NQAS SCORE CARD - HOSPITAL

Version: DH/NQAS-2020 Revision-00

Hospital Score Card (Department wise)

Accident & Emergency	OPD	Labour Room	Maternity Ward	Paediatrics OPD	Hospital Score	
100%	100%	100%	100%	100%		
Paediatrics Ward	SNCU	NRC	OT	M- OT	#REF!	
100%	100%	#REF!	100%	100%		
PP Unit	ICU	IPD	Blood Bank	Lab	LaQshya Score	MusQan Score
#REF!	100%	100%	100%	100%		
Radiology	Pharmacy	Auxiliary	Mortuary	Haemodialysis Centre	100%	#REF!
100%	100%	100%	100%	100%		
General Administration						
100%						

HOSPITAL QUALITY SCORE CARD AREA OF CONCERN WISE

Service Provision	Patient Rights	Inputs	Support Services
#REF!	#REF!	#REF!	#REF!

Hospital Score

#REF!

Clinical Services	Infection Control	Quality Management	Outcome
#REF!	#REF!	#REF!	#REF!

MUSQAN QUALITY SCORE CARD AREA OF CONCERN WISE

Service Provision	Patient Rights	Inputs	Support Services
#REF!	#REF!	#REF!	#REF!

Hospital Score

#REF!

Clinical Services	Infection Control	Quality Management	Outcome
#REF!	#REF!	#REF!	#REF!

Reference No	Area of Concern & Standards	NQAS Score	LaQshya Score	MusQan Score

	Area of Concern A- Service Provision			
Standard A1.	**Facility Provides Curative Services**	#REF!	100%	#REF!
Standard A2	**Facility provides RMNCHA Services**	#REF!	100%	#REF!
Standard A3.	**Facility Provides diagnostic Services**	#REF!	100%	#REF!
Standard A4	**Facility provides services as mandated in National Health Programmes/ State Scheme**	100%	NA	100%
Standard A5.	**Facility provides support services**	#REF!	NA	#REF!
Standard A6.	**Health services provided at the facility are appropriate to community needs.**	#REF!	NA	#REF!
	Area of Concern B- Patient Rights			
Standard B1.	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**	#REF!	100%	#REF!
Standard B2.	**Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**	#REF!	100%	#REF!
Standard B3.	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**	#REF!	100%	#REF!
Standard B4.	**Facility has defined and established procedures for informing patients about the medical condition,and involving them in treatment planning, and facilitate informed decision making patient.**	#REF!	100%	#REF!
Standard B5.	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**	#REF!	100%	#REF!
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**	100%	NA	100%
	Area of Concern C - Inputs			
Standard C1.	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**	#REF!	100%	#REF!
Standard C2.	**The facility ensures the physical safety of the infrastructure.**	#REF!	100%	#REF!
Standard C3.	**The facility has established Programme for fire safety and other disaster**	#REF!	100%	#REF!
Standard C4.	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**	#REF!	100%	#REF!
Standard C5.	**Facility provides drugs and consumables required for assured list of services.**	#REF!	100%	#REF!
Standard C6.	**The facility has equipment & instruments required for assured list of services.**	#REF!	100%	#REF!
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**	#REF!	100%	#REF!
	Area of Concern D- Support Services			
Standard D1.	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**	#REF!	100%	#REF!
Standard D2.	**The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas**	#REF!	100%	#REF!
Standard D3.	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**	#REF!	100%	#REF!
Standard D4.	**The facility has established Programme for maintenance and upkeep of the facility**	#REF!	100%	#REF!
Standard D5.	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**	#REF!	100%	#REF!
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**	#REF!	NA	#REF!
Standard D7.	**The facility ensures clean linen to the patients**	#REF!	100%	#REF!
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**	100%	NA	NA
Standard D9	**Hospital has defined and established procedures for Financial Management**	100%	NA	NA
Standard D10.	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**	#REF!	NA	#REF!
Standard D11.	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**	#REF!	100%	#REF!
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**	#REF!	NA	#REF!
	Area of Concern E- Clinical Services			

Standard E1.	The facility has defined procedures for registration, consultation and admission of patients.	#REF!	100%	#REF!
Standard E2.	The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.	#REF!	100%	#REF!
Standard E3.	Facility has defined and established procedures for continuity of care of patient and referral	#REF!	100%	#REF!
Standard E4.	The facility has defined and established procedures for nursing care	#REF!	100%	#REF!
Standard E5.	Facility has a procedure to identify high risk and vulnerable patients.	#REF!	100%	#REF!
Standard E6.	Facility ensures rationale prescribing and use of medicines	#REF!	100%	#REF!
Standard E7.	Facility has defined procedures for safe drug administration	#REF!	100%	#REF!
Standard E8.	Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage	#REF!	100%	#REF!
Standard E9.	The facility has defined and established procedures for discharge of patient.	#REF!	NA	#REF!
Standard E10.	The facility has defined and established procedures for intensive care.	100%	NA	100%
Standard E11.	The facility has defined and established procedures for Emergency Services and Disaster Management	#REF!	100%	#REF!
Standard E12.	The facility has defined and established procedures of diagnostic services	#REF!	100%	#REF!
Standard E13.	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.	#REF!	100%	#REF!
Standard E14	Facility has established procedures for Anaesthetic Services	#REF!	100%	NA
Standard E15.	Facility has defined and established procedures of Operation theatre services	#REF!	100%	NA
Standard E16.	The facility has defined and established procedures for the management of death & bodies of deceased patients	#REF!	100%	100%
Standard E17	Facility has established procedures for Antenatal care as per guidelines	#REF!	NA	NA
Standard E18	Facility has established procedures for Intranatal care as per guidelines	100%	100%	NA
Standard E19	Facility has established procedures for postnatal care as per guidelines	100%	100%	NA
Standard E20	The facility has established procedures for care of new born, infant and child as per guidelines	#REF!	NA	#REF!
Standard E21	Facility has established procedures for abortion and family planning as per government guidelines and law	#REF!	NA	NA
Standard E22	Facility provides Adolescent Reproductive and Sexual Health services as per guidelines	#REF!	NA	NA
Standard E23	Facility provides National health program as per operational/Clinical Guidelines	100%	NA	100%
Standard E24	The facility has defined and established procedure for Haemodialysis Services	100%	NA	NA
	Area of Concern F- Infection Control			
Standard F1.	Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection	#REF!	100%	#REF!
Standard F2.	Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis	#REF!	100%	#REF!
Standard F3.	Facility ensures standard practices and materials for Personal protection	#REF!	100%	#REF!
Standard F4.	Facility has standard Procedures for processing of equipment and instruments	#REF!	100%	#REF!
Standard F5.	Physical layout and environmental control of the patient care areas ensures infection prevention	#REF!	100%	#REF!
Standard F6.	Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.	#REF!	100%	#REF!
	Area of Concern G- Quality Control			
Standard G1	The facility has established organizational framework for quality improvement	#REF!	100%	#REF!
Standard G2	Facility has established system for patient and employee satisfaction	#REF!	100%	#REF!
Standard G3.	Facility have established internal and external quality assurance programs wherever it is critical to quality.	#REF!	100%	#REF!
Standard G4.	Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.	#REF!	100%	#REF!
Standard G5.	Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages	#REF!	#DIV/0!	#REF!
Standard G6.	The facility has defined Mission, values, Quality policy and objectives, and prepares a strategic plan to achieve them	#REF!	100%	#REF!
Standard G7.	Facility seeks continually improvement by practicing Quality method and tools.	#REF!	#DIV/0!	#REF!
Standard G8.	Facility has de defined, approved and communicated Risk Management framework for existing and potential risks.	100%	NA	NA
Standard G9	Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan	#REF!	100%	#REF!
Standard G10.	The facility has established clinical Governance framework to improve quality and safety of clinical care processes	#REF!	100%	#REF!

	Area of Concern H- Outcome			
Standard H1 .	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks	#REF!	100%	#REF!
Standard H2 .	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark	#REF!	100%	#REF!
Standard H3.	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark	#REF!	100%	#REF!
Standard H4.	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark	#REF!	100%	#REF!

National Quality Assurance Standards for District Hospitals						Version: DH/NQAS-2020/00
Checklist for Accident & Emergency						1
Assessment Summary						
Name of the Hospital				Date of Assessment		
Names of Assessors				Names of Assessee		
Type of Assessment (Internal/External)				Action plan Submission Date		
Accident & Emergency Score Card						
Area of Concern wise Score				Accident & Emergency Score		
A	Service Provision	100%		100%		
B	Patient Rights	100%				
C	Inputs	100%				
D	Support Services	100%				
E	Clinical Services	100%				
F	Infection Control	100%				
G	Quality Management	100%				
H	Outcome	100%				
	Major Gaps Observed					
1						
2						
3						
4						
5						
	Strengths / Good Practices					
1						
2						
3						
4						
5						
	Recommendations/ Opportunities for Improvement					
1						
2						
3						
4						
5						
	Signature of Assessors					
	Date					

Reference No.	Measurable Element	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	EMERGENCY					
	Area of Concern - A Service Provision					
Standard A1.	Facility Provides Curative Services					
ME A1.1.	The facility provides General Medicine services	Availability of Emergency Medical Procedures	2	SI/OB	Poisoning, Snake Bite, CVA, Acute MI, ARF, Hypovolemic Shock , Dyspnoea, Unconscious Patients	
ME A1.2.	The facility provides General Surgery services	Availability of Emergency Surgical Procedures	2	SI/OB	Appendicitis, Rupture spleen, Intestinal Obstruction, Assault Injuries, perforation, Burns	
ME A1.4.	The facility provides paediatrics services	Availability of emergency Paediatric procedures	2	SI/OB	ARI, Diarrhoeal diseases, Hypothermia, PEM,resustication	
ME A1.5.	The facility provides Ophthalmology Services	Availability of Emergency Ophthalmology procedures	2	SI/OB	Foreign body and injuries	
ME A1.6.	The facility provides ENT Services	Availability of Emergency ENT procedures	2	SI/OB	Epitasis, foreign body	
ME A1.7.	The facility provides Orthopaedics Services	Availability of Emergency Orthopaedic procedures	2	SI/OB	Fracture, RTA, Poly trauma	
ME A1.9.	The facility provides Psychiatry Services	Availability of Emergency Psychiatric procedures	2	SI/OB	Conversion Reactions, other Psychiatric emergencies Hysteria, mania, psychosis	
ME A1.13.	The facility provides services for OPD procedures	Availability of Dressing room facility	2	SI/OB	Drainage, dressing, suturing	
		Availability of injection room facilities	2	SI/OB	Injection room facility with ARV, ASV and emergency drugs	
ME A1.14.	Services are available for the time period as mandated	24X7 availability of dedicated emergency Services	2	SI/RR		

ME A1.16.	The facility provides Accident & Emergency Services	Availability of Emergency procedures	2	SI/OB	Defibrillation, CPR, Mobilization, Chest Tube, Intubations, Tracheotomy, Mechanical Ventilation	
Standard A2	**Facility provides RMNCHA Services**					
ME A2.2	The facility provides Maternal health Services	Availability of Emergency Gynaecology procedure	2	SI/OB	(a) Primary management of Severe pelvic pain, severe vaginal bleeding, vulvar abscesses & toxic shock syndrome etc. (b) Emergency laparotomy - Due to uterine perforation, septic abortion, pelvic abscess, ectopic pregnancy	
ME A2.4	The facility provides Child health Services	Triage and emergency management of paediatric cases	2	SI/OB		
Standard A3	**Facility Provides diagnostic Services**					
ME A3.1.	The facility provides Radiology Services	Availability / Linkage to X-ray & USG services	2	SI/OB/RR		
		Radiology Services are functional 24X7	2	SI/OB	Check services are functional at night	
ME A3.2.	The facility Provides Laboratory Services	Availability of Emergency diagnostic tests 24x7	2	SI/OB	HB%, CPC, Blood Sugar, RDK, Urine Protein, Electrolyte (Na+K)	
ME A3.3.	The facility provides other diagnostic services, as mandated	Availability of Functional ECG Services	2	SI/OB		
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**					
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability emergency services cardiovascular diseases & cerebro vascular attack	2	SI/OB	Acute chest pain, Acute /chronic hypertension, pulmonary oedema, congestive cardiac failure & acute arrhythmias	
Standard A5.	**Facility provides support services**					
ME A5.3.	The facility provides security services	Availability of Required Security gaur	2	SI/OB		
ME A5.7.	The facility has services of medical record department	Availability of Medico-legal record services	2	SI/OB		
Standard A6.	**Health services provided at the facility are appropriate to community needs.**					
ME A6.1.	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of specific procedures for local prevalent emergencies	2	SI/OB	Ask for the specific local health frequent emergencies. See if emergency is ready for it or not.	
	Area of Concern - B Patient Rights					
Standard B1.	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1.	The facility has uniform and user-friendly signage system	Availability departmental signage's .	2	OB	Emergency department board is prominently displayed with facility of illumination in night.	
		Availability of Directional Signage's.	2	OB	Direction is displayed from main gate to direct.	
ME B1.2.	The facility displays the services and entitlements available in its departments	List of services including emergencies that are managed at the facility	2	OB		
		Names of doctor and nursing staff on duty are displayed and updated	2	OB		
		Important numbers including ambulance, blood bank , police and referral centres displayed	2	OB		
ME B1.6.	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.7.	The facility provides information to patients and visitor through an exclusive set-up.	Enquiry services are available 24X7.	2	OB	Enquiry services may be provided by registration clerk/Nurse in a small set up. For large and busy emergency departments there should be dedicated enquiry counter	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Treatment note/discharge note is given to patient	2	RR/OB		
Standard B2.	**Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**					
ME B2.1.	Services are provided in manner that are sensitive to gender	Separate room for examination of rape victims	2	OB		
		Availability of sexual assault forensic evidence kit	2	OB		
		Availability of protocols /guidelines for collection of forensic evidence in case of rape victim	2	OB /RR		
		Counselling services are available for rape victim and domestic violence	2	OB/RR		
		Availability of female staff if a male doctor examine a female patients	2	OB/SI		

		Separate toilets for male and females	2	SI/OB		
ME B2.3.	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair/ stretcher for emergency	2	OB		
		Emergency is located at ground floor (perefebly) with barrier free acess	2	OB		
		Ambulance has direct access to the receiving/triage area of the emergency.	2	OB	No vehicle parked on the way /in front of emergency entrance. Access road to emergency is wide enough for streamline moment of emergency	
		Availability of specially abled friendly toilet	2	OB		
Standard B3.	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**					
ME B3.1.	Adequate visual privacy is provided at every point of care	Screens provided at emergency	2	OB	At the examination and procedure area.	
ME B3.2.	Confidentiality of patients records and clinical information is maintained	Confidentiality of patient record maintained	2	SI/OB	1. No information regarding patient / parent identity is displayed 2. Records are not shared with anybody without written permission of parents & appropriate hospital authorities	
		MLC cases are kept in secure place beyond access of general public	2	SI/OB		
ME B3.3.	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	OB/PI		
ME B3.4.	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV, Rape, suicidal cases, domestic violence and psychotic cases	2	SI/OB		
Standard B4.	**Facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitate informed decision making patient.**					
ME B4.1.	There is established procedures for taking informed consent before treatment and procedures	Consent is taken for invasive emergency procedures	2	SI/RR		
ME B4.2.	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.	2	OB		
ME B4.3.	Staff are aware of Patients rights responsibilities	Staff is aware about patient rights and responsibilities	2	SI		
ME B4.4.	Information about the treatment is shared with patients or attendants, regularly	Patient is informed about her clinical condition and treatment been provided	2	PI	Ask patients about what they have been communicated about the treatment plan	
ME B4.5.	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance redressal and whom to contact is displayed	2	OB		
Standard B5.	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Emergency services are free for all including pregnant woman, neonate and children	2	PI/SI		
ME B5.2.	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.	2	PI/SI		
ME B5.3.	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.	2	PI/SI		
ME B5.4.		DELETED			The facility provide treatment to all the benificiaery as per the mandate	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.6	There is an established procedure for information about the conditions critical patients to their attendants	The patient's Relatives informed clearly about the deterioration in the health condition of Patient.	2	SI/RR	Periodic update on the patient's condition is given to the family.	
		Hospital has documented policy for pain management	2	SI/OB		

		Screening of the patient for pain	2	SI/RR	Symptomatic treatment is given to the patient to prevent complications to extent possible	
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient	2	RR/SI	Consequences of LAMA are explained to patient/relative	
	Area of Concern - C Inputs					
Standard C1.	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms					
ME C1.1.	Departments have adequate space as per patient or work load	Adequate space for accommodating emergency load	2	OB	1000 square meters per 100 patient daily loads	
		Availability of adequate waiting area	2	OB		
ME C1.2.	Patient amenities are provide as per patient load	Availability of seating arrangement in the waiting area	2	OB		
		Availability of cold Drinking water	2	OB		
		Availability of functional toilets	2	OB		
ME C1.3.	Departments have layout and demarcated areas as per functions	Demarcated trolley bay	2	OB		
		Demarcated receiving /triage areas	2	OB		
		Demarcated Nursing station	2	OB		
		Demarcated duty room for doctor /nurse	2	OB		
		Demarcated resuscitation area	2	OB		
		Demarcated observation area/beds	2	OB		
		Demarcated dressing area /room	2	OB		
		Demarcated injection room	2	OB		
		Demarcated area for keeping serious patient for intensive monitoring	2	OB		
		Demarcated areas for keeping dead bodies.	2	OB	Separate room or linkage with mortuary/ Post mortem room	
		Lay out is flexible	2	OB	All the fixture and furniture are movable to rearrange the different areas in case of mass casualty	
		Dedicated Minor OT	2	OB		
		Shaded porch for ambulance	2	OB		
		availability of clean and dirty utility room	2	OB		
ME C1.4.	The facility has adequate circulation area and open spaces according to need and local law	Corridors at Emergency are broad enough for easy moment of stretcher and trolley	2	OB	2-3 meter	
ME C1.5.	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
		The ambulance(s) has a proper communication system(at least cell phone)	2	OB		
ME C1.6.	Service counters are available as per patient load	Availability of emergency beds as per load	2	OB	5% of the total beds	
		Availability of buffer beds for handling mass causality and disaster	2			
ME C1.7.	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services.	2	OB	Receiving/Triage-Resuscitation-observation beds-Procedures area. There is no crises cross	
		Separate entrance for emergency department	2	OB	Entrance of Emergency should not be shared with OPD and IPD	
		Emergency has functional linkage with Major OT , ICU and labour room , Indoors and laboratories	2	OB/SI		
		Emergency is located near to the entry of the hospital	2	OB		

Standard C2.	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3.	The facility ensures safety of electrical establishment	Emergency department does not have temporary connections and loosely hanging wires	2	OB		
ME C2.4.	Physical condition of buildings are safe for providing patient care	Floors of the Emergency are non slippery and even	2	OB		
Standard C3.	**The facility has established Programme for fire safety and other disaster**					
ME C3.1.	The facility has plan for prevention of fire	Emergency has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2.	The facility has adequate fire fighting Equipment	Emergency has installed fire Extinguisher that is Class A , Class B, C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3.	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4.	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1.	The facility has adequate specialist doctors as per service provision	Availability of specialist Doctor	2	OB/RR	Check for specialist on call/ full time	
ME C4.2.	The facility has adequate general duty doctors as per service provision and work load	Availability of emergency medical officer	2	OB/RR		
ME C4.3.	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	At least 2 in day and 1 in night	
ME C4.4.	The facility has adequate technicians/paramedics as per requirement	Availability of dresser /paramedic	2	OB/SI		
ME C4.5.	The facility has adequate support / general staff	Dedicated 24X7 house keeping staff	2	SI/RR		
		availability of dedicated security guards 24X7	2	SI/RR		
		Availability of registration clerk	2	SI/RR		
		Availability of Drivers for Ambulance 24X7	2	SI/RR	103/108/State specific ambulance services	
Standard C5.	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1.	The departments have availability of adequate drugs at point of use	Availability of Analgesics/Antipyretics/Anti Inflammatory	2	OB/RR	Tracers as per State's EML	
		Availability of Anti-Infective/Antibiotics	2	OB/RR	Tracers as per State's EML	
		Availability of Solutions Correcting Water, Electrolyte Disturbances and Acid-Base Disturbances	2	OB/RR	Tracers as per State's EML	
		Availability of Drugs acting on Cardiovascular System	2	OB/RR	Tracers as per State's EML	

		Availability of drugs action on Central nervous system and peripheral nervous system	2	OB/RR	Tracers as per State's EML	
		Availability of dressing material and antiseptics	2	OB/RR	Tracers as per State's EML	
		Availability of drugs for Respiratory System	2	OB/RR	Tracers as per State's EML	
		Availability of Hormonal Preparation	2	OB/RR	Tracers as per State's EML	
		Availability of emergency drugs in ambulance	2	OB/RR	Tracers as per State's EML	
		Availability of drugs for obstetric emergencies	2	OB/RR	Magnesium sulphate, Oxytocin, Plasma Expanders	
		Availability of Medical gases	2	OB/RR	Availability of Oxygen Cylinders	
		Availability of Immunological/vaccines	2	OB/RR	Polyvalent Anti snake Venom, Anti tetanus Human Immunoglobin	
		Availability of Antidotes and Other Substances used in Poisoning	2	OB/RR	Activated charcoal, Anti-snake venom	
ME C5.2.	The departments have adequate consumables at point of use	Resuscitation Consumables / Tubes	2	OB/RR	Masks, Ryles tubes, Catheters, Chest Tube, ET tubes etc	
		Availability of disposables at dressing room	2	OB/RR		
		Availability of consumables in ambulance	2	OB/RR	Dressing material / Suture material	
ME C5.3.	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray/ Crash Cart is maintained at emergency	2	OB/RR		
Standard C6.	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1.	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Multiparameter Torch, hammer , Spot Light	
		Availability of Monitoring equipment in ambulance	2	OB		
ME C6.2.	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of dressing tray for Emergency procedures	2	OB		
		Dressing tray are in adequate numbers as per load	2	OB		
		Availability of instruments for emergency Gynae procedure	2	OB		
ME C6.3.	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic devices	2	OB	Glucometer, ECG and HIV rapid diagnostic kit	
ME C6.4.	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.	2	OB	Ambu bag, defibrillator, layrngo scope, nebulizer, suction apparatus , LMA	
		Availability of resuscitation equipment in ambulance	2	OB		
ME C6.5.	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning and sterilization	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush, Boiler	
ME C6.7.	Departments have patient furniture and fixtures as per load and service provision	Availability of patient beds with prop up facility, attachments and accessories	2	OB	Hospital graded Mattress, IV stand, bed rails, Bed pan	
		Availability of fixtures	2	OB	Spot light, electrical fixture for equipment like suction, monitor and defibrillator, X ray view box	
		Availability of furniture at emergency	2	OB	Doctors Chair, Patient Stool, Examination Table, Chair, Table, Footstep, cupboard	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1		DELETED				

ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Triage and Mass Casualty Management	2	SI/RR		
		Basic life support (BLS)/ Advance life support (ALS)	2	SI/RR		
		Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Training on Quality Management System	2	SI/RR		
		Patient Safety	2	SI/RR		
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for emergency procedures	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for resuscitation and use defibrillator	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for maintaining clinical records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1.	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1.	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
		There has system to label Defective/Out of order equipment and stored appropriately until it has been repaired	2	OB/RR		
ME D1.2.	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR		
ME D1.3.	Operating and maintenance instructions are available with the users of equipment	Operating instructions for critical equipment are available	2	OB/SI		
Standard D2.	**The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs	2	SI/RR	Stock level are daily updated Indents are timely placed	
ME D2.3.	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled	2	OB	Labelled with drug name, drug strength and expiry date	
		Empty and filled cylinders are labelled	2	OB		
ME D2.4.	The facility ensures management of expiry and near expiry drugs	Drugs expiry dates' are maintained at emergency drug tray	2	OB/RR		
		No expired drug found	2	OB/RR		
		Records for expiry and near expiry drugs are maintained for drug stored at department	2	RR	Check register/DVDMS/other supply chain software for record of stock of expired and near expiry drugs	
ME D2.5.	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock in Emergency	2	SI/RR		

		Department maintained stock register of drugs and consumables in Emergency	2	RR/SI	Record of drug received, issued and balance stock of drug in hand	
		There is practice of calculating and maintaining buffer stock in ambulance	2	SI/RR		
		Department maintained stock register of drugs and consumables in ambulance	2	RR/SI	Check record of drug received, issued and balance stock in hand	
ME D2.6.	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procedure for replenishing drug tray emergency crash cart	2	SI/RR		
		There is established procedure for replenishing drug tray emergency crash cart in ambulance	2	OB/SI		
		There is no stock out of drugs	2	SI/RR	Random stock check of some essential medicines. E.g. Paracetamol, Atenolol, Amlodipine, Azithromycin, etc.	
ME D2.7.	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day	
ME D2.8.	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotics and psychotropic drugs are kept separately in lock and key	2	OB/SI		
Standard D3.	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1.	The facility provides adequate illumination level at patient care areas	Adequate illumination at procedure area	2	OB	Resuscitation area, dressing room and examination area	
		Adequate illumination at receiving and triage area	2	OB		
ME D3.2.	The facility has provision of restriction of visitors in patient areas	Visitors are restricted at resuscitation and procedure area	2	OB/SI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area	2	PI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation in nursing station/duty room	2	SI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4.	The facility has security system in place at patient care areas	There are set procedures for handling mass situation and violence in emergency	2	SI/OB	See for linkage to police, self protection form staff	
		Hospital has sound security system to manage overcrowding in emergency	2	OB/SI		
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place	2	SI		
Standard D4.	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2.	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3.	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Patients beds are intact and painted	2	OB	Mattresses are intact and clean	
ME D4.5.	The facility has policy of removal of condemned junk material	No condemned/Junk material in the Emergency	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5.	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1.	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		

ME D5.2.	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in Emergency	2	OB/SI		
		Availability of UPS	2	OB/SI		
		Availability of Emergency light	2	OB/SI		
ME D5.3.	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen and vacuum supply	2	OB		
Standard D7.	**The facility ensures clean linen to the patients**					
ME D7.1.	The facility has adequate availability of linen for meting its need.	Clean Linens are provided at observation beds	2	OB/RR		
ME D7.2.	The facility has established procedures for changing of linen in patient care areas	Linen are changed after change shift of each patient or whenever it get soiled	2	OB/RR		
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR		
Standard D10.	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					
ME D10.1.	The facility has requisite licences and certificates for operation of hospital and different activities	Valid licences for ambulances are available	2	RR/SI		
ME D10.3.	The facility ensure relevant processes are in compliance with statutory requirement	Staff is aware of requirements of medico legal cases	2	SI		
Standard D11.	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1.	The facility has established job description as per govt guidelines	Staff is aware of their role and responsibilities	2	SI		
ME D11.2.	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3.	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1.	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1.	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration	2	RR		
		Patient demographic details are recorded in admission records	2	RR	Check for that patient demographics like Name, age, Sex, Address, Chief complaint, etc.	
ME E1.3.	There is established procedure for admission of patients	There is established criteria for admission through emergency department	2	SI/RR		
		There is establish procedure for admission of MLC cases as per prevalent laws	2	SI/RR		
		Admission is done by written order of a qualified doctor	2	SI/RR		
		There is no delay in treatment because of admission process	2	SI/RR		
		Time of admission is recorded in patient record	2	RR		
		There is no delay in transfer of patient to respective department once admission is confirmed	2	SI/RR		
		Emergency department is aware of admission criteria to critical care units	2	SI/RR	Like ICU, SNCU, Burn cases	
		Staff is aware of cases that can not be admitted at the facility due to constraint in scope of services	2	SI		

