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

1st EDITION
EFFECTIVE 1ST APRIL 2026

NABH ACCREDITATION STANDARDS FOR AYUSH HOSPITALS

(Covering Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homoeopathy and Sowa-Rigpa)

QUALITY : SAFETY : WELLNESS

National Accreditation Board For Hospitals and Healthcare Providers (NABH)

NABH Accreditation Standards For Ayush Hospitals, effective 1st April,2026

Accreditation Standards for Ayush Hospitals

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National Accreditation Board for Hospitals & Healthcare Providers (NABH)

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against the
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5th Edition

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is from **June 2022** until **June 2026**

Prof Jeffrey Braithwaite, President

Ms Elaine O'Connor, Head of Operations

FOREWORD

National Accreditation Board for Hospitals and Healthcare Providers (NABH), is continuing its journey for creating an ecosystem for quality in healthcare in India. NABH standards focus on safety and quality of the delivery of services by the organizations in the changing healthcare environment. Without being prescriptive, the standards have been developed with the intent of providing information and guiding the organization in conducting its operations with a focus on patient safety.

Over the year various NABH standards have brought about not only a paradigm shifts in healthcare organization's approach towards delivering the healthcare services to the patients but have equally sensitized the healthcare workers and patients towards their rights and responsibilities.

NABH released 5 separate hospital accreditation standards for various disciplines of Ayush systems of medicine in 2009 for the first time. NABH has now formulated accreditation standards including generic requirements for the Ayush hospitals with one or more disciplines (i.e. Ayurveda/Panchakarma, Yoga and Naturopathy, Unani, Siddha, Homoeopathy and Sowa-rigpa). This is an endeavour to have uniform and comprehensive standards applicable equivalently to all Ayush hospitals irrespective of the discipline. The standards are adapted to the most recent guidelines available in the field of Ayush and the most relevant health care practices available globally in order to improve quality of services and patient safety in the field of Ayush. The standards are designed keeping in view the suggestions made by Ministry of Ayush and various stakeholders. All the NABH accredited Ayush hospitals shall be required to comply with the 1st Edition of Ayush accreditation standards of NABH and assessments shall be carried out on the basis of these standards as per transition plan published by NABH.

The NABH hallmark methodology of **10** standard chapters approach has been followed, having total **86** standards and **492** objective elements. The objective elements have been designed to be assessed as CORE, Commitment, Achievement and Excellence. There are **87** objective elements, which are in CORE category and will be mandatorily assessed during each assessment, **351** objective elements are in Commitment category which will be assessed during the final assessment, **43** objective elements are in Achievement category which will be assessed during surveillance and **11** objective elements are in Excellence category which will be assessed during re-accreditation.

This objective methodology will aid any Ayush hospital in a stepwise progression to mature quality system over the full accreditation cycle. The scoring methodology is in a graded scheme to help recognise every progressive effort made by the Ayush hospital in the implementation of the standards. The accreditation will be a four-year cycle with a midterm surveillance assessment at 21-24 months of accreditation.

I, sincerely hope that Ayush hospital will certainly benefit from the collective efforts of Ayush Technical Committee of NABH and practical suggestions of stakeholders involved in formulating the standards.

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

Jai Hind

Dr. Atul Mohan Kochhar
CEO, NABH

ACKNOWLEDGEMENTS

I acknowledge the contributions of the following in preparing this 1st Edition of the NABH accreditation standards for Ayush hospitals.

I earnestly thank Shri Jaxay Shah, Chairperson, QCI, for his unwavering guidance and support. His vision of taking quality to the grassroots has been instrumental in the milestone of finalizing NABH Ayush accreditation standards for the Ayush hospitals.

I sincerely thank Mr. Chakravarthy T. Kannan, Secretary General, QCI, for his invaluable contribution to the healthcare community and commitment to fostering excellence in healthcare standards.

Mr. Rizwan Koita, Chairperson, NABH, has been the guiding light throughout the development of the 1st Edition of Ayush accreditation standards of NABH. I thank him for his continued support and invaluable suggestions.

I thank all board members of NABH in giving insightful suggestions for betterment of the standards.

The Technical Committee of NABH worked relentlessly and meticulously to accommodate the best practices in the Ayush hospitals, referred to innumerable references and incorporated suggestions made by all of the stakeholders in bringing this standard to reality. It was indeed a mammoth task. I profoundly thank all the members for playing a pivotal role in the development of the 1st Edition of the NABH accreditation standards for Ayush hospitals.

I would also like to express my deepest appreciation to Ministry of Ayush, Govt. of India for being a source of encouragement by its multifarious initiatives which have not only taken the Ayush system of medicine to top-notch, but has also helped NABH in shaping the new 1st Edition of Ayush accreditation standards.

I thank all our passionate assessors, management of the Ayush hospitals, clinicians, nurses and paramedics who gave us extensive feedback to improve upon the standards and their exhaustive interpretation.

I thank the officers at NABH Secretariat for working round the clock, to complete the work within time.

It is entirely due to the overwhelming participation, dedication, and diligence of all concerned that we could present these standards in the current detail and format.

To all of you, a sincere, heartfelt and, profound – Thank you.

Jai Hind

Dr. Atul Mohan Kochhar
CEO, NABH

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About NABH

National Accreditation Board for Hospitals and Healthcare Providers (NABH) is a constituent board of the Quality Council of India (QCI), set up to establish and operate accreditation programs for healthcare organizations. 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 healthcare organizations in a non-discriminatory manner regardless of their ownership, size, and degree of independence.

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

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

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

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

NABH Activities

NABH Accreditation Programs: NABH offers accreditation to Hospitals, Small Healthcare Organizations/Nursing Homes, Digital Health, Blood Banks, Eye Care hospitals, Ayush Hospitals (Ayurveda, Yoga and Naturopathy, Homoeopathy, Unani, Siddha Homoeopathy and Sowa-Rigpa), Medical Imaging Services, Dental Healthcare Service Providers, Allopathic Clinics,Care Homes, Ethics Committees and Ayush Treatment and Wellness Centres.

NABH Certification Programs: NABH offers certification to Medical Laboratories, Nursing Excellence, Emergency Department, Stroke Centres, Entry Level for Hospitals, Entry Level for Small Healthcare Organizations, Entry Level for Dental Clinics, Entry Level for Ayush Hospitals and Entry Level for Ayush Centres.

NABH Empanelment Programs: NABH offers empanelment programs for Central Government Health Scheme (CGHS), Ex-Servicemen Contributory Health Scheme (ECHS) and Medical Value Travel Facilitator (MVTF).

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

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

Scope and Purpose of the Standards

Scope of the Standards

These standards are applicable to any Ayush hospital provided the hospital fulfils the following requirements:

- The hospital is currently in operation as a healthcare provider.
- The hospital is providing services pertaining to one or more discipline of Ayush i.e. Ayurveda, Yoga and Naturopathy, Unani, Siddha, Homoeopathy and Sowa-Rigpa.
- The Ayush hospital has minimum 5 sanctioned beds and 30% of average bed occupancy for last 6 months.
- The Ayush hospital commits to comply with NABH standards and applicable legal/statutory/regulatory requirements.

These standards are to be used by the whole Ayush hospital and not for a specific service within the hospital. The Ayush hospital could have different services and it is equally applicable to all services and both public and private hospitals.

Purpose of the Standards

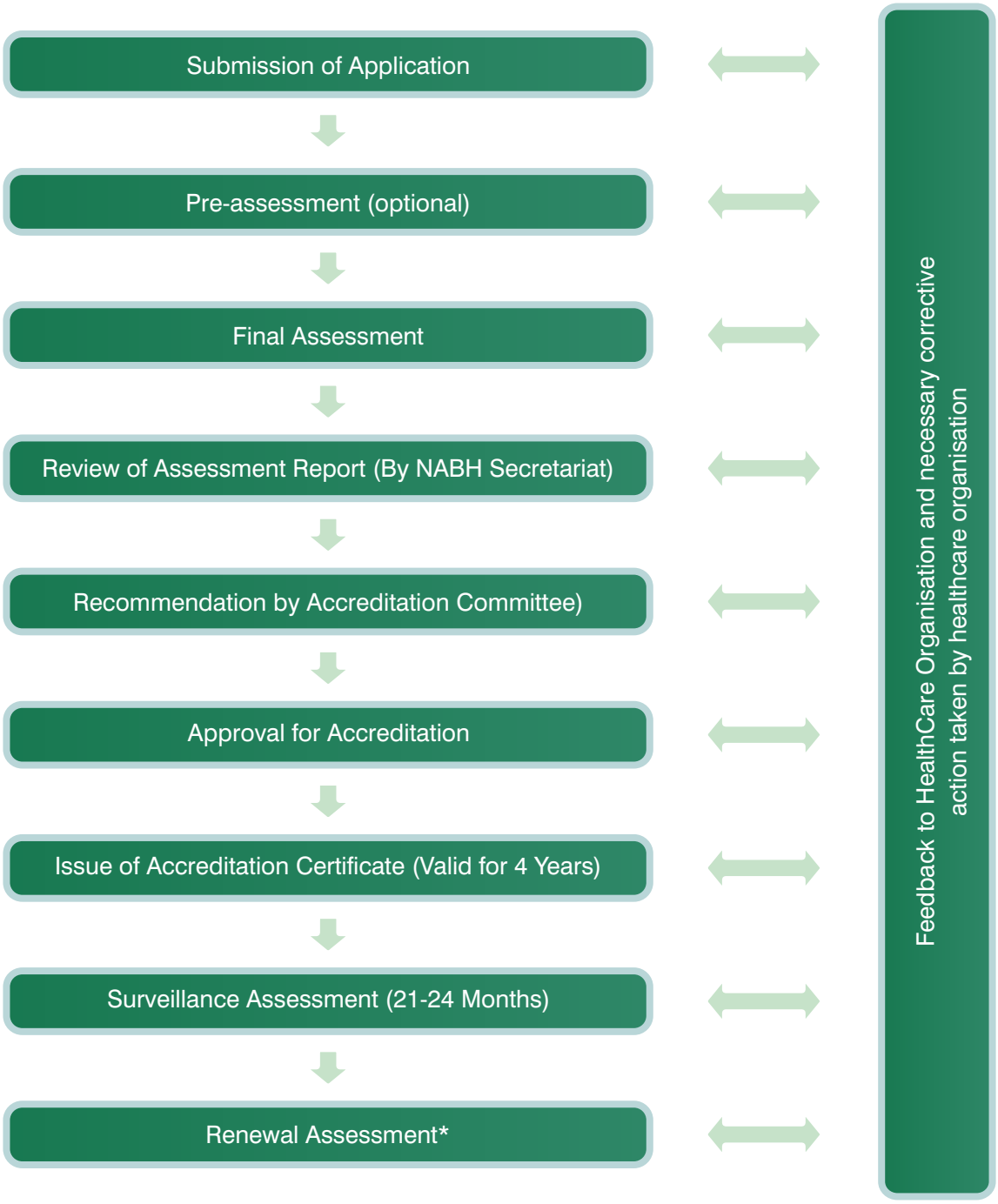
The aim of the standards is to achieve an acceptable level of performance with a view to:

- Improve public trust and community confidence that the organization 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 the Ayush hospital;
- Guide the organization 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 the Ayush hospital;
- Provide an opportunity to explore compliance expectations of standards and the additional requirements related to safety and regulation.

Overview of the NABH Accreditation Process



* For renewal of accreditation, the accredited Ayush hospital must apply six months prior to the expiry of the validity of accreditation

How to read the standard?

The standards focus on the key points required for providing patient-centred, safe and high-quality care. The interests of various stakeholders have been incorporated into the standards. The standards 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 organization must achieve to improve the quality of care. The requirements have been divided into ten chapters. The first five chapters are "patient centric" and the last five chapters are "organization centric". The ten chapters are:

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

Every chapter begins with an 'intent'. The intent states the broad requirements of what the organization 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 organization 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 chapters and the number following this reflects the order of the standard in the chapter, for example, AAC.1 would mean that it is the first standard of the chapter titled 'Access, Assessment and Continuity of Care.

What is an Objective Element?

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

What is an Interpretation?

The interpretation provides guidance on what the organization 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 organization 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 organization 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 the 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 organization 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 organization has the liberty to decide, what/how to implement. However, the requirement of the objective element would have to be adhered.

CORE Objective Element

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

Levels

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

Other Sections Included in the Standard Book

- About NABH
- Scope and purpose of the standards
- Overview of the NABH accreditation process
- 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 organizations 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 organization without depending on anyone else. This will keep the documentation closer to reality and flexible in the hands of the organization 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 standardization of actions across various departments and functional units in the organization. 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 and business continuity documentation etc.

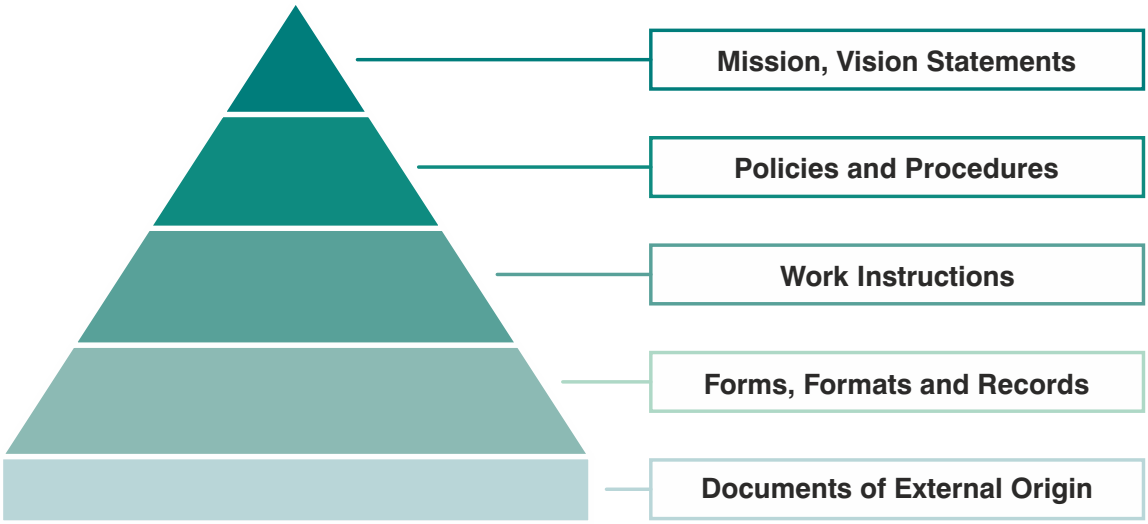
Type of documents

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

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

- **Forms and Formats:** These are various forms and formats to capture information as a record of the execution of various activities. Records are filled forms. The forms, formats, and records can be in a physical or electronic form.

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



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

Mission Statement: Mission statement defines the purpose for which the Organization exists.

Policies: These are statements that transcend time to decide on the way the activities of the organization shall be executed. These statements connect mission and vision statements with the processes and procedures of the organization. These may change over a relatively moderate time frame of a few years. Whenever these are developed or altered, they 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. They can be in the form of multiple manuals specific to departments, or 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 organizations which actively follow 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 the 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 organizations are reluctant to alter these documentations mistaking the word standard for unalterable, sometimes even after their processes have changed.

Forms and Formats: Capture of information in a complete and relevant manner 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 entries are made. The purpose 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. An example of the former is tick marking when some action was carried out and an example of the latter being an elaborate record of the initial assessment of a patient on arrival to the ward. 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 organization wants to assign a separate identity to each filled form which is rarely required.

Documents of External Origin: For the sake of making the documentation system inclusive, some organizations include documents of external origin in their documentation system. These are licenses, statutory documents, memoranda of understanding with various organizations, etc. and are not alterable.

Temporary Document: Many notes, documents, records are created in an informal manner 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 and 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 and safety procedures, etc. These documents are commonly known as Standard Operating Procedures (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 a decision-making step and picture of rolled partially document for the steps where documentation is necessary etc. Most of the word processing software applications have these symbols inbuilt for use.

Which processes should be documented?

Organizations sometimes fall into a dilemma about the extent of documentation that should be followed. 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 organization;
- 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 organization 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 a uniform format to ensure uniformity in visual appearance of documents to cover their appearance, fonts, symbols, page layout, etc.;
- Adding colour codes, font changes for different documents;
- Participation of staff that is involved in carrying out the activities in the development process for documentation;
- Using the same language and structure 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 real time;
- If necessary replicate the documentation related to specific processes and procedures within all relevant documents 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 above, documents bring uniformity and clarity for execution of activities in the Organization. It is, therefore, imperative that they are not altered without the knowledge of the creator or the staff who is specifically authorised for this purpose. Such documents are known as controlled documents. All types of documents described above come under this category, except for temporary documents.

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 (control box) or otherwise at the top of the document This information is an integral part of each controlled document. The designation of authorised staff for preparation/review/release or issue of 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 of the organizations put it on each page. The alphanumeric identity, if assigned to these documents 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 Organization	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 the Document:
- Purpose of the Process that is documented
- Start point
- End Point
- Procedure:
  Step 1: XXXXXXXXXXXX
  Step 2: XXXXXXXXXXXX
  Step 3: XXXXXXXXXXXX
  Step n: XXXXXXXXXXXX
- Related Records
- Related documents

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

Manuals

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

Scoring

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

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

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

Not Applicable (NA) Criteria

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

Accreditation Decision and Maintenance of same

After the completion of the final assessment, the assessment team submits the report and the score sheet to NABH. The organization is expected to submit the corrective and preventive actions/action plan with timelines for rectifying the identified non-conformities. The corrective and preventive actions /action plan is reviewed by the assessment team, and a comment is placed indicating acceptance or non-acceptance.

The accreditation committee reviews the assessment report, the score sheet and the submitted action plan with timelines and the assessment team's comments regarding the same. Following the review, a decision is taken.

Accreditation decision criteria following the final assessment

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

1. The score for every CORE objective element must not be less than 4.
2. No individual standard should have more than one objective element scored as 2 or less.
3. The average score for individual standards must not be less than 4.
4. The average score for an individual chapter must not be less than 4.
5. Every objective element with a score of 3 or below should have an accepted action plan with timelines.

Note: The cumulative score obtained for all objective elements is considered for calculating the overall compliance. At the end of the final assessment, only the objective elements marked as 'CORE and Commitment' level are considered for scoring. Hence, the overall compliance of 80% corresponds to a score of numerator (438x4) and denominator (438x5) i.e. 1752/2190 = 80%. In case of the not applicable objective element(s), the scoring is modified accordingly by excluding them from the numerator and denominator.

Award

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

Maintaining The Award

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

Accreditation decision criteria following the surveillance assessment

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

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

Note: The cumulative score obtained for all objective elements is considered for calculating the overall compliance. At the end of the surveillance assessment, only the objective elements marked at 'CORE', Commitment' and' Achievement' level are considered for scoring. The compliance of 80% of the 'CORE' and 'Commitment' corresponds to a score of numerator (438x4) and denominator (438x5) i.e. 1752/2190 =80%. In addition to the 'CORE' and 'Commitment', the compliance of 80% of the achievement level corresponds to the score of numerator (43x4) and denominator (43x5) i.e. 172/215=80%. Hence, the cumulative score for 'CORE', 'Commitment' and' Achievement' for surveillance assessment corresponds to the numerator (481x4) and denominator (481x5) i.e.1924/2405 =80%. In case of the not applicable objective element(s), the scoring is modified accordingly by excluding them from the numerator and denominator.

