yes		Yes	
Run chart	Yes				Yes
Scatter Diagram/Plot	Yes	Yes			
Fishbone diagram		Yes	Yes		

Continuous Quality Improvement(CQI): CQI is a progressive incremental improvement of processes, safety, and patient care. Introduced by Shewhart and propagated by Deming, CQI is an analytical decision making tool which allows one to see when a process is working predictably and when it is not.

The Model for Improvement(MFI): The MFI asks three fundamental questions before embarking on a quality improvement project, which can be addressed in any order.

- What are we trying to achieve?
- What changes can we make that will result in an improvement?
- How will know that the change is an improvement?

This is followed by PDSA cycles to test changes in real work settings to determine if the change is an improvement.

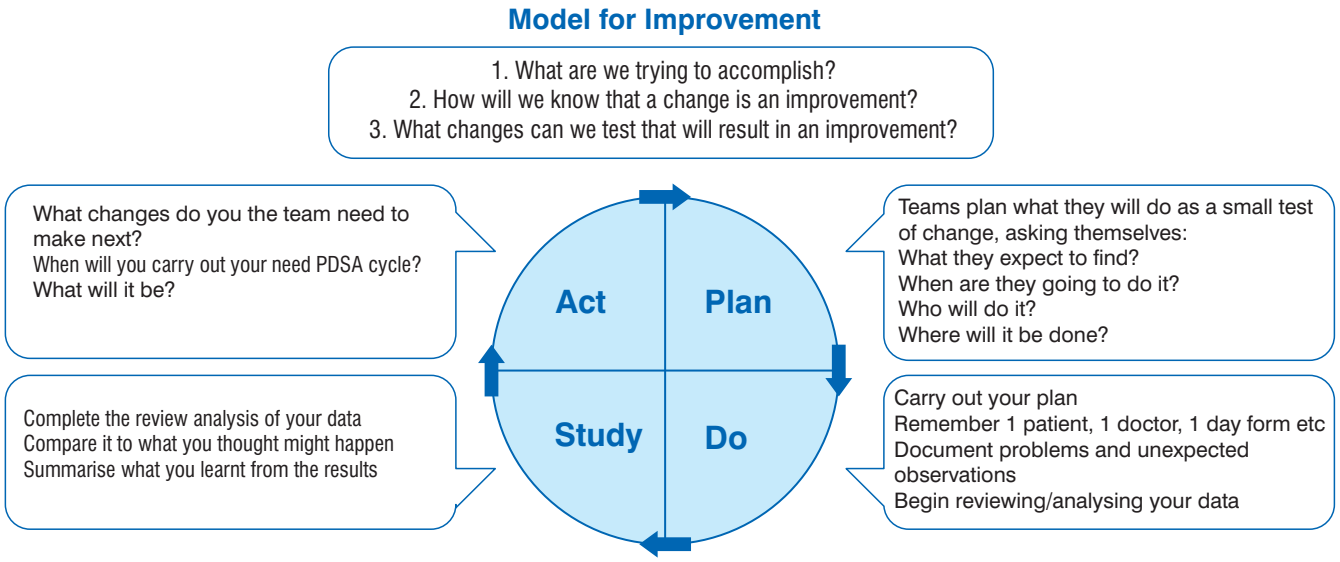


Figure 10: Model for Improvement and PDSA (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/model-for-improvement-and-pdsa-cycles accessed on April 30, 2022)

Models for CQI : The most common CQI methodologies used in healthcare are the API's Model for improvement(MFI), FOCUS plan-do-study-act (PDSA), Six-Sigma, and Lean strategies. They typically include testing of ideas and redesign of process or technology based on lessons learned. Steps involved in CQI are Plan-Do-Study-Act (PDSA) cycle. The MFI and FOCUS frameworks have been developed to precede the use of PDSA and PDCA cycles respectively.

PDSA/PDCA Cycle: Involves a sequence of 4 repetitive steps, Plan-Do-Study/Control-Act, eventually leading to exponential improvements 'Plan' phase involves detailing ideas for improvement, 'Do' phase involves implementation and defect prevention. 'Study' phase involves review and analysis of data(Adapt/Adopt/Abandon the change and repeat PDSA). 'Act' phase includes incorporation of lessons learnt into the test cycle. The cycle is repeated again and again as waves of small improvements are considered, tested, evaluated, and incorporated, if effective. This is the most commonly used tool for clinical audits.