ME E1.4.	There is established procedure for managing patients, in case beds are not available at the facility	The is provision of extra beds, trolley beds in case of high occupancy or mass casualty	2	OB/SI		
Standard E2.	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1.	There is established procedure for initial assessment of patients	Assessment criteria of different kind of medical emergencies is defined and practiced	2	SI/RR	Use of standard criteria of assessment like Glasgow comma scale, Poly trauma, MI, burn patient, paediatric patient, pain assessment criteria etc.	
		Initial assessment and treatment is provided immediately	2	OB/RR		
		Initial assessment is documented preferably within 2 hours	2	RR		
ME E2.2.	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation	2	RR/SI		
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3.	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1.	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure for hand over for patient transfer from emergency to IPD /OT	2	SI/RR	Check for how hand over is given from emergency to ward, ICU, SNCU etc.	
		There is a procedure consultation of the patient to other specialist with in the hospital	2	SI/RR		
ME E3.2.	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	Patient referred with referral slip	2	SI/RR		
		Availability of referral linkages to higher centres.	2	SI/RR	Check how patient are referred if services are not available	
		Advance communication is done with higher centre	2	SI/RR		
		Referral vehicle is being arranged	2	SI/RR		
		Referral in or referral out register is maintained	2	RR		
		Check for if there is any system of follow up	2	RR	1. Check referral out record is maintained 2. Check randomly with the referred cases (contact them) for completion of treatment or follow up.	
ME E3.3.	A person is identified for care during all steps of care	Doctor and nurse is designated for each patient admitted to emergency ward	2	SI/RR		
Standard E4.	**The facility has defined and established procedures for nursing care**					

ME E4.1.	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification before any clinical procedure	2	OB/SI	Patient id band/ verbal confirmation/Bed no. etc.	
ME E4.2.	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained	2	RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.	
		There is a process to ensure the accuracy of verbal/telephonic orders	2	SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period	
ME E4.3.	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR		
		Nursing Handover register is maintained	2	RR		
		Hand over is given bed side	2	OB/SI		
ME E4.4.	Nursing records are maintained	Nursing notes are maintained adequately	2	RR/SI	Check for nursing note register. Notes are adequately written	
ME E4.5.	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for TPR chart, IO chart, any other vital required is monitored	
		Critical patients are monitored continually	2	RR/OB	Check for use of cardiac monitor/multi parameter	
Standard E5.	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1.	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Unstable, irritable, unconscious. Psychotic and serious patients are identified	
ME E5.2.	The facility identifies high risk patients and ensure their care, as per their need	High risk medical emergencies are identified and treatment given on priority	2	OB/SI		
Standard E6.	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1.	Facility ensured that drugs are prescribed as per the prescription policy of ESIC	Check for BHT if drugs are prescribed as per the prescription policy	2	RR	Check for: 1. No. of medicines prescribed 2. High-end antibiotics are not prescribed 3. polypharmacy 4. Medicines are prescribed from EML	TO DISCUSS
ME E6.2.	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use	2	RR		
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per STG	
		Availability of drug formulary at emergency	2	SI/OB		
ME E6.3		DELETED				
Standard E7.	**Facility has defined procedures for safe drug administration**					
ME E7.1.	There is process for identifying and cautious administration of high alert drugs	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride,opiods, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc.	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor	
		There is process to ensure that right doses of high alert drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided	
ME E7.2.	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR		
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI		
ME E7.3.	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI		
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content indented to be used later on	
		Check for separate sterile needle is used every time for multiple dose vial	2	OB	In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events	
ME E7.4.	There is a system to ensure right medicine is given to right patient	Administration of medicines done after ensuring right patient, right drugs , right route, right time	2	SI/OB		

ME E7.5.	Patient is counselled for self drug administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings .	2	SI/PI		
Standard E8.	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1.	All the assessments, re-assessment and investigations are recorded and updated	Assessment findings are written on BHT	2	RR	Day to day progress of patient is recorded in BHT (Manually/e-records)	
ME E8.2.	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT	2	RR	Treatment prescribed in nursing records	
ME E8.3.	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/treatment registers	2	RR	Treatment given is recorded in treatment chat	
ME E8.4.	Procedures performed are written on patients records	Any procedure performed written on BHT	2	RR	CPR, Dressing, mobilization etc	
ME E8.5.	Adequate form and formats are available at point of use	Availability of form formats for emergency	2	OB/SI	MLC,PIB, Lab /X-ray requisition, death certificate, Initial assessment format, referral slip etc.	
ME E8.6.	Register/records are maintained as per guidelines	Emergency Records are maintained	2	OB/RR	Emergency register, death register, MLC register, are maintained	
		All register/records are identified and numbered	2	OB/RR		
ME E8.7.	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of MLC records	2	OB/SI		
Standard E9.	**The facility has defined and established procedures for discharge of patient.**					
ME E9.1.	Discharge is done after assessing patient readiness	Assessment is done before discharging patient from emergency	2	SI/RR	See if there is any procedure/protocol for discharging the patient if the condition of patient improves in emergency itself. What is the procedure for discharge for short stay / day care patients	
		Discharge is done by a responsible and qualified doctor	2	SI/RR		
		Patient / attendants are consulted before discharge	2	PI		
		Treating doctor is consulted/ informed before discharge of patients	2	SI/RR		
ME E9.2.	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided	2	RR/PI	See for discharge summary, referral slip provided.	
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up	2	RR		
		Discharge summary is give to patients going in LAMA/Referral	2	SI/RR		
ME E9.3.	Counselling services are provided as during discharges wherever required	Counselling services are provided wherever it is required	2	SI/PI		
Standard E11.	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.1.	There is procedure for Receiving and triage of patients	Emergency has a implemented system of sorting the patients	2	SI/OB	As care provider how they triage patient- immediate, delayed, expectant, minimal, dead	
		Triage area is marked	2	OB/SI		
		Triage protocols are displayed	2	OB		
		Responsibility of receiving and shifting the patient from vehicle is defined	2	SI		
ME E11.2.	Emergency protocols are defined and implemented	Emergency protocols are available at point of use	2	OB	See for protocols of head injury, snake bite, poisoning, drawing etc.	
		Staff is aware of Clinical protocols	2	SI/RR		
		There is procedure for CPR	2	SI/RR		
ME E11.3.	The facility has disaster management plan in place	Lines of authority is defined	2	SI/RR		

		Procedure for internal communication defined	2	SI/RR		
		There is procedure for setting up control room	2	SI/RR		
		Disaster buffer stock of medicines and other supplies maintained	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
		Staff is aware of disaster plan	2	SI/RR		
ME E11.4.	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement	Check for how ambulances are called and patient is shifted	2	SI/RR		
		Ambulances are equipped	2	OB		
		If the patient is stable then he is transferred in ambulance with the trained driver and one staff from hospital.	2	SI/RR		
		If the patient is serious (as decided by the Doctor), then trained driver and one paramedical staff is mandatory to accompany him.	2	SI/RR		
		The Patient's rights are respected during transport.	2	SI/RR		
		Ambulance appropriately equipped for BLS with trained personnel	2	OB/RR		
		There is a daily checklist of all equipment and emergency medications	2	RR		
		Ambulance has a log book for the maintenance of vehicle and daily vehicle checklist	2	RR		
		Transfer register is maintained to record the detail of the referred patient	2	RR		
ME E11.5.	There is procedure for handling medico legal cases	Medico legal cases are identified by on patient records	2	RR/SI		
		MLC cases are not delayed because of police proceedings	2	SI/OB/RR		
		There is procedure for informing police	2	SI/RR	Discharge is not done before police consent	
		Emergency has criteria for defining medico legal cases	2	SI/RR	Criteria is defined based on cases and when to do MLC	
Standard E12.	**The facility has defined and established procedures of diagnostic services**					
ME E12.1.	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.3.	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different tests	2	SI/RR		
Standard E13.	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.8	There is established procedure for issuing blood	There is a procedure for issuing the blood promptly for life saving measures	2	RR/SI		
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR		
		Patient's identification is verified before transfusion	2	SI/OB		
		Blood is kept on optimum temperature before transfusion	2	RR		
		Blood transfusion is monitored and regulated by qualified person	2	SI/RR		
		Blood transfusion note is written in patient record	2	RR		
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR		

Standard E15.	**Facility has defined and established procedures of Operation Theatre Services**					
ME E15.1.	Facility has established procedures OT Scheduling	There is procedure for emergency surgeries	2	SI/RR	See surgeon is available on call/on duty	
		Procedure for arranging logistics	2	SI	Responsibilities are defined and patient is shifted promptly	
Standard E16.	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1.	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to de**cently** communicate death to relatives	2	SI		
		Death note is written on patient record	2	RR		
ME E16.2.	The facility has standard procedures for handling the death in the hospital	Past history and sign of any medico legal cause is looked for	2	RR	Check what is policy for registering brought in dead, death cases as MLC	
		There is criteria for declaring death	2	SI/RR	ask form how death is declared - Physical examination or ECG is done	
		Procedure for handing over the dead body	2	SI		
		Death certificate is issued	2	SI/RR		
	Area of Concern - F Infection Control					
Standard F1.	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2.	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
ME F1.4.	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxic etc	
		Periodic medical check-ups of the staff	2	SI/RR		
ME F1.5.	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2.	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1.	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin, elbow operated tap near the point of use	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2.	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
ME F2.3.	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3.	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1.	Facility ensures adequate personal protection equipment as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
		Personal protective kit for infectious patients	2	OB/SI		
ME F3.2.	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Cap, Aprons etc	
Standard F4.	**Facility has standard Procedures for processing of equipment and instruments**					
ME F4.1.	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , dressing table, Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like ambubag, suction cannula, Airways, Face Masks, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable	

		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2.	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment's	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/HLD/Chemical Sterilization	
		High level Disinfection of instruments/equipment is done as per protocol	2	OB/SI	Ask staff about method and time required for boiling	
		Chemical sterilization of instruments/equipment is done as per protocols	2	OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization	
		Autoclaved dressing material is used	2	OB/SI		
Standard F5.	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1.	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic	2	OB		
ME F5.2.	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3.	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR		
		Cleaning of patient care area with disinfectant detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
ME F5.4.	Facility ensures segregation infectious patients	Emergency department define list of infectious diseases require special precaution and barrier nursing	2	OB/SI		
		Staff is trained for barrier nursing	2	OB/SI		
Standard F6.	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1.	Facility Ensures segregation of Bio Medical Waste as per guidelines and on-site management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainer's with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.2.	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle	
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	

		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3.	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI		
		Disinfection of liquid waste before disposal	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		
	Area of Concern - G Quality Management					
Standard G1	The facility has established organizational framework for quality improvement					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Emergency	2	SI/RR	1. Check if the quality circle has been constituted and is functional 2. Roles and Responsibility of quality circle has been defined	
Standard G3.	Facility have established internal and external quality assurance programs.					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR		
		There is system for periodic check up of Ambulances by designated hospital staff	2	SI/RR	Inhouse ambulance check is done by designated hospital staff OR ambulance belonging to the agency- the daily checklist is filled, displayed and updated by the designated person	
ME G3.2	Facility has established external assurance programs at relevant departments	There is periodic assessment of preparedness for disaster by competent authority	2	SI/RR		
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	1. NQAS assessment toolkit is used to conduct an internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5		DELETED				
Standard G4.	Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.					
ME G4.1.	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB		
		Work instruction/clinical protocols are displayed	2	OB	Triage, CPR, Medical clinical protocols like Snake bite and poisoning	
ME G4.2.	Standard Operating Procedures adequately describes process and procedures	Emergency has documented procedure for Registration and patient calling system	2	RR		
		Department has documented procedure for triaging	2	RR		
		Department has documented procedure for taking consent	2	RR		
		Department has documented procedure for initial screening of patient	2	RR		
		Department has documented procedure for nursing care	2	RR		
		Department has documented procedure for admission and transfer of the patient to ward	2	RR		
		Emergency has documented procedure for Handling medical records	2	RR		
		Department has documented procedure for maintaining records in Emergency	2	RR		
		Department has documented procedure to handle brought in dead patient	2	RR		
		Department has documented procedure for storage, handling and release of dead body	2	RR		
		Department has documented procedure for storage and replenishing the medicine in emergency	2	RR		

		Department has documented procedure for equipment preventive and break down maintenance	2	RR		
		Department has documented procedure for Disaster management	2	RR		
ME G4.3.	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5.	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1.		DELETED				
ME G5.2.		DELETED				
ME G5.3		DELETED				
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1.		DELETED				
		DELETED				
ME G7.2.		DELETED				
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6		DELETED				
ME G9.7		DELETED				
ME G9.7		DELETED				
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care processes	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/PI	Feedback is taken from patient/family on health status of individual under treatment	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits	2	SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission	
		There is procedure to conduct death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct prescription audits	2	RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings	

		All non compliance are enumerated recorded for medical audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for prescription audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per prescription audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
	Area of Concern - H Outcome					
Standard H1 .	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1.	Facility measures productivity Indicators on monthly basis	No. of trauma cases treated per 1000 emergency cases	2	RR		
		No. of poisoning cases treated per 1000 emergency cases	2	RR		
		No. of cardiac cases treated per 1000 emergency cases	2	RR		
		No of resuscitation done per thousand population	2	RR	Resuscitation should include: Chest Compression, Airway and Breathing	
		Number of emergency cases treated at night per month	2	RR	Check at lease last 3 month data	
Standard H2 .	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1.	Facility measures efficiency Indicators on monthly basis	Response time for ambulance	2	RR		
		Proportion of cases referred	2	RR		
		Response time at emergency for initial assessment	2	RR	Sum of time taken for initial assessment of all patients who accessed emergency services in a period/Total number of patients who accessed emergency services in that period	
		Average Turn Around Time	2	RR	Average time a patient stays at emergency observation bed	
ME H2.2		Proportion of patient referred by state owned/108 ambulance per 1000 referral cases	2	RR		
Standard H3.	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1.	Facility measures Clinical Care & Safety Indicators on monthly basis	No of adverse events per thousand patients	2	RR		
		Death Rate	2	RR	No of Deaths in Emergency/ Total no of emergency attended	
Standard H4.	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1.	Facility measures Service Quality Indicators on monthly basis	LAMA Rate	2	RR	No of LAMA X 100/ No of Patients seen at emergency	
		Absconding rate	2	RR	No of Absconding X 100/ No of Patients seen at emergency	
		Response Time in Emergency department	2	RR	The time from entry of patient at emergency department to admission/transfer-out/discharge	
		Percentage of emergency patients for whom the initial assessment was completed within defined timeframe	2	RR	(Number of patients in emergency for whom the initial assessment was completed within a defined time frame / total number of patients admitted) x 100	

National Quality Assurance Standards for District Hospitals	Version: DH/NQAS-2020/00
Checklist for Outdoor Patient Department	2

Assessment Summary

Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessee	
Type of Assessment (Internal/External)		Action plan Submission Date	

OPD Score Card

	Area of Concern wise Score		OPD Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No.	Measurable Element	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.1	The facility provides General Medicine services	Availability of functional General Medicine Clinic	2	SI/OB	Dedicated General speciality Medicine Clinic	
ME A1.2	The facility provides General Surgery services	Availability of functional General Surgery Clinic	2	SI/OB	Dedicated General speciality Surgical Clinic	
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Functional Obstetrics & Gynaecology Clinic	2	SI/OB	(a) Dedicated speciality Obstetrics & Gynaecology Clinic. (b) High-risk pregnancy cases are referred from the ANC clinic and consulted.	
		Availability of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) services	2	SI/OB	(a) Dedicated clinic of PMSMA (b) Availability MO & ObG specialist (c) 9th of every month - for all pregnant women in 2-3 trimester	
		Availability of daycare Gynaecology procedure	2	SI/OB	(a) PAP smear & biopsy, Cervical VIA staining, Endometrial aspiration, Bartholin cyst excision. (b) MTP (Medical & surgical Method)	
ME A1.5	The facility provides Ophthalmology Services	Availability of functional Ophthalmology Clinic	2	SI/OB	Dedicated ophthalmology clinic providing consultation services	
ME A1.6	The facility provides ENT Services	Availability of Functional ENT Clinic for adult and paediatrics	2	SI/OB	1. Dedicated ENT providing consultation services 2. Foreign Body Removal (Ear and Nose),Stitching of CLW's, Dressings, Syringing of Ear, Chemical Cauterization (Nose & Ear), Eustachian Tube Function Test, Vestibular Function Test/Caloric Test	
ME A1.7	The facility provides Orthopaedics Services	Availability of Functional Orthopaedic Clinic	2	SI/OB	(a) Dedicated clinical for Orthopaedic consultation (b) Plaster room to conduct Orthopaedic procedure	
ME A1.8	The facility provides Skin & VD Services	Availability of functional Skin & VD Clinic	2	SI/OB	Dedicated Clinic providing consultation services	
ME A1.9	The facility provides Psychiatry Services	Availability of functional Psychiatry Clinic	2	SI/OB	Dedicated Clinic providing consultation services	
ME A1.10	The facility provides Dental Treatment Services	Availability of functional Dental Clinic	2	SI/OB	Dedicated Clinic providing consultation services	
		Availability of OPD Dental procedure	2	SI/OB	Accompanied by dental lab. Extraction, scaling, tooth extraction, denture and Restoration.	
ME A1.11	The facility provides AYUSH Services	Availability of Functional AYUSH clinic	2	SI/OB	AYUSH clinic accompanied by dispensary	
ME A1.12	The facility provides Physiotherapy Services	Availability of Functional Physiotherapy Unit	2	SI/OB	Pain Management with cryotherapy, Pain Management with deep heat therapy (SWD), Increase range of motion with mobilization.	
ME A1.13	The facility provides services for OPD procedures	Availability of Dressing facilities at OPD	2	SI/OB	Dressing, Suturing and drainage	
		Availability of Injection room facilities at OPD	2	SI/OB		
ME A1.14	Services are available for the time period as mandated	At least 6 Hours of OPD Services are available	2	SI/RR		
		PMSMA is conducted 9th of every month	2	SI/RR		
ME A1.15	The facility provides services for Super specialties, as mandated	Availability of functional Cardiology clinic	2	SI/OB		
		Availability of functional gastro entomology clinic	2	SI/OB		
		Availability of functional nephrology clinic	2	SI/OB		
		Availability of functional Neurology clinic	2	SI/OB		
		Availability of functional endocrinology Clinic is available	2	SI/OB		
		Availability of functional Oncology Clinic	2	SI/OB		
Standard A2	Facility provides RMNCHA Services					
		DELETED				
Standard A3	Facility Provides diagnostic Services					
ME A3.2	The facility Provides Laboratory Services	Availability of Sample collection Centre	2	SI/OB		
ME A3.3	The facility provides other diagnostic services, as mandated	Functional ECG Services are available	2	SI/OB		
		Availability of TMT services	2	SI/OB		
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme					
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of OPD Services Under NVBDCP	2	SI/RR	OPD Management of Malaria, Kala Azar, Dengue	

ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Availability of Functional DOTS clinic	2	SI/OB		
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of OPD services under NLEP	2	SI/RR		
		Assessment of Disability Status	2	SI/RR		
		Supply of Customized Foot wear	2	SI/RR		
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Availability of Functional ICTC	2	SI/OB		
		Availability of HIV Testing and Counselling	2	SI/RR		
		PPTCT Services for HIV positive Pregnant Women	2	SI/OB		
		Availability of Functional ART Centre	2	SI/OB		
		Availability of CD4 testing facility	2	SI/OB		
ME A4.5	The facility provides services under National Programme for prevention and control of Blindness as per guidelines	Screening and early detection of visual impairment and refraction	2	SI/RR	Refraction, syringing and probing, foreign body removal, Tonometry and retinoscopy	
		Availability of OPD procedures	2	SI/OB	Syringing and probing, foreign body removal , Tonometry ,Perimetry, Retinoscopy, Retrobulbar Injection	
ME A4.6	The facility provides services under Mental Health Programme as per guidelines	Availability of services under MHP	2		(a) Acute/ chronic headache Epilepsy, Dementia , Vertigo. (b) Anxiety disorders, Substance abuse	
		Availability of counselling centre for Suicide prevention	2	SI/OB		
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines	Dedicated Geriatric Clinic	2	SI/OB	(a)Dedicated OPD services for geriatric patients daily (b) Lab investigation & medicine for geriatric cases	
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Functional NCD clinic is available	2	SI/OB	(a) Diagnosis & management of cases of hypertension, diabetes, CVD, Stroke & cancer (b) Follow up chemotherapy cases (c) Rehabilitation and physiotherapy	
ME A4.10	The facility provide services under National health Programme for deafness	Management of case referred from PHC/CHC directly reported to Hospital	2	SI/RR		
ME A4.11	The facility provides services as per State specific health programmes	Availability of OPD services as per State Health Programs	2	SI/RR		
ME A4.14	The facility provides services as per National Viral Hepatitis Program	Availability of services under NVHCP	2	SI/RR	(a) Screening of the suspected cases of HBV & HCV (b) Confirmation of cases - Referral/ Linkage (c) Treatment of uncomplicated cases (d) Referral of complicated cases to Medical college/ Model Hepatitis Treatment Centre (e) Follow-up visits - after starting the treatment	
ME A4.15	The facility provide services under National Programme for palliative care	Availability of palliative care OPD	2	SI/RR	Frequency as mandated the state	
Standard A6	**Health services provided at the facility are appropriate to community needs.**					
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Special Clinics are available for local prevalent endemics	2	SI/OB	Ask for the specific local health problems/ diseases .i.e.. Kala azar, Swine Flue, arsenic poisoning etc.	
	Area of Concern - B Patient Rights					
Standard B1.	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
Standard B1	Facility provides the information to care seekers, attendants & community about the available services and their modalities		2			
ME B1.1	The facility has uniform and user-friendly signage system	Availability departmental signage's	2	OB	(Numbering, main department and internal sectional signage	
ME B1.2	The facility displays the services and entitlements available in its departments	List of OPD Clinics are available	2	OB		
		Timing for OPD are displayed	2	OB		
		Entitlements applicable are Displayed	2	OB	Entitlement under, PMJAY, JSY , JSSK, NSSK and other schemes	
		Important numbers like ambulance are displayed	2	OB		
ME B1.3	The facility has established citizen charter, which is followed at all levels	Display of citizen charter	2	OB		
ME B1.4	User charges are displayed and communicated to patients effectively	DELETED				
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC Material is displayed	2	OB	PMSMA, JSSK, JSY, PMJAY etc	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.	Availability of Enquiry Desk with dedicated staff	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	OPD slip with UID is given to the patient	2	RR/OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Separate queue for female at registration	2	OB		
		Separate toilets for male and female	2	OB		
		Availability of female staff if a male doctor examination a female patients	2	OB		
		Availability of Breast feeding corner	2	OB		
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy access to the OPD	2	OB		
		There is no chaos and over crowding in the OPD	2	OB	Measure are taken to reduce the overcrowding like appointment system/chaos/token system	
		Availability of specially abled friendly toilet	2	OB		
Standard B3	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen at Examination Area	2	OB		
		One Patient is seen at a time in clinics	2	OB		
		Privacy at the counselling room is maintained	2	OB		
ME B3.2	Confidentiality of patients records and clinical information is maintained	Confidentiality of HIV reports at ICTC	2	SI/OB		
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV, Leprosy Patients	2	SI/OB	Check in RTI/STI clinic	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent for before HIV testing at ICTC	2	SI/RR		
ME B4.2	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.	2	OB		

ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient is informed about her clinical condition and treatment been provided	2	PI	Ask patients about what they have been communicated about the treatment plan	
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re redressal and whom to contact is displayed	2	OB		
Standard B5	Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free OPD Consultation / ANC Check-ups	2	PI/SI	For JSSK entitlement	
ME B5.2	The facility ensures that Medicines prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing Medicines or consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.	2	PI/SI		
ME B5.4					Deleted	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	If any other expenditure occurred it is reimbursed from hospital	2	PI/SI/RR		
	Area of Concern - C Inputs					
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms					
ME C1.1	Departments have adequate space as per patient or work load	Clinics has adequate space for consultation and examination	2	OB	Adequate Space in Clinics (12 sq. ft)	
		Availability of adequate waiting area	2	OB	Waiting area at the scale of 1 sq. ft per average daily patient with minimum 400 sq. ft of area	
ME C1.2	Patient amenities are provide as per patient load	Availability of seating arrangement in waiting area	2	OB	As per average OPD at peak time	
		Availability of sub waiting at for separate clinics	2	OB	For clinics has high patient load	
		Availability of cold Drinking water	2	OB	See if its is easily accessible to the visitors	
		Availability of functional toilets	2	OB	Urinals 1 per 50 person water closet and wash basins 1 per 100 person	
		Availability of patient calling system	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions	There is designated area for registration	2	OB		
		Dedicated clinic for each speciality	2	OB		
		Dedicated examination areas is provided with each clinics	2	OB		
		Demarcated dressing area /room	2	OB		
		Demarcated injection room	2	OB		
		Demarcated immunization room for pregnant women and children		OB		
		availability of clean and dirty utility room	2	OB		
		Demarcated trolley/wheelchair bay	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors at OPD are broad enough to manage stretcher and trolleys	2	OB		
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	Availability of Registration counters as per Patient load	2	OB	Average Time taken for registration would be 3-5 min so number of counter required would be worked on scale of 12-20 patient/hour per counter	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services	2	OB	Layout of OPD shall follow functional flow of the patients, e.g.: Enquiry→Registration→Waiting→Sub-waiting→ Clinic Dressing room/Injection Room→ Diagnostics (lab/X-ray)→Pharmacy→Exit	
		All OPD clinics and related auxiliary services are co located in one functional area	2	OB		
Standard C2	The facility ensures the physical safety of the infrastructure.					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	OPD building does not have temporary connections and loosely hanging wires	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the OPD are non slippery and even	2	OB		
		Windows have grills and wire meshwork	2	OB		
Standard C3	The facility has established Programme for fire safety and other disaster					
ME C3.1	The facility has plan for prevention of fire	OPD has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	OPD has installed fire Extinguisher that is Class A , Class B C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2			
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of specialist Doctor at OPD time	2	OB/RR	(a) Check for specialist are available at scheduled time (b) 1 OBG specialist per 100 ANC - regular or private - for PMSMA	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor at Screening Clinic	2	OB/RR		
		Availability of General duty doctor at PMSMA	2	OB/RR		
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	At Injection room/ OPD Clinic as Per Requirement	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of dresser/paramedic at dressing room	2	OB/SI		
		Counsellor for ICTC	2	SI/RR	Full Time	
		Lab technician for ICTC	2	SI/RR	Full time	
		Counsellor for AFHS clinic	2	SI/RR		
		Availability of ECG technician	2	SI/RR		
		Availability of Audiometrician	2	SI/RR		
		Availability of Ophthalmic assistant	2	SI/RR		
		Availability of Physiotherapist	2	SI/RR		
		Availability of Dental technician	2	SI/RR		
		Availability of rehabilitation therapist	2	SI/RR		
ME C4.5	The facility has adequate support / general staff	availability of dedicated security guard for OPD	2	SI/RR		
		Availability of registration clerks as per load	2	SI/RR		
		Availability of housekeeping staff	2	SI/RR		
Standard C5	Facility provides Medicines and consumables required for assured list of services.					