Accreditation decision criteria following the re-accreditation assessment

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

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

Note: The cumulative score obtained for all objective elements is considered for calculating the overall compliance. At the end of the re-accreditation assessment, all the objective elements marked at 'CORE', commitment', 'achievement' and' excellence' level are considered for scoring. The compliance of 80% of the 'CORE' 'commitment' and achievement corresponds to a score of (481x4) and denominator (481x5) i.e. 1924/2405= 80%. In addition to this, the compliance of 80% of the Excellence level corresponds to the score of numerator (11x4) and denominator (11x5) i.e. 44/55 = 80%. Hence, the cumulative score for 'CORE', 'Commitment', 'Achievement' and 'Excellence' for re-accreditation assessment corresponds to the numerator (492x4) and denominator (492x5) i.e.1968/2460=80%. In case of then applicable objective element(s), the scoring is modified accordingly by excluding them from the numerator and denominator.

The table below summarises the accreditation decision criteria.

	Final	Surveillance	Re-accreditation
Overall compliance (cumulative score)	≥80%	≥80%	≥80%
Core (cumulative score)	≥80%	≥80%	≥80%
Commitment (cumulative score)	≥80%	≥80%	≥80%
Achievement (cumulative score)	NA	≥80%	≥80%
Excellence (cumulative score)	NA	NA	≥80%
CORE Objective (individual objective element score)	≥ 4	≥ 4	≥ 4
Average score for individual standard	≥ 4	≥ 4	≥ 4
Average score for individual chapter	≥ 4	≥ 4	≥ 4
Improvement in the score of objective elements that have been scored ≤ 2 in the previous assessment	NA	Required	Required
Objective element with score ≤ 2 in individual standard	1	1	NA
Closure for OEs with a score of ≤ 3	Required	Required	Required

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

Feedback

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

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

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

The feedback will be provided by visiting our feedback proforma hosted on the website of NABH www.nabh.co after launch of 1st Edition of NABH Accreditation Standards for Ayush Hospitals.

ABBREVIATIONS

ABC	Always, Better and Control
ACLS	Advanced Cardiac Life Support
AERB	Atomic Energy Regulatory Board
AHU	Air Handling Unit
AIDS	Acquired Immuno Deficiency Syndrome
AIS	Automotive Industry Standards
ALARA	As Low As Reasonably Achievable
ANOVA	Analysis of Variance
ART	Assisted Reproductive Technology
ATLS	Advanced Trauma Life Support
BAMS	Bachelor of Ayurvedic Medicine and Surgery
BD	Bis in Die
BHMS	Bachelor of Homoeopathic Medicine and Surgery
BLS	Basic Life Support
BMW	Bio-Medical Waste
BNYS	Bachelor of Naturopathy and Yogic Science
BP	Blood Pressure
BSMS	Bachelor of Siddha Medicine and Surgery
BSRMS	Bachelor of Sowa-Rigpa Medicine and Surgery
BUMS	Bachelor of Unani Medicine and Surgery
CCTV	Closed-Circuit Television
CCS (CCA)	Central Civil Services (Classification, Control and Appeal)
CDC	Centres for Disease Control and Prevention
CEO	Chief Executive Officer
COO	Chief Operating Officer
CPR	Cardio-Pulmonary Resuscitation
CSSD	Central Sterile Services Department

CST	Continue same treatment
DDMA	District Disaster Management Authority
DG	Diesel Generator
ECG	Electrocardiogram
ELV	Extra Low Voltage
EMR	Electronic Medical Record
ESG	Environment Social and Governance
ETP	Effluent Treatment Plant
FCU	Fan Coil Unit
FEFO	First Expiry First Out
FMEA	Failure Modes and Effects Analysis
FSN	Fast, Slow and Non-moving
HAI	Healthcare-Associated Infection
HAZMAT	Hazardous Material
HCO	Healthcare Organisation
HIRA	Hazard Identification and Risk Analysis
HIS	Hospital Information System
HISI	Hospital Infection Society-India
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HT	High Tension
HTM	Health Technical Memorandum
HVAC	Heating Ventilation and Air Conditioning
IEC	Information Education & Communication
IPCN	Infection prevention and control Nurse
IPCO	Infection prevention and control Officer
ID	Identification Data
IP	In-Patient
IPD	In-Patient Department

IPHS	Indian Public Health Standards
IT	Information Technology
LAMA	Leaving Against Medical Advice
LaQshya	Labour Room Quality Improvement Initiative
LASA	Look-Alike Sound-Alike
LIS	Laboratory Information System
LPG	Liquefied Petroleum Gas
LT	Low Tension
MLC	Medico-Legal Case
MoU	Memorandum of Understanding
MRD	Medical Records Department
MSDS	Material Safety Data Sheet
MTP	Medical Termination of Pregnancy
NACO	National Aids Control Organization
NCH	National Commission for Homoeopathy
NCISM	National Commission for Indian System of Medicine
NDMA	National Disaster Management Authority
OP	Out-Patient
OPD	Out-Patient Department
OT	Operation Theatre
PC-PNDT	Pre-Conception and Pre-Natal Diagnostic Testing
PDCA	Plan Do Check Act
POCSO	The Protection of Children from Sexual Offences
POSH	Prevention of Sexual Harassment
PPE	Personal Protective Equipment
PREM	Patient-Reported Experience Measures
RIS	Radiology Information System
RO	Reverse Osmosis

SBAR	Situation, Background, Assessment, Recommendation
SDMA	State Disaster Management Authority
SHEA	Society for Healthcare Epidemiology of America
SOP	Standard Operating Procedure
STG	Standard Treatment Guideline
STP	Sewage Treatment Plant
TID	Ter In Die
TLD	Thermo Luminescent Dosimeter
UPS	Uninterrupted Power Supply
VED	Vital, Essential and Desirable
WHO	World Health Organization

Summary of Chapters, Standards and Objective Elements

S. No.	Chapters	Standards	Objective Elements	CORE	Commitment	Achievement	Excellence
1	AAC	10	51	6	36	8	1
2	COP	12	62	10	50	0	2
3	MOM	9	52	8	38	6	0
4	PRE	8	49	11	30	7	1
5	IPC	8	43	11	31	1	0
6	PSQ	7	42	6	28	5	3
7	ROM	6	36	4	22	8	2
8	FMS	7	42	11	28	2	1
9	HRM	12	70	11	55	4	0
10	IMS	7	45	9	33	2	1
Total		**86**	**492**	**87**	**351**	**43**	**11**

Chapter 1 Access, Assessment and Continuity of Care (AAC)

Intent of the chapter

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

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

These assessments result in the formulation of a care plan.

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

SUMMARY OF STANDARDS

AAC.1.	The Ayush hospital defines and displays the healthcare services that it provides.
AAC.2.	The Ayush hospital has a well-defined patient registration and admission process.
AAC.3.	Patients cared for by the Ayush hospital undergo a defined initial assessment.
AAC.4.	Patients cared for by the Ayush hospital undergo a regular re-assessment
AAC.5.	There is an appropriate mechanism for transfer (in and out) or referral of patients.
AAC.6.	Laboratory services, if provided, are as per the scope of the services at the Ayush hospital.
AAC.7.	Imaging services, if provided, are as per scope of services of the Ayush hospital.
AAC.8.	Patient care is continuous and multi-disciplinary.
AAC.9.	There is an established quality assurance and safety program for imaging services.
AAC.10.	The Ayush hospital has an established discharge process and the contents of discharge summary are defined.

*This implies that the objective element requires documentation

Summary of Objective Elements

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

Standards and Objective Elements

Standard

AAC.1.	The Ayush hospital defines and displays the healthcare services, it provides.

Objective Elements

Commitment	a.	The Ayush hospital defines the healthcare services, it provides. *
Commitment	b.	Each defined healthcare service has treatment services provided by suitably qualified and trained Ayush personnel.
Commitment	c.	Scope of the clinical services of each department is defined. *
Commitment	d.	The clinical services provided are displayed prominently.

AAC.2.	The Ayush hospital has a well-defined patient registration and admission process.

Objective Elements

Commitment	a.	The Ayush hospital uses written guidance for registration and admission of patients.*
CORE	b.	A unique identification number is generated at the end of the registration.
Commitment	c.	Patients are accepted only if the Ayush hospital can provide the required services.
Commitment	d.	The written guidance addresses managing patients during non-availability of beds. *
Commitment	e.	Access to the healthcare services in the Ayush hospital is prioritised according to the clinical needs of the patient. *

Standard

AAC.3.	Patients cared for by the Ayush hospital undergo a defined initial assessment.

Objective Elements

CORE	a.	The initial assessment of the out-patients, day-care, in-patients and emergency patients is done as per written guidance. *
Commitment	b.	The initial assessment is performed by qualified and trained Ayush personnel.
Commitment	c.	The initial assessment is performed within a defined time frame based on the clinical needs of the patient. *
CORE	e.	The initial assessment for in-patients results in a documented care plan.*
Achievement	f.	The care plan is countersigned by the clinician-in-charge of the patient within 24 hours.
Achievement	g.	The Ayush hospital identifies special needs of the patient during assessment process.

Standard

AAC.4.	Patients cared for by the Ayush hospital undergo a regular re-assessment

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	Transfer-in of patients to the Ayush hospital is done appropriately. *
Commitment	b.	Transfer- out/referral of patients to another facility is done appropriately. *
Commitment	c.	During transfer or referral, accompanying staff are appropriate to the clinical condition of the patient.
Achievement	e.	The Ayush hospital has a process to identify the transportation needs of the patients and facilitate the same. *

Standard

AAC.6.	Laboratory services, if provided, are as per the scope of the services of the Ayush hospital.

Objective Elements

Commitment	a.	Laboratory services are commensurate with the scope of services.
Commitment	b.	Written guidance governs collection, identification, handling, safe transportation, processing, reporting and disposal of specimens. *
Commitment	c.	Results are reported in a standardised manner.
Achievement	e.	There is a mechanism to address the recall / amendment of reports whenever applicable. *
Commitment	f.	The Ayush hospital has a documented laboratory safety program, as applicable.*
Commitment	g.	The quality assurance program for laboratory services is implemented. *

Standard

AAC.7.	Imaging services, if provided, are as per scope of services of the Ayush hospital.

Objective Elements

CORE	a.	Imaging services are commensurate with the scope of services and comply with applicable local/ and national standards, laws and regulations.
Commitment	b.	Imaging results are available within a defined timeframe. *
Commitment	c.	Results are reported in a standardised manner.
Commitment	d.	Critical results are intimated to the person concerned at the earliest. *
Achievement	e.	There is a mechanism to address the recall / amendment of reports whenever applicable. *
Commitment	f.	The Ayush hospital shall have a documented radiation safety program, as applicable. *
Commitment	g.	The quality assurance program for imaging services is implemented. *

Standard

AAC.8.	Patient care is continuous and multi-disciplinary.

Objective Elements

Commitment	a.	Patient care is coordinated in all care settings within the Ayush hospital.
Commitment	b.	Information about the patient's care and response to treatment is shared among Ayush doctors, nurses/therapists and other care providers.
CORE	c.	The Ayush hospital implements standardised hand-over communication during each staffing shift, between shifts and during transfers between units / departments.*

Achievement	d.	The Ayush hospital ensures predictable service delivery by adhering to defined timelines and informs the patient / family and / or caregiver whenever there is a change in schedule.

Standard

AAC.9.	The preventive and promotive health services are provided in a safe, collaborative and consistent manner.

Objective Elements

Achievement	a.	Written guidance governs the implementation of preventive and promotive care.*
Excellence	b.	A multi-disciplinary approach is adopted in imparting health education on life-style modifications.

Standard

AAC.10.	The Ayush hospital has an established discharge process and the contents of discharge summary are defined.

Objective Elements

Commitment	a.	The patient's discharge process is planned in consultation with the patient and/or family.
Commitment	b.	The Ayush hospital adheres to planned discharge and process is coordinated among various departments. *
Commitment	c.	Written guidance governs the discharge of patients leaving against medical advice. *
Commitment	d.	A discharge summary is given to all the patients leaving the Ayush hospital including patients leaving against medical advice.

Commitment	e.	The Ayush hospital defines the timeframe for discharge process and makes continual improvement.
Commitment	f.	The Ayush hospital defines the content of discharge summary. *
Achievement	g.	The care is provided by expanding access to health practices through domiciliary visits, wherever applicable.

Chapter 2 Care of Patients (COP)

Intent of the chapter

The Ayush hospital provides uniform care to all patients in various settings. The settings include care provided in out-patient units, in-patient units and procedure rooms and operation theatre. When similar care is provided in these different settings, care delivery is uniform. Written guidance, applicable laws and regulations guide emergency and ambulance services and cardio-pulmonary resuscitation etc.

Written guidance, applicable laws and regulations also guide the care of patients who are at higher risk of morbidity / mortality, paediatric patients, vulnerable patients and the patients undergoing procedures.

Pain management, nutritional therapy and rehabilitative services are also addressed commesurating with the scope of services to provide comprehensive health care.

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

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

SUMMARY OF STANDARDS

COP.1.	Uniform care is provided to the patients in all settings of the Ayush hospital as per the written guidance.
COP.2.	Emergency services, if applicable, are provided in accordance with written guidance, applicable laws and regulations.
COP.3.	Ambulance services (in-house or out-sourced) ensure safe transportation of patient with appropriate care.
COP.4.	Care provided to patient by nurses is in consonance with scope of services provided by the Ayush hospital.
COP.5.	Cardio-pulmonary resuscitation services are provided uniformly across the organisation.
COP.6.	Ayush hospital provides safe obstetric care, if applicable.
COP.7.	Ayush hospital provides safe paediatric & neonatal services, if applicable.
COP.8.	The Ayush hospital identifies and manages patients who are at higher risk of morbidity and mortality.
COP.9.	Pain management for patients is done in a consistent manner.
COP.10.	Rehabilitation services, if applicable, are provided in a safe, collaborative and consistent manner.
COP.11.	Nutritional assessment and diet planning of the patients is done as per the written guidance.
COP.12.	End-of-life-care is provided in a compassionate and considerate manner.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

COP.1.	Uniform care is provided to the patients in all settings of the Ayush hospital as per the written guidance.

Objective Elements

CORE	a.	Uniform care is provided to the patients following written guidance. *
CORE	b.	The Ayush hospital has a uniform process for identification of patients and uses at least two identifiers.
CORE	c.	During all phases of care, there is a qualified and trained individual available for the patient's care.
CORE	d.	Care shall be provided in consonance with applicable laws and regulations..
Excellence	e.	The Ayush hospital implements evidence based clinical practice guidelines and clinical protocols to guide uniform care.
Excellence	f.	Telemedicine facility, if applicable, is provided safely and securely based on written guidance. *

Standard

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

Objective Elements

Commitment	a.	The Ayush hospital identifies an area which is easily accessible to receive and manage emergency patients, with adequate and appropriate resources.
CORE	b.	Emergency care, if provided, is in consonance with statutory requirements and in accordance with the written guidance. *

CORE Commitment Achievement Excellence

CORE	c.	The Ayush hospital manages medico-legal cases in accordance with statutory requirements. *
Commitment	d.	Admission, discharge to home, or transfer to another organization is documented.
Commitment	e.	In case of discharge to home or transfer to another health care organization, a discharge/transfer note shall be given to the patient.
Commitment	f.	The Ayush hospital has systems in place for the management of patients found dead on arrival and patients who die within a few minutes of arrival.*

Standard

COP.3.	Ambulance services (in-house or out-sourced) ensure safe transportation of patient with appropriate care.

Objective Elements

Commitment	a.	The Ayush hospital provides ambulance services (in-house or outsourced) as per the scope of the healthcare services provided by it.
Commitment	b.	There is adequate access and space for the ambulance(s).
Commitment	d.	The ambulance (s) is operated by trained personnel.
Commitment	e.	The ambulance(s) is checked on daily basis for functioning status, medical equipment, emergency medications and consumables.
Commitment	f.	The ambulance(s) has a proper communication system.*

Standard

COP.4.	Care provided to patient by nurses is in consonance with scope of services provided by the Ayush hospital.

Objective Elements

Commitment	a.	Care provided to patient by nurses is in accordance with written guidance. *
Commitment	b.	The Ayush hospital implements acuity-based staffing to improve patientcare.
Commitment	c.	Nursing care is aligned and integrated with overall patient care.

Standard

COP.5.	Clinical procedures (surgical, para surgical and other treatment procedures) are performed in a safe manner and are in consonance with the written guidance.

Objective Elements

Commitment	a.	Procedures are performed based on the clinical needs of the patient.
Commitment	b.	Performance of various clinical procedures is based on written guidance. *
Commitment	c.	Qualified personnel plan, order and perform the procedures.
CORE	d.	The prior informed consent is taken by the personnel performing the procedure.
CORE	e.	Care is taken to prevent adverse events such as wrong patient, wrong procedure and wrong site. *
Commitment	h.	The Ayush hospital has appropriate facilities such as procedure room/operation theatre/therapy room.
Commitment	i.	The procedures are done adhering to standard precautions. *
Commitment	j.	The Ayush hospital has infection control surveillance activities for its procedure room/ operation theatres/therapy room.

Standard

COP.6.	Ayush hospital provides safe obstetric care, if applicable.

Objective Elements

Commitment	a.	Obstetric services, if applicable, are organized and provided safely as per the written guidance. *
Commitment	c.	The Ayush hospital caring for high risk obstetric cases has appropriate facilities.
Commitment	d.	Ayush hospital treats pregnant woman and her companion cordially and respectfully and ensures privacy and confidentiality for pregnant woman during her stay.

Standard

COP.7.	Ayush hospital provides safe paediatric & neonatal services, if applicable

Objective Elements

Commitment	a.	Paediatrics and neonatal services are organized and provided safely as per the written guidance. *
Commitment	b.	The Ayush hospital providing paediatric/neonatal services has provisions for special care of children/neonates.
Commitment	c.	Paediatric assessment includes growth, developmental and immunisation assessment.
Commitment	d.	The child's family members are educated about nutrition, immunisation and safe parenting.
Commitment	e.	The Ayush hospital has measures in place to prevent child/neonate abduction and abuse.

Standard

COP.8.	The Ayush hospital identifies and manages patients who are at higher risk of morbidity and mortality.

Objective Elements

CORE	a.	The Ayush hospital identifies vulnerable patients and manages them as per the scope of services. *
CORE	b.	The Ayush hospital provides a safe and secure environment to the vulnerable patients.
Commitment	c.	The Ayush hospital identifies and manages patients who are at risk of fall.*
Commitment	d.	The Ayush hospital identifies and manages patients who are at risk of developing/worsening of pressure ulcers. *
Commitment	e.	The Ayush hospital identifies and manages patients who need restraints. *

Standard

COP.9.	Pain management for patients is done in a consistent manner.

Objective Elements

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

Standard

COP.10.	Rehabilitation services, if applicable, are provided in a safe, collaborative and consistent manner.