FOCUS-PDCA: This model also has two phases. The 'FOCUS' phase focusses attention at the opportunity to improve, and the 'PDCA' phase for pursuit of improvement and assessment of effectiveness of the interventions.

- F = Find what needs to be improved on;
- O = Organize team with good knowledge in the process
- C = Clarify the present knowledge of the process
- U = Understand factors responsible for variations
- S = Select interventions that evidently might improve process

Six-sigma: Six-sigma is a widely used model that is now making steady in-roads into medicine. It seeks to improve performance through identifying causes of process defects/errors and eliminating them. At Six Sigma, error rates should be less than 3.7/million opportunities. Two methods have mainly been employed- DMAIC and DMADV. DMAIC is applicable for existing process improvement; DMADV is used for new design process optimization.

Lean and Lean-Sigma : Originated by Toyota Inc., Japan, this model is essentially geared towards improving process / product / service flow and eliminates waste by identifying and removing non-value added steps Embracing Lean in healthcare, eliminates waste throughout the entire operational system; whilst simplifying and improving the processes, resulting in low cost of production and fast through-put times. A few establishments, have combined Lean and Six Sigma concepts to obtain better quality improvement effects. Such a combination is known as Lean-Sigma.

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Annexure-4 : NABH standards on recording cause of death at health facility

1.1 Introduction

Precise and standardized documentation of cause of deaths is essential for effective clinical governance, legal compliance, and public health monitoring. This is particularly critical in relation to India's commitment to SDG 3 goal and the National NCD (Non-Communicable Disease) Action Plan (1-2), which identifies the unconditional probability of dying between the ages of 30 and 70 from NCDs (including cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases) as its primary indicator. Accurate measurement of mortality hinges on having strong, high-quality cause-of-death data, which can only be guaranteed when hospitals follow best practices in death certification and documentation.(3,4) In addition, the coverage of medical certification of cause of death of all registered deaths is stagnant at 22 % for more than a decade (5), warranting major changes in the MCCD system in India.

1.2 Justification

Review of MCCD under the RBD Act, 2023 (6): The Registration of Births and Deaths (Amendment) Act, 2023, Sections 10, 12, 17, and 30 concerns MCCD issuance, timelines, content, and penalties. Section 10(2) of the RBD Act (2023) mandates that hospitals must issue the MCCD free of charge and provide a copy of the form to the relative of the deceased. Under Section 12, the Registrar must issue a registration certificate within seven days of completing registration. Section 17(1) ensures that the cause of death is not disclosed on the death certificate to maintain confidentiality. Section 23(2) stipulates that failure to issue or deliver the MCCD under Section 10 incurs a fine of up to ₹50, and informants listed in Section 8(1)(b)–(e) who fail without reasonable cause may be fined up to ₹1,000 per event. Finally, Section 30(2)(d) empowers the Central Government to prescribe the format and content of the medical certificate of cause of death.

Studies on MCCD in India that have evaluated MCCD practices in India have found that there are errors in almost 80-100 % of the certificates (3,4,7,8,9). Studies conducted by ICMR-NCDIR have identified deficiencies such as the lack of a standardized death summary template, ambiguity in distinguishing between clinical conditions and certifiable causes of death, and no guidance on MCCD completion process, roles and responsibilities of certifiers, lack of training to doctors during academic courses or on-the job formal training, lack of audit or review systems for MCCD in the hospital and absent ICD-10 coding of cause of death in the medical record and MCCD form (Unpublished results).

Review of NABH Standards relevant for documentation on cause of death: The 6th Edition Standards (2025) (10) established by the National Accreditation Board for Hospitals & Healthcare Providers (NABH) set the standard for quality, safety, and regulatory compliance in hospitals across India. These standards are divided into ten chapters, each highlighting a crucial aspect of hospital operations and clinical care. In the NABH 6th Edition Hospital Accreditation Standards, two chapters are especially relevant for death

documentation:

Chapter 1: Access, Assessment and Continuity of Care (AAC)

This chapter comprises 13 standards that cover the entire continuum of patient care from admission to discharge. Among these, AAC.13 standard specifically mandates that the organisation must define the content of the discharge summary. Objective element AAC.13. e states: "In case of death, the summary of the case also includes the cause of death."