ME C5.1	The departments have availability of adequate Medicines at point of use	Availability of injectables at injection room	2	OB/RR	ARV, TT	
		Availability of drugs for management of GDM	2		Metformin & insulin	
ME C5.2	The departments have adequate consumables at point of use	Availability of disposables at dressing room and clinics	2	OB/RR	Examination gloves, Syringes, Dressing material , suturing material	
		HIV testing Kits I, II and III at ICTC	2	OB/RR		
		Availability of glucometer & OGTT	2		for screening of GDM	
ME C5.3	Emergency Medicine trays are maintained at every point of care, where ever it may be needed	Emergency Medicine Tray is maintained at injection room & immunization room	2	OB/RR		
Standard C6	The facility has equipment & instruments required for assured list of services.					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, thermometer, weighting machine, torch, stethoscope, Examination table	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional Instruments/Equipment for Gynae and obstetric	2	OB	PV examination kit, Inch tape, fetoscope, Weighting machine, BP apparatus etc.	
		Availability of functional Equipment/Instruments for Orthopaedic Procedures	2	OB	X ray view box, Equipment for plaster room	
		Availability of functional Instruments / Equipment for Ophthalmic Procedures	2	OB	Retinoscope, refraction kit, tonometer, perimeter, distant vision chart, Colour vision chart.	
		Availability of Instruments/ Equipment Procedures for ENT procedures	2	OB	Audiometer, Laryngoscope, Otoscope, Head Light, Tuning Fork, Bronchoscope, Examination Instrument Set	
		Availability of functional Instruments/ Equipment for Dental Procedures	2	OB	Dental chair, Air rotor, Endodontic set, Extraction forceps	
		Availability of functional Equipment/Instruments of Physiotherapy Procedures	2	OB	Traction, Wax bath, Short Wave Diathermy, Exercise table Etc .	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Equipment for ICTC lab	2	OB	Micropipettes, Centrifuge, Needle destroyer, Refrigerators	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for Medicines	2	OB	Refrigerator, Crash cart/Medicine trolley, instrumental trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
		Availability of equipment for sterilization and disinfection	2	OB	Boiler	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of Fixtures	2	OB	Spot light, electrical fixture for equipment, X ray view box	
		Availability of furniture at clinics	2	OB	Doctors Chair, Patient Stool, Examination Table, Attendant Chair, Table, Footstep, cupboard	
Standard C7	Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff					
ME C7.1					DELETED	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Check the competency of staff to use OPD equipment like BP apparatus etc	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		At ANC clinic staff is skilled to identify high risk pregnancies	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for maintaining clinical records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	BP apparatus, thermometer are calibrated	
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of Medicines in pharmacy and patient care areas					
ME D2.1	There is established procedure for forecasting and indenting Medicines and consumables	There is established system of timely indenting of consumables and Medicines	2	SI/RR	Stock level are daily updated Indents are timely placed	
ME D2.3	The facility ensures proper storage of Medicines and consumables	Medicines are stored in containers/tray/crash cart and are labelled	2	OB	Labelled with Medicine name, Medicine strength and expiry date	
		Empty and filled cylinders are labelled	2	OB		
ME D2.4	The facility ensures management of expiry and near expiry Medicines	Medicines expiry dates' are maintained at emergency Medicine tray	2	OB/RR		
		No expired Medicine found	2	OB/RR		
		Records for expiry and near expiry Medicines are maintained for Medicine stored at department	2	RR	Check register/DVDMS/other supply chain software for record of stock of expired and near expiry Medicines	
ME D2.5	The facility has established procedure for inventory management techniques	There is established system of calculating and maintaining buffer stock	2	SI/RR		
		Department maintained stock register of drugs and consumables	2	SI/RR	Check record of drug received, issued and balance stock in hand and are updated	
ME D2.6	There is a procedure for periodically replenishing the Medicines in patient care areas	There is established procedure for replenishing drug tray /crash cart	2	SI/RR		
		There is no stock out of drugs	2	SI/RR	Random stock check of some essential medicines. E.g. Paracetamol, Atenolol, Amlodipine, Azithromycin, etc.	
ME D2.7	There is process for storage of vaccines and other Medicines, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day	
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination in clinics	2	OB	Examination table	
		Adequate Illumination in procedure area	2	OB	Dressing room, injection room and immunization room	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Only one patient is allowed one time at clinic	2	OB/SI		
		Limited number of attendant/ relatives are allowed with patient	2	OB/SI		
		Medical representative are restricted in OPD timings	2	OB/SI		

ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in waiting areas	2	PI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation in clinics	2	SI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4	The facility has security system in place at patient care areas	Hospital has sound security system to manage overcrowding in OPD	2	OB/SI		
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Patients beds are intact and painted	2	OB		
		Mattresses are intact and clean	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material lying in the OPD	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OPD	2	OB/SI		
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor	2	RR/SI		
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Availability of linen in examination area	2	OB		
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration	2	RR		
		Patient demographic details are recorded in OPD registration records	2	RR	Check for that patient demographics like Name, age, Sex, Address etc.	
		Patients are directed to relevant clinic by registration clerk based on complaint	2	PI/SI		
ME E1.2	The facility has a established procedure for OPD consultation	There is procedure for systematic calling of patients one by one	2	OB	Patient is called by Doctor/attendant as per his/her turn on the basis of "first come first examine" basis.	
		Patient History is taken and recorded	2	RR	Check OPD records for the same	
		Physical Examination is done and recorded wherever required	2	OB/RR	Check details of the physical examination, provisional diagnosis and investigations (if any) is mentioned in the OPD ticket	
		Provisional Diagnosis is recorded	2	OB/RR	Check treatment plan and confirmed diagnosis is recorded	
ME E1.3	There is established procedure for admission of patients	There is establish procedure for admission through OPD	2	SI/RR		
		There is establish procedure for day care admission	2	SI/RR		
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	There is screening clinic for initial assessment of the patients	2	OB		
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation	2	SI/RR		
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check treatment/care plan is prepared as per patient's need	2	SI/RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during departmental transfer	2	SI/RR		
		There is a procedure consultation of the patient to other specialist with in the hospital	2	SI/RR		
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	Availability of referral linkages for OPD consultation.	2	RR/OB	(a) Check how patient are referred if services are not available (b) Check the referral linkage for PMSMA	
		Facility has functional referral linkages to higher facilities	2	SI/RR		

		There is a system of follow up of referred patients	2	RR	1. Check referral out record is maintained 2. Check randomly with the referred cases (contact them) for completion of treatment or follow up.	
ME E3.4	Facility is connected to medical colleges through telemedicine services	Telemedicine service are used for consultation	2	RR/SI		
		Patient records are maintained for the cases availing the telemedicine services	2	RR/PI	Check the records for completion.	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	For any critical patient needing urgent attention queue can be bypassed for providing services on priority basis	2	OB/SI		
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	Facility ensured that Medicines are prescribed ias per the prescription policy of ESIC	Check for OPD slip if Medicines are prescribed as per the prescription policy	2	RR	Check for: 1. No. of medicines prescribed 2. High-end antibiotics are not prescribed 3. polypharmacy 4. No of multivitamins prescribed 5. No of injectables prescribed 6. Medicines are prescribed from EML	
		A copy of Prescription is kept with the facility	2	RR		
ME E6.2	There is procedure of rational use of Medicines	Check for that relevant Standard treatment guideline are available at point of use	2	RR	TO DISCUSS	
		Availability of Medicine formulary	2	SI/OB		
ME E6.3		DELETED				
Standard E7	**Facility has defined procedures for safe Medicine administration**					
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and sienature	2	RR		
ME E7.3	There is a procedure to check Medicine before administration/ dispensing	Medicines are checked for expiry and other inconsistency before administration	2	OB/SI	Check in Injection room	
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content intended to be used later on	
		Check for separate sterile needle is used every time for multiple dose vial	2	OB	In multi dose vial needle is not left in the septum	
		Any adverse Medicine reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events	
ME E7.5	Patient is counselled for self Medicine administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings .	2	SI/PI		
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Patient History, Chief Complaint and Examination Diagnosis/ Provisional Diagnosis is recorded in OPD slip	2	RR	(Manually/e-records)	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Written Prescription Treatment plan is written	2	RR	(Manually/e-records)	
ME E8.4	Procedures performed are written on patients records	Any dressing/injection, other procedure recorded in the OPD slip	2	RR	(Manually/e-records)	
ME E8.5	Adequate form and formats are available at point of use	Check for the availability of OPD slip, Requisition slips etc.	2	OB/SI		
ME E8.6	Register/records are maintained as per guidelines	OPD records are maintained	2	OB/RR	OPD register, ANC register, Injection room register etc	
		All register/records are identified and numbered	2	OB/RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of OPD records	2	OB/SI		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.3	There are established procedures for Post-testing Activities	Clinics is provided with the critical value of different tests	2	SI/RR		
	Maternal & Child Health Services					
Standard E17	**Facility has established procedures for Antenatal care as per guidelines**					
ME E17.1	There is an established procedure for Registration and follow up of pregnant women.	Facility provides and updates "Mother and Child Protection Card".	2	RR/SI	Line listing	
		Records are maintained for ANC registered pregnant women	2	RR	Records of each ANC check-ups is maintained in Mother and child protection card	
ME E17.2	There is an established procedure for History taking, Physical examination, and counselling for each antenatal visit.	ANC check-ups is done by Qualified personnel	2	RR/SI		
		At ANC clinic, Pregnancy is confirmed by performing urine test	2	RR/SI		
	TO DISCUSS	Last menstrual period (LMP) is recorded and Expected date of Delivery (EDD) is calculated	2	RR/SI		
		Assessment of Clinical condition of pregnant women & foetus during all ANC Check-up	2	RR/SI	Gestational Age, general & systemic examination including breast examination , medical, surgical & personal history etc	
		Weight & Blood pressure measurement	2	RR/SI		
		Pallor, oedema and icterus.	2	RR/SI		
		Abdominal palpation for foetal growth, foetal lie	2	RR/SI		
		Auscultation for foetal heart sound	2	RR/SI		
		PV examination during 4th ANC	2	RR/SI	to check pelvic adequacy - in 37 weeks	
		4 ANC & 1 PMSMA check-ups of women is done	2	RR/SI		
		Identification & Management of hypertensive disorders	2	RR/SI	(a) Confirm hypertension & identify the pregnant women with severe PE/E (b) Manage hypertension as per guidelines	
		Management of the Syphilis reactive pregnant women	2	RR/SI	(a) Treatment as per the guidelines (b) Quantitative & qualitative RPR/VDRL test (c) Test/treat the spouse/partner	
		Management of the Syphilis non reactive high risk pregnant women	2	RR/SI	Retest high-risk women in third trimester or soon after delivery	

		Management of pregnant women with GDM	2		(a) Medical Nutrition Therapy (MNT) & Physical exercise for 2 weeks (b) After 2 weeks of MNT & physical exercise - 2hrs PPBS - if 2hrs PPBS is less than 120mg/dl- repeat the test as per protocol- one test every month during 2nd & 3rd trimesters - if 2hrs PPBS is more 120mg/dl - medical management (metformin or insulin therapy to be started as per guidelines (c) Foetal surveillance - Foetal auscultation in Antenatal visit	
		Identification & management of hypothyroidism	2		(a) Screening of high-risk Pregnant women (Areas with moderate to severe iodine deficiency, obesity, history - of thyroid dysfunction/ surgery, to first-degree relatives, mental retardation, autoimmune disease, frequent miscarriage, pre-term delivery etc.) (b) Hormonal assay - TSH & FT4 (c) Treatment as per guidelines- Levothyroxine	
ME E17.3	Facility ensures availability of diagnostic and Medicines during antenatal care of pregnant women	Diagnostic test under ANC check up are prescribed by ANC clinic	2	RR/SI	Check for Haemoglobin, urine albumin, urine sugar, blood group and Rh factor ,Syphilis (VDRL/RPR) HIV, blood sugar, malaria & Hepatitis B	
		Oral glucose tolerance test (OGTT) is done for all pregnant women	2	RR/SI	(a) Universal screening of all pregnant women at the time of first antenatal contact. (b) if the first test is negative second test - 24-28 week of gestation	
ME E17.4	There is an established procedure for identification of High risk pregnancy and appropriate treatment/referral as per scope of services.	High risk pregnant women are referred to specialist	2	RR/SI	(a) PIH, GDM, Malaria, HIV, syphilis, APH, (b) From ANC clinic to PMSMA (c) Sticker indicating the risk factor/ condition of the pregnant woman - placed in MCP card in PMSMA	
ME E17.5	There is an established procedure for identification and management of moderate and severe anaemia	Line listing of pregnant women with moderate and sever anaemia	2	RR/SI		
		Provision for Injectable Iron Treatment for moderate anaemia	2	RR/SI		
ME E17.6	Counselling of pregnant women is done as per standard protocol and gestational age	Nutritional counselling	2	RR/PI		
		Nutrition & Rest	2	RR/PI	Iron, folic acid & calcium supplementation	
		Recognizing danger sign of labour	2	RR/PI		
		Breast feeding	2	RR/PI		
		Institutional delivery	2	RR/PI		
		Arrangement of referral transport	2	RR/PI		
		Birth preparedness	2	RR/PI		
		Family planning	2	RR/PI		
Standard E22	**Facility provides Adolescent Reproductive and Sexual Health services as per guidelines**					
ME E22.1	Facility provides Promotive ARSH Services	Provision of Antenatal natal check up for pregnant adolescent	2	SI/RR	Nutritional Counselling, contraceptive counselling, Couple counselling ANC check-ups, ensuring institutional delivery	
		Counselling and provision of emergency contraceptive pills	2	SI/RR	Check for the availability of Emergency Contraceptive pills (Levonorgestrel)	
		Counselling and provision of reversible Contraceptives	2	RR/SI	Check for the availability of Oral Contraceptive Pills, Condoms and IUD	
		Availability and Display of IEC material	2	OB	Poster Displayed, Reading Material handouts etc.	
		Information and advice ob. sexual and reproductive health related issues	2	SI/RR	Advice on topic related to Growth and development,puberty,sexuality cancers, myths & misconception, pregnancy, safe sex, contraception, unsafe abortion, menstrual disorders,anemia, sexual abuse ,RTI/STI's etc.	
ME E22.2	Facility provides Preventive ARSH Services	Services for Tetanus immunization	2	SI/RR	TT at 10 and 16 year	
		Services for Prophylaxis against Nutritional Anaemia	2	SI/RR	Haemoglobin estimation, weekly IFA tablet, and treatment for worm infestation	
		Nutrition Counselling	2	SI/RR		
		Services for early and safe termination of pregnancy and management of post abortion complication	2	SI/RR	MVA procedure for pregnancy up to 8 week Post abortion counselling	
ME E22.3	Facility Provides Curative ARSH Services	Treatment of Common RTI/STI's	2	SI/RR	Privacy and Confidentiality, treatment Compliance, Partner Management, Follow up visit and referral	
		Treatment and counselling for Menstrual disorders	2	SI/RR	Symptomatic treatment , counselling	
		Treatment and counselling for sexual concern for male and female adolescents	2	SI/RR		
		Management of sexual abuse amongst Girls	2	SI/RR	ECP, Prophylaxis against STI, PEP for HIV and Counselling	
ME E22.4	Facility Provides Referral Services for ARSH	Referral Linkages to ICTC and PPTCT	2	SI/RR		
		Privacy and confidentiality maintained at ARSH clinic	2	SI/RR	Screens and curtains for visual privacy,confidentaility policy displayed, one client at a time	
Standard E23	**Facility provides National health program as per operational/Clinical Guidelines**					
ME E23.1	Facility provides service under National Vector Borne Disease Control Program as per guidelines	Ambulatory care of uncomplicated P. Vivax malaria	2	SI/RR	As per Clinical Guidelines for Treatment of Malaria	
		Ambulatory care of uncomplicated P. Falciparum Malaria	2	SI/RR	As per Clinical Guidelines for Treatment of Malaria	
		Ambulatory care of Medicine resistant malaria	2	SI/RR	As per Clinical Guidelines for Treatment of Malaria	
ME E23.2	Facility provides service under National TB Elimination Program as per guidelines	Staff is aware of symptoms or signs Presumptive pulmonary TB as per revised guidelines	2	SI/RR	Cough >2 weeks, fever >2 weeks, significant weight loss, haemoptysis, any abnormalities in chest radiography. Addition, contact of microbiologically confirmed TB patients, PL HIV, diabetics, malnourished, cancer patients, patients on immunosuppressive therapy	
		Staff is aware of Signs and symptoms of Extra pulmonary Tuberculosis	2	SI/RR	Organ specific symptoms and signs like swelling of lymph nodes, pain & swelling in joints, neck stiffness, disorientation, etc or constitutional symptoms like weight loss, fever> 2 weeks night sweat	
		Staff is aware of signs and symptoms of presumptive paediatric TB cases as per revised guidelines	2	SI/RR	Child with persistent fever and/ or cough for more than 2 weeks. Unexplained Loss of weight/no weight gain in past 3 months/here loss of body weight loss of >5% body weight as compared to highest weight recorded in the last 3 months.	
		Staff is aware of presumptive DRTB cases as per revised guidelines	2	SI/RR	(1)TB patients who have failed treatment with first-line anti-tubercular Medicines (ATD). (2)Paediatric TB non-responded. (3)TB patients who are contacts of DRTB. (4)TB patients who are found positive on any follow-up sputum smear examination during treatment with first-line ATD. (5) Previously treated TB cases (6)TB patients with HIV co-infection	

		Staff is aware of classification done on the basis of Medicine resistance as per revised guidelines	2	SI/RR	1. Mono resistance (MR) – Biological specimen of TB Patient resistant to one first line anti TB Medicine only. 2. Poly resistance (PDR) – Biological specimen resistant to more than one anti TB Medicine, other than INH & Rifampicin. 3. Multi-Medicine resistance (MDR) – Biological specimen resistant to both INH and Rifampicin or with or without resistance to other first line ATD 4. Rifampicin resistance (RR) – Resistance to Rifampicin detected by phenotypic or genotypic method with or without resistant to other ATD excluding INH. Patient with RR manged as if MDR-TB case. 5. Extensive Medicine resistance- MDR TB case whose biological specimen resistant to Fluroquinolone (FQ) and a second line injectable ATD	
		Diagnosis and treatment of Presumptive pulmonary TB as per revised guidelines	2	RR/SI	All the presumptive TB cases undergo sputum smear examination (spot early morning or spot-spot). If first sputum is positive not at risk of DRTB, it is microbiologically confirmed. Treatment of New Cases: Treatment in IP will consist of 8weeks of INH, Rifampicin, Pyrazinamide and Ethambutol in daily dose as per weight band categories. Only Pyrazinamide will be stopped in CP rest 3 Medicines will be continue for 16 weeks. (Daily regimen with administration of daily fixed dose combination of first line ATD as per weight band)	
		Diagnosis and treatment of smear positive and presumptive multi Medicine resistance TB (MDR-TB) as per revised guidelines	2	RR/SI	Cartridge based Nucleic Acid Amplification test (CBNAAT) performed to rule out Rifampicin resistance and categorized as microbiologically confirmed Medicine sensitive TB or RIF resistant. Treatment: IP will be of 12 weeks, where injection Streptomycin will be stopped after 8 weeks and remaining four Medicines in daily dose for another 4 weeks as per weight band. At CP, Pyrazinamide will be stopped while rest of Medicines will be continue for another 20 weeks as daily dosage	
		Diagnostic algorithm for pulmonary, extra pulmonary and paediatric TB as per revised guidelines are readily available	2	RR/SI	Check algorithm for all the three cases are available.	
		Management of extra pulmonary TB cases as per revised guidelines	2	RR/SI	The CP in both new and previously treated cases may be extended 3-6 months in cases such as CNS, skeletal etc. ATD given in fixed dose on daily basis as per weight band	
		Management of MDR/RRTB(without additional resistance) as per revised guidelines	2	RR/SI	6-9 months of IP with Kanamycin, Levofloxacin, Ethambutol, Pyrazinamide, Ethionamide, And Cyclomerize. !8 month of CP with Levofloxacin, Ethambutol, Ethionamide, And Cyclomerize	
		Management of Paediatric Tuberculosis	2	SI/RR	As per revised RNTCP Technical Guidelines	
		Management of Patients with HIV infection and Tuberculosis	2	SI/RR	As per revised RNTCP Technical Guidelines	
		Patient and family is counselled before initiating TB treatment	2	SI/PI/RR	Educate patient and family about disease, dose schedule, duration, common side effects, methods of prevention, consequence of irregular treatment or premature cessation of treatment	
		Treatment card and TB identity card is given	2	PI/RR	Treatment card will be issued in duplication if required	
		Monitoring and follow up of patient done as per protocols	2	SI/RR	Clinical follow up: Should be at least monthly – the patient may visit the clinical facility or medical officer call for review may even visit the house of patient. Laboratory follow up: Sputum smear examination at the end of IP & end of treatment (for every patient) Long term follow up: After completion of treatment, the patient should be followed up at the end of 6, 12, 18 and 24 months. Any clinical symptoms and/or cough, sputum microscopy and/or culture should be considered.	
		There is functional Linkage between DMC and ICTC	2	SI/RR		
ME E23.3	Facility provides service under National Leprosy Eradication Program as per guidelines	Validation and Diagnosis of Referred and Directly Reported Cases	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Treatment of all diagnosed cases including Reaction and Neuritis	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Assessment of Disability Status	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Management of Lepra Reactions	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Management of Complicated Ulcers	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Management of Eye Complications	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Physiotherapy including Pre and Post Operative Care	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Follow-up of cases treated at tertiary Level	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Supply of Customized Foot wear	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Self care Counselling	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Outreach Services to Leprosy Clinics	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
		Screening of Cases of RCS	2	SI/RR	As per Operation/ Clinical Guidelines of NLEP	
ME E23.4	Facility provides service under National AIDS Control program as per guidelines	Pre Test Counselling is done as per protocols	2	SI/RR	basic information and benefits of HIV testing potential risks such as discrimination. The client is also informed about their right to refuse, follow-up services . Pregnant women are given additional information on nutrition, hygiene, the importance of an institutional delivery and HIV testing so as to avoid HIV transmission from mother to child.	
		Post test counselling given as per protocol	2	SI/RR	window period, a repeat test is recommended, clients with suspected tuberculosis are referred to the nearest microscopy centre. In case of a positive test result, the counsellor assists the client to understand the implications of the positive test result and helps in coping with the test result. The counsellor also ensures access to treatment and care, and supports disclosure of the HIV status to the spouse.	
		Diagnosis and treatment of opportunistic Infections	2	SI/RR	As per NACO guidelines	
		Screening of PLHA for initiating ART	2	SI/RR	As per NACO guidelines	
		Monitoring of patients on ART and management of side effects	2	SI/RR	As per NACO guidelines	
		Counselling and Psychological support for PLHA	2	SI/RR	As per NACO guidelines	

ME E23.6	Facility provides service under Mental Health Program as per guidelines	Identification and treatment of mental illness as per guidelines	2		(a) Management of the acute psychosis, obsession, anxiety, depression, neurosis & epilepsy (b)Ensure availability medicines & regular follow up (c) Referferal of the cases as per requirement	
		Identification of the cases for substance abuse	2	SI/RR	Treat/ refer to the de addiction centre	
		Psychosocial support is provided	2	SI/RR	(a) Basic psycho education about treatment adherence (b) Motivation enhancement (c) Reduction of high risk behaviour (d) Relapse prevention (e) Counselling for occupational rehab. (d) Patient support group / individual counselling	
ME E23.7	Facility provides service under National programme for the health care of the elderly as per guidelines	Geriatric Care is provided as per Clinical Guidelines	2	SI/RR	(a) Linkage with specialists like medicine, ortho, health., ENT services (b) Referral services to Regional Geriatric centre/MC	
ME E23.8	Facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines	Opportunistic screening for diabetes, hypertension, cardiovascular diseases	2	SI/RR	Screening of persons above age of 30 - History of tobacco examination, BP Measurement and Blood sugar estimation Look for records at NCD clinic	
		Screen women of the age group 30-69 years approaching to the hospital	2	SI/RR	for early detection of cervix cancer and breast cancer	
		Health Promotion through IEC and counselling	2	OB	Increased intake of healthy foods, Increased physical activity through sports, exercise, etc.; Avoidance of tobacco and alcohol; stress management & warnine siens of cancer etc	
		Counselling the identified cases for self care	2	PI/RR	Council the patient for monitoring of their BP (using digital BP apparatus) , sugar (using glucometer) , self care for ulcer etc	
ME E23.9	Facility provide service for Integrated disease surveillance program	Weekly reporting of Presumptive cases on form "P" from OPD clinic	2	SI/RR	(a) Submitted to District surveillance officer (b) Data is submitted manually or through IHIP (integrated health information platform)	
ME E23.10	Facility provide services under National program for prevention and control of deafness	Early detection and screening for detection of deafness	2	SI/RR	As per Clinical guidelines	
ME E23.11	Facility provides services under National Viral Hepatitis Control Programme	Assessment & treatment of uncomplicated cases of Viral Hepatitis	2	SI/RR	(a) Routine assessment of HBsAg & LFT (b) Assessment of the severity of liver disease (c) Management of the cases with evidence of compensated or decompensated cirrhosis- as per guidelines	
		Follow up of the cases of the Viral Hepatitis	2	SI/RR	(a) Medication refill- after 25 days (b) Educate the patient on adherence & regular follow up (c) Check for side effects & investigate as per requirements & guidelines (d) Update the investigation in the treatment card	
ME E 23.12	Facility provide services under National program for palliative care	Clinical assessment by trained & competent physician	2	SI/RR	(a) Assessment, treatment plan & prescription for cases (b) Pain Management (c) Counselling & psycho social interventions	
	Area of Concern - F Infection Control					
Standard F1	Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection					
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxic etc	
		Periodic medical check-ups of the staff	2	SI/RR		
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin, elbow operated tap near the point of use	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3	Facility ensures standard practices and materials for Personal protection					
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the gloves	2	SI	Gloves, Masks, Cap, Aprons etc	
Standard F4	Facility has standard Procedures for processing of equipment and instruments					
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , dressing table, Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like Stethoscope, Dressing Instruments, Examination Instruments, Blood Pressure Cuff etc (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/HLD/Chemical Sterilization	
		Autoclaved dressing material is used	2	OB/SI		
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention					
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic	2	OB		