Objective Elements

Commitment	a.	Rehabilitation services are in accordance with written guidance. *
Commitment	b.	The Ayush hospital has adequate space and equipment for rehabilitation services.
Commitment	c.	An appropriately qualified and trained personnel carries out the functional assessment and periodic re-assessment of the patient undergoing rehabilitation treatment.
Commitment	d.	The rehabilitation services and care given to the patients are planned in a collaborative manner.
Commitment	e.	Care is provided adhering to infection prevention and control and safety practices.

Standard

COP.11.	Nutritional assessment and diet planning of the patients is done as per the written guidance.

Objective Elements

Commitment	a.	The Ayush hospital conducts the nutritional assessment of all its patients.
Commitment	b.	The therapeutic diet is planned for patient wherever required.
Commitment	c.	Patients receive food according to the written order for the diet.
Commitment	d.	The patients and family members are educated about the diet plan.
Commitment	e.	When family provides food, they are educated about the patient's diet limitations.

Standard

COP.12.	End-of-life care is provided in a compassionate and considerate manner.

Objective Elements

Commitment	a.	A multi-disciplinary approach is used to provide end-of-life care.
Commitment	b.	Treatment measures, appropriate to end of life care are planned and provided.
Commitment	c.	End-of-life care also addresses the identification of the unique needs of such patient and family.

Chapter 3 Management of Medication (MOM)

Intent of the chapter

The Ayush hospital has a safe and organised medication management process. The availability, safe storage, prescription, dispensing and administration of medications is governed by written guidance.

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

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

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

Medical supplies and consumables are available for use.

SUMMARY OF STANDARDS

MOM.1.	Pharmacy services and medication management is done safely.
MOM.2.	The Ayush hospital develops, updates and implements a drug formulary.
MOM.3.	Medications are stored appropriately and are available where required.
MOM.4.	Medications are prescribed safely and rationally.
MOM.5.	Medications orders are written in a uniform manner.
MOM.6.	Medications are dispensed in a safe manner.
MOM.7.	Medications are administered safely.
MOM.8.	Patients are monitored after medication administration.
MOM.9.	Medical supplies and consumables are stored appropriately and are available where required.

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

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

Objective Elements

Commitment	a.	Pharmacy services and medication management are implemented following written guidance. *
Commitment	b.	A multi-disciplinary committee guides the formulation and implementation of pharmacy services and medication usage.
Achievement	c.	The multi-disciplinary committee updates medication management processes.
Commitment	d.	There is a procedure to obtain medication when the pharmacy is closed. *

Standard

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

Objective Elements

CORE	a.	A list of medications appropriate for patients as per the scope of the clinical services of Ayush hospital, is developed collaboratively by multidisciplinary committee.
Commitment	b.	The current drug formulary is available to Ayush doctors for reference.
Achievement	c.	Ayush doctors adhere to the current drug formulary.
Commitment	d.	The Ayush hospital adheres to the written guidance for procurement/ acquisition of formulary medications/preparation. *
Commitment	e.	The Ayush hospital adheres to the procedure to obtain medications not listed in the formulary. *

CORE Commitment Achievement Excellence

Standard

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

Objective Elements

CORE	a.	Medications are stored in a clean, safe and secure environment; incorporating the manufacturer's recommendation(s) if any.
Commitment	b.	Sound inventory control practices guide the medication management.
CORE	c.	The Ayush hospital defines a list of high-risk medication(s) and look alike and sound alike medicines and stores them separately. *
CORE	d.	Ayush hospital, if uses Narcotic and Psychotropic drugs, follows the written guidance. *

Standard

MOM.4.	Medications are prescribed safely and rationally.

Objective Elements

Commitment	a.	Medication prescription is in consonance with good practices/guidelines for the rational prescription of medications.
CORE	b.	The Ayush hospital adheres to the determined minimum requirements of a prescription. *
Commitment	c.	Drug allergies and previous adverse drug reactions are ascertained before prescribing.
CORE	d.	Verbal orders are implemented following written guidance. *
Achievement	e.	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.
Achievement	f.	Corrective and/ or preventive action (s) is taken based on audit, where appropriate.

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Commitment	g.	Reconciliation of medications occurs at transition points of patient care.

Standard

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

Objective Elements

Commitment	a.	The Ayush hospital ensures that only authorised personnel write orders. *
Commitment	b.	Orders for medicines are written in a uniform location in the medical records.
Commitment	c.	Medication orders are legible, dated, timed and signed.
Commitment	d.	Medication orders contain the name of the medicine, route of administration, strength to be administered and frequency / time of administration.

Standard

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

Objective Elements

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

Standard

MOM.7.	Medications are administered safely.

Objective Elements

Commitment	a.	Medications are administered by those who are permitted by law to do so. *
Commitment	b.	Prepared medications are labelled
Commitment	c.	The patient is identified prior to administration.
Commitment	d.	Medications are verified from the prescription and physically inspected before administration.
Commitment	e.	Strength is verified from the order before medication administration.
Commitment	f.	Route is verified from the order before medication administration.
Commitment	g.	Timing is verified from the order before medication administration.
Commitment	h.	Medication administration is documented.*
Commitment	i.	Measures to govern patient's self-administration of medications are implemented.*
Commitment	j.	Measures to govern patient's medications brought from outside the Ayush hospital shall be implemented. *

Standard

MOM.8.	Patients are monitored after medication administration.

Objective Elements

Commitment	a.	Patients are monitored after medication administration.

Commitment	b.	Medications are changed where appropriate based on the monitoring.
Commitment	c.	The Ayush hospital captures near miss, medication error and adverse drug reaction. *
Commitment	c.	The Ayush hospital captures near miss, medication error and adverse drug reaction. *
Commitment	d.	Near miss, medication error and adverse drug reaction are reported within a specified time frame. *
Commitment	e.	Near miss, medication errors and adverse drug reaction are collected and analysed.
Commitment	f.	Corrective and/or preventive action(s) are taken based on the analysis.
Achievement	g.	Patients are monitored for any possible adverse drug reaction in case of long-term usage of certain Ayush medications.

Standard

MOM.9.	Medical supplies and consumables are stored appropriately and are available where required.

Objective Elements

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

Chapter 4 Patient Rights and Education (PRE)

Intent of the chapter

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

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

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

Patients are educated about the mechanisms available for addressing grievances.

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

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

The Ayush hospital has a mechanism to capture the patient experience including patient reported experience measures.

The Ayush hospital develops effective patient-centred communication.

SUMMARY OF STANDARDS

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

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

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

Objective Elements

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

Standard

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

Objective Elements

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

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Commitment	e.	Patient and family rights include the refusal of treatment.
Commitment	f.	Patient and family right include right to seek additional opinion regarding clinical care.
Commitment	g.	Patient and family rights include a right to complaint and information on how to voice a complaint.
Commitment	h.	Patient has a right to have an access to his / her clinical records.
Commitment	i.	Patient and family rights include information on the name of the treating doctor, care plan, progress and information on their health care needs
Achievement	j.	Patient and family rights include determining what information regarding their care can be provided to self and family.

Standard

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

Objective Elements

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

Standard

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

Objective Elements

CORE	a.	The patient and family rights include obtaining informed consent by the treating Ayush doctor, for situations where informed consent is required. *
CORE	b.	Informed consent process adheres to statutory norms.
CORE	c.	Informed consent includes information regarding the procedure; its risks, benefits, alternatives and as to who will perform the requisite procedure, in a language that the patient/family can understand.
Commitment	d.	The Ayush hospital describes who can give consent when patient is incapable of independent decision-making. *
CORE	e.	Informed consent is taken by the person performing the procedure.

Standard

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

Objective Elements

Commitment	a.	Patient and family are educated in a language and format that they can understand.
Commitment	b.	Patient and/or family are educated about the safe and effective use of medication and the potential adverse drug events of the medication, when appropriate.
Commitment	c.	Patient and family are educated about diet and nutrition and food-medicine interaction.
Commitment	d.	Patient and / or family are educated about immunisations.

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

Standard

PRE.6.	Patient and family have a right to information on expected costs.

Objective Elements

Commitment	a.	The Ayush hospital has an appropriate pricing policy in different settings and the patient and family is made aware of the same. *
Commitment	b.	The relevant tariff list is available to patients.
Commitment	c.	Patient and/or family members are educated about the expected cost of treatment.
Commitment	d.	Patient and / or family members are informed about the financial implications when there is a change in the care plan.

Standard

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

Objective Elements

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

Standard

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

Objective Elements

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

Chapter 5 Infection Prevention and Control (IPC)

Intent of the chapter

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

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

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

The program includes disinfection / sterilization activities and biomedical waste (BMW) management.

SUMMARY OF STANDARDS

IPC.1.	The Ayush hospital has a comprehensive and coordinated Infection Prevention and Control (IPC) program aimed at reducing / eliminating risks to patients, visitors, providers of care and community.
IPC.2.	The Ayush hospital provides adequate and appropriate resources for infection prevention and control.
IPC.3.	The Ayush hospital implements the infection prevention and control processes in clinical areas.
IPC.4.	The Ayush hospital implements the infection prevention and control processes in support services.
IPC.5.	The Ayush hospital takes actions to prevent healthcare associated infections (HAI) in patients.
IPC.6.	The Ayush hospital performs surveillance to capture and monitor infection prevention and control data.
IPC.7.	Infection prevention measures include sterilization and / or disinfection of instruments, equipment and devices.
IPC.8.	The Ayush hospital takes action to prevent or reduce healthcare associated infections in its staff.

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

IPC.1.	The Ayush hospital has a comprehensive and coordinated Infection Prevention and Control program aimed at reducing / eliminating risks to patients, visitors, providers of care and community.

Objective Elements

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

Standard

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

Objective Elements

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

Standard

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

Objective Elements

CORE	a.	The Ayush hospital adheres to standard precautions at all times. *
CORE	b.	The Ayush hospital adheres to hand hygiene guidelines. *
Commitment	c.	The Ayush hospital adheres to transmission based precautions. *
Commitment	c.	The Ayush hospital adheres to transmission based precautions. *

Standard

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

Objective Elements

Commitment	a.	The Ayush hospital has appropriate engineering controls and its regular maintenance to prevent infections. *

Commitment	b.	The Ayush hospital designs and implements a plan to reduce the risk of infection during construction and renovation.*
CORE	c.	The Ayush hospital adheres to housekeeping procedures. *
CORE	d.	Biomedical waste is handled appropriately and safely.
Commitment	e.	The Ayush hospital adheres to laundry and linen management processes. *
Commitment	f.	The Ayush hospital adheres to kitchen sanitation and food handling issues. *

Standard

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

Objective Elements

Commitment	a.	The Ayush hospital takes action to prevent catheter associated urinary tract infections
Commitment	b.	The Ayush hospital takes action to prevent procedure associated infection.
Commitment	c.	The Ayush hospital takes action to prevent central line associated blood stream infections, if applicable.
Commitment	d.	The Ayush hospital takes action to prevent surgical site infections.

Standard

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

Objective Elements

CORE	a.	The scope of surveillance incorporates tracking and collection of infection risks, rates and trends.
Commitment	b.	Verification of data is done regularly by the infection prevention and control team.
Commitment	c.	Surveillance is directed towards the identified areas/procedures.
CORE	d.	Surveillance includes monitoring compliance with hand hygiene guidelines.
CORE	e.	Surveillance includes monitoring the effectiveness of housekeeping services.
Commitment	f.	Feedback regarding surveillance data is provided regularly to the appropriate health care provider.
Commitment	g.	Surveillance data is analysed and appropriate corrective and preventive actions are taken.

Standard

IPC.7.	Infection prevention measures include disinfection and or sterilisation of instruments, equipment and devices as per the scope of services.

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	The Ayush hospital implements occupational health and safety practices as per written guidance to reduce the risk of transmitting micro organisms among health care providers. *
Commitment	b.	The Ayush hospital implements an immunization policy for its staff. *
Achievement	c.	The Ayush hospital encourages the health care providers to report their illness or exposures with transmissible infections.
Commitment	d.	The Ayush hospital implements measures for blood and body fluid exposure prevention.
Commitment	e.	Appropriate post-exposure prophylaxis is provided to all staff members concerned. *

Chapter 6

Patient Safety and Quality Improvement (PSQ)

Intent of the chapter

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

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

National / international patient safety goals / solutions / framework shall be implemented.

The Ayush hospital shall collect data on structures, processes and outcomes. The collected data shall be collated, analysed and trends are used for further improvement. Appropriate quality tools shall be used for carrying out quality improvement projects. Clinical audits shall be used as a tool to improve the quality of patient care in a sustained manner. Department leaders play an active role in patient safety and quality improvement.

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

The management shall support the patient safety and quality program.

SUMMARY OF STANDARDS

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

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

PSQ.1.	The Ayush hospital implements a structured patient safety program.

Objective Elements

CORE	a.	The patient safety program is developed, implemented and maintained by a multidisciplinary safety committee as per the scope of services of Ayush hospital. *
Commitment	b.	The patient safety program is comprehensive and covers all the major elements related to patient safety.
Commitment	c.	The Ayush hospital covers incidents ranging from “no harm” to “sentinel events”.
Commitment	e.	The patient safety program is reviewed and updated at least once a year.*
Commitment	f.	The Ayush hospital performs proactive analysis of patient safety risks and makes improvements accordingly.

Standard

PSQ.2.	The Ayush hospital implements a structured quality improvement and continuous monitoring program.

Objective Elements

CORE	a.	The quality improvement program is developed, implemented and maintained by a multidisciplinary committee. *
Commitment	b.	The quality improvement program is comprehensive and covers all the major elements related to quality assurance.*
Excellence	c.	The quality improvement program improves process efficiency and effectiveness..

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Commitment	d.	There is a designated individual for coordinating and implementing the quality improvement program. *
Commitment	e.	The quality improvement program is reviewed and updated at least once a year. *
Commitment	f.	Audits are conducted at regular intervals as a means of continuous monitoring.*
CORE	g.	There is an established process in the organization to monitor and improve the quality of nursing care.*

Standard

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

Objective Elements

Commitment	a.	The Ayush hospital identifies and monitors key performance indicators to oversee the clinical structures, processes and outcomes.
CORE	b.	The Ayush hospital identifies and monitors the key indicators to oversee infection prevention and control activities.
Commitment	c.	The Ayush hospital identifies and monitors key indicators to oversee the managerial structures, processes and outcomes.
CORE	d.	The Ayush hospital identifies and monitors key indicators to oversee patient safety activities.
Commitment	e.	Verification of data is done regularly by the quality team.
Commitment	f.	There is a mechanism for analysis of data which results in identifying opportunities for improvement.
Commitment	g.	The identified opportunities for quality and patient safety improvement are implemented and evaluated.
Achievement	h.	Feedback about care and service is communicated to staff.

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Standard

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

Objective Elements

Achievement	a.	The Ayush hospital undertakes quality improvement projects.
Excellence	b.	The Ayush hospital uses appropriate analytical tools for its quality improvement projects.

Standard

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

Objective Elements

Commitment	a.	Clinical audits are performed to improve the quality of patient care.
Commitment	b.	The parameters to be audited are defined by the Ayush hospital.
Commitment	c.	Clinical and nursing/therapeutic staff participate in clinical audit.
Commitment	d.	Patient and staff anonymity is maintained.
Commitment	e.	Clinical audits are documented.*
Commitment	f.	Remedial measures are implemented.

Standard

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

Objective Elements

Achievement	a.	The management promotes a culture of safety.
Commitment	b.	The leaders at all levels in the Ayush hospital are aware of the intent of the patient safety and quality improvement program and the approach to its implementation.
Commitment	c.	Departmental leaders are involved in patient safety and quality improvement.
Commitment	d.	The management makes available adequate resources required for patient safety and quality improvement program.
Commitment	e.	Ayush hospital earmarks adequate funds in its annual budget for patient safety and quality improvement program.
Achievement	f.	The management identifies performance improvement targets for the hospital
Excellence	g.	The management uses the feedback obtained from the workforce to improve patient safety and quality improvement program.

Standard

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

Objective Elements

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

CORE Commitment Achievement Excellence

Chapter 7 Responsibilities of Management (ROM)

Intent of the chapter

The management of the Ayush hospital is aware of and manages all the key components of governance. Those responsible for governance are identified and their roles defined. The standards encourage the governance of the Ayush hospital professionally and ethically. The responsibilities of management are defined. The responsibilities of the leaders at all levels are defined. The management executes its responsibility for compliance with all applicable regulations. Those responsible for governance address the Ayush hospital's social responsibility.

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

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

Note- 2: "Leadership" refers to appointed leader for example Chief Executive Officer, Chief Operating Officer, Managing Director, Dean / Director, Medical Director / Medical Superintendent.

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

SUMMARY OF STANDARDS

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

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

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

Objective Elements

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

Standard

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

Objective Elements

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

Standard

ROM.3.	Those responsible for governance ensure sustainability of hospitals by addressing environmental, social and economic factors for long- term well-being of healthcare system and community.

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	The person heading the Ayush hospital has appropriate qualifications and administrative experience.
CORE	b.	The leader is responsible for and complies with the laid-down and applicable legislations, regulations and notifications.
Commitment	c.	The leader appoints / participates in the recruitment of department leaders of the Ayush hospital.
Achievement	d.	The leader ensures that each Ayush hospital program, service, site or department has effective leadership.
Achievement	e.	The performance of the Ayush hospital's leader is reviewed for effectiveness.

Standard

ROM.5.	The Ayush hospital displays professionalism in its functioning.

Objective Elements

Commitment	a.	The Ayush hospital has strategic and operational plans, including long-term and short-term goals commensurate to the Ayush hospital's vision, mission and values in consultation with the various stakeholders.
Commitment	b.	The Ayush hospital coordinates the functioning with departments and external agencies and monitors the progress in achieving the defined goals and objectives.*
Commitment	c.	The Ayush hospital plans and budgets for its activities annually.
Achievement	d.	The functioning of committees is reviewed for their effectiveness.

Commitment	e.	The Ayush hospital documents the service standards that are measurable and monitors them. *
Excellence	f.	Systems and processes are in place for change management.*

Standard

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

Objective Elements

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

Chapter 8

Facility Management and Safety (FMS)

Intent of the chapter

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

The Ayush hospital provides for safe water and electricity. The Ayush hospital has a program for medical and utility equipment management. The Ayush hospital plans for fire and non-fire emergencies within the facilities. The Ayush hospital is a no-smoking area.

The Ayush hospital safely manages hazardous materials.

The Ayush hospital works towards measures on being energy efficient.

SUMMARY OF STANDARDS

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

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

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

Objective Elements

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

Standard

FMS.2.	The Ayush hospital's environment and facilities operate in a planned manner and implement environment friendly measures.

Objective Elements

Commitment	a.	Facilities and space provisions are appropriate to the scope of services.
Commitment	b.	As built and updated drawings are maintained as per statutory requirements.
CORE	c.	There are internal and external sign postings in the Ayush hospital in a manner understood by the patient, families and community.

CORE	d.	Potable water and electricity are available round the clock.
Commitment	e.	Alternate sources for electricity and water are provided as a backup for any failure / shortage.
Commitment	f.	The Ayush hospital tests the functioning of these alternate sources at a predefined frequency.