Chapter 10: Information Management System (IMS)

This chapter includes 6 standards that emphasize the management, confidentiality, and integrity of medical records. Among these, IMS.4 standard ensuring that the medical record demonstrates continuity of care. Objective element IMS.4. g states: "In the case of death, the medical record contains a copy of the Medical Certificate of Cause of Death."

1.3 Proposal for NABH standards on recording cause of death at health facility

Focusing on these standards and objective elements ensures adherence to both

accreditation and legal mandates (Registration of Births and Deaths (amendment) Act, 2023) while also facilitating accurate public health reporting.

Chapter No.	Chapter	Standard	Objective Element	Gap	Recommendation
1	Access, Assessment and Continuity of Care (AAC)	AAC.13: The organisation defines the content of the discharge summary.	AAC.13. e: In case of death, the summary of the case also includes the cause of death.	No standard template for death summary structure. Lacks guidance on distinguishing clinical vs. certifiable cause of death.	Standard : A standardized death summary template to be implemented in health facility Objective element: Death summary to document immediate, antecedent cause/s of death as per the requirements of the Medical certification of cause of death (MCCD)
10	Information Management System (IMS)	IMS.4: The medical record reflects the continuity of care.	IMS.4. g: In case of death, the medical record contains a copy of the medical certificate of the cause of death.	No guidance on MCCD completion process, responsibility of certifiers, ICD-10 coding, legal forms to be used, and audit of forms	Expand objective element : Form 4 (for institutional deaths) and Form 4A (for non- institutional deaths) should be used as per the RBD Act. Health facilities to mandate periodic MCCD training, implement audit mechanisms for MCCD form completeness and accuracy, and integrate ICD-10 coding at hospital

In addition, the recent NABH digital EMR/ HIS standards (11) were also reviewed for recording of cause of death. The following table summarises the findings:

- **NABH Digital Standards for HIS/EMR System on death documentation:**

Chapter	Standard	Objective Element	Gap	Recommendation
1.Access, Assessment, and Continuity of Care (AAC)	AAC.6: The system manages patient discharge and transfer processes.	AAC.6. a: The system creates / modifies a discharge summary.	Absence of Death Summary Feature and Lack of Standardized Format.	Objective element : Introduce "Digital Death Summary" as a New AAC Standard & Adopt a Standardized Death Summary Template with documentation of immediate, antecedent cause/s of death as per the requirements of the Medical certification of cause of death (MCCD)
2.Care of Patients (COP)	COP.4: The system manages emergency and medico-legal cases.	COP.4.b: The system has the capability to label a case as a medico-legal case (MLC).	No standardized digital checklist for medico-legal documentation.	Introduce a digital checklist for capturing medico-legal details and documentation of immediate, antecedent cause/s of death, manner of death and details of injury as per the requirements of the Medical certification of cause of death (MCCD)
Information Management System (IMS)	IMS.1: The system supports healthcare data and interoperability standards for patient, clinical, and administrative information to ensure continuity of care, including ABDM.	IMS.1. e: The system supports ICD 10/11 or SNOMED CT covering clinical terminologies for diagnosis, morbidity and mortality data accurately.	MCCD Not Integrated & No MCCD Audit-Framework Review Checklist	Objective element: The system supports digital MCCD Form In addition, the health facility to establish a multi-level MCCD Audit Checklist to ensure completeness and accuracy of MCCD.

1.3.1 Development and Integration of a Comprehensive Death Summary Template

A comprehensive template for death summaries was developed by combining essential elements from national guidelines and practice documents. The Death Summary format captures demographic, clinical, and investigation data. The format is described for different age categories and groups, namely: Stillbirth, New-born, Child, Maternal, Medico-legal. The templates are provided in Appendix. It includes fields for immediate, antecedent, and underlying cause, other contributory causes, and ICD-10 coding for cause of death. The Cause of Death in the death summary should match with part I & part II of Form 4 (MCCD). (12-20)

Documentation and storage of Death summary:

In the event of a patient's death, hospital shall issue MCCD, and must be completed by the attending doctor. This is for the purpose of the declaration of death, assigning cause of death, and disposal of body. One copy is given to the attendant, and one copy is filed in the medical record. The final copy is sent to the MRD for processing the death certificate. The medical record with copy of MCCD form shall be maintained separately by the medical records department.

All inpatient deaths are recorded in the Death Register. Brought in dead are not included in the death register. This information is recorded in a separate register. Any Admission, Discharge, and Transfer (ADT) of brought in dead needs to be recorded in a register or Hospital Information System.