		Clinics for infectious diseases are located away from main traffic	2	OB	Preferably in remote corner with independent access	
		Sitting arrangement in TB clinic is as per guideline	2	OB		
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipment like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB		
		Availability of colour coded non chlorinated plastic bags	2	OB	Adequate number. Covered. Foot operated.	
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle	
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2			
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	There is a designated departmental nodal person for coordinating Quality Assurance activities	2	SI/RR	1. Check if the quality circle has been constituted and is functional 2. Roles and Responsibility of quality circle has been defined	
Standard G2	**Facility has established system for patient and employee satisfaction**					
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	OPD Patient satisfaction survey done on monthly basis	2	RR		
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR		
ME G3.2	Facility has established external assurance programs at relevant departments	External Quality assurance program is established at ICTC lab	2	SI/RR		
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	1. NQAS assessment toolkit is used to conduct internal assessment 2. SaQushal assessment toolkit	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5		DELETED				
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	Relevant protocols are displayed like Clinical Protocols for ANC check-ups	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	OPD has documented procedure for Registration	2	RR		
		OPD has documented procedure for patient calling system in OPD clinics	2	RR		
		OPD has documented procedure for receiving of patient in clinic	2	RR		
		OPD has documented process for OPD consultation	2	RR		
		OPD has documented procedure for investigation	2	RR		
		OPD has documented procedure for prescription and Medicine dispensing	2	RR		
		OPD has documented procedure for nursing process in OPD	2	RR		
		OPD has documented procedure for patient privacy and confidentiality	2	RR		
		OPD has documented procedure for conducting, analysing patient satisfaction survey	2	RR		
		OPD has documented procedure for equipment management and maintenance in OPD	2	RR		

		Department has documented procedure for Administrative and non clinical work at OPD	2	RR		
		OPD has documented procedure for duty roaster, punctuality, dress code and identity for OPD staff	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1		DELETED				
ME G5.2		DELETED				
ME G5.3		DELETED				
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1		DELETED				
ME G7.2		DELETED				
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/PI	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co-ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct prescription audits	2	SI/RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings	
		All non compliance are enumerated recorded for prescription audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per prescription audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	Proportion of follow-up patients	2	RR		
		No of ANC done per thousand	2	RR		
		ART patient load per thousand	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Medicine OPD per Doctor	2	RR		
		Surgery OPD per Doctor	2	RR		
		OBG OPD per Doctor	2	RR		
		Dental OPD per Doctor	2	RR		
		Ophthalmology OPD per doctor	2	RR		
		Skin & OPD per doctor	2	RR		
		TB/DOT pod per doctor	2	RR		
		ENT OPD per doctor	2	RR		
		Psychiatry OPD per doctor	2	RR		
		AYUSH OPD per doctor	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Consultation time at ANC Clinic	2	RR	Time motion study	
		Consultation time at General Medicine Clinic	2	RR		
		Consultation time for General Surgery Clinic	2	RR		
		Proportion of High risk pregnancy detected during ANC	2	RR	No of High Risk Pregnancies X100/ Total no PW used ANC services in the month	
		Proportion of severe anaemia cases	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					

ME H4.1	Facility measures Service Quality Indicators on monthly basis	Patient Satisfaction Score	2	RR		
		Waiting time at registration counter	2	RR		
		Waiting time at ANC Clinic	2	RR		
		Waiting time at general OPD	2	RR		
		Waiting time at paediatric Clinic	2	RR		
		Waiting time at surgical clinic	2	RR		
		Average door to Medicine time	2	RR		

National Quality Assurance Standards for District Hospitals					Version: DH/NQAS-2020/00
Checklist for Labour Room					3
Assessment Summary					
Name of the Hospital			Date of Assessment		
Names of Assessors			Names of Assessees		
Type of Assessment (Internal/Peer/External)			Action plan Submission Date		

Labour room Score Card

Area of Concern wise Score			LaQshya Labour Room Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	

	Strengths / Good Practices
1	
2	
3	
4	
5	

	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	

	Signature of Assessors	
	Date	

Reference No	Measurable Element	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	The facility provides Curative Services					
ME A1.14	Services are available for the time period as mandated	Labour room service is functional 24X7	2	SI/RR	Verify with records that deliveries have been conducted in night on regular basis	
Standard A2	The facility provides RMNCHA Services					
ME A2.1	The facility provides Reproductive health Services	Availability of Post Partum IUD insertion services	2	SI/RR	Verify with records that PPIUD services have been offered in labour room	
ME A2.2	The facility provides Maternal health Services	Availability of Vaginal Delivery services	2	SI/RR	Normal vaginal & assisted (Vacuum / Forceps) delivery	
		Availability of Pre term delivery services	2	SI/RR	Check if pre term delivery are being conducted at facility and not referred to higher centres unnecessarily	
		Management of Postpartum Haemorrhage	2	SI/RR	Check if Medical /Surgical management of PPH is being done at labour room	
		Management of Retained Placenta	2	SI/RR	Check staff manages retained placenta cases in labour room . Verify with records	
		Septic Delivery & Delivery of HIV positive Pregnant Women	2	SI/RR	Check if infected delivery cases are managed at labour room and not referred to higher centres unnecessarily	
		Management of PIH/Eclampsia/ Pre eclampsia	2	SI/RR	Check services for management of PIH/ Eclampsia are being proved at labour room	
ME A2.3	The facility provides Newborn health Services	Availability of New born resuscitation	2	SI/OB	Check if labour room has a functional New born resuscitation services available in labour room	
		Availability of Essential new born care	2	SI/OB	Check essential newborn care provisions such as Keeping baby on mother's abdomen, immediate drying of baby, Skin to skin contact, delayed chord clamp, initiation of breast feeding, recording of vitals and Vit. K are provided	
Standard A3	The facility Provides diagnostic Services					
ME A3.2	The facility Provides Laboratory Services	24 *7 Availability of point of care diagnostic tests	2	SI/OB	HIV, Hb% , Random blood sugar , Protein Urea Test	
	Area of Concern - B Patient Rights					
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental signage's	2	OB	Numbering, main department and internal sectional signage, Restricted area signage displayed. Directional signages are given from the entry of the facility	
ME B1.2	The facility displays the services and entitlements available in its departments	Necessary Information regarding services provided is displayed	2	OB	Name of doctor and Nurse on duty are displayed and updated. Contact details of referral transport / ambulance displayed	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC Material is displayed	2	OB	Breast feeding, kangaroo care, family planning etc (Pictorial and chart) in circulation & waiting area	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB	Check all information for patients/ visitors are available in local language	
Standard B2	Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.					

ME B2.1	Services are provided in manner that are sensitive to gender	Only on duty staff is allowed in the labour room when it is occupied	2	OB	Pregnant woman, her birth companion, doctor, nurse/ANM on duty, and other support staff only, is allowed in the labour room	
ME B2.3	Access to facility is provided without any physical barrier & friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the labour room	2	OB		
		Availability of ramps and railing & Labour room is located at ground floor	2	OB	If not located on the ground floor availability of the ramp / lift with person for shifting	
ME B2.4	There is no discrimination on basis of social and economic status of the patients	Check care to pregnant women is not denied or differed due to discrimination	2	OB/PI	Discrimination may happen because of religion, caste, ethnicity, cast, language, paying capacity and educational level.	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen/ partition at delivery tables	2	OB	Screens / Partition has been provided from three side of the delivery table or Cubicle for ensuring visual privacy	
		Curtains / frosted glass have been provided at windows	2	OB	Check all the windows are fitted with frosted glass or curtains have been provided	
		No two women are treated on common bed/ Delivery Table	2	OB/PI	Check that observation beds and delivery tables are not shared by multiple women at the same time because of any reason	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB	Check records are not lying in open and there is designated space for keeping records with limited access. Records are not shared with anybody without permission of hospital administration	
ME B3.3	The facility ensures the behaviour of staff is dignified and respectful, while delivering the services	Behaviour of labour room staff is dignified and respectful	2	OB/PI	Check that labour staff is not providing care in undignified manner such as yelling, scolding , shouting, blaming and using abusive language, unnecessary touching or examination	
		Pregnant women is not left unattended or ignored during care in the labour room	2	OB/PI	Check that care providers are attentive and empathetic to the pregnant women at no point of care they are left alone.	
		Care provided at labour room is free from physical abuse or harm	2	OB/PI	Check if the physical abuse practices such as pinching, slapping, restraining , pushing on the abdomen, extensive episiotomy etc.	
		Pregnant women is explicitly informed before examination and procedures	2	OB/PI	Check if care providers verbally inform the pregnant women before touching, examination or starting procedure.	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV status of patient is not disclosed except to staff that is directly involved in care	2	SI	Check if HIV status of pregnant women is not explicitly written on case sheets and avoiding any means by which they can be identified in public such as labelling or allocating specific beds.	
Standard B4	**The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making**					
ME B4.1	There is established procedure for taking informed consent before treatment and procedures	Consent is taken before delivery and or shifting	2	SI/RR	Check the labour room case sheet for consent has been taken	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Labour room has system in place to involve patient's relative in decision making about pregnant women treatment	2	PI	Check if pregnant women and her family members have been informed and consulted before shifting the patient for C-Section or referral to higher centre	
Standard B5	**The facility ensures that there are no financial barrier to access, and that there is financial protection given from the cost of hospital services.**					
ME B5.1					DELETED	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space as per delivery load	2	OB	Labour tables should be placed in a way that there is a distance of at least 3 feet from the sidewall, at least 2 feet from head end wall, and at least 6' from the second table	
ME C1.2	Patient amenities are provided as per patient load	Availability of patients amenities such as Drinking water, Toilet & Changing area	2	OB	Dedicated Toilets for Labour Room area and Staff Rooms. LDR concept for Labour Room should have attached toilet with each LDR unit . Toilets are provided with western style toilet seats. Drinking water Facility within labour room For Pregnant women & companion	
ME C1.3	Departments have layout and demarcated areas as per functions	Labour Room layout is arranged in LDR concept	2	OB	Labour Room and associated services are arranged according to Labour-Delivery-Recovery Concepts with each LDR unit comprising of 4 Labour Beds and dedicated Nursing Station and New Born Corner	
					DELETED	
		Availability of Triage and Examination Area	2	OB	Dedicated Triage & Examination room with two examination beds for segregation of High & Low Risk patients Entry to the labour room should not be direct. Check if there is any buffer area	
		Dedicated nursing station and Duty Rooms	2	OB	One common Nursing station for Conventional Labour Room Dedicated Nursing station for Each unit if LDR concept is followed	
		Availability of Storage Area	2	OB	A dedicated sub store with cabinets and storage racks for storing supplies Separate Clean room & Dirty Utility room for Storing Sterile and Used goods respectively	
		Availability of Newborn Care area	2	OB	One Dedicated Newborn care area for each four tables. In case of LDR dedicated NBCA for each unit. There should be no obstruction between labour table and Newborn corner for swift shifting of newborn requiring resuscitation Radiant Warmer Should have free space from three sides	
		Availability of Staff Room & Doctor's Duty Room	2	OB	Dedicated rooms for Nursing staff and Doctors provided with beds, storage furniture and attached toilets	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors connecting labour room are broad enough to manage stretcher and trolleys	2	OB	Corridor should be wide enough that 2 stretcher can pass simultaneously without any hassle	

ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB	Check availability of functional telephone and intercom connections	
ME C1.6	Service counters are available as per patient load	Availability of labour tables as per delivery load	2	OB	Less than 20 Deliveries/ Month -1 20-99 Deliveries/ Month - 2 100- 199 Deliveries/Month -4 200- 499 Deliveries/Month -6 More than 500 Deliveries- Conventional Labour Room - Monthly Delivery Cases X 0.014 (Labour- Delivery-Recovery) LDR format - Monthly Delivery Cases X.028	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Labour room is in Proximity and function linkage with OT & SNCU	2	OB	Check labour room is located in the proximity of Maternity OT and SNCU/ NICU in one block only with means of swift shifting of patients in case of emergency. If located on different floor lift/ ramp with manned trolley should be provided	
		Unidirectional flow of care	2	OB	Labour room lay out and arrangement of services are designed in a way, that there is no criss cross movement of patient, staff, supplies & equipment	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	Labour room does not have temporary connections and loosely hanging wires	2	OB	Switch Boards other electrical installations are intact. Check adequate power outlets have been provided as per requirement of electric appliances	
ME C2.4	Physical condition of buildings are safe for providing patient care	Check if safety features have been provided in infrastructure	2	OB	The floor of the labour room complex should be made of anti-skid material. Each window have 2-panel sliding doors. The outside panel be fixed The second panel should be moving with frosted glass and a lock.	
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Labour room has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI	Check the fire exits are clearly visible and routes to reach exit are clearly marked.	
ME C3.2	The facility has adequate fire fighting Equipment	Labour room has installed fire Extinguishers & expiry is displayed on each fire extinguisher	2	OB	Class A , Class B, C type or ABC type. Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR	Check staff is aware of RACE (Rescue-Alarm-Contain-Extinguish) method for in case of fire and confident in using fire extinguisher.	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Ob&G specialist	2	OB/RR	100-200 Deliveries -1 (OBG/EMOC) 200 - 500 Deliveries - 1 OBG (Mandatory + 4 (OBG/EMOC) >500 3 OBG + 4 EMOC	
		Availability of Paediatrician	2	OB/RR	At least 1 paediatrician	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor	2	OB/RR	At least 4 Medical Officers	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff /ANM	2	OB/RR/SI	Deliveries Per month- 100-200- 8 200-500 -12 > 500 - 16	
ME C4.5	The facility has adequate support / general staff	Availability of house keeping staff & Security Guards	2	SI/RR	Housekeeping Staff as per delivery load 100-200- 4 200-500 - 8 Security Guards as per Delivery Load > 500 - 12 100-200- 4 200-500 - 6 > 500 - 8	
Standard C5	**The facility provides drugs and consumables required for assured services.**					
ME C5.1	The departments have availability of adequate medicine at point of use	Availability of uterotonic medicine	2	OB/RR	Inj Oxytocin 10 IU (to be kept in fridge) Tab Misoprostol 200mg	
		Availability of Anti-infective medicine	2	OB/RR	Cap Ampicillin 500mg, Tab Metronidazole 400mg, Inj Gentamicin	
		Availability of Antihypertensive , analgesic and antipyretic and Anesthetic medicine	2	OB/RR	Nifedipine, Methyldopa, Inj Hydralazine, Tab Paracetamol, Tab Ibuprofen, Inj Xylocaine 2%,	
		Availability of IV Fluids	2	OB/RR	IV fluids, Normal saline, Ringer lactate,	
		Availability of Vitamins	2	OB/RR	Vit K	
ME C5.2	The departments have adequate consumables at point of use	Availability of dressings material and Sanitary pads	2	OB/RR	Gauze piece and cotton swabs, sanitary Napkins (2 for Each Delivery), Sanitary Pads (4 for each delivery, needle (round body and cutting), chromic catgut no. 0, antiseptic solution	
		Availability of syringes and IV Sets /tubes and consumables for newborn	2	OB/RR	Paediatric IV sets,urinery catheter, Gastric tube and cord clamp, Baby ID tag	
ME C5.3	Emergency drug trays are maintained at every point of care, wherever it may be needed	Emergency Drug Tray is maintained	2	OB/RR	Inj Magsulf 50%, Inj Calcium gluconate 10%, Inj Dexamethasone, inj Hydrocortisone Succinate, Inj Ampicillin, Inj Gentamicin, inj metronidazole, , Inj diazepam, inj Pheniramine maleate, inj Corboprost, Inj Pentazocine, Inj Promethazine, Betamethasone, Inj Hydralazine, Nifedipine, Methyldopa,ceftriaxone	
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	One set of Digital BP apparatus, Stethoscope, Adult Thermometer , Baby Thermometer, baby forehead thermometer, Handheld Fetal Doppler , Fetoscope, baby weighting scale, Measuring Tape for four labour tables or at least two sets., Wall clock	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of instrument arranged in Delivery trays	2	OB	Cord Cutting Scissor, Artery forceps, Cord clamp, Sponge holder, speculum, kidney tray, bowl for antiseptic lotion are present in tray	
		Delivery kits are in adequate numbers as per load	2	OB	One autoclaved delivery tray for each table plus 4 extra trays	

		Availability of Instruments arranged for Episiotomy trays	2	OB	Episiotomy scissor, kidney tray, artery forceps, allis forceps, sponge holder, toothed forceps, needle holder, thumb forceps, are present in tray	
		Availability of Baby tray	2	OB	Two pre warmed towels/sheets for wrapping the baby, mucus extractor, bag and mask (0 &1 no.), sterilized thread for cord/cord clamp, nasogastric tube are present in tray	
		Availability of instruments arranged for MVA/EVA tray	2	OB	Speculum, anterior vaginal wall retractor, posterior wall retractor, sponge holding forceps, MVA syringe, cannulas, MTP, cannulas, small bowl of antiseptic lotion, are present in tray	
		Availability of instruments arranged for PPIUCD tray	2	OB	PPIUCD insertion forceps, CuIUCD 380A/Cu IUCD375 in sterile package are present in tray	
		Availability of Radiant Warmers	2	OB	1 Functional Radiant warmer for each four tables	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Diagnostic Instruments	2	OB	At least 2 Glucometers, Protein Urea Test Kit , HB Testing Kits, HIV Kits.	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of resuscitation Instruments for Newborn & Mother	2	OB	Availability of Neonatal Resuscitation Kit Paediatric resuscitator bag (volume 250 ml) with masks of 0 and 1 size for each Radiant warmer Adult Resuscitation Kit	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Movable Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning & sterilization	2	OB	Buckets for mopping, Separate mops for labour room and circulation area duster, waste trolley, Deck brush, Autoclave	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of Labour Beds with attachment/accessories	2	OB	Each labour bed should be have following facilities Adjustable side rails, Facilities for Trendelenburg/reverse positions, Facilities for height adjustment, Stainless steel IV rod, wheels & brakes ,Steel basins attachment, Calf support, handgrip, legs support.	
		Availability of Mattress for each Labour Beds	2	OB	Mattress should be in three parts and seamless in each part with a thin cushioning at the joints, detachable at perineal end. It should be washable and water proof with extra set.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1					DELETED	
ME C7.2					DELETED	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Biomedical Waste Management& Infection control and hand hygiene ,Patient safety	2	SI/RR	Check training records	
		Training on Respectful Maternal Care	2	SI/RR	Check training records	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Labour room staff is provided refresher training	2	SI/RR	Check with training records the labour room staff have been provided refresher training at lest once in every 12 month on Intrapartum care, Identification and & management of obstetric emergencies and Essential Newborn care & Breast feeding support	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	Check with AMC records/ Warranty documents	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	Check for breakdown & Maintenance record in the log book	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	BP apparatus, thermometers, weighing scale , radiant warmer etc are calibrated . Check for records /calibration stickers	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipment are readily available with labour room staff.	2	OB/SI	Check operating and trouble shooting instructions of equipment such as radiant warmer are available at labour room	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting medicine and consumables	There is established system of timely indenting of consumables and medicine	2	SI/RR	Stock level are daily updated Requisition are timely placed well before reaching the stock out level. Check with stock and indent registers.	
ME D2.3	The facility ensures proper storage of medicine and consumables	medicine are stored in containers/tray/crash cart and are labelled	2	OB	Check medicine and consumables are kept at allocated space in Crash cart/ Drug trolleys and are labelled. Look alike and sound alike medicine are kept separately	
		Empty and filled cylinders are labelled and updated	2	OB	Empty and filled cylinders are kept separately and labelled, flow meter is working and pressure/ flow rate is updated in the checklist	
ME D2.4	The facility ensures management of expiry and near expiry medicine	Expiry dates' are maintained at emergency drug tray / Crash cart	2	OB/RR	Expiry dates against medicine are mentioned crash cart/ emergency drug tray No expiry drug found	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	At least one week of minimum buffer stock is maintained all the time in the labour room. Minimum stock and reorder level are calculated based on consumption in a week accordingly	
		Department maintained stock and expenditure register of medicine and consumables	2	RR/SI	Check stock and expenditure register is adequately maintained	
ME D2.6	There is a procedure for periodically replenishing the medicine in patient care areas	There is procedure for replenishing drug tray /crash cart	2	SI/RR/OB	There is no stock out of medicine	
ME D2.7	There is process for storage of vaccines and other medicine, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records are maintained	2	OB/RR	Check for temperature charts are maintained and updated periodically. Refrigerators meant for storing medicine should not be used for storing other items such as eatables	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					

ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at delivery table & observation area	2	OB	Labour Area - 500 Lux Support Area - 150 Lux	
ME D3.2	The facility has provision of restriction of visitors in patient areas	There is no overcrowding in labour room	2	OB	Visitors are restricted at labour room. One birth companion is allowed to stay with the Pregnant women	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area	2	PI/OB	Temperature of the labour room should be kept around 26-28 degree	
ME D3.4	The facility has security system in place at patient care areas	Security arrangement in labour room	2	OB	Dedicated security guards preferably female security staff. CCTV Camera at entrance / circulation areas	
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place	2	SI	Check adequate security measures have been taken for safety and security of staff working in labour room	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior & Interior of the facility building is maintained appropriately	Interior & exterior of patient care areas are plastered & painted & building are white washed in uniform colour	2	OB	Wall and Ceiling of Labour Room are painted in white colour. The walls of the labour room complex should be made of white wall tiles, with seamless joint, and extending up to the ceiling.	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs. Surface of furniture and fixtures are clean	
		Toilets are clean with functional flush and running water	2	OB	Check toilet seats, floors, basins etc are clean and water supply with functional cistern has been provided.	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster Window panes , doors and other fixtures are intact	2	OB	Check for delivery as well as auxiliary areas	
		Delivery table are intact and without rust & Mattresses are intact and clean	2	OB	Observe for any signs for rusting or accumulation of dirt/ grease/ encrusted body fluid	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the Labour room	2	OB	Check of any obsolete article including equipment, instrument, records, drugs and consumables	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB	Check for no stray animal in and around labour room	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and portable water	2	OB/SI	Availability of 24X7 Running water & hot water facility.	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in labour room	2	OB/SI	Check for 24X7 availability of power backup including Dedicated UPS and emergency light	
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Availability & use of clean linen	2	OB/RR	Clean Delivery gown is provided to Pregnant Women & sterile drape for baby.	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen	2	SI/RR	Quantity of linen is checked before sending it to laundry. Cleanliness & Quantity of linen is checked received from laundry. Records are maintained	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.2	The facility has an established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		Staff posted in the labour room should not be rotated outside the labour room	2	RR/SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB	As per hospital administration or state policy	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number & patient demographic records are generated during process of registration & admission	2	RR	Check for demographics like Name, age, Sex, Chief complaint, etc.	
ME E1.3	There is established procedure for admission of patients	There is procedure for admitting Pregnant women directly coming to Labour room	2	SI/RR/OB	Admission is done by written order of a qualified doctor	
		There is no delay in admission of pregnant women in labour pain	2	OB/SI/RR	Co relate the time admission with & clinical intervention (vital chart , partograph, medication given etc.)	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Check how service provider cope with shortage of delivery tables due to high patient load	2	OB/SI	Provision of extra tables.	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Rapid Initial assessment of Pregnant Women to identify complication and Prioritize care	2	RR/SI/OB	Recording of vitals and FHR. immediate sign if following danger sign are present - difficulty in breathing, fever, sever abdominal pain, Convulsion or unconsciousness, Severe headache or blurred vision	
		Recording and reporting of Clinical History	2	RR/SI	Recording of women obstetric History including LMP and EDD Parity, Gravid status, h/o CS, Live birth, Still Birth, Medical History (TB, Heart diseases, STD etc) HIV status and Surgical History	
		Recording of current labour details	2	RR	Time of start, frequency of contractions, time of bag of water leaking, colour and smell of fluid and baby movement	
		Physical Examination	2	RR/SI	Recording of Vitals , shape & Size of abdomen , presence of scars, foetal lie and presentation. & vaginal examination	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation	2	SI/RR		
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	

ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	SI/RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2		Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer	There is procedure of handing over patient / new born from labour room to OT/ Ward/SNCU	2	SI/RR	Hand over from Labour Room to the destination department is given while shifting the Mother & Baby. Shifting to ward should be done at least two hours after delivery in case of conventional LR and 4 hours in case of LDR	
		There is a procedure for consultation of the patient to other specialist with in the hospital	2	SI/RR	check if there are linkages and established process for calling other specialist in labour room if required	
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.	Reason for referral is clearly stated and referral is authorized competent person (Gynaecologist or Medical Officer on duty)	2	RR	Verify with referral records that reasons for referral were clearly mentioned and rational. Referral is authorized by Gynaecologist or Medical officer on duty after ascertaining that case can not be managed at the facility Labour room staff confirms the suitability of referral with higher centres to ascertain that case can be managed at higher centre and will not require further referrals	
		Essential information regarding referral facilities are available at labour room	2	RR/OB	Check for availability of following - Referral Pathway Names, Contact details and duty schedules for responsible persons higher referral centres Name , Contact details, duty schedule of Ambulance services	
		Advance communication regarding the patient's condition is shared with the higher centre	2	SI/RR	The information regarding the case, expected time of arrival and special facilities such as specialist, blood, intensive care may be required is communicated to the higher centre	
		Patient referred with referral slip	2	RR/SI	A referral slip/ Discharge card is provided to patient when referred to another health care facility. Referral slip includes demographic details, History of woman, examination findings, management done , drugs administered, any procedure done, reason for referral, detail of referral centre including whom to contact and signature of approving medical officer	
		Referral vehicle is being arranged	2	SI/RR	Check labour room staff facilitates arrangement of ambulance for transferring the patient to higher centre . Patient attendant are not asked to arrange vehicle by their own Check if labour room staff checks ambulance preparedness in terms of necessary equipment, drugs, accompanying staff in terms of care that may be required in transit	
		Referral checklist & Referral in/ Out register is maintained all referred cases	2	RR	Referral check list is filled before referral to ensure all necessary steps have been taken for safe referral including advance communication, transport arrangement, accompanying care provider, referral slip , time taken for referral etc. regarding referral cases including demographics, date & time of admission, date & time of referral, diagnosis at referral and follow up of outcome is recorded in referral register	
		Follow-up of referral cases is done	2	SI/RR	Check that labour room staff follow up of referred cases for timely arrival and appropriate care provided at higher centre. Outcome and deficiencies if any should be recorded in referral out register.	
ME E3.3	A person is identified for care during all steps of care	Nurse is assigned for each pregnant women	2	RR/SI	Check for nursing hand over	
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification before any clinical procedure	2	OB/SI	Identification tags for mother and baby	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	There is a process to ensure the accuracy of verbal/telephonic orders	2	SI/RR	Verbal orders are rechecked before administration. Verbal orders are documented in the case sheet	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	RR/SI	Nursing Handover register is maintained	
		Hand over is given bed side	2	SI/RR/OB	Handover is given during the shift change beside the pregnant women explaining the condition, care provided and any specific care if required	

ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for BP, pulse,temp,Respiratory rate FHR,dilation Uterine Contractions, blood loss any other vital required is monitored and recoded in case sheet	
Standard E5	The facility has a procedure to identify high risk and vulnerable patients.					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Check the measure taken to prevent new born theft, sweeping and baby fall	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High Risk Pregnancy cases are identified and kept in intensive monitoring	2	OB/SI	List of cases identified as High Risk is available with labour room staff . Check for the frequency of observation: Its stage :half an hour and 2nd stage: every 5 min	
Standard E6	Facility ensures rationale prescribing and use of medicines					
ME E6.1	The facility ensured that drugs are prescribed in generic name only	Check for case sheet if drugs are prescribed under generic name only	2	RR	Check all the drugs in case sheet and discharge slip are written in generic name only.	
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment protocols are available at point of use	2	RR	Intrapartum care, Essential new-born care, Newborn Resuscitation, Pre- Eclampsia, Eclampsia, Postpartum haemorrhage , Obstructed Labour, Management of preterm labour	
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per treatment protocols &Check for rational use of uterotonic drugs	
Standard E7	The facility has defined procedures for safe drug administration					
ME E7.1	There is process for identifying and cautious administration of high alert drugs	High alert drugs available in department are identified	2	SI/OB	Check high alert drugs such as Magsulf, Oxytocin, Carbopost, Adrenaline are identified in the labour room	
		Maximum dose of high alert drugs are defined and communicated & there is process to ensure that right doses of high alert drugs are only given	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor. A system of independent double check before administration, Error prone medical abbreviations are avoided	
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR	Verify case sheets of sample basis	
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI	Verify case sheets of sample basis	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI	Check for any open single dose vial with left over content intended to be used later on. In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Check if adverse drug reaction form is available in labour room and reporting is in practice	
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them	2	SI/RR	Administration of medicines done after ensuring right patient, right drugs , right route, right time, Right dose , Right Reason and Right Documentation	
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Progress of labour is recorded	2	RR	Partograph	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment prescribed in nursing records	2	RR	Medication order, treatment plan, lab investigation are recoded adequately	
ME E8.4	Procedures performed are written on patients records	Delivery note is adequate	2	RR	Outcome of delivery, date and time, gestation age, delivery conducted by, type of delivery, complication if any ,indication of intervention, date and time of transfer, cause of death etc	
		Baby note is adequate	2	RR	Did baby cry, Essential new born care, resuscitation if any, Sex, weight, time of initiation of breast feed, birth doses, congenital anomaly if any.	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available	2	RR/OB	Availability of standardized labour room case sheets including partograph and safe Birthing checklist	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	Labour room register, OT register, MTP register, Maternal death register and records, lab register, referral in /out register, internal & PPIUD register , NBCC register, handover register	
		All register/records are identified and numbered	2	RR	Check records are numbered and labelled legibly	
Standard E12	The facility has defined and established procedures of diagnostic services					
ME E12.3	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different test	2	SI/RR	Check for list of critical values is available at nursing station	
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.					
ME E13.9	There is established procedure for transfusion of blood	Protocol of blood transfusion is monitored & regulated	2	RR	blood is kept on room temperature (28 degree C) before transfusion. Blood transfusion is monitored and regulated by qualified person	
Standard E16	The facility has defined and established procedures for the management of death & bodies of deceased patients					
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note is written as per mother & neonatal death review guidelines	2	RR	Maternal and neonatal death are recorded as per MDR guideline. Death note including efforts done for resuscitation is noted in patient record. Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	
		There is established criteria for distinguishing between new-born death and still birth	2	SI/RR	Every still birth is examined, classified by paediatrician before declaration & record is maintained	
Standard E18	The facility has established procedures for Intranatal care as per guidelines					
ME E18.1	Facility staff adheres to standard procedures for management of second stage of labour.	Ensures 'six cleans' are followed during delivery	2	SI/OB	Ensures 'six cleans' are followed during delivery Clean hands, Clean Surface, clean blade, clean cord tie, clean towel & clean cloth to wrap mother	
		Allows spontaneous delivery of head	2	SI/OB	By flexing the head and giving perineal support	
		Delivery of shoulders and Neck	2	SI/OB	Manages cord round the neck; assists delivery of shoulders and body; delivers baby on mother's abdomen	
		Check no unnecessary episiotomy performed	2	SI/RR	Check with records and interview with staff if they are still practicing routine episiotomy.	