Standard

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

Objective Elements

Commitment	a.	Operational planning identifies areas which need to have extra security and describes access to different areas in the hospital by staff, patients, and visitors.
Excellence	b.	Patient safety aspects in terms of structural safety of hospitals, especially of critical areas are considered while planning, designing and construction of new hospital and re-planning, assessment and retrofitting of existing hospital.
Commitment	c.	The Ayush hospital conducts electrical safety audits for the facility.
Commitment	d.	There is a procedure which addresses the identification and disposal of material(s) not in use in the Ayush hospital. *
CORE	e.	Hazardous materials are identified and used safely within the Ayush hospital. *
Commitment	f.	The plan for managing spills of hazardous materials is implemented. *

Standard

FMS.4.	The Ayush hospital has a program for the facility, engineering support services and utility system.

Objective Elements

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

Standard

FMS.5.	The Ayush hospital has a program for medical equipment management.

Objective Elements

Commitment	a.	The Ayush hospital plans for medical equipment in accordance with its services and strategic plan.
Commitment	b.	Medical equipment is inventoried and proper logs are maintained as required.
CORE	c.	The documented operational and maintenance (preventive and breakdown) plan for medical equipment is implemented. *

Commitment	d.	Medical equipment is periodically inspected and calibrated for their proper functioning.
Commitment	e.	Qualified and trained personnel operate and maintain medical equipment.
Commitment	f.	Written guidance supports medical equipment replacement and disposal. *
Achievement	g.	Downtime for critical equipment breakdown is monitored from reporting to inspection and implementation of corrective actions.

Standard

FMS.6.	The Ayush hospital has a program for medical gases.

Objective Elements

Commitment	a.	Written guidance governs the implementation of procurement, handling, storage, distribution, usage and replenishment of medical gases. *
CORE	b.	Medical gases are handled, stored, distributed and used in a safe manner.
Commitment	c.	There is an operational, inspection, testing and maintenance plan for piped medical gas.*
CORE	d.	Alternate sources for medical gases, are provided for, in case of failure.
Commitment	e.	The Ayush hospital regularly tests the functioning of these alternate sources.

Standard

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

Objective Elements

CORE	a.	The Ayush hospital has plans and provisions for early detection, abatement, containment of fire and evacuation in the event of fire emergencies. *

CORE	b.	The Ayush hospital has plans and provisions for identification, and management of non-fire emergencies. *
Commitment	c.	The Ayush hospital has a documented and displayed exit plan in case of fire and non-fire emergencies.
Commitment	d.	Mock drills are held at least twice a year.
Commitment	e.	There is a maintenance plan for fire-related equipment and infrastructure *

Chapter 9 Human Resource Management (HRM)

Intent of the chapter

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

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

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

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

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

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

Note:

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

SUMMARY OF STANDARDS

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

*This implies that the objective element requires documentation.

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

Summary of Objective Elements

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

Standards and Objective Elements

Standard

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

Objective Elements

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

Standard

HRM.2.	The Ayush hospital implements a defined process for staff recruitment.

Objective Elements

CORE	a.	Written guidance governs the process of recruitment. *
Commitment	b.	A pre-employment medical examination is conducted on the staff.

CORE	c.	The Ayush hospital defines and implements a code of conduct for its staff.*
Commitment	d.	Administrative procedures for human resource management are documented. *

Standard

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

Objective Elements

CORE	a.	Staff are provided with induction training.
Commitment	b.	The induction training includes orientation to the Ayush hospital's vision, mission and values.
Commitment	c.	The induction training includes awareness on staff rights and responsibilities and patient rights and responsibilities.
Commitment	d.	The induction training includes training on safety.
Commitment	e.	The induction training includes training on cardio-pulmonary resuscitation for staff providing direct patient care.
Commitment	f.	The induction training includes training in hospital infection prevention and control.
Commitment	g.	The induction training includes orientation to the service standards of the organization.
Commitment	h.	The induction training includes an orientation on administrative procedures.
Commitment	i.	The induction training includes an orientation on relevant department/ unit/service/program's policies and procedures.

Standard

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

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	Staff involved in the therapeutic procedure are trained on handling the procedures.
Commitment	b.	Staff are trained in handling vulnerable patients.
Commitment	c.	Staff are trained in control and restraint techniques.
Commitment	d.	Staff are trained in healthcare communication techniques.

CORE	e.	Staff involved in direct patient care are provided training on cardiopulmonary resuscitation periodically.
Commitment	f.	Staff are provided training on infection prevention and control.

Standard

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

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	Performance appraisal is done for staff within the organization.*

Commitment	b.	The staff are made aware of the system of appraisal at the time of induction.
Commitment	c.	Performance is evaluated based on the pre-determined criteria.
Commitment	d.	The appraisal system is used as a tool for further development.
Commitment	e.	Performance appraisal is carried out at defined intervals and is documented.
Commitment	g.	Staff are trained in the Ayush hospital's quality improvement program.

Standard

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

Objective Elements

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

Standard

HRM.9.	The Ayush hospital promotes and addresses the health and safety needs of staff.

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

Standard

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

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	Ayush doctors permitted by law, regulation and the Ayush hospital to provide patient care without supervision are identified.

Commitment	b.	The education, registration, training and experience of the identified Ayush professionals are documented and updated periodically.
Commitment	c.	The information about Ayush professionals is appropriately verified when possible.
CORE	d.	Ayush professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.
Commitment	e.	The requisite services to be provided by the Ayush professionals are known to them and various departments/units of the organization.
Commitment	f.	Ayush professionals admit and care for patients as per their privileging.a

Standard

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

Objective Elements

Commitment	a.	Nursing staff and therapists permitted by Ayush hospital, or in line with applicable government guidelines (if any) for providing patient care without supervision are identified.
Commitment	b.	The education, registration, training and experience of nursing staff and or therapists are documented and updated periodically.
Commitment	c.	The information about the nursing staff and therapist is appropriately verified.
Commitment	d.	Nursing staff and therapists are granted privileges in consonance with their qualification, training, experience and registration as applicable.
Commitment	e.	The requisite services to be provided by the nursing staff and therapists are known to them as well as to various departments/units of the Ayush hospital.
Commitment	f.	Nursings/therapists care for patients as per their privileging.

Chapter 10 Information Management System (IMS)

Intent of the chapter

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

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

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

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

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

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

SUMMARY OF STANDARDS

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

*This implies that the objective element requires documentation.

Summary of Objective Elements

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

Standards and Objective Elements

Standard

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

Objective Elements

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

Standard

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

Objective Elements

Commitment	a.	Processes for data collection are standardised.

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

Standard

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

Objective Elements

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

Standard

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

Objective Elements

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

Standard

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

Objective Elements

CORE	a.	The organization maintains the confidentiality of records, data and information. *
CORE	b.	The Ayush hospital maintains integrity of records, data and information.
CORE	c.	The Ayush hospital maintains security of records, data and information. *
Achievement	d.	The Ayush hospital uses developments in appropriate technology for improving confidentiality, integrity and security.

CORE Commitment Achievement Excellence

Commitment	e.	The Ayush hospital discloses privileged health information as authorized by the patient and / or as required by law.
Commitment	f.	Request for access to information in the medical records by patients / physicians and other public agencies are addressed consistently.*

Standard

IMS.6.	The Ayush hospital ensures availability of current and relevant documents, records, data and information and provision for retention of the same.

Objective Elements

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

Standard

IMS.7.	The Ayush hospital carries out a review of medical records.

Objective Elements

CORE	a.	The medical records are reviewed periodically.
Commitment	b.	The review uses a representative sample based on statistical principles.
Commitment	c.	The review is conducted by identified individuals.
Commitment	d.	The review of records is based on identified parameters.

Commitment	e.	The review process includes records of both active and discharged patients.
Commitment	f.	The review points out and documents any deficiencies in records.
Commitment	g.	Appropriate corrective and preventive measures are undertaken.

GLOSSARY

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

Term	Definition
Access / Accessible	Ability of patients/service users or potential patients/service users to obtain required or available services when needed within an appropriate time.
Accreditation	Accreditation is self-assessment and external peer review process used by health care organization 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.
Acuity	Acuity refers to the severity or complexity of a patient's medical condition. It is often used in healthcare settings to determine the level of care required and the allocation of resources. Acuity levels help healthcare providers prioritize patients, assign appropriate staff, and ensure that patients receive the right level of medical attention and resources based on the severity of their condition.
Advance life support	The preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.
Adverse drug event	An injury resulting from a medical intervention related to a medication, including harm from an adverse drug reaction or a medication error.
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.

Term	Definition
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.
Appropriate	The degree to which something is suitable for a specific purpose. This may be that a service is consistent with a patient/service user's expressed requirements.
Appropriate care	Patients are receiving the right care, and the right amount of care according to their needs and preferences, at the right time. The care offered should also be based on the best available evidence.
Appropriateness	Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.
Assessment	All activities including history taking, physical examination, laboratory investigations that contribute towards determining the prevailing clinical status of the patient.
Audit	A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.
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. The preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator.

Term	Definition
Benchmarking	A process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).
Best practice	Clinical, scientific, or professional technique, method, or process, that is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice.
Best-practice guidelines	A set of recommended actions that are developed using the best available evidence. They provide healthcare providers with evidence-informed recommendations that support clinical practice, and guide healthcare provider and patient decisions about appropriate health care in specific clinical practice settings and circumstances.
Breakdown maintenance	Activities which are associated with the repair and servicing of site infrastructure, buildings, plant or equipment within the site's agreed building capacity allocation which have become inoperable or unusable because of the failure of component parts.
Byelaws	A rule governing the internal management of an organisation. It can supplement or complement the government law but cannot countermand it, for example municipal by-laws for construction of hospitals/nursing homes, for disposal of hazardous and/or infectious waste.
Calibration	Set of operations that establish, under specified conditions, the relationship between values of quantities indicated by a measuring instrument or measuring system, or values represented bya 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.

Term	Definition
Child Abuse	A violation of the basic human rights of a child. It includes all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.
Citizen's charter	Citizen's Charter is a document which represents a systematic effort to focus on the commitment of the organisation towards its citizens in respects of standard of services, information, choice and consultation, non-discrimination and accessibility, grievance redress, courtesy and value for money.
Cleaning	Removal of visible foreign material (for example, soil, organic material) from objects and surfaces, which is normally accomplished manually or mechanically using water with detergents or enzymatic products.
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical practice guidelines	Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Clinical practice guidelines are used in making care decisions and developing clinical care processes for diagnoses and conditions and often require clinical pathways and clinical protocols.
Community	A community refers to a group of people within certain geographical boundaries or who share common characteristics such as health risks or disease processes. Individuals, families, groups and organization that usually reside in the same locality.
Competence	Demonstrated ability to apply knowledge and skills. Knowledge is the understanding of facts and procedures. Skill is the ability to perform a specific action. A determination of an individual's skills, knowledge, and capability to meet defined expectations, as frequently described in a job description.
Competency	The knowledge, skills, abilities, behaviours, experience and expertise to be able to perform a particular task and activity.

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

Term	Definition
Corrective action	Action to eliminate the cause of a non-conformity and to prevent recurrence.
Credentialing	The process of obtaining, verifying and assessing the qualification of a healthcare provider.
Criteria	The expected levels of achievement or specifications against which performance or quality may be compared. For example, criteria for appropriate initial care of a patient with a headache may be a measurement of body temperature and blood pressure and performance of a neurological examination. The specific steps to be taken, or activities to be done, to reach a decision or a standard.
Critical result	A variance from normal range that represents a pathophysiologic state that is high-risk or life-threatening, is considered urgent or emergent in nature, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic occurrence.
Culture / Cultural needs	A shared system of values, beliefs and behaviours. The design and delivery of services consistent with the cultural values of those who use them.
Culture of safety	A collaborative environment in which skilled clinicians treat each other with respect; leaders drive effective teamwork and promote psychological safety; teams learn from errors and near misses; caregivers are aware of the inherent limitations of human performance in complex systems (stress recognition); and there is a visible process of learning and driving improvement through debriefings. Staff members are able to report concerns about safety or quality of care without fear of retaliation from health care organization leaders or other staff.
Data	Data is a record of the event.
Department / service leaders	The individuals who manage and direct the varied services of the organization, commonly referred to as departments, services, and/or units.
Disaster preparedness	The ability of the health care organization to maintain operations, respond to the potentially increased volume and acuity of patients, and meet the needs of the community affected by the disaster.

Term	Definition
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.
Drug Administration	The giving of a therapeutic agent to a patient, for example by infusion, inhalation, injection, paste, pessary, suppository or tablet.
Effective communication	Effective Communication is a communication between two or more persons wherein the intended message is successfully delivered, received and understood. The effective communication also includes several other skills such as non-verbal communication, engaged listening, ability to speak assertively, etc.
Efficiency	The degree to which resources are brought together to achieve desired results most cost effectively, with minimal waste, re-work and effort.
Effectiveness	The degree to which services, interventions or actions are provided in accordance with current best practice in order to meet goals and desired outcome(s) for the patient.
Employees	All members of the healthcare organisation who are employed full time and are paid suitable remuneration for their services as per the laid-down policy.
End-of-life Care	An approach to a terminally ill patient that shifts the focus of care to symptom control, comfort, dignity, quality of life and quality of dying rather than treatments aimed at cure or prolongation of life. It includes physical, emotional, social, and spiritual support for patients and their families. The goal of end-of-life care is to control pain and other symptoms so the patient can be as comfortable as possible.

Term	Definition
Enhanced communication	Enhanced communication is using the methods of communication to ensure meaning and understanding through the recognition of the limitations of others. The intent is to ensure purposeful, timely and reliable communication. The communication must be sensitive, empathetic and inclusive.
Ethics/Ethical	Moral principles that govern a person's or group's behaviour. An acknowledged set of principles which guide professional and moral conduct.
Evaluation	A formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.
Evidence-based medicine	Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.
Family	The person(s) with a significant role in the patient's life. It mainly includes spouse, children and parents. It may also include a person not legally related to the patient but can make healthcare decisions for a patient if the patient loses decision-making ability.
Failure Mode and Effect Analysis (FMEA)	A systematic approach to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to help organizations create design improvements that will have the most benefit. This tool assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur.
Formulary	An approved list of drugs for use. Drugs contained in the formulary are generally those that are determined to be cost-effective and medically effective.
Framework	An outline, overview, or skeleton of interconnected items that can be modified at any time by adding or deleting items.
Goal	A broad statement describing a desired future condition or achievement without being specific about how much and when. The term "goals" refers to a future condition or performance level that one intends to attain. Goals can be both short- and longer-term. Goals are ends that guide actions.

Term	Definition
Governance	The set of relationships and responsibilities established by a healthcare service between its management, workforce and stakeholders (including patients and consumers). Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organization objectives. Governance structures will be tailored to the size and complexity of an organisation. The function of determining the organization direction, setting objectives and developing policy to guide the organisation in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.
Grievance-handling procedures	The sequence of activities carried out to address the grievances of patients, visitors, relatives and staff.
Handoff / Handover	The process by which one healthcare provider transfers responsibility for a patient's care to another care provider. A handoff involves communicating essential patient-specific information, including medication-related information, to the next care provider. The transfer of responsibility for a patient and the patient's care that is achieved through effective communication (for example, between health care practitioners; from one department, unit, or service of the organization to another; between the organization and other levels of health care; between staff and patients/families).
Hazard Identification and Risk Assessment (HIRA)	Hazard Identification Risk Assessment (HIRA) is a process of defining and describing hazards by characterizing their probability, frequency, and severity and evaluating adverse consequences, including potential losses and injuries.
Hazardous materials	Substances dangerous to human and other living organisms. Types of hazardous materials and waste include pharmaceutical, chemical, cytotoxic, radioactive and infectious.
Hazardous waste	Waste materials dangerous to living organisms. Such materials require special precautions for disposal. They include the biologic waste that can transmit disease (for example, blood, tissues) radioactive materials, and toxic chemicals. Other examples are infectious waste such as used needles, used bandages and fluid-soaked items.

Term	Definition
Healthcare-associated infection	Healthcare-associated infection (HAI), also referred to as "nosocomial" or "hospital" infection, is an infection occurring in a patient during the process of care in a health care organisation or other health care facility which was not present or incubating at the time of admission.
Healthcare organisation	The generic term is used to describe the various types of organisation that provide healthcare services. This includes ambulatory care centres, hospitals, laboratories, etc.
Health literacy	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make informed healthcare decisions, promoting better health outcomes and patient empowerment. Health literacy is divided into two components – individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.
Health promotion	Activities that increase an individual's control over his or her own health, thereby improving it. These activities may occur at the individual, family, community, and system levels; they promote healthy behaviours and other changes that decrease the risk for acute and chronic diseases and injury. The process of actively supporting and enabling people to increase control over and improve their health.
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.

Term	Definition
Informed consent	The process of informing a patient about a procedure, treatment, or research so that the patient can make a voluntary, informed decision to accept or refuse to have the procedure or treatment. The patient must be fully informed and understand the information that he or she is provided before giving consent. The elements of informed consent include, but are not limited to, information about, and potential benefits and risks of, the proposed procedure, treatment, clinical trial/research study; and possible alternatives to the procedure/treatment.
In-service education/training	Organised education/training, usually provided in the workplace for enhancing the skills of staff members or to teach them new skills relevant to their jobs/tasks and disciplines.
Indicator	Performance measurement tool that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process, and outcomes and are rate based, i.e. have a numerator and denominator so that they can be compared and benchmarked.
Information	Processed data which lends meaning to the raw data.
Intent	A brief explanation of the rationale, meaning and significance of the standards laid down in a particular chapter.
Inventory control	The method of supervising the intake, use and disposal of various goods in hands. It relates to supervision of the supply, storage and accessibility of items in order to ensure an adequate supply without stock-outs/excessive storage. It is also the process of balancing ordering costs against carrying costs of the inventory so as to minimise total costs.
Isolation	Separation of an ill person who has a communicable disease (for example,measles, chickenpox, mumps, SARS) from those who are healthy. Isolation prevents transmission of infection to others and also allows the focused delivery of specialised health care to ill patients. The period of isolation varies from disease-to-disease. Isolation facilities can also be extended to patients for fulfilling their individual, unique needs.

Term	Definition
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.
Just culture	Just culture is a concept related to systems thinking which emphasizes that mistakes are generally a product of faulty organizational cultures, rather than solely brought about by the person or persons directly involved. A just culture balances the need for an open and honest reporting environment with the end of a quality learning environment and culture.
Maintenance	The combination of all technical and administrative actions, including supervision actions, intended to retain an item in, or restore it to, a state in which it can perform a required function.
Material safety data sheet (MSDS)	A formal document with information about the characteristics and actual or potential hazards of a substance; includes instructions related to first aid, spills, and safe storage, among other information.
Medical device	An instrument, apparatus, or machine that is used in the prevention, diagnosis, or treatment of illness or disease, or for detecting, measuring, restoring, correcting, or modifying the structure or function of the body for health care purposes.
Medical equipment	Any fixed or portable non-drug item or apparatus used for diagnosis, treatment, monitoring and direct care of a patient.
Medical record	A written or electronic documentation of varied patient health information, such as assessment findings, treatment details, progress notes, and discharge summary.