1.3.2. Standard recording of MCCD at health facility

Periodic training on MCCD for certifying doctors (21,22), regular audits, and policy updates to ensure compliance with NABH and the RBD Act requirements should be a regular feature and integrated with routine quality processes at health facility.

a) Use of MCCD forms: As per the Registration of Births and Deaths (amendment) Act, 2023, it is specified that 'death that occurs in any medical institution providing specialised treatment or general treatment, every such institution, irrespective of ownership, shall, free of charge, provide a certificate of the cause of death, including the history of illness, if any, signed by the medical practitioner who attended that person during his recent illness to the Registrar in such form as may be prescribed and provide a copy of such certificate to the nearest relative of the deceased'. The recommended Form 4 for deaths that occur in the hospital (institutional) and Form 4 A for deaths that occur elsewhere (non-institutional) are provided in Appendix 1.

b) Integrate Digital formats for Death Summary & MCCD Form: All components of Form 4 as an integrated MCCD module to be embedded in the Electronic Medical record or Health Information system. This shall include mandatory field validation and dropdowns for ICD-10 coding. Digital integration of death documentation and MCCD will enhance compliance and the quality of cause of death data.(23)

c) Establish a Multi-Level MCCD Audit in the hospital : This is based on the Framework of audit of MCCD at health facility (24) that aims to reduce missing data and improve accuracy of cause of death in the MCCD form, and supports timely submission to the Civil Registration system.

- Level 1 (Nursing Staff for Completeness): Ensure all necessary data fields (demographics, time/place of death, cause fields, etc.) are fully completed.
- Level 2 (Accuracy by Physician): Verify the correct order of causes (immediate, antecedent, underlying) and agreement to the events leading to death as documented in the medical record and death summary.

- Level 3 (ICD-10 Coding by MRD): MRD personnel may assign and validate ICD- 10 codes.
- Workflow Rule: Completion of Levels 1 & 2 reviews is required before sign-off; Level 3 is conditional based on completion of level 1 and 2 review, and has to be done before the data entry of MCCD in the Civil Registration portal for the purpose of death registration.

d) Ensure Interoperability & Linkage: Automatically connect the finalized death summary and MCCD record to the patient's ABHA, EMR audit trail, and external reporting systems.

e) Ensure MCCD coverage: Following the review of MCCD form 4 for completeness of fields and accuracy of cause of death, MCCD details with ICD 10 code are entered in the CRS software portal to complete death registration.

Recommendations : The above steps present a structured strategy for aligning hospital death documentation practices with NABH standards, statutory responsibilities, and public health goals, thereby supporting both accreditation and national monitoring initiatives. The main steps are summarised :

a) A standardized death summary template to be implemented in health facility to document immediate, antecedent cause/s of death as per the requirements of the Medical certification of cause of death (MCCD).

b) Form 4 (for institutional deaths) and Form 4A (for non-institutional deaths) should be used as per the RBD Act.

c) Health facilities to mandate periodic MCCD training, implement audit mechanisms for MCCD form completeness and accuracy, and integrate ICD-10 coding at hospital

d) Digital systems may be ensured for recording death summary, MCCD and audit processes.

1.4 Role of ICMR-NCDIR in adoption and translation of NABH standards

ICMR-NCDIR shall support and facilitate the adoption and implementation of NABH standards on documentation of cause of death through the following activities in collaboration with NABH :

a) Integrate Digital formats for Death summary and MCCD forms

1. Finalize Death summary template through expert consultations

2. Integration as part of NABH accreditation : Train and develop capacity of NABH assessors, medical superintendents , and doctors on MCCD and MCCD audit systems

3. Develop and test prototypes within NABH certified EHR systems :Develop software workflows for generation of MCCD forms with in-built data quality measures by review of EHR systems

b) Establish multilevel MCCD audit in hospital : Develop capacity in hospitals to establish and implement MCCD audit systems; provide technical inputs to assess MCCD quality generated in hospitals.

c) Improve mortality audit systems in hospitals and use of cause of mortality statistics for monitoring and planning in hospitals : Develop templates,indicators and processes for mortality audit systems.

In this effect, ICMR-NCDIR proposes to get into an agreement with NABH to formally develop and implement some of the activities in consultation with the NABH and other stakeholders

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