		Unnecessary augmentation and induction of labour is not done using uterotonics	2	SI/RR	Check uterotonics such as oxytocin and misoprostol is not used for routine induction normal labour unless clear medical indication and the expected benefits outweigh the potential harms Outpatient induction of labour is not done	
ME E18.2	Facility staff adheres to standard procedure for active management of third stage of labour	Rules out presence of second baby by palpating abdomen	2	SI	Check staff competence	
		Use of Uterotonic Drugs	2	SI/RR	Administration of 10 IU of oxytocin IM immediately after Birth . Check if there is practice of preloading the oxytocin inj for prompt administration after birth.	
		Control Cord Traction	2	SI/RR	Only during Contraction	
		Uterine tone assessment	2	SI/RR	Check staff competence	
		Checks for completeness of placenta before discarding	2	SI/RR	After placenta expulsion , Checks Placenta & Membranes for Completeness	
ME E18.3	Facility staff adheres to standard procedures for routine care of new-born immediately after birth	Wipes the baby with a clean pre-warmed towel and wraps baby in second pre-warmed towel;	2	SI/OB	Check staff competence through demonstration or case observation	
		Performs delayed cord clamping and cutting (1-3 min);	2	SI/OB	Check staff competence through demonstration or case observation	
		Initiates breast-feeding soon after birth	2	SI/OB	Check staff competence through demonstration or case observation	
		Records birth weight and gives injection vitamin K	2	SI/OB	Check staff competence through demonstration or case observation	
ME E18.4	There is an established procedure for assisted and C-section deliveries per scope of services.	Staff is aware of Indications for referring patient for to Surgical Intervention	2	SI	Ask staff how they identify slow progress of labour , How they interpret Partogram	
		Management of Obstructed Labour	2	SI/RR	Diagnosis obstructed labour based on data registered from the partograph, Re-hydrates the patient to maintain normal plasma volume, check vitals, gives broad spectrum antibiotics, perform bladder catheterization and takes blood for Hb & grouping, Decides on the mode of delivery as per the condition of mother and the baby	
ME E18.5	Facility staff adheres to standard protocols for identification and management of Pre Eclampsia / Eclampsia	Records BP in every case checks for proteinuria	2	SI/RR	Check staff competence through demonstration or case observation	
		identifies danger signs of severe PE and convulsions;	2	SI/RR	Check staff competence through demonstration or case observation	
		Administers injection magnesium sulphate appropriately;	2	SI/RR	Check staff competence through demonstration or case observation	
		provides nursing care & ensures specialist attention.	2	SI/RR	Check staff competence through demonstration or case observation	
ME E18.6	Facility staff adheres to standard protocols for identification and management of PPH.	Checks uterine tone and bleeding PV regularly	2	SI/OB	Check staff competence through demonstration or case observation	
		Identifies PPH	2	SI?OB/RR	Assessment of bleeding (PPH if >500 ml or > 1 pad soaked in 5 Minutes or any bleeding sufficient to cause signs of hypovolemia in patient.	
		Manages PPH as per protocol	2	SI/OB/RR	starts IV fluids, manages shock if present, gives uterotonic, identifies causes, performs cause specific management.	
		Staff knows the use of oxytocin for Management of PPH	2	SI/OB/RR	Initial Dose: Infuse 20 IU in 1 L NS/RL at 60 drops per minute Continuing dose: Infuse 20 IU in 1 L NS/RL at 40 drops per minute Maximum Dose: Not more than 3 L of IV fluids containing oxytocin	
		Management of Retained Placenta	2	SI/RR	Administration of another dose of Oxytocin 20IU in 500 ml of RL at 40-60 drops/min an attempt to deliver placenta with repeat controlled cord traction. If this fails performs manual removal of Placenta	
ME E18.7	Facility staff adheres to standard protocols for Management of HIV in Pregnant Woman & Newborn	Provides ART for seropositive mothers/ links with ART centre	2	SI/RR	Check case records and Interview of staff	
		Provides syrup Nevirapine to newborns of HIV seropositive mothers	2	SI/RR	Check case records and Interview of staff	
ME E18.8	Facility staff adheres to standard protocol for identification and management of preterm delivery.	Correctly estimates gestational age to confirm that labour is preterm	2	SI/RR	Assessment and evaluation to confirm gestational age, administration of corticosteroid and tocolytics for 24-34 weeks Magnesium sulphate given to preterm labour < 32 weeks	
		identifies conditions that may lead to preterm birth	2	SI/RR	(severe PE/E, APH, PPROM);	
		administers antenatal corticosteroids in pre term labour and conditions leading to pre term delivery (24-34 weeks);	2	SI/RR	Review case records	
ME E18.9	Staff identifies and manages infection in pregnant woman	Records mother' s temperature at admission and assesses need for antibiotics	2	SI/RR	Review case records	
		Administers appropriate antibiotics to mother	2	SI/RR	Review case records	
ME 18.10	There is Established protocol for newborn resuscitation is followed at the facility.	Facility staff adheres to standard protocol for resuscitating the newborn within 30 seconds.	2	SI/OB	Performs initial steps of resuscitation within 30 seconds: immediate cord cutting and PSSR at radiant warmer.	
		Facility staff adheres to standard protocol for preforming bag and mask ventilation for 30 seconds if baby is still not breathing.	2	SI/OB	Initiates bag and mask ventilation using room air with 5 ventilator breaths and continues ventilation for next 30 seconds if baby still does not breathe.	
		Facility staff adheres to standard protocol for taking appropriate actions if baby does not respond to bag and mask ventilation after golden minute.	2	SI/OB	If baby still not breathing/ breathing well, continues ventilation with oxygen, calls or arranges for advanced help or referral.	
ME E18.11	Facility ensures Physical and emotional support to the pregnant women means of birth companion of her choice	Women are encouraged and counselled for allowing birth companion of their choice	2	PI/SI		
		Orientation session and information is available for Birth companion	2	PI/SI		

Standard E19	**The facility has established procedures for postnatal care as per guidelines**					
ME E19.1	Facility staff adheres to protocol for assessment of condition of mother and baby and providing adequate postpartum care	Performs detailed examination of mother	2	SI/RR/PI	Check for records of Uterine contraction, bleeding, temperature, B.P, pulse, Breast examination, (Nipple care, milk initiation), Check for perineal washes performed	
		Looks for signs of infection in mother and baby	2	OB/SI	Staff Interview	
		Looks for signs of hypothermia in baby and provides appropriate care	2	RR/SI/PI	Skin to skin contact with mother, regular monitoring and specialist attention as required	
ME E19.2	Facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding	Staff counsels mother on vital issues	2	PI/SI	Counsels on danger signs to mother at time of discharge; Counsels on post partum family planning to mother at discharge; Counsels on exclusive breast feeding to mother at discharge	
ME E19.3	Facility staff adheres to protocol for ensuring care of newborns with small size at birth	Facilitates specialist care in newborn <1800 gm	2	SI/RR	Facilitates specialist care in newborn <1800 gm (seen by paediatrician)	
		Facilitates assisted feeding whenever required	2	SI/RR/PI		
		Facilitates thermal management including kangaroo mother care	2	SI/RR/PI	Facilitates thermal management including kangaroo mother care	
ME 19.4	The facility has established procedures for stabilization/treatment/referral of post natal complications	There is established criteria for shifting newborn to SNCU	2	SI/RR	Check if criteria has been defined and in practice by labour room staff	
	Area of Concern - F Infection Control					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces such as delivery tables , door, handles, procedure lights etc.	
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization & medical check up of the staff	2	SI/RR	Hepatitis B, Tetanus Toxic .	
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing with running Water Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted. Availability of Alcohol based Hand rub	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Handwashing station is as per specification	2	OB	Availability of elbow operated taps & Hand washing sink is wide and deep enough to prevent splashing and retention of water	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Staff is aware of when and how to hand wash	2	SI/OB	Ask for demonstration of six steps & check staff awareness five moments of handwashing	
ME F2.3	The facility ensures standard practices and materials for antisepsis	Availability & Use of Antiseptics	2	OB	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter &Proper cleaning of perineal area before procedure with antisepsis	
		Check Shaving is not done during part preparation/delivery cases	2	SI	Staff Interview	
Standard F3	**The facility ensures standard practices and materials for Personal protection**					
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Availability of Masks , caps and protective eye cover	2	OB/SI/ RR	Check if staff is using PPEs Ask staff if they have adequate supply Verify with the stock / Expenditure register	
		Sterile gloves are available at labour room	2	OB/SI /RR	Check if staff is using PPEs Ask staff if they have adequate supply Verify with the stock / Expenditure register	
		Use of elbow length gloves for obstetrical purpose	2	OB/SI /RR	Check if staff is using PPEs Ask staff if they have adequate supply Verify with the stock / Expenditure register	
		Availability of disposable gown/ Apron	2	OB/SI /RR	Check if staff is using PPEs Ask staff if they have adequate supply Verify with the stock / Expenditure register	
		Heavy duty gloves and gum boots for housekeeping staff	2	OB/SI /RR	Check if staff is using PPEs Ask staff if they have adequate supply Verify with the stock / Expenditure register	
		Personal protective kit for delivering HIV cases	2	OB/SI	Cap & Mask, protective Eye cover, Disposable apron	
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Entry to the labour Room is only after change of shoes and wearing Mask & Cap	2	OB		
Standard F4	**The facility has standard procedures for processing of equipment and instruments**					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Disinfection of operating & Procedure surfaces	2	SI/OB	Cleaning of delivery tables tops after each delivery with 2% carbolic acid	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Cleaning of instruments	2	SI/OB	Cleaning is done with detergent and running water after use	
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving	
		Autoclaving of delivery kits is done as per protocols	2	OB/SI	Ask staff about temperature, pressure and time. Ask staff about method, concentration and contact time required for chemical sterilization	
		There is a procedure to ensure the traceability of sterilized packs & their storage	2	OB/SI	Sterile packs are kept in clean, dust free, moist free environment.	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of routes for clean and dirty items	2	OB		

ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant & cleaning agents as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Spill management protocols are implemented	2	SI/RR	spill management kit staff training, protocol displayed	
		Cleaning of patient care area with detergent solution	2	SI/RR	Staff is trained for preparing cleaning solution as per standard procedure	
		Standard practice of mopping and scrubbing are followed & three bucket system is followed	2	OB/SI	Unidirectional mopping from inside out. Cleaning protocols are available / displayed Cleaning equipment like broom are not used in patient care areas	
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins & Plastic bags at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut} and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters & puncture proof, leak proof, temper proof white container for segregation of sharps	2	OB	See if it has been used or just lying idle.	
		Availability of post exposure prophylaxis & Protocols	2	OB/SI	Ask if available. Where it is stored and who is in charge of that. Also check PEP issuance register Staff knows what to do in condition of needle stick injury	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Includes used vials, slides and other broken infected glass	
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	OB/SI	Bins should not be filled more than 2/3 of its capacity	
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Labour Room	2	SI/RR	Check if quality circle formed and functional in the Labour Room	
Standard G2	**The facility has established system for patient and employee satisfaction**					
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals	Client satisfaction survey done on monthly basis	2	RR		
ME G2.2	The facility analyses the patient feed back, and root-cause analysis	Analysis of low performing attributes of client feedback is done	2	RR		
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients	Action plan prepared is prepared to address the areas of low satisfaction	2	RR		
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system of daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Facility In charge should visit at least twice in a week. OBG In charge should visit Labour room at least twice a day, Matron/Nursing supervisor should visit at once in each shift Findings/instructions during the visits are recorded	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or prevalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR	Check if SOPs available at labour room are formally approved	
		Current version of SOP are available with process owner	2	OB/RR	Check current version of SOP is available with all staff members of labour room	
		clinical protocols for Intrapartum care and Management of obstetric emergency are Displayed	2	OB	Clinical Protocols on AMSTL, Preparing Partograph, , PPH, Eclampsia, Infection control, Referral, Infection Control	
		Clinical protocols on Newborn Care are displayed	2	OB	Clinical Protocols on Essential Newborn Care, New born resuscitation	
		Don'ts/ Harmful Activities are Displayed at labour Room	2	OB	1. No routine enema 2. No routine shaving 3. No routine induction/augmentation of labour 4. No place for routine suctioning of the baby 5. No pulling of the baby. 6. No routine episiotomy 7. No fundal pressure 8. No immediate cord cutting 9. No immediate bathing of the newborn 10. No routine resuscitation on warmer	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for ensuring patients rights including consent, privacy, confidentiality & entitlement	2	RR	Review the Labour Room SOPs for description of processes pertaining to ensuring privacy, confidentiality, respectful maternity care and consent	

		Department has documented procedure for safety & risk management	2	RR	Review the Labour Room SOPs for inclusion for processes to Physical as well as patient safety, assessment of risks and their timely mitigation	
		Department has documented procedure for support services & facility management.	2	RR	Review the Labour Room SOPs for process description of support services such as equipment maintenance , calibration, housekeeping, security, storage and inventory management	
		Department has documented procedure for general patient care processes	2	RR	Review Labour room SOPS for processes of triage, assessment, admission, identification of high risk patients, Referral , Medication management and maintenance of clinical records	
		Department has documented procedure for specific processes to the department	2	RR	Review Labour room SOPs for process of intrapartum care, management of complications, immediate postpartum care , Natural Birthing Process and Birth Companion	
		Department has documented procedure for infection control & bio medical waste management	2	RR	Review Labour room SOPs for process description of Hand Hygiene, personal protection, environmental cleaning, instrument sterilization, asepsis, Bio Medical Waste management , surveillance and monitoring of infection control practices, Periodic quality review such as Maternal Death Audit, Newborn Death Audit, Referral audit and Near miss audit.	
		Department has documented procedure for quality management & improvement	2	RR	Review Labour room SOPs for process description of function of quality circles, internal quality assessment, Quality improvement using PDCA cycle client satisfaction surveys, processes improvement , Maternal Death Audit, Newborn Death Audit, Referral Death Audit and Near Miss audits.	
		Department has documented procedure for data collection, analysis & use for improvement	2	RR	Review Labour room SOPs for description of process related to collection of data & quality indicators , their analysis and use for quality improvement	
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check Staff is aware of relevant part of SOPs	2	SI/RR	Interview labour room staff for their awareness about content of SOPs	
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1					DELETED	
ME G5.2					DELETED	
ME G5.3					DELETED	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4					DELETED	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1					DELETED	
ME G7.2					DELETED	
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/PI	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct referral audits	2	SI/RR	(1) Random referral slips are audited (2) The reasons of the referral is clearly mentioned (3) Referral is written by authorized competent person (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct maternal death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct neonatal death audits	2	RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	

		All non compliance are enumerated recorded for referral audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for maternal death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for neonatal death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per referral audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per maternal death audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per neonatal death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or prevalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
	Area of Concern - H Outcome					
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks					
ME H1.1	Facility measures productivity Indicators on monthly basis	Percentage of deliveries conducted at night	2	RR		
		Percentage of complicated cases managed	2	RR		
		% PPIUCD inserted against total number of normal delivery	2	RR		
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Percentage of cases referred to OT	2	RR		
		% of newborns required resuscitation out of total live births	2	RR		
		No of drugs stock out in the month	2	RR		
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Percentage of deliveries conducted using real time partograph	2	RR		
		Percentage of deliveries conducted using safe birth checklist	2	RR		
		No of adverse events per thousand patients	2	RR		
		The percentage of Women, administered Oxytocin, immediately after birth.	2	RR		
		Intrapartum stillbirth rate	2	RR		
		Percentage newborn breastfed within 1 hour of birth	2	RR		
		No. of cases of Neonatal asphyxia	2	RR		
		No. of cases of Neonatal Sepsis	2	RR		
		Percentage of antenatal corticosteroid administration in case of preterm labour	2	RR		
		No. of cases of Maternal death related to APH/ PPH	2	RR		
		No of cases pf maternal death related to Eclampsia/ PIH	2	RR		
		OSCE Score	2	RR		
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Percentage of Deliveries attended by Birth Companion	2	RR		
		Client Satisfaction Score	2	RR		

National Quality Assurance Standards for District Hospitals						Version: DH/NQAS-2020/00
Checklist for Maternity Ward						4
Assessment Summary						
Name of the Hospital					Date of Assessment	
Names of Assessors					Names of Assessees	
Type of Assessment (Internal/External)					Action plan Submission Date	

Maternity Ward Score Card			
	Area of Concern wise Score		Maternity Ward Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference no	Measurable Element	Checkpoints	Compliance	Assessment	Means of verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	The facility provides Curative Services					
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Obs and Gynaecology indoor services	2	SI/OB	(a) IPD services for Obstetric Cases (General & post Surgical cases) (b) IPD Services for Gynae cases (General & post-surgical cases) (c) 250-500 Deliveries - 8-bedded HDU or 500-1000 deliveries - 8 bedded hybrid ICU (6 HDU & 2 ICU beds or more 1000 Deliveries- 4 bed ICU & 8-bed HDU	
ME A1.14	Services are available for the time period as mandated	Availability of nursing services 24X7	2	SI/RR		
ME A1.18	The facility provides Blood bank & transfusion services	Availability of blood transfusion services	2	SI/OB	Availability/ linkage with blood bank	
Standard A2	The facility provides RMNCHA Services					
ME A2.2	The facility provides Maternal health Services	Availability of indoor services for Antenatal cases	2	SI/OB	Antenatal ward- Clean Ward	All the services being provided in a single ward
		Availability of indoor services for normal delivery	2	SI/OB	Postnatal ward -Normal delivery	
		Availability of indoor services for C section	2	SI/OB	Postnatal ward -C-section delivery	
		Availability of indoor services for Septic cases	2	SI/OB	Septic ward	
		Availability of indoor services for Eclampsia cases	2	SI/OB	Eclampsia room	
		Availability of Gynae Services	2	SI/RR	Hysterectomy & mastectomy services as per disease indication	
ME A2.3	The facility provides Newborn health Services	Prevention of hypothermia and initiation of breast feeding	2	SI/OB		
ME A2.4	The facility provides Child health Services	Screening of New born for Birth Defects	2	SI/OB		
Standard A3	The facility Provides diagnostic Services					
ME A3.1	The facility provides Radiology Services	Availability / linkage for Radiology and USG	2	SI/OB		
ME A3.2	The facility Provides Laboratory Services	Availability / linkage with laboratory	2	SI/OB		
Standard A4	The facility provides services as mandated in national Health Programmes/ state scheme					
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Treatment of Malaria in pregnancy	2	SI/OB	check the records for management of cases in last one year	
ME A4.10					DELETED	
	Area of Concern - B Patient Rights					
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities					
ME B1.1	The facility has uniform and user-friendly signage system	Availability departmental signage's	2	OB	(Numbering, main department and internal sectional signage	
		Visiting hours and visitor policy are displayed	2	OB		
ME B1.2	The facility displays the services and entitlements available in its departments	Entitlements applicable are Displayed	2	OB	JSSK, JSY and PM JAY	
		List of drugs available are displayed and updated	2	OB		
		Contact details of referral transport / ambulance displayed	2	OB		

ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC Material is displayed	2	OB	Breast feeding and care of breast, kangaroo care, family planning, Danger signs, PN advice, Information material about PCPNDT etc	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.7					DELETED	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	No Male attendant allowed to stay in female wards at night	2	OB/SI		
		Availability of female staff if a male doctor examine a female patients	2	OB/SI		
		Availability of Breast feeding corner	2	OB		
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the ward	2	OB		
		Availability of ramps and railing	2	OB		
		Availability of disable friendly toilet	2	OB		
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen at Examination Area	2	OB	Bracket screen	
		Curtains have been provided at windows	2	OB		
		Patients are dressed/covered while shifting the patients from one department to other	2	OB		
		No two patients are treated on one bed	2	OB		
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB	1. No information regarding patient / parent identity is displayed 2. Records are not shared with anybody without written permission of parents & appropriate hospital authorities	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	OB/PI		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV status of patient is not disclosed except to staff that is directly involved in care	2	SI/OB		
Standard B4	**The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	General Consent is taken before admission	2	SI/RR		
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient and their attendant is informed about her clinical condition and treatment being provided	2	PI		
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance redressal and whom to contact is displayed	2	OB		
Standard B5	**The facility ensures that there are no financial barrier to access, and that there is financial protection given from the cost of hospital services.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Availability of Free drugs	2	PI/SI		
		Stay and diet provided in ward is free of cost	2	PI/SI		
		Availability of free diagnostic	2	PI/SI		
		Availability of Free drop back	2	PI/SI		
		Availability of Free referral vehicle/Ambulance services	2	PI/SI		
		Availability of Free Blood	2	PI/SI		
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.	2	PI/SI		
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	If any other expenditure occurred it is reimbursed from hospital	2	PI/SI/RR		
		JSY Payment is done before discharge	2	PI/SI/RR		
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.6	There is an established procedure for 'end-of-life' care	The patient's Relatives informed clearly about the deterioration in the health condition of Patient.	2	SI/RR	Periodic update on the patient's condition is given to the family.	
		Policy & procedures like DNR , DNI etc for critical cases are in consonance with legal requirement	2	SI/RR	Patient right "Do not resuscitate" or " Do not intubate"/ allow natural death are respected	
		There is a procedure to allow patient relative/Next of Kin to observe patient in last hours	2	SI/OB		
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient	2	RR/SI	Consequences of LAMA are explained to patient/relative	

	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space in wards with no cluttering of beds	2	OB	Distance between centres of two beds – 2.25 meter	
ME C1.2	Patient amenities are provide as per patient load	Functional toilets with running water and flush are available as per strength and patient load of ward	2	OB	one toilet for 12 patients	
		Functional bathroom with running water are available as per strength and patient load of ward	2	OB	one toilet for 12 patients	
		Availability of drinking water	2	OB		
		Patient/ visitor Hand washing area	2	OB		
		Separate toilets for visitors	2	OB		
		Adequate shaded waiting area is provide for attendants of patient	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions	Availability of Dedicated nursing station	2	OB		
		Availability of Examination room	2	OB		
		Availability of Treatment room	2	OB		
		Availability of Doctor's and Nurse Duty room	2	OB		
		Availability of Store	2	OB	Drug &Linen store	
		Availability of Dirty room	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	There is sufficient space between two bed to provide bed side nursing care and movement	2	OB	Space between two beds should be at least 4 ft and clearance between head end of bed and wall should be at least 1 ft and between side of bed and wall should be 2 ft	
		Corridors are wide enough for patient, visitor and trolley/ equipment movement	2	OB	Corridor should be 3 meters wide	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	There is separate nursing station for each ward	2	OB	1. ANC, PNC, C-Section ward. Depending upon Wards available for maternity cases 2. Location of nursing station and patients beds enables easy and direct observation of patients	
		Availability of adequate beds as per delivery load	2	OB	10 beds for 100 delivery per month	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Prepartum and post partum wards are in proximity and functional linkage with labour room	2	OB		
		Postpartum ward and SNCU are in proximity and functional linkage	2	OB		
		C section ward is in Proximity and has functional linkage with OT	2	OB/SI		
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	IPD building does not have temporary connections and loosely hanging wires	2	OB	Switch Boards other electrical installations are intact. There is proper earthing	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the maternity ward are non slippery and even	2	OB		
		Windows have grills and wire meshwork	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Maternity ward has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	Maternity ward has installed fire Extinguisher that is either Class A , Class B, C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Bog specialist on duty and on call paediatrician	2	OB/RR		
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor at all time	2	OB/RR		
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	6 for 100-200 Deliveries/Month 8 for More than 200 deliveries per month	
ME C4.4					DELETED	
		Availability of dresser for C section ward	2	SI/RR		
ME C4.5	The facility has adequate support / general staff	Availability of ward attendant	2	SI/RR	Availability of mamta/ ayahs and Sanitary worker	
		Availability Security staff	2	SI/RR		
Standard C5	**The facility provides drugs and consumables required for assured services.**					

ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Uterotonic Drugs	2	OB/RR	Tocolytic agent, Isoxsuprine	
		Availability of Anti - Infective - Antibiotics, Antifungal	2	OB/RR	Tab. Metronidazole 400mg, Gentamicin,	
		Availability of Antihypertensive	2	OB/RR	Tab. Misprostol 200mg, Labetalol	
		Availability of analgesics and antipyretics	2	OB/RR	Tab. Paracetamol, Tab. Ibuprofen, Piroxicam	
		Availability of IV Fluids	2	OB/RR	IV fluids, Normal saline, Ringer lactate,	
		Availability of other emergency drugs	2	OB/RR	Tab. Ritodrine, Misoprostol, Carboprost, steroid as Hydrocortisone, dexamethasone, iron, calcium, and folic acids tablets	
		Availability of drugs for newborn	2	OB/RR	Inj. Vit K 10mg, Vaccine OPV, Hepatitis B, BCG, paracetamol syrup/drops, Syp Calcium with Vit D, Multivitamin drops, Simethicone + Fennel Oil + Dill Oil drops, Nevirapine drops (for HIV + ve mother born children), gentian Violet (0.50%)	
ME C5.2	The departments have adequate consumables at point of use	Availability of dressings and Sanitary pads	2	OB/RR	gauze piece and cotton swabs, sanitary pads, needle (round body and cutting), chromic catgut no. 0,	
		Availability of syringes and IV Sets /tubes	2	OB/RR	Paediatric iv sets, urinary catheter with bag, Foyle's catheter Nasogastric tube, Syringe A/D	
		Availability of Antiseptic Solutions	2	OB/RR	Povidone Iodine Solution	
		Availability of consumables for new born care	2	OB/RR	gastric tube and cord clamp, dressing pad	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Availability of emergency drug tray in Maternity ward	2	OB/RR		
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Thermometer, foetoscope, baby and adult weighing scale, Stethoscope, Doppler	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional Equipment/Instruments Gynae & Obstetric Procedures	2	OB	Dressing and suture removal kit, speculum, Anterior vaginal wall retractor.	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments	2	OB	Glucometer and HIV rapid diagnostic kit	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of resuscitation equipments	2	OB	Adult and baby bag and mask, Oxygen, Suction machine, Airway, Laryngoscope, ET tube	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
		Availability of equipment for sterilization and disinfection	2	OB	Boiler	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of patient beds with prop up facility	2	OB		
		Availability of attachment/ accessories with patient bed	2	OB	Hospital graded mattress, Bed side locker , IVstand, Bed pan	
		Availability of Fixtures	2	OB	Spot light, electrical fixture for equipments like suction, X ray view box	
		Availability of furniture	2	OB	cupboard, nursing counter, table for preparation of medicines, chair.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1					DELETED	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infant and young Child Feeding (IYCF) practices	2	SI/RR		
		Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Infection control and hand hygiene	2	SI/RR		
		Patient Safety	2	SI/RR		
		Training on Quality Management System	2			
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Nursing staff is skilled identificaton and managing complication	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	

		Staff is skilled for maintaining clinical records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Counsellor is skilled for postnatal counselling	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR	BP apparatus, thermometers etc are calibrated	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting medicine and consumables	There is established system of timely indenting of consumables and medicine at nursing station	2	SI/RR	Stock level are daily updated Indents are timely placed	
ME D2.3	The facility ensures proper storage of medicine and consumables	medicine are stored in containers/tray/crash cart and are labelled	2	OB	medicine are stored in separate containers, trays and carts and labelled with drug name, drug strength and expiry date	
		Empty and filled cylinders are labelled	2	OB		
ME D2.4	The facility ensures management of expiry and near expiry medicine	Expiry dates' are maintained at emergency drug tray	2	OB/RR	Check medicine are arranged in tray as per First Expiry and First Out (FEFO) and expiry date are mentioned against the drug.	
		No expired drug found	2	OB/RR		
		Records for expiry and near expiry medicine are maintained for drug stored at department	2	RR	Check register/DVDMS/other supply chain software for record of stock of expired and near expiry medicine	
ME D2.5	The facility has established procedure for inventory management techniques	There is established system of calculating and maintaining buffer stock	2	SI/RR		
		Department maintained stock register of medicine and consumables	2	RR/SI	Check record of drug received, issued and balance stock in hand and are updated	
ME D2.6	There is a procedure for periodically replenishing the medicine in patient care areas	There is procedure for replenishing drug tray /crash cart	2	SI/RR		
		There is no stock out of medicine	2	OB/SI	Random stock check of some medicine	
ME D2.7	There is process for storage of vaccines and other medicine, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day. Refrigerators meant for storing medicine should not be used for storing other items such as eatables.	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic medicine	Narcotics and psychotropic medicine are kept separately in lock and key	2	OB/SI	Separate prescription for narcotic and psychotropic medicine by a registered medical practioner	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at nursing station	2	OB		
		Adequate illumination in patient care areas	2	OB	Spot light is available	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Visiting hour are fixed and practiced	2	OB/PI		
		There is no overcrowding in the wards during to visitors hours	2	OB		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area	2	PI/OB	Optimal temperature and warmth is ensured Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation in nursing station/duty room	2	SI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4	The facility has security system in place at patient care areas	New born identification band and foot prints are in practice	2	OB/RR		
		Security arrangement in maternity ward	2	OB/SI		
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff weather they feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		

		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Patients beds are intact and painted	2	OB	Mattresses are intact and clean	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the ward	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
		Availability of hot water	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in ward	2	OB/SI		
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done specially for high risk pregnancy and other specified cases	2	RR/SI	For hypertensive patient, diabetic cases. Check nutrition advice from records	
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check for the adequacy and frequency of diet as per nutritional requirement	2	OB/RR	Check that all items fixed in diet menu is provided to the patient	
		Check for the Quality of diet provided	2	PI/SI	Ask patient/staff weather they are satisfied with the Quality of food	
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	There is procedure of requisition of different type of diet from ward to kitchen	2	RR/SI	diet for diabetic patients, low salt and high protein diet etc	
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Clean Linens are provided for all occupied bed	2	OB/RR		
		Gown are provided at least to the cases going for surgery	2	OB/RR		
		Availability of Blankets, draw sheet, pillow with pillow cover and mackintosh	2	OB/RR		
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled	2	OB/RR		
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR		
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB		
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration	2	RR		
		Patient demographic details are recorded in admission records	2	RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.	
ME E1.3	There is established procedure for admission of patients	There is no delay in treatment because of admission process	2	SI/RR/OB		
		Admission is done by written order of a qualified doctor	2	SI/RR/OB		
		There is separate counter for admission of patients	2	OB/RR		
		Time of admission is recorded in patient record	2	RR		
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	There is provision of extra Beds	2	OB/SI		
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all admitted patient done as per standard protocols	2	RR/SI/OB	The assessment criteria for different clinical conditions are defined and measured in assessment sheet	
		ANC history of pregnant women is reviewed and recorded	2	RR/SI		
		Physical Examination is done and recorded wherever required	2	RR	Assesses general condition, including: vital signs, conjunctiva for pallor and jaundice, and bladder and bowel function, conducts breast examinations	

		Dangers signs are identified and recorded	2	RR/SI	Examines the perineum for inflammation, status of episiotomy/tears, lochia for colour, amount, consistency and odour, Checks calf tenderness, redness or swelling	
		Initial assessment and treatment is provided immediately	2	RR/SI		
		Initial assessment is documented preferably within 2 hours	2	RR		
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for assessment of stable patients	2	RR/OB		
		For critical patients admitted in the ward there is provision of reassessment as per need	2	RR/OB		
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients from maternity ward	2	SI/RR	to OT/labour room/USG	
		There is a procedure for consultation of the patient to other specialist with in the hospital	2	SI/RR		
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.	Patient referred with referral slip	2	RR/SI		
		Advance communication is done with higher centre	2	RR/SI		
		Referral vehicle is being arranged	2	RR/SI		
		Referral in or referral out register is maintained	2	SI/RR		
		Facility has functional referral linkages to lower facilities	2	RR	Check for referral cards filled from lower facilities	
		Facility has functional referral linkages to higher facilities	2			
		There is a system of follow up of referred patients	2	SI/RR		
ME E3.3	A person is identified for care during all steps of care	Duty Doctor and nurse is assigned for each patients	2	RR/SI		
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification before any clinical procedure	2	OB/SI	Identification tags for mother and baby / foot print are used for identification of newborns	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained	2	RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.	
		There is a process to ensue the accuracy of verbal/telephonic orders	2	SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR		
		Nursing Handover register is maintained	2	RR		
		Hand over is given bed side	2	SI/RR		
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately	2	RR/SI	Check for nursing note register. Notes are adequately written	
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for TPR chart, IO chart, any other vital required is monitored	
		Critical patients are monitored continually	2	RR/SI		
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Check the measure taken to prevent new born theft, sweeping and baby fall	

ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High Risk Pregnancy cases are identified and kept in intensive monitoring	2	OB/SI	High risk cases : Eclampsia, Sepsis, diabetic, cardiac diseases and Intrauterine growth retardation	
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	The facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only	2	RR		
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use	2	RR		
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per STG	
		Availability of drug formulary	2	SI/OB		
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Check complete medication history including over-the- counter medicines is taken and documented	
		Established mechanism for Medication reconciliation process	2	SI/RR	1. Medication Reconciliation is carried out by a trained and competent health professional during the patient's admission, interdepartmental transfer or discharged 2. Medicine reconciliation includes Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements.	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome	
		Complete medication history is documented and communicated for each patient at the time of discharge	2	SI/RR	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary"	
		Patients are engaged in their own care	2	PI/SI	"1. Clinician/Nurse counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge"	
Standard E7	**The facility has defined procedures for safe drug administration**					
ME E7.1	**There is process for identifying and cautious administration of high alert drugs**	High alert drugs available in department are identified	2	SI/OB	Magsulf (to be kept in fridge) , Methergine	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor	
		There is process to ensure that right doses of high alert drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided	
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR		
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI		
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI		
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content kept to be used later on	
		Check for separate sterile needle is used every time for multiple dose vial	2	OB	In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events	
ME E7.4	There is a system to ensure right medicine is given to right patient	Administration of medicines done after ensuring right patient, right drugs , right route, right time	2	SI/OB		
ME E7.5	Patient is counselled for self drug administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings .	2	RR/SI		
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Day to day progress of patient is recorded in BHT	2	RR		
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT	2	RR	Treatment prescribed in nursing records	
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/treatment registers	2	RR	Treatment given is recorded in treatment chat	
ME E8.4	Procedures performed are written on patients records	Any procedure performed written on BHT	2	RR	Dressing, mobilization etc	
ME E8.5	Adequate form and formats are available at point of use	Standard Format for bed head ticket/ Patient case sheet available as per state guidelines	2	RR/OB	Availability of formats for Treatment Charts, TPR Chart , Intake Output Chat Etc.	

ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, OT register, FP register, Diet register, Linen register, Drug indent register	
		All register/records are identified and numbered	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB		
Standard E9	**The facility has defined and established procedures for discharge of patient.**					
ME E9.1	Discharge is done after assessing patient readiness	Assessment is done before discharging patient	2	SI/RR		
		Maternity ward has established criteria for discharge	2	SI/RR	Primary illness is resolved, All infections and other medical complications have been treated, vitals are stable, etc.	
		Discharge is done by a responsible and qualified doctor after assessment in consultation with treating doctor	2	SI/RR	Discharge is done in consultation with treating doctor	
		Patient / attendants are consulted before discharge	2	PI/SI	Time of discharge is communicated to patient in prior	
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided	2	RR/PI	See for discharge summary, referral slip provided.	
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up	2	RR		
		Discharge summary is give to patients going in LAMA/Referral	2	SI/RR		
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge	2	SI/PI	Advice includes the information about the nearest health centre (Dispensary) for further follow up. Counsel mother for treatment, follow up, feeding, discharge timings are explained prior	
		Advice includes the information about the nearest health centre for further follow up	2	RR/SI		
		Time of discharge is communicated to patient in prior	2	PI/SI		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.3	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different tests	2	SI/RR		
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR		
		Patient's identification is verified before transfusion	2	SI/OB		
		blood is kept on optimum temperature before transfusion	2	RR		
		Blood transfusion is monitored and regulated by qualified person	2	SI/RR		
		Blood transfusion note is written in patient recorded	2	RR		
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR		
Standard E14	**The facility has established procedures for Anaesthetic Services**					
ME E14.1	The facility has established procedures for Pre-anaesthetic Check up and maintenance of records	Pre anaesthesia check up is conducted for elective / Planned surgeries	2	SI/RR		
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives	2	SI		
		Death note is written on patient record	2	RR		
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	2	SI/RR	Maintenance of records as per guideline	
		Death note including efforts done for resuscitation is noted in patient record	2	RR	Maternal and neonatal death	
	Maternal Health					
Standard E17	**The facility has established procedures for Antenatal care as per guidelines**					
ME E17.1	There is an established procedure for Registration and follow up of pregnant women.	Facility provides and updates "Mother and Child Protection Card".	2	RR/SI		
ME E17.4	There is an established procedure for identification of High risk pregnancy and appropriate treatment/referral as per scope of services.	Management of PIH/Eclampsia	2	RR/SI		
		Management of sepsis	2	RR/SI		
		Management of diabetic pregnant mother	2	RR/SI		

		Management of cardiac cases	2	RR/SI		
		Management of IUGR	2	RR/SI		
ME E17.5	There is an established procedure for identification and management of moderate and severe anaemia	Management of of severe anaemia	2	RR/SI	Blood Transfusion services available for anaemic patients	
Standard E19	**The facility has established procedures for postnatal care as per guidelines**					
ME E19.1	Facility staff adheres to protocol for assessment of condition of mother and baby and providing adequate postpartum care	Post Partum Care of Newborn	2	SI/RR	Maintains hand hygiene, keeps the baby wrapped (maintains temperature), Checks weight, temperature, respiration, heart rate, colour of skin and cord stump	
		Initiation of Breastfeeding with in 1 Hour	2	PI	Checks and discusses with the mother on breastfeeding pattern, emphasising exclusive and on demand feeding. Demonstrates the proper positioning and attachment of the baby	
		Post partum care of mother	2	PI	Check uterine contraction, bleeding as per treatment plan, check for TPR and output chart, Breast examination and milk initiation and perineal washes	
ME E19.2	Facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding	Staff counsels mother on vital issues	2	PI/SI	Counsels on danger signs to mother at time of discharge; Counsels on post partum family planning to mother at discharge; Counsels on exclusive breast feeding to mother at discharge	
ME E19.3	Facility staff adheres to protocol for ensuring care of newborns with small size at birth	Facilitates specialist care in newborn <1800 gm	2	SI/RR	Facilitates specialist care in newborn <1800 gm (seen by paediatrician)	
		Facilitates assisted feeding whenever required	2	SI/RR/PI		
		Facilitates thermal management including kangaroo mother care	2	SI/RR/PI		
ME E19.4	The facility has established procedures for stabilization/treatment/referral of post natal complications	There is established criteria for shifting newborn to SNCU	2	SI/RR		
ME E19.5	The facility ensure adequate stay of mother and new born in a safe environment as per standard protocols	48 Hour Stay of mothers and new born after delivery	2			
ME E19.6	There is established procedure for discharge and follow up of mother and newborn.	Check patient is explained about follow up visits, advice and counselling is done before discharge	2	RR/PI		
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**					
ME E20.1	The facility provides immunization services as per guidelines	Zero dose vaccines are given	2	RR	Check for records BCG, Hepatitis Band OPV 0 given to New born	
ME E20.3	Management of Low birth weight newborns is done as per guidelines	Care of Low Birth Weight and Premature babies	2	SI/RR	Premature and LBW babies are identified: Weight less than 2500 g for low birth weight babies, gestation of less than 37 weeks for prematurely, Kangaroo Mother Care (KMC) is implemented for Low Birth Weight/Prematurely and assisted feeding arranged, if required	
	Area of Concern - F Infection Control					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.3	The facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection	2	SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .	
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
		Periodic medical check-ups of the staff	2	SI/RR		
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	The facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
ME F2.3	The facility ensures standard practices and materials for antisepsis		2	OB		
			2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3	**The facility ensures standard practices and materials for Personal protection**					

ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the gloves	2	SI		
Standard F4	**The facility has standard procedures for processing of equipment and instruments**					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , Patients Beds Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like Stethoscope, Dressing Instruments, Examination Instruments, Blood Pressure Cuff etc (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/HLD/Chemical Sterilization	
		High level Disinfection of instruments/equipment is done as per protocol	2	OB/SI	Ask staff about method and time required for boiling	
		Autoclaved dressing material is used	2	OB/SI		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipment like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
ME F5.4	The facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases	2	OB/SI		
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2	OB		
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.	
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	

		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2			
		Staff is aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with	
	Area of Concern - G Quality Management					
Standard G1	**Facility has established organizational framework for quality improvement**					
ME G1.1					DELETED	
Standard G2	**The facility has established system for patient and employee satisfaction**					
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals	Client/Patient satisfaction survey done on monthly basis	2	RR		
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR		
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5					DELETED	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	Patient safety, Identification of danger sign, postnatal care and counselling, new born care etc	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for receiving and initial assessment of the patient in Maternity ward	2	RR		
		Department has documented procedure for admission, shifting and referral of pregnant mother	2	RR		
		Department has documented procedure for shifting the mother to labour room	2	RR		
		Department has documented procedure for requisition of diagnosis and receiving of the reports	2	RR		
		Department has documented procedure for preparation of the patient for surgical procedure	2	RR		
		Department has documented procedure for transfusion of blood in maternity ward	2	RR		
		Department has documented procedure for maintenance of rights and dignity of pregnant women	2	RR		
		Department has documented procedure for record Maintenance including taking consent	2	RR		
		Department has documented procedure for discharge of the patient from maternity ward	2	RR		
		Department has documented procedure for post natal inpatient care of mother	2	RR		
		Department has documented procedure for post natal inpatient care of new born	2	RR		
		Department has documented procedure for payment/ incentives of beneficiary	2	RR		
		Department has documented procedure for counselling of the patient at the time of discharge	2	RR		
		Maternity ward has documented procedure for environmental cleaning and processing of the equipment	2	RR		

		Maternity ward has documented procedure for arrangement of intervention for maternity ward	2	RR		
		Maternity ward has documented procedure for sorting, cleaning and distribution of clean linen to patient	2	RR		
		Maternity ward has documented procedure for providing free diet to the patient as per their requirement	2	RR		
		Department has documented procedure for end of life care	2	RR		
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1					DELETED	
ME G5.2					DELETED	
ME G5.3					DELETED	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	as per individual hospital
ME G6.7					DELETED	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1					DELETED	
ME G7.2					DELETED	
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits	2	SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are	
		There is procedure to conduct death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	

		There is procedure to conduct prescription audits	2	SI/RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings	
		All non compliance are enumerated recorded for medical audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for prescription audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per prescription audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
		Check the mapping of existing clinical practices processess is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks					
ME H1.1	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate for normal delivery ward	2	RR		
		Bed Occupancy Rate for C section ward	2			
		Proportion of Severe anaemia cases treated with blood transfusion	2	RR		
		The proportion of high-risk pregnancies managed	2	RR	GDM, hypothyroidism & syphilis	
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Referral Rate	2	RR		
		Bed Turnover rate	2	RR		
		Discharge rate	2	RR		
		No. of drugs stock out in the ward	2	RR		
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average length of stay for normal delivery	2	RR		
		Average length of stay for Surgical Cases	2	RR	(a) C Section Cases (b) Hysterectomy Cases	
		Newborns Breastfed within 1 hr of Birth	2	RR		
		Maternal Death per 1000 deliveries	2	RR		
		No of adverse events per thousand patients	2	RR		
		Proportion of mother given postnatal counselling	2	RR		
		Time taken for initial assessment	2	RR		
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate	2	RR		
		Patient Satisfaction Score	2	RR		
		Proportion of mothers given drop back facility	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Paediatric Outdoor Patient Department			5
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assesses	
Type of Assessment (Internal/External)		Action plan Submission Date	

Paediatric OPD Score Card

	Area of Concern wise Score		Paediatric OPD Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed	
1		
2		
3		
4		
5		
	Strengths / Good Practices	
1		
2		
3		
4		
5		
	Recommendations/ Opportunities	
1		
2		
3		
4		
5		
	Signature of Assessors	
	Date	

Reference No.	Measurable Element	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.4	The facility provides Paediatric Services	Availability of Paediatric Clinic	2	SI/OB	(1) Dedicated Paediatric Clinic for diagnosis and treatment for common childhood ailments (2) Screening for admission (3) Follow up for care & care after discharge	
		Availability of services for early identification and intervention of 4 D's	2	SI/OB	Established linkage with DEIC (inhouse or referral)	
ME A1.5	The facility provides Ophthalmology Services	Availability of functional Ophthalmology Clinic	2	SI/OB	1. Ophthalmology Clinic providing Paediatrics consultation services (shared with main hospital) 2. Check records for no. of paediatric cases seen in past three months	Available at respective department
ME A1.6	The facility provides ENT Services	Availability of Functional ENT Clinic	2	SI/OB	1. ENT clinic providing paediatrics consultation services (shared with main hospital) 2. Check records for no. of paediatric cases seen in past three months	
		Availability of OPD ENT procedures	2	SI/OB	1. Check records for no. of paediatric cases seen in past three months 2. Foreign Body Removal (Ear and Nose),Stitching of CLW's, Dressings, Syringing of Ear, Chemical Cauterization (Nose & Ear), Eustachian Tube Function Test, Vestibular Function Test etc.	
ME A1.7	The facility provides Orthopaedics Services	Availability of Functional Orthopaedic Clinic	2	SI/OB	1. Orthopaedic Clinic providing Paediatric consultation services (shared with main hospital) 2. Check records no. of paediatric cases seen in past three months	
		Availability of OPD Orthopaedic procedure	2	SI/OB	1. Check records for no. of paediatric cases seen in past three months 2. Plaster room procedure	
ME A1.8	The facility provides Skin & VD Services	Availability of functional Skin & VD Clinic	2	SI/OB	1. Skin & VD Clinic providing consultation paediatrics services (shared with main hospital) 2. Check records for no. of paediatric cases seen in past three months	
ME A1.10	The facility provides Dental Treatment Services	Availability of functional Dental Clinic	2	SI/OB	1. Dental Clinic providing consultation services (shared with main hospital) 2. Check records no. of paediatric cases seen in past three months	
		Availability of OPD Dental procedure	2	SI/OB	1. Check records for no. of paediatric cases seen in past three months 2. Accompanied by dental lab. Extraction, scaling, tooth extraction, denture and Restoration.	
ME A1.11	The facility provides AYUSH Services	Availability of Functional Ayush clinic	2	SI/OB	1. AYUSH Clinic providing Paediatrics consultation services (shared with main hospital) 2. Check records for no. of paediatric cases seen in past three months	
ME A1.12	The facility provides Physiotherapy Services	Availability of Functional Physiotherapy Unit	2	SI/OB	1. Physiotherapy Clinic providing Paediatric consultation services (shared with main hospital) 2. Check records for no. of paediatric cases seen in past three months	
ME A1.13	The facility provides services for OPD procedures	Availability of Dressing facilities at OPD	2	SI/OB		
		Availability of Injection room facilities at OPD	2	SI/OB		
ME A1.14	Services are available for the time period as mandated	Check OPD Services are available at least for 6 hours	2	SI/RR		
		Check emergency services are provided to paediatric cases even after OPD hrs	2	SI/RR	(1) Functional linkage with SNCU for all newborns (upto 28 days) (2)Functional linkage with emergency department for paediatric triage - assessment & stabilization	
ME A1.16	The facility provides Accident & Emergency Services	Availability of services for ETAT	2	SI/OB	Linkage with emergency department and inpatient services	
		Availability of services for sexually assaulted child	2	SI/OB	Provide first aid services , medical treatment & inform the police	
Standard A2	Facility provides RMNCHA Services					
ME A2.3	The facility provides Newborn health Services	Availability of immunization services	2	SI/OB	Availability of Functional immunization clinic	
ME A2.4	The facility provides Child health Services	Availability of Functional IYCF clinic	2	SI/OB	Assessment of physical growth & immunisation status and age-appropriate nutritional counselling services	

		Availability of promotion services of overall growth and development of children	2	SI/OB	Provision of health education, health & nutrition counselling	
Standard A3	**Facility Provides diagnostic Services**					
ME A3.1	The facility provides Radiology Services	Availability of Functional Radiology Services	2	SI/OB	Hassle free diagnostic services are available for paediatric cases	
ME A3.2	The facility Provides Laboratory Services	Availability of functional laboratory services	2	SI/OB	Availability of a dedicated Lab technician for sample collection of paediatric cases	
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**					
ME A4.12	The facility provides services as per Rashtriya Bal Swasthya Karykram	Screening and early detection of 4 Ds	2	SI/RR	DELETED	
Standard A5	**Facility provides support services**					
ME A5.3	The facility provides security services	Availability of security services	2	SI/OB	Dedicated staff for paediatric OPD	
ME A5.4	The facility provides housekeeping services	Availability of Housekeeping services	2	SI/OB	Dedicated staff for paediatric OPD	
ME A5.6	The facility provides pharmacy services	Availability of drug storage and dispensing services	2	SI/OB	Dedicated drug dispensing counter for paediatric OPD	
Standard A6	**Health services provided at the facility are appropriate to community needs.**					
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Special Clinics are available for local prevalent diseases/ endemics	2	SI/OB	Ask for the specific local health problems/ diseases .i.e. arsenic poisoning, endosulfane, hameophilia,Acute encephalitis Syndrome (AES) in children, followup for Birth defects etc.	
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	1. Numbering, main department and internal sectional signage are placed. 2. Directional signages are available clearly indicating the paediatric OPD and its ancillary areas vis a vis counselling room, immunization room , breastfeeding corner, lab etc.	
		Display of layout/floor directory	2	OB	The layout should indicate the paediatric services vis a vis examination room, consultation room, immunisation, IYCF counselling, drugs dispensing , lab, imaging, emergency, SNCU, paediatric wards etc very clearly	
ME B1.2	The facility displays the services and entitlements available in its departments	Information regarding services are displayed	2	OB	1. List of available Paediatric OPD Clinic/s 2. Timing for OPD (opening and closing) 3. Important numbers like ambulance ,blood bank etc 4. Turn around time for investigation, 5. grievance re addressal are displayed	
		Names of doctor on duty is displayed and updated	2	OB	Name of doctor, Nurse and Counsellor on duty are displayed and updated.	
		Entitlement under JSSK , RBSK, PMJAY and other schemes are displayed	2	OB	Relevant national or state guidelines are followed for provision of diagnostics, drugs, treatment of children.	
ME B1.3	The facility has established citizen charter, which is followed at all levels	Display of citizen charter in OPD complex	2	OB	Check Citizen charter is shared with main OPD complex, it includes information on: 1. Services available at the facility 2. Timings of different services available 3. Rights of Patients 4. Responsibilities of Patients and Visitors 5. Beds available 6. Complaints and Grievances Mechanism 7. Help desk number	
ME B1.4					DELETED	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC Material is displayed	2	OB	Breastfeeding, Immunization schedule, Management of diarrhoea using Zn & ORS, nutrition requirement of children, KMC and hand washing etc	
		Education material for counselling are available in Counselling room	2	OB	Education material, job aids, dolls, mama's breasts model etc are available for lactation and nutrition Counselling	
		No display of poster/ placards/ pamphlets/videos in any part of the Health facility for the promotion of breast milk substitute , feeding bottles, teats or any product as mentioned under IMS Act	2	OB	Check in Immunization, paediatric OPDs , waiting areas etc.	
		No display of items and logos of companies that produce breast milk substitute, feeding bottles, teats or any product as mentioned under IMS Act	2	OB	1. Check in Immunization, paediatric OPDs , waiting areas etc. 2. Check staff is not using pen, note pad, pen stand etc. which have logos of companies' producing breast milk substitute etc.	
		No information, counselling and educational material is provided to mothers and families on Formula Feed	2	OB	During counselling Mothers and families has been specially educated about ill effects of breast milk substitutes.	
ME B1.6	Information is available in local language and easy to understand	Signages and information are available in local language	2	OB	Check all information are available in local language	
ME B1.7					DELETED	Commom help desk centre availble
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	OPD slip with UID is given to the patient	2	RR/OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female staff if a male doctor examines a female patient	2	OB	1. Due care is taken in examining older female child (she should be examined in the presence of a parent/ relative or a female staff. 2. Examination of mother for lactation support is also provided ensuring complete privacy and dignity	
		Separate toilets for male and female	2	OB	Separate toilets for parent accompanying the children/attendant	
ME B2.3	Access to facility is provided without any physical barrier and friendly to people with disabilities	Dedicated registration counter for paediatric cases	2	OB	Facility takes effort to ensure hassle free registration. Have dedicated counter/ separate counter in centralized OPD registration (provision of dedicated que for school going children)	
		Registration to drug processes are hassle free.	2	OB	Check computerised registration, token system for queuing and patient calling system with electronic display are available to systematise outpatient consultation.	
		Availability of Wheel chair or stretcher for easy Access to the OPD	2	OB	Dedicated wheelchair /stretchers are available for paediatric patients.	
		Availability of ramps with railing	2	OB	At least 120 cm width, gradient not steeper than 1:12	
		Availability of differently abled toilet	2	OB	Wide , placed at lower level, supported with bars & door of toilet is opening outside	
Standard B3	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen/curtain at Examination Area	2	OB	Curtain/screen are available in examination area	
		Availability of screen/curtain at breastfeeding corner	2	OB	(1) Secondary curtain/ screen is used to create a visual barrier in breastfeeding area (2) Curtains/frosted glasses at windows for maintaining privacy	
		One Patient is seen at a time in clinics	2	OB	Only patient and the parent- attendant are permitted inside the clinic	
		Privacy at the counselling room is maintained	2	OB	Privacy (verbal and visual) of mother/parent is ensured while providing counselling services	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Records are placed at secure place beyond access to general staff and visitor	2	SI/OB	1. No information regarding patient / parent identity is displayed 2. Records are not shared with anybody without written permission of parents & appropriate hospital authorities	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB	Check staff is not providing care in undignified manner such as yelling, scolding, shouting and using abusive language for patient or parent-attendant	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of health conditions having social stigma are maintained	2	PI/OB	Check if HIV/leprosy/abuse case etc is not explicitly written on case sheets/slips and avoiding any means by which they can be identified in public	
Standard B4	**Facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitate informed decision making patient.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent is taken from parent/guardian before any investigation	2	RR /PI	Explained about the whole process	
ME B4.2	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.	2	OB	Patient 's rights & responsibilities are displayed (may be shared with main hospital)	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Parent- attendant is informed about the clinical condition and treatment been provided	2	PI	Ask parent attendants/guardians about what they have been communicated about the clinical condition and treatment plan .	