Term	Definition
Medication error	A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labelling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.
Medication Order	A written order by a physician, dentist, or other designated health professionals for a medication to be dispensed by a pharmacy for administration to a patient.
Mission	A written expression that sets forth the purpose of an organization or one of its components. The generation of a mission statement usually precedes the formation of goals and objectives. A broad written statement in which the organisation states what it does and why it exists.
Monitoring	The performance and analysis of routine measurements aimed at identifying and detecting changes in the health status or the environment, for example monitoring of growth and nutritional status, air quality in operation theatre. It requires careful planning and use of standardised procedures and methods of data collection.
Multidisciplinary	A generic term which includes representatives from various disciplines, professions or service areas.
Natural justice	A common law doctrine that provides procedural rights in administrative decision-making to support people being treated fairly and without bias. Those who are affected by a decision that is made by the Commission have access to natural justice provisions through review processes such as reconsiderations. Or, may receive a notice of intent that sets out a decision that may be made in the absence of any response from the recipient. The bias rule in administrative law requires that a decision-maker must approach a matter with an open mind that is free of prejudgment and prejudice.
Near-miss	A near-miss is an unplanned event that did not result in injury, illness, or damage--but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorised as near-misses.

Term	Definition
No harm event	This is used synonymously with a near miss. However, some authors draw a distinction between these two phrases.A near-miss is defined when an error is realised just in the nick of time,and abortive action is instituted to cut short its translation. In no harm scenario, the error is not recognised,and the deed is done,but fortunately for the healthcare professional, the expected adverse event does not occur. The distinction between the two is important and is best exemplified by reactions to administered drugs in allergic patients. A prophylactic injection of cephalosporin may be stopped in time because it suddenly transpires that the patient is known to be allergic to penicillin (near-miss). If this vital piece of information is overlooked,and the cephalosporin administered, the patient may fortunately not develop an anaphylactic reaction (no harm event)
Notifiable disease	Certain specified diseases, which are required by law to be notified to the public health authorities. Under the international health regulation (WHO's International Health Regulations 2005), the following diseases are always notifiable to WHO: a. Smallpox b. Poliomyelitis due to wild-type poliovirus c. Human influenza caused by a new subtype d. Severe acute respiratory syndrome (SARS). In India, the following is an indicative list of diseases which are also notifiable, but may vary from state to state: a. Polio b. Influenza c. Malaria d. Rabies e. HIV/AIDS f. Louse-borne typhus g. Tuberculosis h. Leprosy I. Leptospirosis j. Viral hepatitis k. Dengue fever
Objective	A specific statement of a desired short-term condition or achievement includes measurable end-results to be accomplished by specific teams or individuals within time limits.
Objective element	It is that component of standard which can be measured objectively on a rating scale. Acceptable compliance with the measurable elements will determine the overall compliance with the standard.

Term	Definition
Occupational health hazard	The hazards to which an individual is exposed during the course of the performance of his job. These include physical, chemical, biological, mechanical and psychosocial hazards.
Operational plan	A plan which clearly defines the actions that the organisation will take within a defined timeframe to deliver its stated objectives and enable the organisation to meet its longer-term strategic objectives. The operational plan provides detailed information about how the organisation will achieve its stated objectives and identifies what activities must be undertaken; who has responsibility for undertaking each of the stated activities; the timeframes in which the activities must be completed; and the resources (financial, human and other) required to achieve the identified activities.
Organogram	A graphic representation of the reporting relationship in an organisation.
Orientation	A formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation. The process by which staff become familiar with all aspects of the work environment and their responsibilities.
Outsourcing	Hiring of services and facilities from other organisation based upon one's own requirement in areas where such facilities are either not available or else are not cost-effective. For example, outsourcing of house-keeping, security, laboratory/certain special diagnostic facilities. When an activity is outsourced to other institutions, there should be a memorandum of understanding that clearly lays down the obligations of both organization: the one which is outsourcing and the one who is providing the outsourced facility. It also addresses the quality-related aspects.
Palliative Care	The coordinated support for individuals and families who are living with a life-threatening illness, usually at an advanced stage. It focuses on physical, psychological, social, cultural, emotional and spiritual needs of the ill person and his or her family.
Patient-centred Care	An approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among healthcare providers and patients. Care that is respectful of and responsive to individual patient preferences, needs, and values and ensures patient values guide all clinical decisions; care that is coordinated, communicative, and supportive.

Term	Definition
Patient engagement	The process of building the capacity of patients, families, carers as well as health care providers, to facilitate and support the active involvement of patients in their own care, in order to enhance safety, quality and people centredness of health care service delivery. World Health Organization. Patient Engagement: Technical Series on Safer Primary Care 2016.
Patient record/ medical record/ clinical record	A document which contains the chronological sequence of events that a patient undergoes during his stay in the healthcare organisation. It includes demographic data of the patient, assessment findings, diagnosis, consultations, procedures undergone, progress notes and discharge summary.
Patient-reported experience measures (PREMs)	Patient-reported experience measures are questionnaires measuring the patients' perceptions of their experience whilst receiving care.
Patient Safety Solutions	Patient Safety Solutions are defined as any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.
Patient Satisfaction	Patient satisfaction is a measure of the extent to which a patient is content with the health care which they received from their health care provider. Patient satisfaction is thus a proxy but a very effective indicator to measure the success of Health care providers.
Patient Experience	Patient Experience is the sum of all interactions, shaped by an organization 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.
Policies	They are the guidelines for decision-making, for example admission, discharge policies, antimicrobial policy, etc.

Term	Definition
Prescription	A prescription is a document given by a physician or other healthcare practitioner in the form of instructions that govern the care plan for an individual patient. Legally, it is a written directive, for compounding or dispensing and administration of drugs, or for other service to a particular patient.
Preventive action	Action to eliminate the cause of a potential non-conformity.
Preventive maintenance	It is a set of activities that are performed on plant equipment, machinery, and systems before the occurrence of a failure in order to protect them and to prevent or eliminate any degradation in their operating conditions. The maintenance carried out at predetermined intervals or according to prescribed criteria and intended to reduce the probability of failure or the degradation of the functioning of an item.
Privileging	It is the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications and skills.
Privileged communication	Confidential information furnished (to facilitate diagnosis and treatment) by the patient to a professional authorised by law to provide care and treatment.
Procedure	1. A specified way to carry out an activity or a process. 2. A series of activities for carrying out work which when observed by all help to ensure the maximum use of resources and efforts to achieve the desired output.
Process	A set of interrelated or interacting activities which transforms inputs into outputs.
Program	The program identifies needs, lists strategies to meet those needs, includes staff involved, and sets goals and objectives. The format of the program may include policies and procedures, plans, protocols, practice guidelines, clinical pathways, or a combination of these.

Term	Definition
Protocol	A detailed plan, or set of steps, to be followed in a study, an investigation, or an intervention, as in the management of a specific clinical condition. Systematically developed statements to assist practitioners and patients with decisions about appropriate health care for specific clinical circumstances.
Quality	1. Degree to which a set of inherent characteristics fulfil requirements. Characteristics imply a distinguishing feature. Requirements are a need or expectation that is stated, generally implied or obligatory. 2. Degree of adherence to pre-established criteria or standards.
Quality assurance	Part of quality management focussed on providing confidence that quality requirements will be fulfilled.
Quality improvement	Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers/patients.
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 andNon-Ionizing Radiation. This is implemented by taking steps to ensure that people will not receive excessive doses of radiation and by monitoring all sources of radiation to which they may be exposed. In a Healthcare setting, this commonly refers to X-ray machines, CT/PET CT Scans, Electron microscopes, Particle accelerators, Cyclotron etc. Radioactive substances and radioactive waste are also potential Hazards. **Imaging Safety** includes safety measures to be taken while performing an MRI, Radiological interventions, Sedation, Anaesthesia, Transfer of patients, Monitoring patients during imaging procedure etc.
Re-assessment	It implies a continuous and ongoing assessment of the patient, which is recorded in the medical records as progress notes.

Term	Definition
Reconciliation of medications	Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
Referral	Referral is a recommendation by a primary care physician for a patient to see a specialist or receive specific medical services beyond the primary care provider's scope of practice.
Rehabilitation services	Rehabilitation services refer to medical treatments, therapies, and interventions aimed at restoring physical, cognitive, or functional abilities lost due to injury, illness, or disability.
Resources	It implies all inputs in terms of men, material, money, machines, minutes (time), methods, metres (space), skills, knowledge and information that are needed for the efficient and effective functioning of an organisation.
Restraints	Any practice, device or action used to ensure safety by restricting and controlling a person's movement. Many facilities are "restraint-free" or use alternative methods to help modify behaviour. Restraint may be physical or chemical (by use of sedatives).
Risk assessment	Risk assessment is the determination of the quantitative or qualitative value of risk related to a concrete situation and a recognised threat (also called hazard). This is followed by prioritizing areas for improvement based on the actual or potential impact on care, treatment, or services provided. Risk assessment is a step in a risk management procedure.
Risk management	Clinical and administrative activities to identify, evaluate and reduce the risk of injury.
Risk 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)	An analytic tool that can be used to perform a comprehensive, system-based review of critical incidents. It includes the identification of the root and contributory factors, determination of risk reduction strategies, and development of action plans along with measurement strategies to evaluate the effectiveness of the plans.
Safety	The degree to which the risk of an intervention/procedure, in the care environment is reduced for a patient, visitors and healthcare providers.
Safety program	A program focused on patient, staff and visitor safety.
Scope of services	Range of clinical and supportive activities that are provided by a healthcare organisation.
Screening	A process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.
Second victim	A health care practitioner involved in an unanticipated adverse patient event, a medical error, and/or a patient- related injury who becomes victimized in the sense that the practitioner is traumatized by the event.
Security	Protection from loss, destruction, tampering, and unauthorised access or use.
Sentinel events	An unanticipated event or occurrence involving death or serious physical or psychological injury not related to the patient's illness, but related to the medical equipment, supplies, or care being provided.
Service standards	A service standard specifies requirements that should be fulfilled by a service to establish its fitness for purpose. A service standard helps to define what a customer can expect from a service and how it should be delivered by the service provider, for example in terms of timeliness, accuracy and suitability.
Social responsibility	A balanced approach for an organisation to address economic, social and environmental issues in a way that aims to benefit people, communities and society,for example adoption of villages for providing health care, holding of medical camps and proper disposal of hospital wastes.

Term	Definition
Sound clinical practice	Practitioner decisions based on available knowledge, principles and practices for specific clinical situations.
Staff	All personnel working in the organisation including employees, “fee-for-service” medical professionals, part-time workers, contractual personnel and volunteers.
Stakeholder	Individuals, organization or groups that have an interest or share in services.
Standard precautions	1. A method of infection prevention and control in which all human blood and other bodily fluids are considered infectious for HIV, HBV and other blood-borne pathogens, regardless of patient history. It encompasses a variety of practices to prevent occupational exposure, such as the use of personal protective equipment (PPE), disposal of sharps and safe housekeeping 2. A set of guidelines protecting first aiders or healthcare professionals from pathogens. The main message is: "Don't touch or use anything that has the victim's body fluid on it without a barrier." It also assumes that all body fluid of a patient is infectious, and must be treated accordingly. **Standard Precautions** apply to blood, all body fluids, secretions, and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin and mucous membranes
Standards	A statement of expectation that defines the structures and process that must be substantially in place in an organisation to enhance the quality of care.
Sterilisation	It is the process of killing or removing microorganisms including their spores by thermal, chemical or irradiation means.
Strategic plan	Strategic planning is anorganization process of defining its strategy or direction and making decisions on allocating its resources to pursue this strategy, including its capital and people. Various business analysis techniques can be used in strategic planning, including SWOT analysis (Strengths, Weaknesses, Opportunities and Threats), for example Organisation can have a strategic plan to become a market leader in the provision of cardiothoracic and vascular services. The resource allocation will have to follow the pattern to achieve the target. The process by which an organisation envisions its future and develops strategies, goals, objectives and action plans to achieve that future.
Surveillance	The continuous scrutiny of factors that determines the occurrence and distribution of diseases and other conditions of ill health. It implies watching over with great attention, authority and often with suspicion. It requires professional analysis and sophisticated interpretation of data leading to recommendations for control activities.

Term	Definition
Swastha Panchkarma	Panchakarma that can also be administered in Swastha (healthy individual).
Table-top exercise	A table-top exercise is an activity in which key personnel assigned emergency management roles and responsibilities are gathered to discuss, in a non-threatening environment, various simulated emergency situations.
Telemedicine	The use of technology, such as video conferencing or remote monitoring, to provide medical care to patients from a distance.
Traceability	Traceability is the ability to trace the history, application, use and location of an item or its characteristics through recorded identification data.
Transfusion reaction	A transfusion reaction is a problem that occurs after a patient receives a transfusion of blood.
Transitions of care	The situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.
Transmission-based precautions	The extra work practices used in situations when standard precautions alone may not be enough to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions.
Turn-around-time	Turnaround time (TAT) means the amount of time taken to complete a process or fulfil a request.
Unstable patient	A patient whose vital parameters need external assistance for their maintenance.
Validated tool	A validated tool refers to a questionnaire/scale that has been developed to be administered among the intended respondents. The validation processes should have been completed using a representative sample, demonstrating adequate reliability (the ability of the instrument to produce consistent results) and validity (the ability of the instrument to produce true results).
Validation	Validation is verification, where the specified requirements are adequate for the intended use.

Term	Definition
Values	The fundamental principles, beliefs or statements of philosophy that drive organisational behaviour and decision-making, and that may involve social or ethical issues. This refers to the guiding principles and behaviours that embody how an organisation and its people are expected to operate. Values reflect and reinforce the desired culture of an organisation.
Variation	A difference in healthcare processes or outcomes, compared to peers or to a standard such as an evidence-based guideline recommendation.
Verbal order	Verbal orders are those orders given by a physician with prescriptive authority to a licensed person who is authorised by the organisation.
Verification	Verification is the provision of objective evidence that a given item fulfils specified requirements.
Vision	An overarching statement of the way an organisation wants to be, an ideal state of being at a future point. This refers to the desired future state of an organisation. The vision describes where the organisation is headed, what it intends to be, or how it wishes to be perceived in the future.
Vulnerable patient	Those patients who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status, for example infants, elderly, physically- and mentally-challenged, semiconscious/unconscious, those on immunosuppressive and/or chemotherapeutic agents.
Well-being	Well-being is a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions.
Workplace violence	A violent act (or acts) including physical assaults or threats of assaults directed towards a person at work or while on duty. Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.
Written guidance	A written document providing help, advice and direction for implementation of a policy and procedure. Written guidance has been used to guide implementation of NABH Standards.

ANNEXURE I - Medication Errors

Definition

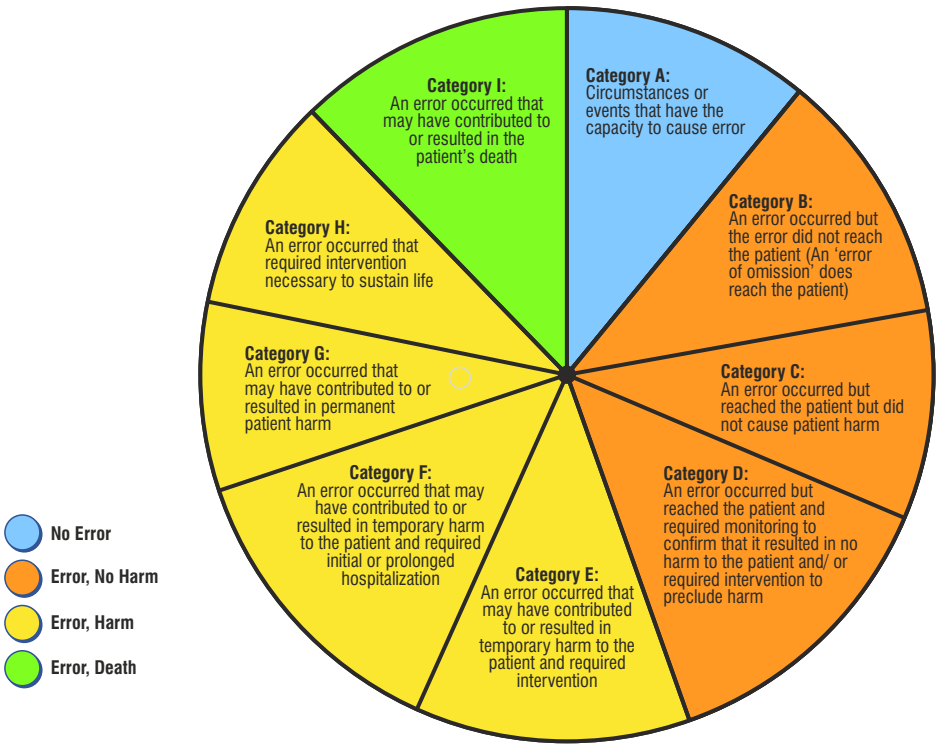
NCC-MERP (National Coordinating Council for Medication Error Reporting and Prevention) defines medication error as

"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.

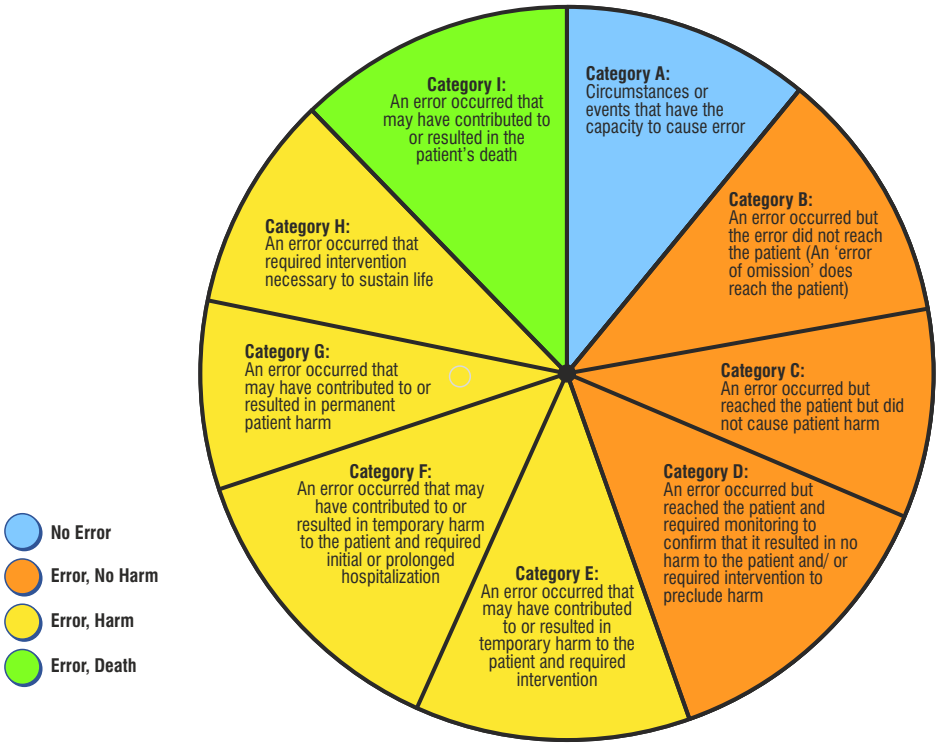
Monitoring
To observe or record relevant physiological or psychological signs.

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



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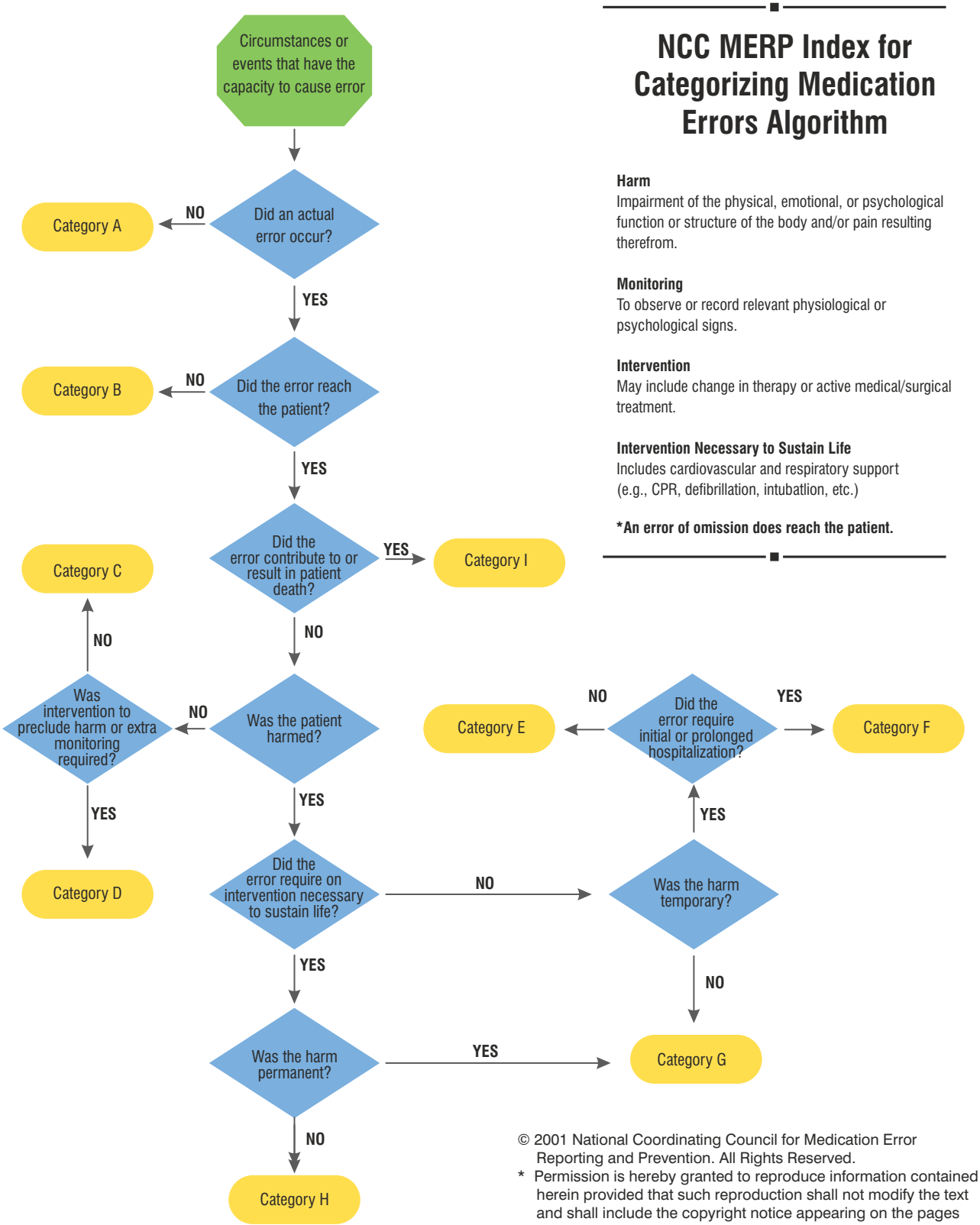
NCC MERP Index for Categorizing Medication Errors Algorithm



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Monitoring
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Intervention
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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
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

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ANNEXURE II - Quality Tools

Quality Tools:

Key Performance Indicator data should be analyzed using statistical/quality tools to assess compliance with the targets and identify areas for improvement. Some important quality tools for illustration purpose are mentioned below. The Ayush hospitals can use the given examples in the context of Ayush services provided by the them.

a. **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.

b. **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 have 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.

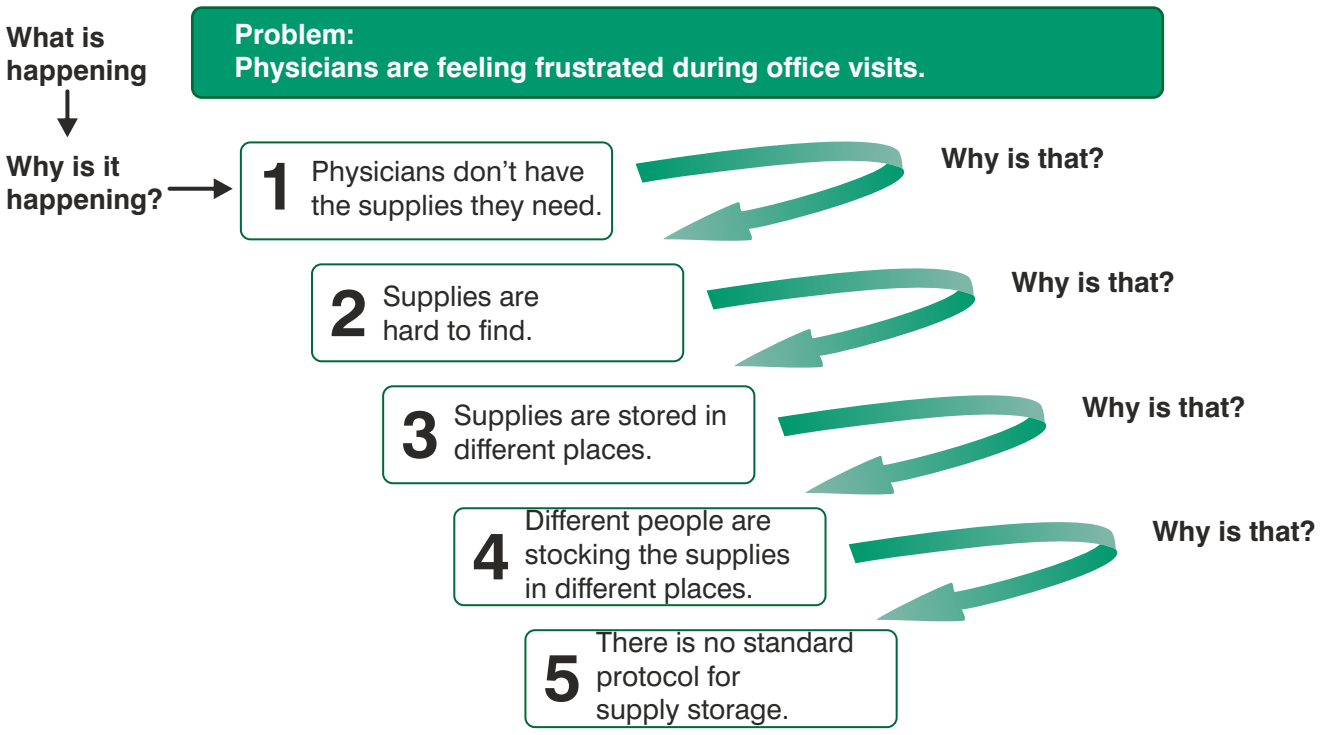

Figure 1: Illustration of 5-Why's Approach for carrying out a root cause analysis. (https://www.aafp.org/fpm/2007/0500/p30.html accessed on April 30, 2022)

c. **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. Fishbone/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.

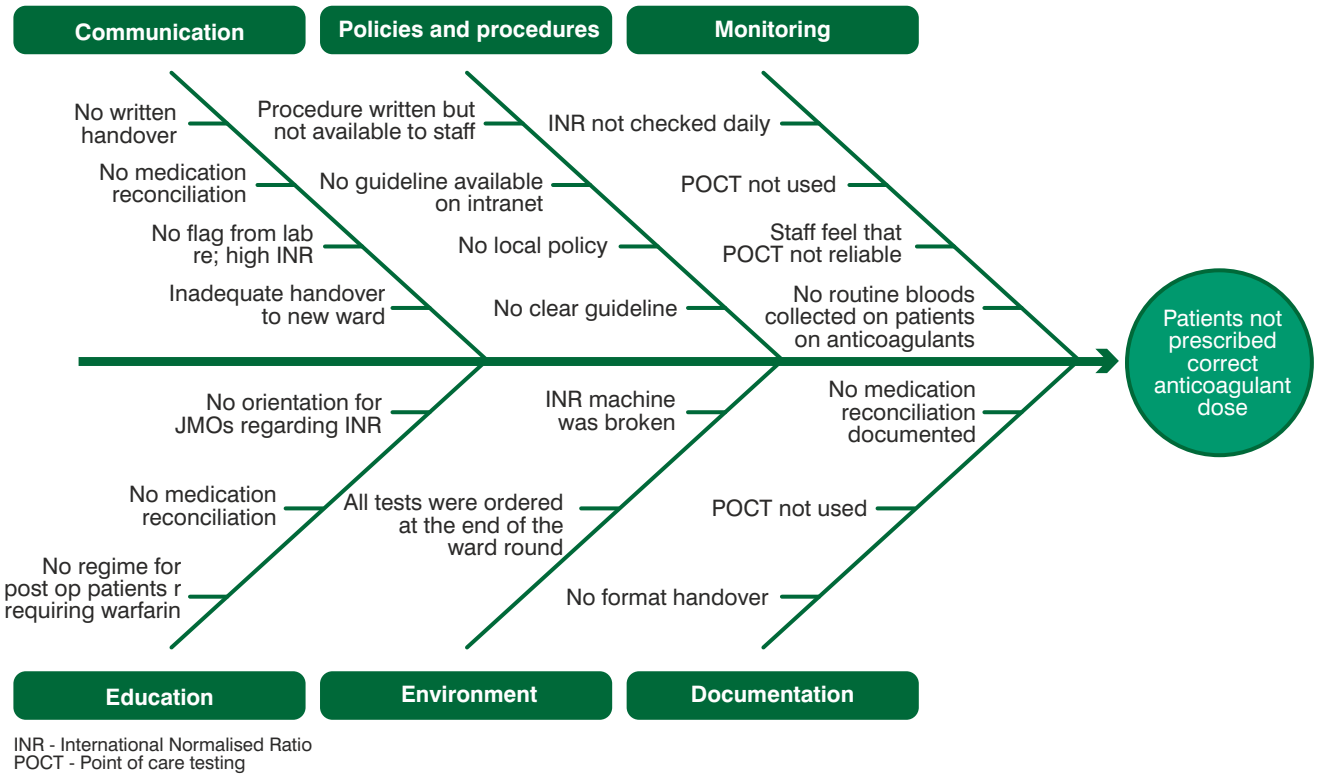

Figure 2: Example of a Cause & Effect Diagram by Clinical Excellence Commission. Reasons why patients are not on a standardized anticoagulation pathway (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/cause-and-effect-diagrams)

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

e. **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.

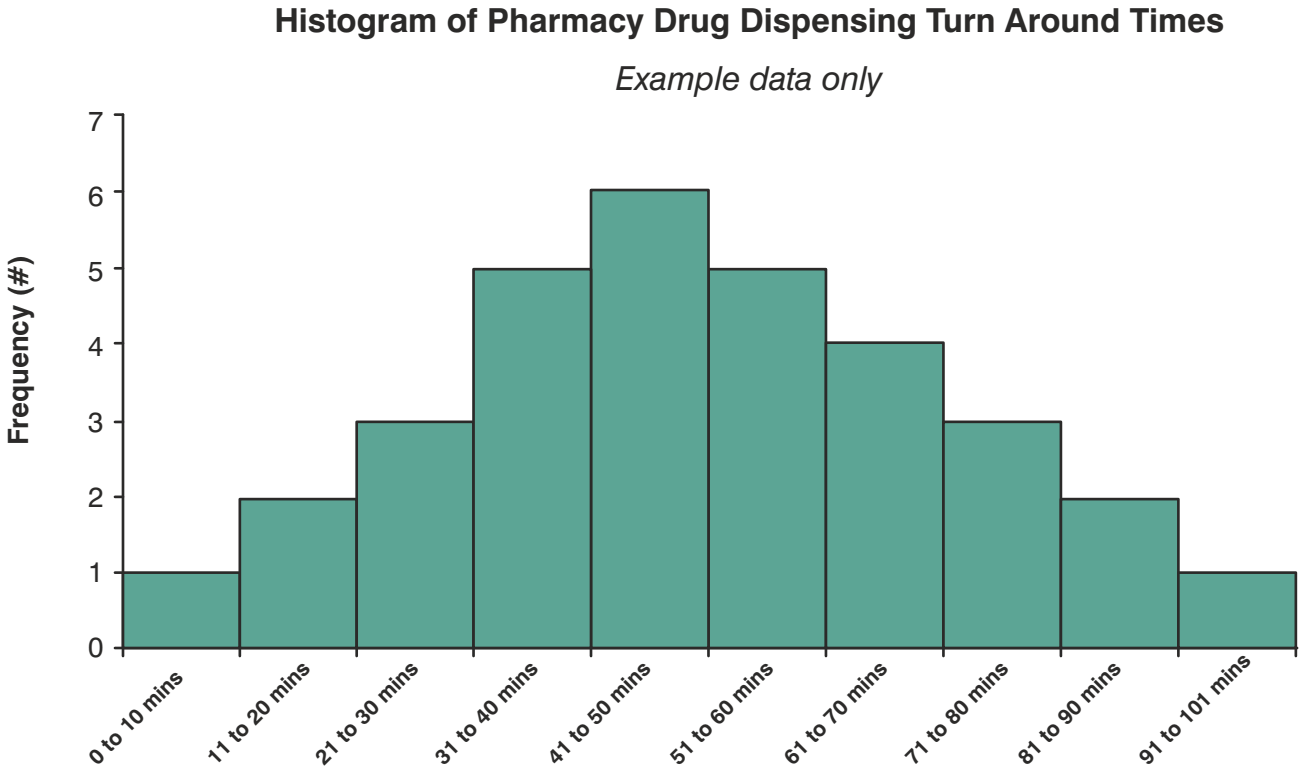

Figure 3: Histogram on Turnaround time for dispensing of the drug (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/histogram accessed on April 30, 2022)

f. **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)

G. 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-

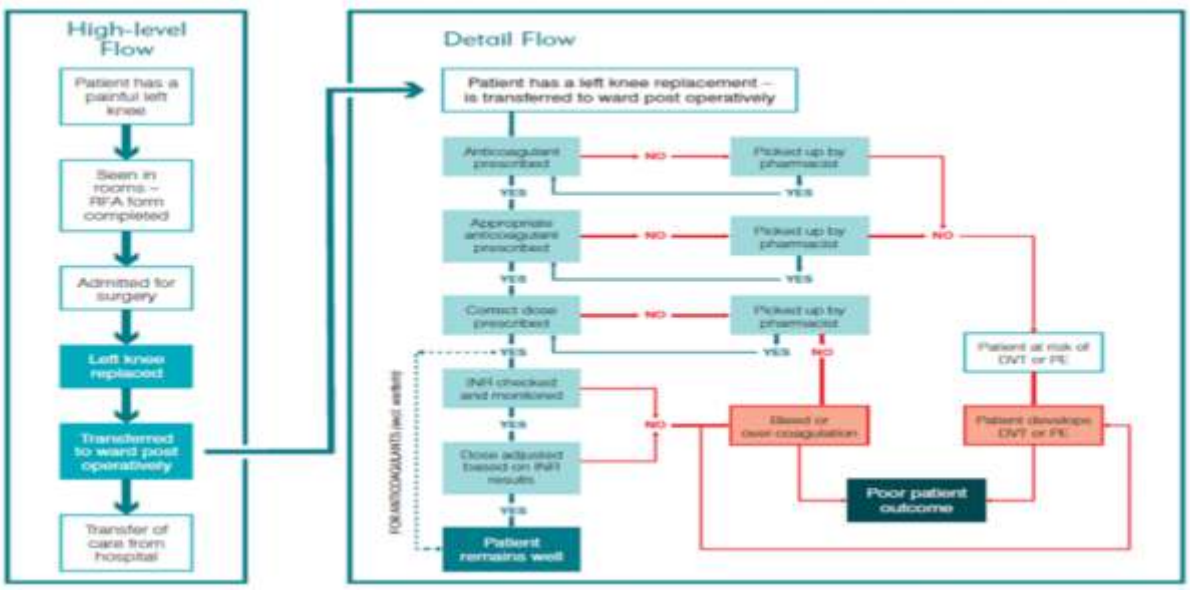

Figure 5: Flow chart of a patient's journey within the hospital
(https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/flow-charts accessed on April 30, 2022)

h. **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.