		Pre and Post procedure counselling is given	2	PI/RR	Parent attendant/guardians are counselled before conducting a test, imaging, immunisation or any procedure. Ask parents if they have been counselled about the process and requirement.	
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance redressal and whom to contact is displayed	2	OB	check the completeness of the Grievance redressal mechanism , from complaint registration till its resolution	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**					
ME B5.1					DELETED	
ME B5.2					DELETED	
ME B5.3					DELETED	
ME B5.4					DELETED	
ME B5.5					DELETED	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.9	There is an established procedure to issue of medical certificates and other certificates	Check hospital has documented policy for issuing medical certificates	2	RR/PI	1. Check for policy 2. Who can issue certificates 3. Formats which shall used 4. Record keeping of issued certificate procedures for issuing duplicate certificates 5. Check turn around time to issue certificate	
		Check hospital has documented policy for issuing disability certificates under RBSK	2	RR/PI	1. Check for policy 2. Who can issue certificates 3. Formats which shall used 4. Record keeping of issued certificate procedures for issuing duplicate certificates 5. Check turn around time to issue certificate	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Clinic has adequate space for consultation and examination	2	OB	a. Adequate Space in Clinic, ample space to seat 4-5 people b. The room has handwashing facility .	
		Availability of adequate waiting area	2	OB	a. Waiting area has adequate space and is adjacent or close to the paediatric clinic b. check ambience of the waiting area is child friendly vis a vis cartoon/animals/flowers painting on the wall, child play zone with safe toys, puzzles, blocks, stacking bottle tops and swings.	
ME C1.2	Patient amenities are provide as per patient load	Availability of seating arrangement in waiting area	2	OB	a. As per average OPD at peak time b. separate , movable, safe and comfortable chairs for children are available	
		Availability of sub waiting for separate clinics	2	OB	Separate seating arrangement for immunisation , IYCF Counselling centre, etc.	
		Availability of Drinking water	2	OB	See if water cooler is easily accessible to the visitors	
		Functional toilets with running water and flush are available	2	OB	Two WC and a washbasin should be reserved for children visiting the OPD and fitted accordingly (low WC seats; washbasins at appropriate height, lever operated taps).	
ME C1.3	Departments have layout and demarcated areas as per functions	Dedicated examination area is provided with each clinics	2	OB	Examination table along with foot steps	
		Demarcated area for the assessment and examination of medico-legal cases	2	OB	Such as rape/sexual assault survivors in OPD / Linkage with emergency	
		Demarcated dressing area /room & injection room	2	OB	Can be shared with main OPD	
		Dedicated IYCF Counselling Centre	2	OB	Check availability of IYCF room	
		Dedicated immunization room for children	2	OB		
		OPD has separate entry and exit from IPD and Emergency	2	OB		
		Availability of clean and dirty utility room	2	OB		
		Demarcated Drug dispensing counter for paediatric patients	2	OB	Separate pharmacy/ Separate dispensing counter at OPD pharmacy	
		Check paediatric complex/services are away from isolation and restricted areas	2	OB	TB clinic, isolation room, radiology etc.	
		Demarcated trolley/wheelchair bay	2	OB	Available separately for children	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors at OPD are broad enough to manage stretcher and trolleys	2	OB	Corridor should be wide enough so that 2 stretchers can pass simultaneously	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services in clinics	2	OB	Check availability of functional telephone and intercom connections	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services	2	OB	Layout of OPD shall follow functional flow of the patients, e.g.: Enquiry→Registration→Waiting→Sub-waiting→ Clinic→Dressing room/Injection Room/immunisation→ Diagnostics (lab/X-ray)→Pharmacy→Exit	
		All clinics and related auxiliary services are co located in one functional area	2	OB	Paediatric OPD clinic, emergency, immunisation room, IYCF counselling centre, Pharmacy/drug dispensing counter and any other	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	OPD building does not have temporary connections and loosely hanging wires	2	OB	a. Switch Boards other electrical installations are intact. B. Check adequate power outlets have been provided as per requirement of electric appliances and c. Electrical points are out of reach of children / covered	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the department is non slippery and even	2	OB		
		Paediatric OPD is safe and secure	2	OB	Open spaces are properly secured to prevent fall and injury	
		Windows have grills and wire meshwork	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	OPD has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB	Check the fire exits are clearly visible and routes to reach exit are clearly marked. Check there is no obstruction in the route of fire exits. Staff is aware of assembly points .	
ME C3.2	The facility has adequate fire fighting Equipment	OPD has installed fire Extinguisher that is Class A , Class B, C type or ABC type	2	OB	Check the expiry date for fire extinguishers are displayed as well as due date for next refilling is clearly mentioned.	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR	Staff is aware of RACE (Rescue, Alarm, Confine & Extinguish) & PASS (Pull, Aim, Squeeze & Sweep)	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of paediatric specialist at OPD time	2	OB/RR	a. As per patient load b. 1 for every 50-60 cases; c. Check for specialist are available at scheduled time	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor	2	OB/RR	a. As per patient load b. Trained in paediatric care	
		Availability of Dentist	2	OB/RR	As per patient load	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	a. As per patient load At Injection room, OPD Clinics, immunisation room, IYCF Counselling room DEIC as Per Requirement	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of paramedical staff	2	OB/SI	1 with each doctor where children are weighed & weight is correctly recorded, immunisation status is checked, children < five years are screened for SAM using MUAC, and those with emergency and priority signs are triaged. Check dedicated staff is also available with IYCF counselling centre	
		Availability of staff for lab	2	SI/RR	A dedicated Lab technician for sample collection of paediatric cases	
		Availability of Nutrition Counsellor	2	SI/RR	A Nutrition Counsellor/ IYCF counsellor is appointed to manage this centre and is available for fixed hours (coinciding with timing of outpatient services) to counsel and address referral cases.	
		Availability of technician/ Assistant	2	SI/RR	Audiometrician, Ophthalmic assistant, Dental technician (As per patient load & Shared with main hospital) a. Check services are available for paediatric cases , b. Check record how many paediatric cases have availed services in last three months	

		Availability of Physiotherapist & rehabilitation therapist	2	SI/RR	a. Check services are available for paediatric cases , b. Check record how many paediatric cases have availed services in last three months (As per patient load & Shared with main hospital)	
		Availability of dedicated staff for DEIC as per RBSK guideline	2	SI/RR	Availability of dedicated staff under RBSK: 1. Paediatrician 2. Medical Officer 3. Dentist 4. Physiotherapist / Occupational therapist / Early Interventionist with Physiotherapy/ Occupational therapy background 5. Clinical Psychologist/ Rehabilitation Psychologist 6. Paediatric Optometrist 7. Paediatric Audiologist & Speech pathologist / Early Interventionist with Paediatric Audiology & Speech pathology background 8.Special Educator 9. Lab Technician 10. Dental Technician 11. Manager 12. DEO 13. Counsellor	
ME C4.5	The facility has adequate support / general staff	Availability of house keeping staff & security guards	2	SI/RR	Dedicated for paediatric opd	
		Availability of registration clerks as per load	2	SI/RR	Dedicated for paediatric opd	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate medicine at point of use	Availability of injectables at injection room	2	OB/RR	ARV & TT	
		Analgesics/ Antipyretics/Anti inflammatory	2	OB/RR	As per DG-ESIC list	
		Antibiotics	2	OB/RR	As per DG-ESIC list	
		Anti Diarrhoeal	2	OB/RR	As per DG-ESIC list	
		Antiseptic lotion	2	OB/RR	As per DG-ESIC list	
		Dressing material	2	OB/RR	As per DG-ESIC list	
		IV fluids	2	OB/RR	As per DG-ESIC list	
		Eye and ENT drops	2	OB/RR	As per DG-ESIC list	
		Anti allergic	2	OB/RR	As per DG-ESIC list	
		medicine acting on Digestive system	2	OB/RR	As per DG-ESIC list	
		medicine acting on cardio vascular system	2	OB/RR	As per DG-ESIC list	
		medicine acting on central/Peripheral Nervous system	2	OB/RR	As per DG-ESIC list	
		medicine acting on respiratory system	2	OB/RR	As per DG-ESIC list	
		Other medicine and materials	2	OB/RR	As per DG-ESIC list	
		Availability of vaccine as per National Immunization Program	2	OB/RR	As per Immunization schedule	
ME C5.2	The departments have adequate consumables at point of use	Availability of disposables at dressing room and clinics	2	OB/RR	Examination gloves, Syringes, Dressing material , suturing material etc.	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained at immunization room	2	OB/RR	AEFI Kit - 1 mL ampoule of adrenaline (1:1000) – 3 nos., 1 mL tuberculin syringes / 40 unit insulin syringes without fixed neEMLes, 24/25 G neEMLes of 1 inch length, Swabs. New-born resuscitation kit - Suction catheter (5F, 6F, 8F, 10F) , bag and mask, laryngoscope, endotracheal tubes(2.5, 3, 3.5, 4 and stylets, umbilical catheters , three way stop check	
		Emergency Drug Tray is maintained at injection cum treatment room in OPD	2	OB/SI	Normal Saline (NS),Glucose 25%,Ringer Lactate (RL),Dextrose 5%,Potassium Chloride,Calcium Gluconate,Sodium Bicarbonate,Inj Pheniramine,Inj Hydrocortisone Hemisuccinate/ Hydrocortisone Sodium Succinate ,Inj Phenobarbitone,Inj Phenytoin,Inj Diazepam,Inj Midazolam,Salbutamol Respiratory,Ipratropium Respirator solution for use in nebulizer,Inj Dopamine,I.V Infusion set,I.V Cannula (20G/22G/24G/26G) & Nasal Cannula(Infant, Child, Adult) & oxygen	
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB/RR	Non-invasive blood pressure monitoring (Paediatric and adult cuffs) -1 each, thermometer, Weighing scales (digital) for infants and children (1 each), stethoscope (paediatric), Stadiometer, Infant meter , Measuring tape	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional equipment &Instruments for paediatric clinic	2	OB/RR	Spatula (disposable) -multiple torch Stethoscope (paediatric) Otoscope Resuscitation kit Direct Ophthalmoscope Paediatric Auroscope Ear speculum Magnifying glass Knee hammer	
		Availability of functional equipment &Instruments for IYCF nutrition counselling	2	OB/RR	Digital weighing scales for infants & children, Stadiometer, Infantometer WHO growth standards (Charts) MUAC tapes, Mother Child Protection Card, Dolls and breast models (such as for demonstrating expression of breastmilk), Steel bowl, spoon	
		Availability of functional Equipment/Instruments for emergency Procedures	2	OB/RR	Self-inflating bags & mask with oxygen reservoir: newborn (250 ml), infant (500) & paediatric (750 mL), Newborn, Infant, child masks (00,0,1,2), Oxygen concentrator (if assured power supply) or oxygen cylinder (as backup) with regulator, pressure gauge and flow meter, Suction pumps (electric & foot operated),Nebuliser, Infusion pump, Laryngoscope handle and blades: curved 2,3; straight 1,2; handle 0 size, Pulse oximeter (adult / paediatric probes),Noninvasive blood pressure monitoring (infant, child cuffs)	
		Availability of functional Equipment/Instruments for Orthopaedic Procedures	2	OB	X ray view box, Equipment for plaster room - Traction etc.	
		Availability of functional Instruments / Equipment for Ophthalmic Procedures	2	OB	Retinoscope, refraction kit, tonometer, perimeter, distant vision chart, Colour vision chart.	
		Availability of Instruments/ Equipment Procedures for ENT procedures	2	OB	Audiometer, Laryngoscope, Otoscope, Head Light, Tuning Fork, Bronchoscope, Examination Instrument Set	
		Availability of functional Instruments/ Equipment for Dental Procedures	2	OB	Dental chair, Air rotor, Endodontic set, Extraction forceps	
		Availability of functional Equipment/Instruments for Physiotherapy Procedures	2	OB	Traction, Short Wave Diathermy, Exercise table etc .	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
		Availability of equipment for maintenance of cold chain	2	OB	Deep freezer and ILR , insulated carrier boxes with ice packs	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning & disinfection	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
		Availability of equipment for sterilization	2	OB	Autoclave	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of Fixtures	2	OB	Spot light, electrical fixture for equipment, X ray view box	
		Availability of furniture at clinics	2	OB	Doctors Chair, Patient Stool, Examination Table, Attendant Chair, Table, Footstep, cupboard, wheelchair, trolley, Almirah/ wall mounted cabinets (for storage of consumables, records) etc.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Training on Infection prevention & patient safety	2	SI/RR	Biomedical Waste Management & Infection control and hand hygiene ,Patient safety	

		Training on IYCF	2	SI/RR	Especially for lactation failure or breast problems like engorgement, mastitis etc, and provide special counselling to mothers with less breast milk, low birth weight babies, sick new-born, undernourished children, adopted baby, twins and babies born to HIV positive mothers. At least two service providers trained in advanced lactation management and IYCF counselling skills should be available to deal with difficult and referred cases.	
		Training for RBSK	2	SI/RR	screening, diagnosis , management and referral	
		Training on F-IMNCI (Faility based Integrated Management of Newborn and Child Illnesses)	2	SI/RR	Emergency triage, Resuscitation, monitoring & stabilization	
		Training on Quality Management	2	SI/RR	Triage, Quality Assessment & action planning, PDCA, 5S & use of checklist for quality improvement	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Check facility has system of on job monitoring and training	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	1.BP apparatus, thermometers, weighing scale etc. are calibrated. 2.Check for calibration records and next due date	
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of Medicines in pharmacy and patient care areas					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is process for indenting consumables and drugs in injection/ dressing and immunisation room	2	SI/RR	1. Requisition are timely placed (check with registers) 2. Monthly vaccine utilization including wastage report is updated 3. Stock level are daily updated	
		Check drugs are available in paediatric doses/formulation	2	OB/RR		
		Forecasting of drugs and consumables is done scientifically based on consumption and disease load	2	RR/SI	Staff is trained to forecast the requirement using scientific system	
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in emergency tray and drugs dispensing counter and are labelled	2	OB	1. Check drugs and consumables are kept at allocated space in emergency tray and drugs dispensing counter 2. Drug shelves are labelled. 3. Look alike and sound alike drugs are kept separately 4.EARLY EXPIRY FIRST OUT (EEFO) is practised	
		Vaccine are kept at recommended temperature at immunization room	2	OB	1. Daily cleanliness of cold chain equipment; 2. Twice daily temperature recording	
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates for injectables are maintained at injection and immunization room	2	OB/RR	Records for expiry and near expiry drugs are maintained for stored drugs	
		Expiry dates' are maintained at emergency drug tray and drug dispensing counter	2	OB/RR	Expiry dates against drugs are mentioned at emergency drug tray and drug dispensing counter	
		No expired drug found	2	OB/RR	At drug dispensing counter and emergency tray	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	Minimum reorder level is defined and buffer stock is kept	
		Department maintains stock and expenditure register of drugs and consumables	2	SI/RR	Check stock and expenditure register is adequately maintained	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is no stock out of vital and essential drugs	2	SI/RR	There is procedure for replenishing drugs in emergency tray and drug dispensing counter	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records are maintained	2	OB/RR	1. Check for temperature charts are maintained and updated periodically 2. Refrigerators meant for storing drugs should not be used for storing other items such as eatables	
		Cold chain is maintained at immunization room	2	OB/RR	Check for four conditioned Ice packs are placed in Carrier Box, DPT, DT, TT and Hep B Vaccines are not kept in direct contact of Frozen Ice line	
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination in clinics & procedure area	2	OB	Examination table, Dressing room, injection room, circulation area, counselling room, immunization room, drugs dispensing counter and waiting area	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Only one patient is allowed at a time in clinic	2	OB/SI	1. Adequate seating for parent - patient 2. One clinic is not shared by 2 doctors at one time	
		Limited number of attendant/ relatives are allowed with patient	2	OB/SI	As per hospital policy	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in clinics & waiting areas	2	PI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4	The facility has security system in place at patient care areas	Hospital has sound security system to manage overcrowding in OPD	2	OB/SI	1. Dedicated security guards. 2. Functional CCTV at all entrance, all exit and circulation areas (may be shared with main hospital)	
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place	2	SI		
Standard D4	The facility has established Programme for maintenance and upkeep of the facility					
ME D4.1	Exterior & Interior of the facility building is maintained appropriately	Interior & exterior of patient care areas are plastered , painted & building are white washed in uniform colour	2	OB	1. Building is painted/whitewashed in uniform colour 2. Paediatric OPD is easy to identify	
		Ambience of paediatric OPD is bright and child friendly	2	OB	Check walls are painted with cartoon characters/ animals/ plants/ under water/ jungle themes etc	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof tops, sinks, patient care and circulation areas are Clean	2	OB	1. All area are clean with no dirt, grease, littering and cobwebs. 2. Surface of furniture and fixtures are clean 3. Cleanliness and maintenance of child zone including their swings and toys is ensured	
		Toilets are clean with functional flush and running water	2	OB	Check toilet seats, floors, basins etc are clean and water supply with functional cistern	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB	Window panes , doors and other fixtures are intact	
		Patients Examination couch / beds are intact and painted	2	OB	Mattresses are intact and clean	
ME D4.4	Hospital maintains the open area and landscaping of them	Gardens and child zone are well maintained	2	OB	1. No overgrown bushes /trees 2. Bushes / trees are shaped as animal/birds/child friendly topiaries	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material lying in the OPD	2	OB	Check if any obsolete article including equipment, instrument, records, drugs and consumables	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB	(1) No lizard, cockroach, mosquito, flies, rats, bird nest etc. (2) Anti Termite treatment on wooden items on defined intervals	
Standard D5	The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OPD	2	OB/SI	1. Check for availability of power backup 2. Uninterrupted power supply for cold chain maintenance	
StandardD6	Dietary services are available as per service provision and nutritional requirement of the patients.					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor	2	RR/SI	All children below two years are directed from outpatients to the counselling centre for assessment of physical growth & immunisation status (if not already done in the Paediatric Clinic) and age-appropriate counselling services	
Standard D7	The facility ensures clean linen to the patients					
ME D7.1	The facility has adequate sets of linen	Availability of linen in examination area	2	OB/RR	1. Adequate linen is available in examination area. 2. Child friendly bright coloured and soft linen is used	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Cleanliness & Quantity of washed linen is checked.	2	OB/RR	(1) A person is dedicated for management of OPD laundry. (2) Records are maintained	
Standard D10	Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government					
ME D10.1					DELETED	
ME D10.2					DELETED	
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.					

ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system of recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB	As per hospital administration or state policy	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number & patient demographic records are generated during process of registration & admission	2	RR	Check for patient demographics like baby Name, father's/mother's name , age, Sex, Chief complaint, etc. are clearly recorded	
		Patients are directed to relevant clinic by registration clerk	2	PI/SI	Registration clerk are well versed with hospital processes and lay out	
		Registration clerk is aware of categories of the patient exempted from user charges	2	SI/RR	JSSK, RBSK , ABPMJAY , BPL or any other state specific schemes	
ME E1.2	The facility has a established procedure for OPD consultation	There is procedure for systematic calling of patients one by one	2	OB	Patient is called by Doctor/attendant as per his/her turn on the basis of "first come first examine" basis. However, in case of emergency out of turn consultation is provided.	
		Patient History is taken and recorded	2	RR	Check OPD records for the same	
		Physical Examination is done and recorded wherever required	2	OB/RR	Check details of the physical examination, provisional diagnosis and investigations (if any) is mentioned in the OPD ticket	
		Check OPD records for the treatment plan	2	OB/RR	Check treatment plan and confirmed diagnosis is recorded	
		No Patient is Consulted in Standing Position	2	OB	Proper seating arrangement for the patient and parent-attendant is there. Care is provided in a dignified way.	
		Clinical staff is not engaged in administrative work	2	OB/SI	During OPD hours clinical staff is not engaged in other administrative tasks	
ME E1.3	There is established procedure for admission of patients	There is establish procedure for admission through OPD	2	SI/RR	Check the linkage between OPD , emergency and IPD services. Staff is aware about linkage and no time is wasted in the admission process.	
		There is establish procedure for day care admission	2	SI/RR	Patients requiring day care services receive the care hassle free	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	There is screening clinic for initial assessment of the patients	2	OB	Initial screening is done for all paediatric patients. They are weighed & weight is correctly recorded, immunisation status is checked, children < five years are screened for SAM using MUAC and those with emergency and priority signs are triaged.	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	Procedure for follow up of patients	2	OB/RR	1. Patients (inborn and out born) are followed up for nutritional status and the completion of the treatment & immunisation . 2.Provisioning for follow up at lower level healthcare facilities vis a vis CHC , PHC and HWC.	
		There is fixed schedule for reassessment of patient under observation	2	SI/RR		
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relvent care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is a procedure for consultation of the patient to other specialist with in the hospital	2	SI/RR	Check the established procedure for intradepartmental refer to other specialist if required	
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	Facility has defined criteria for referral	2	SI/RR	1. Referral criteria are defined as per FBNC and state specific guidelines 2. Referral criteria clearly mention the cases referred to the higher and lower centre for treatment/follow up	
		Facility has functional referral linkages to higher facilities	2	SI/RR	1. Details of Referral linkages are clearly displayed in OPD 2. Verify with referral records that reasons for referral were clearly mentioned and rational. 3. Referral is authorized by paediatrician or Medical officer on duty after ascertaining that case can not be managed at the facility.	
		Facility has functional referral linkages to lower facilities	2	SI/RR	Referral linkage to lower down facility for the compliance of the treatment and further follow up.	
		There is a system of follow up of referred patients	2	RR/PI	1. Check referral out record is maintained 2. Check randomly with the referred cases (contact them) for completion of treatment or follow up.	
		ICTC has functional Linkages with ART and state reference Labs	2	RR/SI		
ME E3.4	Facility is connected to medical colleges through telemedicine services	Telemedicine service are used for consultation	2	RR/SI	1. Telemedicine services are available on a fixed day for paediatric cases (for both old and new cases) 2. There is a system in place to give the prior appointment	
		Patient records are maintained for the cases availing the telemedicine services	2	RR/PI	Check the records for completion.	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable cases are identified and safe care is given	2	SI/RR/OB	1.Paediatric cases who are left unattended , orphan/lawaaris are identified and care is provided 2. Police is informed in such cases 3. Appropriate arrangement is made with local NGOs etc.	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	For any critical patient needing urgent attention queue can be bypassed for providing services on priority basis	2	OB/SI	In case of emergency out of turn consultation is provided.	
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for OPD slip if drugs are prescribed under generic name only	2	RR	Check all the drugs in case sheet and slip are written in generic name only	
		A copy of Prescription is kept with the facility	2	RR	Check records	
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use	2	RR	STG for management of pneumonia, AEFI management , management of diarrhoea, new-born resuscitation etc. are available and are followed	
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check OPD slips that drugs are prescribed as per STG	
		Check of drug formulary is available	2	SI/OB	(1) Check On duty doctor is aware of status of drugs available in pharmacy. (2) Updated list of available drugs is provided by pharmacy	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Check complete medication history including over-the- counter medicines is taken and documented	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome specially in chronic cases, Non communicable diseases etc	
Standard E7	**Facility has defined procedures for safe drug administration**					
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR	Verify with prescriptions/OPD slips on sample basis	
		Check for the writing, It is comprehendible by the concerned staff	2	RR/SI	Verify with prescriptions/OPD slips on sample basis	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI	Check for any open single dose vial with left over content intended to be used later on. In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	1. Check availability of formats for reporting and 2. Monthly reporting (nil reporting too)	