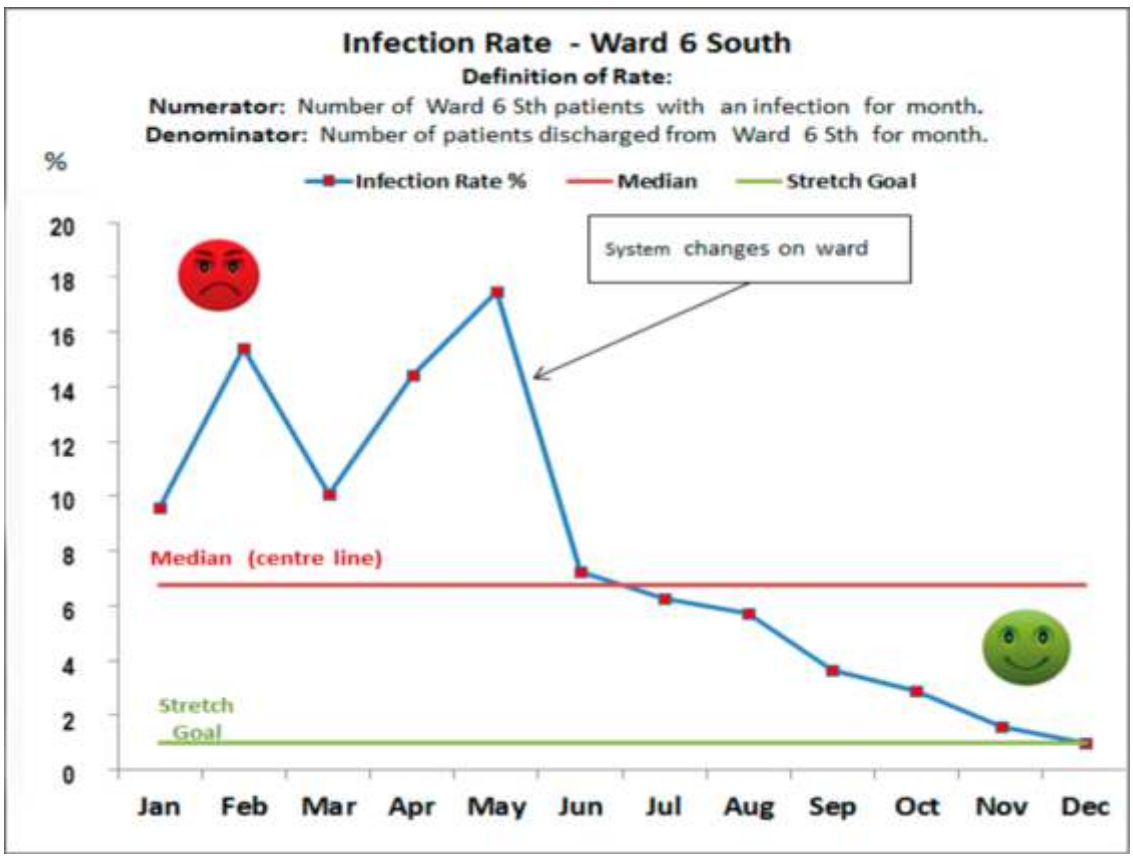

Figure 6: Pareto Analysis of Medication Error in a hospital

I. **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.

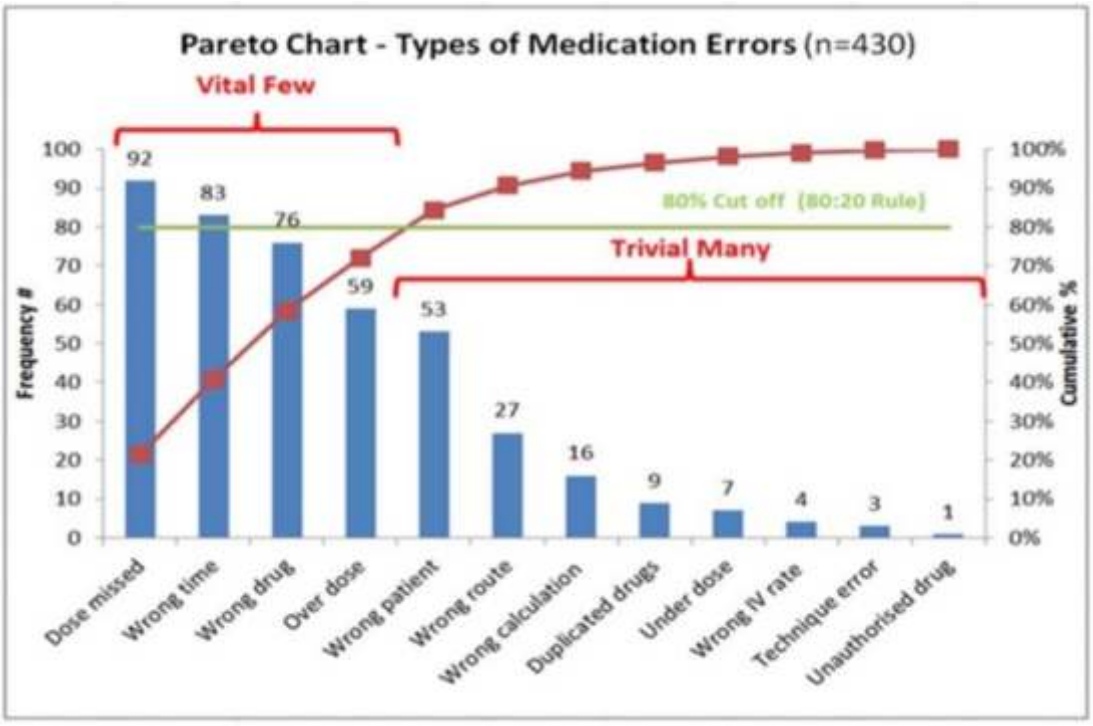

Figure 7: Simple Annotated Run chart with UCL and LCL of an infection rate over time (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/run-charts accessed on April 30, 2022)

j. **Scatter Diagram/Plot:** Scatter diagrams are used to identify cause-and-effect relationships between two variables. A scatter diagram does not prove causation.

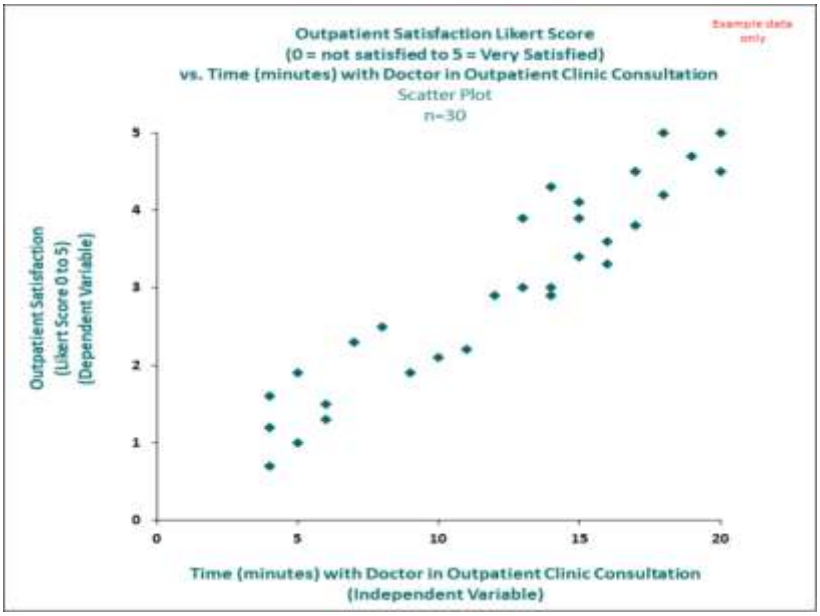

Figure 8: Scatter diagram showing patient satisfaction using likert's score v/s time with doctor consultation (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/scatter-plot accessed on April 30, 2022)

k. **Project Planning Form:** This tool helps teams think systematically about their improvement project. It tracks various elements like Plan-Do-Study-Act (PDSA) cycles.

Table 1. Quality improvement tool applications adapted from Butch S.

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		

l. **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.

m. **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.

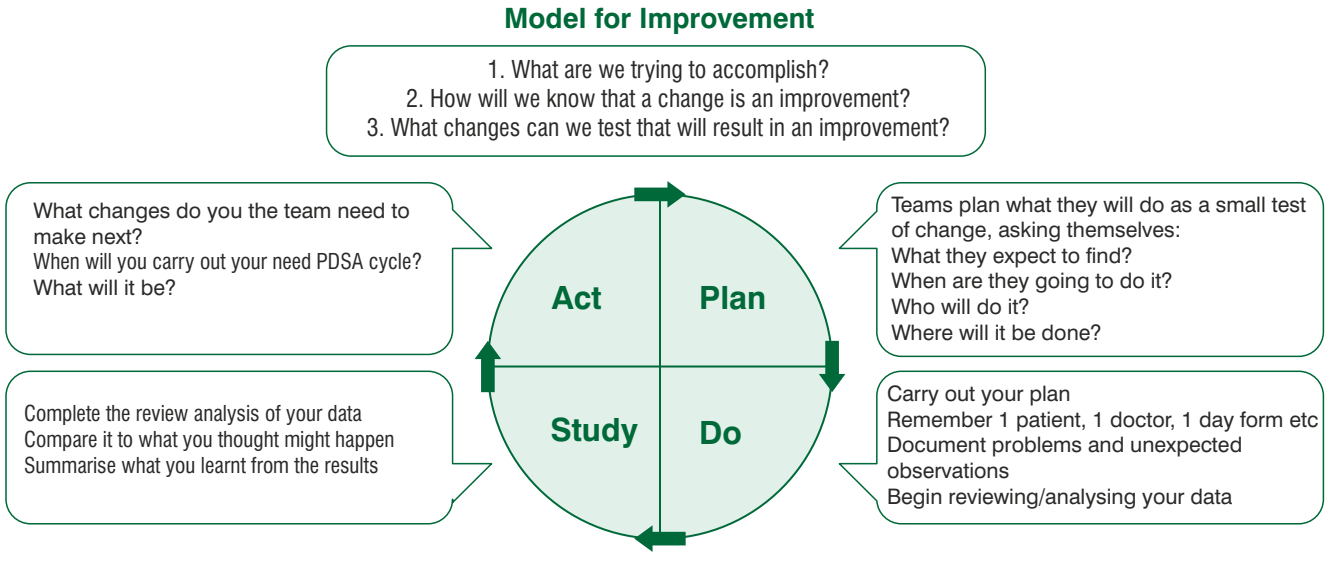

Figure 09: Model for Improvement & PDSA (https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/model-for-improvement-and-pdsa-cycles accessed on April 30, 2022)

n. **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.

o. **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.

p. **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**

q. **Six-sigma:** Six-sigma is a widely used model that is now making steady in-roads into transfusion 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.

r. **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 III - Key Performance Indicators (KPI)

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

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

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

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

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

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

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

Key Performance Indicators (KPI)

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

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
1	PSQ 3a	Time for initial assessment of indoor patients	The time shall begin from the time that the patient has arrived at the bed of the ward until the time that the initial assessment has been completed and documented by a doctor.	Sum of time taken for the assessment Total number of admissions		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.
2	PSQ 3a	Number of reporting errors/1000 investigations		Number of reporting errors Number of tests performed	X1000	/1000 tests	Monthly	This includes reporting errors picked up after dispatch. This shall be captured in the laboratory and radiology (If inhouse). Reporting errors include transcription errors. For better analysis, the organization could capture the data separately for different laboratory departments (For example, Biochemistry/Microbiology/Pathology) and imaging modalities (for example, X-Ray/USG/CT/MRI). If a report has more than one error in it, the total number of errors should be counted. For example, 10 tests were performed, one report was generated for these 10 tests and if the results of two tests are revised, the value of the numerator shall be two and denominator shall be 10. Further, the organization could consider capturing data pertaining to reporting errors that were identified and rectified before the dispatch of the reports. This would enable the organization to improve its process. Although the indicator is collated on a monthly basis, immediate correction is to be initiated when such instances happen. Sampling: No

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
3	PSQ 3a	Percentage of adherence to safety precautions by staff working in diagnostics.		Number of staff adhering to safety precautions / Number of staff audited	X 100	Percentage	Monthly	This shall be captured in the laboratory and radiology. This shall be captured by doing an audit on a monthly basis. The audit should be done by an individual outside of the department being audited. Even if the staff is not adhering to any one of the organization's/statutory safety requirements, it shall be considered as non-adherence. Sampling: Yes Sampling methodology: Stratified random
4	PSQ 3a	Incidence of medication errors	A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. (Ref: Annexure I.).	Total number of medication errors / Total number of inpatient days	X100	Percentage	Monthly	The methodology for capture shall be as stated in NABH's document on medication errors. The indicator shall be captured for admitted patients. Sampling: Yes Sampling methodology: Stratified random
5	PSQ 3a	Percentage of in-patients developing adverse drug reaction(s).	Adverse Drug reaction is a response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function.	Number of adverse drug reactions / Number of inpatients days	X100	Percentage	Monthly	The organization needs to have a mechanism in place to ensure that all adverse drug reactions are captured and reported. Sampling: No

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
6	PSQ 3a	Incidence of hospital-associated pressure ulcers after admission (Bedsore per 1000 patient days)	A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.	Number of patients who develop new/worsening of pressure ulcer Total number of inpatient days	X 1000	/1000 patient days	Monthly	The organization shall use The European and US National Pressure Ulcer Advisory Panels (EPUAP and NPUAP) staging system to look for worsening pressure ulcers. Sampling: No
7	PSQ 3b	Catheter-associated Urinary tract infection rate	As per the latest CDC/NHSN definition	Number of urinary catheter-associated UTIs in a month Number of urinary catheter days in that month	X1000	/1000 urinary catheter-days	Monthly	Sampling: No
8	PSQ 3a	Surgical/Procedure site infection rate	As per the latest CDC/NHSN definition	Number of surgical site infections in a given month Number of surgeries/procedures performed in that month	X100	/100 procedures	Monthly	Keeping in mind the definition of SSI, the numbers would have to be updated on a continual basis until such time that the monitoring period is over. For example, in January, the data for December would be reported. The denominator would be the number of surgeries performed in December, and that would not change. With respect to the numerator, there would be some data but it would not be complete data. Hence, whatever value the organization gets at this stage would at best be a preliminary value. The organization will continue to monitor the patients and by the end of January, will have complete data with respect to procedures which have a 30-day surveillance period.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
								At this point in time, based on the data that the organization has collated the numerator may change and hence, the SSI rate. However, this again would not be the final data. The organization will continue to monitor procedures that have a 90-day surveillance period, and if there are new SSIs, it would get added to the numerator and thus the rate would change. The surveillance period for surgeries which are done in December and have a 90-day surveillance period would end on March 30th (give or take a few days). It is only at this point in time that the organization can have the final SSI rate for December. Sampling: No
9	PSQ 3b	Compliance to hand hygiene practices		Total number of actions performed Total number of hand hygiene opportunities	X100	Percentage	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
10	PSQ 3c	Percentage of rescheduling of procedures/ surgeries	Re-scheduling of surgeries/procedures includes cancellation and postponement (beyond 4 hours) of the procedures/ surgery.	Number of cases re-scheduled Number of surgeries planned	X100	Percentage	Monthly	Any case included in the procedure list/ surgery (including tentative/provisional) but rescheduled/cancelled shall be included in the numerator. The start time for calculation of any delay shall be the first booked time for that particular case. Sampling: No

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
11	PSQ 3c	Therapist/Nurse-patient ratio for wards		Number of Therapist/ nursing staff Number of occupied beds		Ratio	Continuous	The organization should calculate the staffing patterns for the wards. The in-charge/supervisor of the area shall not be included for calculating the number of staff. To be calculated for each shift separately. Sampling: No
12	PSQ 3c	Waiting time for outpatient consultation	Waiting time is the length of time which one must wait in order for a specific action to occur after that action is requested or mandated. Waiting time for outpatient consultation is the time from which the patient has come to the concerned outpatient department (it may or may not be the same time as registration) till the time that the concerned consultant (not the junior doctor/resident) begins the assessment.	Sum total of waiting time for consultation Total Number of outpatients		Minutes	Monthly	In the case of appointment patients, the time shall begin with the scheduled appointment time and end when the concerned consultant (not the junior doctor/resident) begins the assessment. In cases where the patient has been seen ahead of the appointment time, the waiting time shall be taken as zero minutes. Sampling: No
13	PSQ 3c	Number of variations observed in mock drills	Waiting time for diagnostics is the time from which the patient has come to the diagnostic service (the requisition form has been presented to the counter) until the time that the test is initiated.	Sum total time Number of patients reported in Diagnostics		Minutes	Monthly	Waiting time for diagnostics is applicable only for outpatients and for laboratory and imaging (if inhouse). In the case of appointment patients, the time shall begin with the scheduled appointment time and end when the diagnostic procedure begins. In cases where the patient's diagnostic test commences ahead of the appointment time, the waiting time shall be taken as zero minutes. Sampling: No

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
14	PSQ 3c	Time taken for discharge	The discharge process is deemed to have started when the consultant formally approves discharge and ends with the patient leaving the clinical unit	Sum of time taken for discharge Number of patients discharged		Minutes	Continuous	In case patients request additional time to leave the clinical unit that shall not be added. The discharge is deemed to have been completed when the formalities for the same have been completed. Day care patients are not included. Sampling: No
15	PSQ 3c	Percentage of medical records having incomplete and/or improper consent	Informed consent is a type of consent in which the health care provider has a duty to inform his/her patient about the procedure, its potential risk and benefits, alternative procedures with their risk and benefits so as to enable the patient to make an informed decision of his/her health care	Number of medical records having incomplete and/ or improper consent Number of inpatient days	X100	Percentage	Monthly	If any of the essential elements/requirements of consent is missing, it shall be considered incomplete. If any consent obtained is invalid/void (consent obtained from the wrong person/consent obtained by the wrong person, etc.), it is considered improper. Sampling: No
16	PSQ 3c	Number of stock-outs of medications	A stock-out is an event that occurs when an item listed in drug formulary by the organization is not available in the organization.	Number of stock-outs of medication		Number	Monthly	To capture this, the organization should maintain a register in the pharmacy and stores (and also, if necessary, in the wards) wherein all such events are captured. The organization shall capture the number of instances. In one instance, it is possible that there was a stock-out of more than one drug. For example, if on the 7th there was an instance of stock out of two drugs and on 24th there was an instance of stock out of one emergency drug, the value of the indicator would be two. Sampling: No

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks
17	PSQ 3d	Number of variations observed in mock drills	A mock drill is a simulation exercise of preparedness for any type of event. It could be an event or disaster. This is basically a dry run or preparedness drill. For example, Fire -mock drill, disaster drill, Code Blue Drill.	Total number of variations in a mock drill		Number	Monthly	To capture the variation, it is suggested that every organization develop a checklist to capture the events during a mock drill. This shall also include tabletop exercises. Sampling: No
18	PSQ 3d	Incidence of patient falls	The US Department of Veteran Affairs National Centre for Patient Safety defines fall as "Loss of upright position that results in landing on the floor ground or an object or furniture or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair." It is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.	Number of patient falls Total number of inpatient days	X100	/1000 patient days	Monthly	Falls may be: • at different levels – i.e., from one level to ground level, for example from beds, wheelchairs or downstairs • on the same level as a result of slipping, tripping, or stumbling, or from a collision, pushing, or shoving, by or with another person • below ground level, i.e. into a hole or other opening in the surface All types of falls are to be included whether they result from physiological reasons (fainting) or environmental reasons. Assisted falls (when another person attempts to minimize the impact of the fall by assisting the patient's descent to the floor) should be included. (NDNQI, 2005). Sampling: No

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	
19	PSQ 3d	Percentage of near misses	A near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Errors that did not result in patient harm, but could have, can be categorized as near misses.	Number of near misses reported Number of incidents reported	X100	Percentage	Monthly	Sampling: No	
20	PSQ 3d	Rate of needlestick injuries	Needlestick injury is a penetrating stab wound from a needle (or other sharp objects) that may result in exposure to blood or other body fluids. Needlestick injuries are wounds caused by needles that accidentally puncture the skin. (Canadian Centre for Occupational Health and Safety)	Number of needlestick injuries Average occupied beds	X1000	Rate	Monthly on a cumulative basis	The denominator is the average of the sum of the daily figures for the number of beds occupied by patients. The rate will be monitored on a monthly basis but reported cumulatively i.e. in the form of year to date. For example, in January it would be January data but in February it would be January + February data, in July it would be data from January to July, and so on so that by the end of the year the annual rate is obtained. Sampling: No	The number of needle stick injuries can be captured through an incident reporting module/software (stand alone or integrated with HIS). Keeping in mind the challenges of data capture for this indicator through the HIS, the system should have a provision for entering the manual/ electronically collected (app/ online forms) data. The system shall calculate the average occupied beds.

S. No.	Standard	Indicator	Definition	Formula		Unit	Frequency of data collation/ Monitoring	Remarks	
21	PSQ 3d	Appropriate handovers during shift change		Total number of handovers done appropriately Total number of handover opportunities	X100	Percentage	Monthly	Handover is an important communication tool used by healthcare workers. The data can be collated together but it has to be captured separately for doctors and nurses. Handover documentation by each shift can be used as a guide to capturing the information. The handover information shared shall consist of the patient's current condition, recent changes in condition, ongoing treatment, and possible changes or complications. If the organization is using a standardized handover template (for example SBAR), for the handover to be deemed appropriate, all the components need to be filled. Though the organization shall use all or none 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 handovers done appropriately. Keeping in mind the challenges of data capture for this indicator through the HIS, the system should have a provision for entering the manual/ electronically collected (app/ online forms) data. The system shall calculate the total number of handover opportunities based on the staff ROTA.

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

Sample size calculation (Monthly)

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

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

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

ANNEXURE: IV - Clinical Audit

What is Audit?

Evaluation of data, documents and resources to check if performance of systems meets specified standards.

What is Clinical Audit?

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery". (NICE)

The aim of clinical audit is to measure the gap between ideal practice (determined from evidence and guidelines) and actual practice. Audit does not seek to apportion blame on individual practitioners but aims to improve the systems in which individuals work. If done correctly, clinical audit can bring about change and improve practice & clinical effectiveness.

Advantages of Clinical audit

The overarching aim of clinical audit is to improve service user outcomes by improving professional practice and the general quality of services delivered. Some of the advantages are as below-

For healthcare professionals:

- Provides workable standards.
- Resolves problems.
- Improves and increases team-working and levels of communication.
- Ensures appropriate use of skills and resources.
- Increases knowledge and skills.
- Can identify training needs.
- Measures quality in current practice

For Patients:

- Improves quality of care and service received.
- Prompt changes in delivery of care.
- Highlights precise patient needs.
- Involves patients in decision-making.
- Raises patients' confidence in service and care levels.
- Provides clear information about care and risks involved.

For Healthcare Organization:

- Improved care of patients
- Enhanced professionalism of staff
- Efficient use of resources
- Aids in continuing education
- Aids in administration
- Accountability to those outside the profession

How does Clinical Research differ from Clinical Audit?

Clinical audit is not research. Research is about obtaining new knowledge and finding out the most effective treatments. Clinical audit is about quality and finding out if best practice is being practised.

Clinical Research	Clinical Audit
Discovers the right thing to do	Determines whether the right thing is being done
Aims to generate new knowledge	Aims to improve the quality delivery of best care
Designed to test a hypothesis	Compare to pre-determined standards
Addresses clearly defined questions, aims and objectives	Measures against a standard
Study design may involve allocating patients to intervention groups	No allocation to intervention
Normally requires Research Ethics Committee review	Does not typically require Research Ethics Committee review

Are clinical audit and medical audit synonymous?

Medical Audit may be defined as “peer review of evaluation of medical care through retrospective and concurrent analysis of medical record.” Its aim is to improve the quality of health care services rendered by doctors to the patients.

Clinical audit is usually a multi-disciplinary activity where in aspects of structure, process and outcomes of care are selected and evaluated against explicit criteria. Most of the clinical audits are also 'multi-sectoral', that is, they may involve health and social services, primary and acute care providers, education and health.

Types of Clinical audit:

The different ways of carrying out clinical audit may be classified as follows:

1. **Standards-based audit (criteria-based audit):** This is the recommended process. Current practice is compared against defined criteria, standards or best practices, through the 'audit cycle'.

Example: Treatment of any disease given in the hospital as per Ayush is compared with textual/ classical regimen as advised such as Treatment of Vatavyadhi given is compared with Chikitsa Sutra given in the text or standard treatment guidelines)

2. **Peer review audit:** With the benefit of hindsight, the quality of services provided is assessed by a team, reviewing case notes and seeking ways to improve clinical care. This is especially applicable in 'interesting' or 'unusual' cases.

   Example: Treatment of any disease provided by the Ayush hospital is thoroughly analysed for its uniqueness yet giving the results, such as Kukkutnada twak swedana in Ardita vata- special fomentation procedures adopted for a Facial paralysis case).

3. **Significant event audit:** Adverse occurrences, critical incidents, unexpected outcomes, and problematic cases causing concern are reviewed systematically and solutions implemented, for example, any unwanted event occurred during Ayush procedure such as Vyapad of Panchakarma).

4. **Patient Surveys:** Targets for opinions or suggestions may include patients or special focus groups. Information gathered is then analysed and change implemented as appropriate.

Methodology:

Following steps may be followed:

1. **Selection of Topic**

   a) Should be common because it is common or high risk or bears high cost.

   b) Should be having local clinical concern or known wide variance in clinical practice.

   c) Topic should be well defined, focused and amenable to standard setting.

   Few Examples are as follows:

   - Long/short stay cases
   - Specific disease/specific procedures
   - Vulnerable groups
   - Increase incidence of a disease
   - Vyapad/complications arising due to any Ayush procedures

2. **Setting of standards**

   a) To be set prior to the study

   b) Criteria to be based on objective measures.

   c) The case diagnosis and treatment plan should be pre-defined, for example, administering Agasthya Haritaki in Tamaka swasa (Good reference could be Ayurveda Standard Treatment Guidelines (ASTG) and Siddha Standard treatment Guidelines as developed by Ministry of AYUSH, GOI available at https://namayush.gov.in/)

   d) Criteria should be well justified.

Target should be set at realistic level for defined patient groups and consider local circumstances. A target describes the level of care to be achieved for any particular criteria, for example,98 per cent of patients requesting for urgent appointment will be seen on that day.

Example of Criteria and Target Applicable to Structure, Process and Outcome Variables

	Structure	Process	Outcome	
Criteria	Availability of consultants/medicine/ pharmacists and other requirements	Audit process for its utility	Usefulness concluded at the end of the audit (in percentage)	
Example	Usefulness of Administering Agasthya Haritaki in Tamaka swasa	Availability of doctor, drug manpower etc.	The treatment plan should already being in use with all other criteria like diet, exercise etc. are constant	Agasthya Haritaki in Tamaka swasa found useful in percentage, for example in 40% patients only against expected 95% patients

a) Objective criteria are explicit but clinical judgment can be used to answer the question: "Was the management of this case satisfactory"? This is an implicit criterion.

b) Use of explicit criteria should be preferred. The problem with implicit criteria is that important deficiencies in care may be overlooked and rates may differ in their assessments of the acceptability of management.

3. Worksheet preparation and methodology of administration

a) Should be made simple and user friendly.

b) Only essential data is collected.

c) Suitable sample size is to be selected.

i. Random sampling – generate.

ii. Stratified samples

iii. Systematic sampling

iv. Cluster sampling

d) Probability of bias is to be considered.

i. Non-response to a survey

ii. Unavailability of certain type of case note

iii. Selective referral of certain types of patients

iv. Failure of patient to turn up for follow up.

4. Tabulation of evaluation

5. Interpretations

a. Deficiency of care recognised.

b. Specific solutions are proposed. They may not be possible every time.

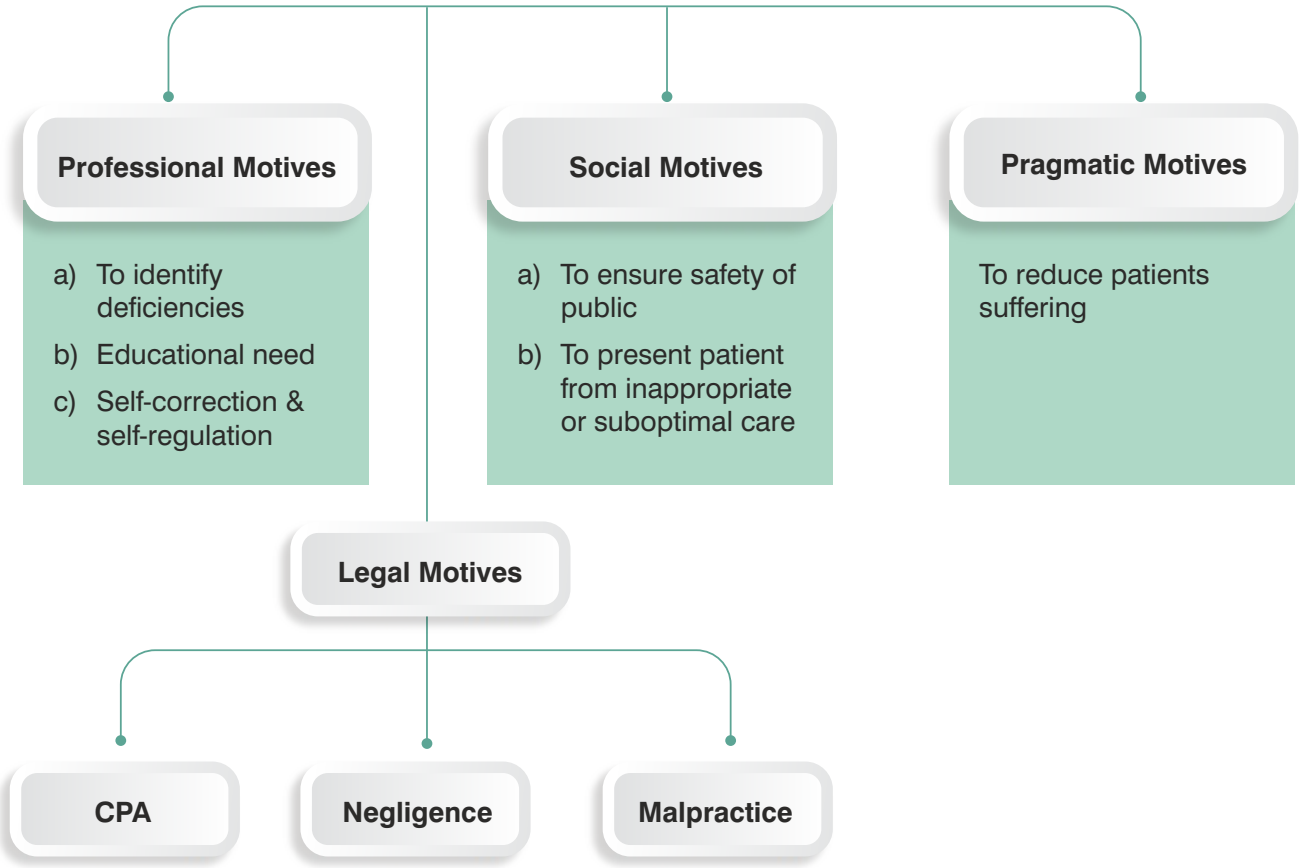
c. Education impact is appreciated.

d. Planned program for change.

e. All staff is involved.

f. Active feedback

g. Audit is evaluated.



1. **Effective change:**
   - Planned program for change
   - All staff is involved
   - Active feedback
   - Audit is evaluated
2. Action plan:
   - What needs to change?
   - How change could be achieved – what actions need to take place?
   - Who needs to take these actions?
   - When will the proposed actions begin?
   - How these actions will be monitored and by whom?
   - How and when to assess whether the actions taken have achieved the desired outcome?

Implementing change

What are the problem areas, i.e. what standards are not being met?

What are the potential causes of the problems (e.g. lack of resources, inadequate knowledge/skills, lack of procedures, etc.) and which of these are most likely?

How could these problems be overcome (i.e. ideas for change? And which solutions are most likely to be successful?

Whose support will be needed for change to be implemented?

Develop a clinical audit action plan

Re-audit

What are the key lessons from various audits?

1. Foster an environment for audit.
   - Audit is a valued activity.
   - Can augment both career and professional development.
   - Provision of protected time for audit
   - Commitment from staff to provide a request and act on the study findings.
2. Tackle the problems of multidisciplinary audit.
   - Can be seen as threatening.
   - Exposing one mistakes to another.
   - Staff training in interpersonal skills and in dealing with conflict.
   - Benefits outweigh disadvantage.
3. Review staff training program.
   - Importance of planning
   - Benefits of pilot study
4. Emphasise audit facilitation.
5. Establish confidentiality of finding
6. Ensure all relevant staff are involved.
7. Establish evaluation program.

	Question	Criteria
1.	Why was the audit done?	Reason for choice
		(a) Should be clearly defined
		(b) Should include potential for change
2.	How was the audit done?	(a) Criteria choice i Should be relevant to the subject. ii Should be justified, e.g. literature surveys or statutory demands.
		(b) Preparation and planning should show adequate teamwork and methodology in carrying out the audit
		(c) If standards are set, they should be appropriate and justifiable
3.	What was found?	Interpretation of the data
	✔ Should use all relevant data to allow. appropriate conclusion to be drawn	
4.	What next?	Detailed proposal for change should show. explicit details of the proposed change

Few Examples

1. Structure based examples.

The setting and resources (what you need – Ayush doctors, staff, buildings and equipment required to deliver a service), e.g. reference books, examination instruments and equipments, medicine storage and availability as per formulary, computers with software-based repertories etc.

2. Clinical process

Communication with patients at first appointment in child, geriatric and mental health service, hand hygiene compliance, Unique procedures like cupping therapy (Unani), Administering certain medicaments/certain procedures in clinical conditions.

Organisational/administrative process, e.g. discharge practice, waiting times etc.

3. Outcome

The effect of Ayush treatment on a patient's health status (what you expect).

For example, control of the disease, non-recurrence of the disease by adopting certain special Ayush procedures like Panchakarma Regimental Therapies etc.

4. Other sources of information/indicators for topics for audit could include:

Risk register, Activity information, for example, re-admissions, waiting lists.

Conclusion

Audit appears deceptively simple. Current care is observed so that it can be compared with standards and the necessary charges in patient care are implemented.

In practice

- Topics for audit need to be chosen with care and refined to make them suitable.
- Standard setting requires clarity of thought and careful definition.
- Data collection to observe practice can consume endless time and money.
- Lasting change is notoriously difficult to achieve.
- Not withstanding the above, once audit is understood and planned, it is one of the best ways to check quality of care being rendered, to bring about changes for improving care, to improve patient and employee satisfaction and for professional development.

Clinical Audit Report Format:

- Project title
- Speciality/Department
- Project lead
- Other members of staff involved
- Background/rationale
- Aim
- Objectives
- Standards
- Sample
- Data source
- Methodology – including data collection methods
- Results
- Observations
- Presentation/discussion
- Recommendations
- Learning points
- Action plan
- References

Additional Examples of Clinical Audit

- Remedy response analysis as per Kent's 12 observations in homoeopathy system of medicine
- Evidence based prescription with differentiation of remedies
- Outcome of Panchakarma therapies in musculoskeletal cases

Sample of Clinical Audit (illustrative example for Ayurveda discipline of Ayush)

Punarnava Mandoora (alone or in combination with other drugs) improves the clinical condition of the patients suffering from Pandu Roga as per the Ayurveda standard treatment guidelines given by Ministry of Ayush

Topic of Clinical Audit

Effectiveness of administering Punarnavadi Mandoora in Pandu patients.

Audit Setting

Specialty:

OPD/IPD:

Disciplines involved:

Doctors, and Allied Health Professionals like Pharmacist:

Clinical Audit Lead:

Dr ABC, Head of the Department-Kayachikitsa

Clinical Audit Team (Other staff members involved):

Pharmacist, Nursing staff

Introduction

Pandu (Anaemia) is a disease classification involving mainly the Rasa Dhatu with Panduta (pallor) as the presenting cardinal symptom. Other associated symptoms are fatigue, malaise, fever, weight loss, night sweats, palpitation, dyspnoea on mild exertion. Various disease conditions affecting formation of haemoglobin falls under the umbrella of Pandu Roga. Pandu condition occurs in all age groups specifically in the pregnant women, children, and geriatric patients.

Duration of Clinical Audit

The study was conducted on sample IPD patients suffering from Pandu Roga for a duration between January 2024 and July 2024.

Purpose of Clinical Audit

The purpose of audit was be:

i. To study whether the anaemia patients were receiving Punarnava mandoora once diagnosed with anaemia.

ii. To study the effectiveness of Punarnava Mandoora in improving the haemoglobin level and clinical condition of patients suffering from Pandu Roga, if given regularly.

iii. To conduct a root cause analysis, in case, if the Pandu Roga patients were not improving upon their haemoglobin level and clinical conditions.

iv. To identify opportunities for improvement.

Standards

At least 70% of the Pandu patients getting treatment should have improvement in their level of the haemoglobin and clinical symptoms associated with Pandu.

Data Collection Methodology of Clinical Audit

The data of the patients suffering from anaemia was extracted from the database of the hospital/ Registry. The case sheets and CBC reports of the patients were thoroughly reviewed to ensure that they fit into the selected criterion. The data was entered into the formats for further analysis.

Data Analysis

The collected data was analysed using standard statistics.

Observations

Upon data analysis, the following were the observations:

I. Number of cases studied: **63**

II. Number of Pandu patients who were receiving Punarnava mandoora: **27**

III. Improvement in the haemoglobin level and clinical condition of the patients: **16**

IV. Comparison with the Standards

Duration	Sample Size	Standard Set	Compliance
January - July 2024	**63**	**70%**	**43%** Patients received Punarnava mandoora **59%** Patient receiving the Punarnava mandoora got improvement in haemoglobin level and clinical conditions.

Root Cause Analysis

Upon conducting Root Cause Analysis, the clinical audit team identified the following reasons for not meeting the set standards/ outcome:

i. Consultants were not prescribing Punarnava mandoora in their prescriptions given to the Pandu patients.

ii. Inappropriate prescriptions and counselling/ education of the patients by the doctors regarding pathya and apathya ahar vihar, ritucharya, right dosage, form (Vati/kashay/churna), anupana, frequency of punarnavadi mandoora

iii. Patients drop out from the treatment

iv. Non-availability of the punarnava mandoora in the pharmacy

Identified Opportunity for Improvements

I. Doctor's training on prescribing Punarnava Mandoora to all Pandu patients and right and complete prescription writing

ii. Doctor's training on imparting effective education/counselling to the patients

iii. Ensuring the availability of Punarnava Mandoora in hospital pharmacy for indoor patients.

iv. Patient follow up and repeated counselling to minimize the patient drop out from the treatment

v. Adding other drug(s) to the treatment regimen from the Medicines at level 1/2/3 for Pandu as per Ayurveda standard treatment guidelines given by ministry of Ayush for the patients who despite of getting Punarnava Mandoora and adhering to all other do's and don'ts.

Conclusion

Against the set standard of 70%, only 43% Pandu patients were receiving Punarnava mandoora and out this only 59% patients got improvement in haemoglobin level and clinical conditions. Hence, the set standard has not been reached.

Recommendation:

i. Ayush doctors should adhere to standard protocol which includes using Punarava Mandoora (single or in combination with other drugs) for treatment of Pandu patients.

ii. The staff involved in the treatment of Pandu patients should be trained on standard protocol and effectiveness of the training should be checked.

iii. There should be peer reviews and repeated clinical audits of case file of Pandu patients to check the compliance to the standard treatment protocols and to identify the further opportunities of improvement i.e. a PDSA cycle should be followed till the targets are met.

References

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SUB ANNEXURE – A

Pandu Patient's Case Study	
Subject Number	
UHID	
Age	
Sex	
Date of Admission/Visit to the hospital	
Chief Complaints and symptoms	
Diagnosis	
Treatment Plan (Punarnava Mandoora (single or in combination prescribed)	
Rights Dosage, Route, Form, Timings, Anupana etc. Prescribed	
Pathya-Apathya Aahar Vihar and Ritucharya prescribed	
Patient follow up	
Hemoglobin level	
Hemoglobin level (repeat at 1 month's treatment)	
Improvement in Clinical sysmptoms (repeat at 1 month's treatment)	
Name of the Treating Ayush Doctor	

SUB ANNEXURE – B
DATA SHEET

Study duration	Total No of Patients	No of Patient received the required drug	Number of the patient who Improved their Haemoglobin level and symptoms
Jan 2024	16	4	2
Feb 2024	11	5	4
Mar 2024	8	1	0
April 2024	14	4	2
May 2024	12	7	3
June 2024	5	3	2
July 2024	7	3	3
Total	**63**	**27**	**16**

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