		Any adverse event following immunisation is recorded and reported	2	RR/SI	1. Check availability of formats for reporting and 2. Monthly reporting (nil reporting too)	
ME E7.5	Patient is counselled for self drug administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings .	2	SI/PI	Drugs and dosages are well explained by the doctor/nurses or pharmacists	
		Check drugs are not given in hand	2	PI/RR	(1) Check drugs are given in envelop (2) Check envelops are patient friendly having representation of morning, afternoon evening. (3) Check representations are ticked as per prescription for better understanding	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Patient History, Chief Complaint and Examination Diagnosis/ Provisional Diagnosis is recorded in OPD slip	2	RR	Check prescriptions/OPD slips for completion of records	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan and follow up is written	2	RR/PI	1.Detailed treatment and follow up plan is written and is also explained to the parent-attendant 2. Check with parent/guardian are able to explain information received from doctor	
ME E8.4	Procedures performed are written on patients records	Any dressing/injection, other procedure recorded in the OPD slip	2	RR	Details are written and is also explained to the parent-attendant	
ME E8.5	Adequate form and formats are available at point of use	Check for the availability of OPD slip, Requisition slips etc.	2	OB/SI	Check availability of OPD slip, investigation requisition slip , investigation reporting format	
ME E8.6	Register/records are maintained as per guidelines	OPD records are maintained	2	OB/RR	OPD register, immunisation records, counselling register, Injection room register etc	
		All register/records are identified and numbered	2	OB/RR	Check the facility has quality management system in place	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of OPD records	2	OB/SI	(1) Facility ensure safe keeping and easy retrieval of the OPD registers, OPD tickets (as per state guidelines). (2) Electronic patient recording system is available	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.1	There is procedure for Receiving and triage of patients	Emergency & OPD has established & implemented system for sorting of the paediatric patients	2	SI/OB	A. EMERGENCY SIGNS -who require immediate emergency treatment. B. PRIORITY SIGNS- indicating that they should be given priority in the queue, so that they can rapidly be assessed and treated without delay. C. NON-URGENT cases- children can wait their turn in the queue for assessment and treatment.	
		Triage area is earmarked	2	OB	(1) Check triage protocols are displayed (2) All children attending an emergency/OPD are visually assessed immediately (within 30sec) upon arrival by paramedics /support staff positioned in the emergency and in OPD (3) Triage is completed within 15 minutes of arrival or registration by a competent and appropriately trained nurse or doctor &and receive an initial triage assessment	
		Check the procedure is established to identify children with emergency signs in OPD queue	2	SI/OB	Quickly be directed to a place where treatment can be provided immediately, e.g. the emergency room or ward equipped ETAT /SNCU	
		Responsibility of receiving & shifting the patient is defined	2	SI/OB	All staff such as gatemen, record clerks, cleaners, janitors who have early patient contact are trained in triage for emergency signs and know where to send children for immediate management.	
ME E11.2	Emergency protocols are defined and implemented	Emergency protocols for management of paediatric conditions are available	2	SI/RR	(1) Protocols for management of trauma, surgical, orthopaedics, poisoning, drowning , dyspnoea, unconscious, shock & burn (2) Drug dosage charts are available	
		Check physician follows clinical protocols	2	SI/RR	As per disease condition	
		All the emergency paediatric cases are closely monitored	2	SI/RR	(1) Ensure vitals are stable and the child is in no immediate danger of deteriorating. (2) The paediatrician on call assess the child before the transfer is made. to ward/ HDU/referred	
		No patient is transferred to ward/ HDU without primary management & stabilization	2	PI/RR	Check emergency department is conducting initial assessment - provide primary treatment, not only registering the patient & transferring	
		Staff follows stabilisation protocols	2	SI/RR	Stabilisation include some or all: (1) Securing the airway. (2) Establishing secure venous access. Correcting poor perfusion and acidaemia. (3) Obtaining a full history. (4) Carrying out a full physical examination. (5) Performing baseline investigations, e.g.; a chest X-ray, electrolytes or glucose. (6) Performing acute 'aetiological' investigations, e.g.; blood culture before giving antibiotics. (7) Initial treatment of the causative pathology, e.g.; bronchodilators for asthma and antibiotics for sepsis. (8) Deciding on the location of continuing care. (9) Arranging transfer to an appropriate unit (like paediatric ward) or health facility.	
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR	1.Role and responsibilities of staff in disaster is defined 2. Mock drills have been conducted 3. Assembly point and exit points are defined	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB	1. Preferably a personnel has been dedicated for sample collection from Paediatric OPD 2. Labelling is done correctly 3. Pre testing instructions are given properly to the parent-attendant	
ME E12.3	There are established procedures for Post-testing Activities	Clinics are provided with the critical value of different tests	2	SI/RR	1. Reporting mechanism is explained to the parent-attendant; the process should be hassle free 2.Values are displayed in the consultation room. 3. Staff is aware normal reference values 4. System in place for urgent reporting of critical cases	
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**					
ME E20.1	The facility provides immunization services as per guidelines	Availability of diluents for Reconstitution of measles vaccine	2	RR/SI	Use diluent provided by the manufacturer with the vaccine	
		Recommended temperature of diluents is insured before reconstitution	2	RR/SI	Check diluents are kept under cold chain at least for 24 hours before reconstitution Diluents are kept in vaccine carrier only at immunization clinic but should not be in direct contact of ice pack	
		Reconstituted vaccines are not used after recommended time	2	RR/SI	Ask staff about when Rotavirus vaccine, BCG, Measles/MR and JE vaccine are constituted and till when these are valid for use. Should not be used beyond 4 hours after reconstitution.	
		Time of opening/ Reconstitution of vial is recorded	2	RR	Check for records	
		Staff checks VVM level before using vaccines	2	SI	Ask staff how to check VVM level and how to identify discard point	
		Staff is aware of how check freeze damage for T-Series vaccines	2	SI	Ask staff to demonstrate how to conduct Shake test for DPT, TT, HepB, PCV and Penta vaccines Shake Test is not applicable for IPV	
		Staff is aware of applicability of OVP vaccines	2	SI	DPT, TT, Hep B, OPV, Hib containing pentavalent vaccine (Penta), PCV and injectable inactivated poliovirus vaccine (IPV).	
		Discarded vaccines are kept separately	2	SI/OB	Check for no expired, frozen or with VVM beyond the discard point vaccine stored in cold chain	
		Check for DPT, TT, IPV, HepB, PCV and Penta vaccines vials are not kept in direct contact of ice pack	2	SI/OB		
		AD syringes are available as per requirement	2	SI/OB	Check for 0.1 ml AD syringe for BCG and 0.5 ml syringe for others are available	
		Staff knows correct use AD syringe	2	SI	Ask for demonstration , How to peel, how to remove air bubble and injection site	
		Check for AD syringes are not reused	2	OB		
		Check for injection site is not cleaned with spirit before administering vaccine dose	2	OB/SI	Cleaning of injection site with spirit swab is not recommended	
		Vaccine recipient is asked to stay for half an hour after vaccination	2	OB/PI	To observer any Adverse effect following immunization	

		Check the availability of anaphylaxis kit	2	OB	Kit constitute of job-aid, dose chart for adrenaline as per age (1 ml ampoule -3 no.), Tuberculin syringe (1ml-3 no.), 24H/25G needle- 3 no, swabs-3 no. updated contact information of DIO, local ambulance services and adrenaline administration record slip.	
		Check adrenaline is not expired in kit	2	OB	Give non compliance if kit is not available	
		Check person responsible for notifying & reporting of the AEFI is identified	2	OB	Ask the staff regarding the responsibility for notifying and reporting the AEFI	
		Process of reporting and route is communicated to all concerned	2	OB	Ask staff to whom the cases are reported & how	
		Reporting of AEFI cases is ensured by ANM/ Staff nurse/ person providing immunization	2	SI/RR	1. Verify weekly report of AEFI cases. 2. Nil reporting in case of no AEFI case. 3. Verify HMIS report of previous months	
		Antipyretic medicines available	2	SI/RR	Paracetamol Syrup	
		Availability of Immunization card	2	SI/RR	Immunisation card is available and updated	
		Counselling on side effects and follow up visits done	2	SI/RR		
		Staff is aware of minor and serious adverse events (AEFI)	2	SI		
		Staff knows what to do in case of anaphylaxis	2	SI		
ME E20.7	Management of children presenting with fever, cough or respiratory distress is done as per guidelines	Staff is able to identify the babies with respiratory distress	2	SI/RR	(1) RR >60 breaths per min (2) Severe chest in drawing (3) Grunting (4) Apnoea or gasping	
		Staff is aware of common causes of respiratory distress in new-born	2	SI/RR	(1) Pre Term : RDS, Congenital pneumonia, hypothermia & hypoglycaemia (2) Term: Transient tachypnoea of new-born (TTNB), meconium aspiration, pneumonia, asphyxia (3) Surgical cases: Diaphragmatic hernia, Tracheo - oesophageal fistula, B/L choanal atresia (4) other causes: Congenital heart disease, acidosis, inborn errors of metabolism	
		Staff is aware of sign & symptoms of severe pneumonia in children 2 month to 5 yrs.	2	SI/RR	Cough or difficulty in breathing in children with at least one of the following condition : (1) Central Cyanosis or oxygen saturation <90% (2) Severe respiratory distress (laboured of very fast breathing (RR<70 per minute) or severe lower chest indrawing or head nodding or stridor or grunting) (3) Sign of pneumonia with general danger sign (inability to breastfed or lethargy or reduced level of consciousness or convulsions)	
		Staff is aware of assessment & grading of hypothermia	2	SI/RR	Normal Axillary temp- 36.5 -37.5 ^{O}C Cold Stress- 36.4- 36^{O}C Moderate Hypothermia- 35.9- 32^{O}C Severe Hypothermia- <32^{O}C. Assessment through Axillary temp., Skin temperature (using radiant warmer probe) and Human touch.	
		Staff is aware of clinical conditions in which baby can exhibit signs of hypothermia	2	SI/RR	LBW, preterm babies, hypoglycemia,sclerema, DIC and internal bleeding Hypothermic babies show signs of lethargy, irritability, poor feeding, tachypnoea/apnoea etc	
		Staff is aware of common causes of hyperthermia	2	SI	(1) Sepsis (2) Envt. too hot for baby (3) Wrapping the baby in too many layers of clothes, esp. in hot humid climate (4) Keeping new-born close to heater/hot water bottle (5) Leaving the under heating devices i.e. radiant warmer, incubator, phototherapy that is not functioning properly and/to not check regularly	
		Staff is aware of management protocols for hyperthermic babies	2	SI/RR	Examine every hyperthermic baby for infection (1) If temp. is above 39^{O}C, the neonate should be undressed and sponged with tepid water at app. 35^{O}C until temperature is below is below 38 OC (2) If temp. is 37.5- 39^{O}C- Undressing & exposing to room temp is usually all that is necessary. (3) If due too envt. temperature: move baby into colder environment & using loose & light clothes. (4) If due to device- remove the baby from source of heat (5) Give frequent breastfeeds to replace fluids. if the baby cannot breastfeed, give EBM. If does not tolerate feeds, IV fluids may be given (6) Measures the temp. hourly till it become normal	
		Staff is aware of the therapeutic doses of Vitamin D and Calcium Supplementation	2	SI/RR	1. For neonates and infants till 1 year of age, daily 2000 IU of vitamin D with 500 mg of calcium for a 3-month period is recommended. At the end of 3 months, response to treatment should be reassessed 2. From one year onwards till 18 years of age, 3000-6000 IU/day of vitamin D along with calcium intake of 600-800 mg/day is recommended for a minimum of 3 months. 3. Staff is aware of side-effects of excessive administration of Vitamin - D can lead to hypervitaminosis, particularly in infants.	
ME E20.8	Management of children with severe Acute Malnutrition is done as per guidelines	Screening of children coming to OPDs using weight for height and/or MUAC	2	SI/RR	Screening is done and the cases are referred to NRC for appropriate treatment	
		All the children reporting to healthcare facility for any illness are routinely assessed for anaemia	2	SI/RR	All the clinically suspected anaemic children (reported for any illness) undergo Hb estimation All the children referred from field due to palmer pallor- undergo HB level estimation before initiation of treatment.	
		Staff is aware of categorise of anaemia on basis of HB level among the children	2	SI/RR	Among children between 6 month and 5 yrs.) >11 gm/dl- No anaemia 10-10.9 gm/dl- Mild anaemia 7-9.9gm/dl-Moderate anaemia <7gm/dl- Severe Anaemia Among children between 5 yrs-10 yrs. 11–11.4 gm/dl- Mild anaemia 8–10.9 gm/dl- Moderate anaemia <8 gm/dl- Severe anaemia	
		Staff is aware of management of anaemia on basis of Hb	2	SI/RR	No anaemia- 20 mg of elemental iron in 100 mcg folic acid in biweekly regimen Mild & Moderate Anaemia-3mg of iron/kg/day for two months-follow up every 14 days, HB estimation after 2 months. After completion of treatment of anaemia and documenting Hb level >11 gm/dl, the IFA supplementation to be resumed.	
		Staff is aware of dose of IFA syrup for anaemic children (6 months–5 years)	2	SI/RR	6-12month (6-10kg)--1 ml of IFA syrup, once a day 1yr -3 yrs. (10-14kg)--1.5 ml of IFA syrup, once a day 3yrs-5yrs(14-19yrs)-- 2ml of IFA syrup, once a day	
		Staff is aware of clinical manifestation for severe anaemia in children (from 6 month to 10 yrs.)	2	SI/RR	**H/O**- Duration of symptoms, Usual diet (before the current illness), Family circumstances (to understand the child's social background), Prolonged fever, Worm infestation, Bleeding from any site, Any lumps in the body, Previous blood transfusions and Similar illness in the family (siblings) **Examination for-** Severe palmar pallor, Skin bleeds (petechial and/or purpuric spots),Lymphadenopathy,Hepato-splenomegaly, Signs of heart failure (gallop rhythm, raised JVP, respiratory distress, basal crepitations) **Investigation-** Full blood count and examination of a thin film for cell morphology, Blood films for malaria parasites, Stool examination for ova, cyst and occult blood	
		Staff is aware of indications for blood transfusion due severe anaemia	2	SI/RR	All children with Hb ≤4 gm/dl, Children with Hb 4–6 gm/dl with any of the following: – Dehydration – Shock – Impaired consciousness – Heart failure – Deep and laboured breathing – Very high parasitaemia (>10% of RBC)	

ME E20.9	Management of children presenting diarrhoea is done per guidelines	Check for adherence to clinical protocols	2	SI/RR	1. Give ORS to all children with Diarrhoea 2.Give Zinc for 14 days, even if diarrhoea stops	
		Check parents are guided for diarrhoea management	2	SI/RR	1. Continue feeding, including breast feeding in those children who are being breastfed 2. Make a habit of regular hand washing with soap 3. Use clean drinking water	
		Availability of ORT corner	2	SI/RR	Check ORS is freshly prepared. Mother's are counselled to prepare ORS	
ME E20.10	Facility ensures optimal breast feeding practices for new born & infants as per guidelines	Availability of services for Assessment of physical growth & development of children attending OPD	2	SI/RR	Maintenance and updating of growth chart	
		Communication and counselling on optimal infant & young child feeding practices	2	SI/RR	1. Facility supports mothers to maintain breastfeeding and manage its common difficulties 2. Awareness is generated for exclusive breastfeeding till 6 months of age 3. Awareness is generated for complementary feeding from 6 months of age till two years of age	
		Communication and counselling of mothers with less breast milk & sick babies on optimal feeding practices	2	SI/RR	One to one counselling session should be conducted with the mother/caregiver for children born prematurely or with low birth weight, undernourished children, adopted baby, twins and babies born to HIV positive mothers, of mothers producing less milk. Also ensure follow up visits to the facility/ referral centre	
		Check staff is aware and follow the protocol for management of cracked nipples and engorged breast	2	SI/RR	(1) Cracked Nipples- Apply hind milk 2. Engorged breast- encourage the mother to let baby suck without causing too much discomfort. Putting a warm compress on the breast may relieve breast engorgement	
		Check staff is aware and follow the protocol for management of abscess and inverted nipple	2	SI/RR	(1) If an abscess is suspected in one breast, advise the mother to continue feeding from the other breast & refer for consultation (2) Inverted/flat nipple- corrected using syringe	
		Breast milk substitutes are not promoted for newborn or infant unless medically indicated	2	SI/RR	Ask Parents about the counselling	
		Advise & prescription is given for micronutrient supplements (Vitamin A and iron syrup)	2	SI/RR		
ME E20.11	The facility provide services under Rashtriya Bal Swasthya Karyakram (RBSK)	Screening of newborns	2	SI/RR	(1) All newborns delivered at the District Hospital or from outside but admitted in SNCU, postnatal and children wards irrespective of their sickness are screened for hearing, vision, congenital heart disease. (2) In case DEIC is not associated with the facility- appropriate linkage is established for the screening , diagnosis and treatment.	
		Providing referral services to children for confirmation of diagnosis and treatment	2	SI/RR	Screened cases are referred to tertiary care centre for diagnosis and treatment.	
	Area of Concern - F Infection Control					
Standard F1	Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection					
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization & periodic check-up of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Handwashing and infection control audits are done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR	Antibiotic policy is available and staff is aware about it	
Standard F2	Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis					
ME F2.1	Hand washing facilities are provided at point of use	Availability of handwash basin with running water facility at Point of Use	2	OB/SI	1. Check for availability of wash basin and running water at point of use. 2. Ask Staff about regularity of water supply.	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted. Availability of Alcohol based Hand rub	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Handwashing Station is as per specification	2	OB	Availability of taps & Hand washing sink which is wide and deep enough to prevent splashing and retention of water	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Staff is aware of when and how to handwash	2	SI/OB	Ask for demonstration of 6 steps of Hand washing and knowledge among staff about moments of handwash	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability and Use of Antiseptic Solution	2	OB		
Standard F3	Facility ensures standard practices and materials for Personal protection					
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Availability of PPE (Gloves, mask, apron & caps)	2	OB/SI /RR	1.Check if staff is using PPEs. 2. Ask staff if they have adequate supply. 3. Verify with the stock/Expenditure register	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the gloves and masks	2	SI/OB		
Standard F4	Facility has standard Procedures for processing of equipment and instruments					
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of Procedural surfaces	2	SI/OB	Ask staff about how they decontaminate the procedural surface like Examination table , Patients Beds Stretcher/Trolleys etc. (Wiping with 1% Chlorine solution)	
		Cleaning of instruments	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff knows how to make chlorine solution	2	SI/OB		
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	RR/SI	1. Ask staff about temperature, pressure and time for autoclaving. 2. Ask staff about method, concentration and contact time required for chemical sterilization. 3.Check records	
		There is a procedure to ensure the traceability of sterilized packs &their storage	2	OB/SI	1. Sterile packs are kept in dry, clean, dust free, moist free environment 2. separate from unsterilised items- no mixing with unsterile items	
		Autoclaved dressing material is used	2	OB/SI		
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention					
ME F5.1	Functional area of the department are arranged to ensure infection control practices	Facility layout ensures separation of general traffic from patient traffic	2	OB	General patient flow doesn't pass through paediatric OPD	
		Clinics for infectious diseases are located away from main traffic	2	OB	Preferably away from main OPD with independent access, with no access through paediatric OPD	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade disinfectant	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Spill management protocols are implemented	2	SI/RR	Check availability of Spill management kit ,staff is trained for managing small & large spills , check protocols are displayed	
		Cleaning of patient care area with detergent solution	2	SI/RR	Three bucket system is followed	
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping is followed. Staff is trained for preparing cleaning solution as per standard procedure. Cleaning equipment like broom are not used in patient care areas	
Standard F6	Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB		
		Availability of Non chlorinated plastic, colour coded plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI		
		Segregation of infected plastic waste in red bin	2	OB/SI		
		Display of work instructions for segregation and handling of Biomedical waste	2	OB		
		There is no mixing of infectious and general waste	2	OB		
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters and puncture proof box	2	OB	Check if needle cutter has been used or just lying idle, it should be available near the point of generation like nursing station	

		Availability of post exposure prophylaxis	2	OB/SI	1. Staff knows what to do in condition of needle stick injury. 2. Ask if PEP is available. Where it is stored and who is in-charge of that. 3. Also check PEP issuance register	
		Glass sharps and metallic implants are disposed in Blue colour coded puncture proof box	2	OB	Includes used vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled & staff is aware of when to empty the bin	2	SI/OB	Bins should not be filled more than 2/3 of its capacity	
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		
		Staff aware of mercury spill management	2	SI/RR	Check whether department is replacing mercury products with digital products (Aspire for mercury free)	
	Area of Concern - G Quality Management					
Standard G1	The facility has established organizational framework for quality improvement					
ME G9.3					DELETED	
ME G9.4					DELETED	
Standard G2	Facility has established system for patient and employee satisfaction					
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	Client satisfaction survey is done on monthly basis	2	SI/RR	Survey is done amongst parents/guardians	
ME G2.2	Facility analyses the patient feed back and do root cause analysis	Analysis of low performing attributes is undertaken	2	SI/RR		
ME G2.3	Facility prepares the action plans for the areas of low satisfaction	Action plan is prepared and improvement activities are undertaken	2	SI/RR		
Standard G3	Facility have established internal and external quality assurance programs wherever it is critical to quality.					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is a system of daily round by matron/hospital manager/ hospital superintendent for monitoring of services	2	SI/RR	Findings /instructions during the visit are recorded and actions are taken	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5					DELETED	
Standard G4	Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR	Check that SOP for management of OPD services has been prepared and is formally approved	
		Current version of SOP are available with process owner	2	OB/RR	Check current version is available with all staff of Paediatric OPD	
		Work instruction/clinical protocols are displayed	2	OB	Relevant protocols are displayed like management of pneumonia, Summary of the 10 steps to successful breastfeeding is displayed, lactation position and milk expression protocol are displayed in breastfeeding corner and OPD	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Paediatric OPD has documented procedure for Registration and patient calling system	2	RR	Review the SOP for procedure being followed for registration of cases. Paediatric cases should be registered on priority. It is preferable to have separate counter for paediatric cases .	
		Paediatric OPD has documented procedure for receiving of patient in clinic	2	RR	Review the SOP for receiving the patient in clinic . OPD must be equipped to handle emergency cases, in- case a patient seeking emergency care reaches OPD , the triage and transfer process is defined and implemented	
		Paediatric OPD has documented process for consultation	2	RR	Review the process for consultation including examination process, counselling etc.	
		Paediatric OPD has documented procedure for investigation	2	RR/PI	Review the SOP for procedure for conducting investigation. A specific lab personnel is designated for collection of blood samples in children. All other investigations are facilitated and are made hassle free	
		Paediatric OPD has documented procedure for prescription and drug dispensing	2	RR/PI	1. Review the SOP for procedure for legible and rational prescription writing . 2. For drug dispensing , a separate pharmacy or a Drug Dispensing Counter for children is made functional. 3. Pharmacists/nurse explain the drug dosage and route clearly to the parents/guardians (ask patients)	
		Paediatric OPD has documented procedure for nursing process in OPD including initial investigation	2	RR	Review the SOP for procedure for initial assessment of children (weighed & weight correctly recorded, immunisation status, children < five years are screened for SAM using MUAC, and those with emergency and priority signs are triaged).	
		Paediatric OPD has documented procedure for patient privacy and confidentiality	2	RR	Review the SOP for ensuring Privacy and confidentiality.	
		Paediatric OPD has documented procedure for data collection , analysis and undertaking improvement activities	2	RR	Review SOP for various processes which circle undertakes to measure quality of service (client satisfaction form, checklists , audits , performance indicators etc.) , analysis of the data , identification of low attributes, Root cause analysis and improvement activities using PDCA methodology	
		Paediatric OPD has documented procedure for support services and facility management	2	RR	Review the SOP for process description of support services such as equipment maintenance, calibration, housekeeping, security, storage and inventory management	
		Paediatric OPD has documented procedure for infection control and biomedical waste management	2	RR	Review SOP for process description of Hand Hygiene, personal protection, environmental cleaning, instrument sterilization, asepsis, Bio Medical Waste management, surveillance and monitoring of infection control practices	
		Paediatric OPD has established & documented policy for IYCF	2	RR	Check breastfeeding policy is part of or linked with IYCF policy	
		Paediatric OPD has documented procedure for safety & risk management	2	RR	1. Check the availability of updated Risk Management Framework. 2. Check the components of physical, fire, operational and pt safety are covered. 3. Review the updated mitigation plan.	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is aware of relevant part of SOPs	2	SI/RR		
Standard G 5	Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages					
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR	Critical processes are identified and mapped. Value and non value adding processes/ activities are listed.	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR	Non value adding activities are wastes. MUDAS in terms of waste, delays, waiting, motion, over processing , over production etc are identified	
ME G5.3	Facility takes corrective action to improve the processes	Processes are improved and implemented	2	SI/RR	Check the non value adding activities are removed and processes are made lean. Improvement is sustained over a period of time	
Standard G6	The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them					
ME G6.4					DELETED	
ME G6.5					DELETED	
Standard G7	Facility seeks continually improvement by practicing Quality method and tools.					
ME G7.1					DELETED	
ME G7.2					DELETED	
Standards G9	Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all processes should be done using pre define criteria at least once in three month.	
Standard G10	The facility has established clinical Governance framework to improve quality and safety of clinical care processes					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	

ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct prescription audits	2	SI/RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings	
		All non compliance are enumerated recorded for prescription audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per prescription audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
		Check the mapping of existing clinical practices processes is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks					
ME H1.1	Facility measures productivity Indicators on monthly basis	Number of cases in paediatric OPD per month	2	RR	Total and age group wise (neonate, 1 month to 6 months, 6months to 1 year, 1 -2 year , 2 - 5 years)	
		Number of follow-up cases per month	2	RR	Total and age group wise (neonate, 1 month to 6 months, 6months to 1 year, 1 -2 year , 2 - 5 years)	
		Immunization OPD per month	2	RR		
		Number of cases screened under RBSK per month	2	RR	Total and age group wise (neonate, 1 month to 6 months, 6months to 1 year, 1 -2 year , 2 - 5 years)	
		Proportion of cases being given IYCF counselling per month	2	RR	Total and age group wise (neonate, 1 month to 6 months, 6months to 1 year, 1 -2 year , 2 - 5 years)	
		Proportion of cases being referred per month	2	RR	Total and age group wise (neonate, 1 month to 6 months, 6months to 1 year, 1 -2 year , 2 - 5 years)	
		No. of cases disease wise	2	RR	Diarrhoea, pneumonia, fever etc.	
		Proportion of cases being referred disease wise	2	RR	Diarrhoea, pneumonia, fever etc.	
		Proportion of BPL patients	2	RR		
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Paediatric OPD per Doctor	2	RR		
		No. of Stock out days for essential medicines	2	RR	check for pharmacy/drug dispensing counter dedicated to paediatric OPD	
		Drop out rate for Pentavalent vaccination	2	RR		
		IYCF counselling sessions per counsellor	2	RR		
		No. of paediatric Cases seen per paediatrician	2	RR		
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	No. of needle stick injuries reported	2	RR		
		Percentage of AEFI cases reported	2	RR		
		Consultation time at Clinic	2	RR	Time motion study	
		Number of children with diarrhoea treated with ORS and Zinc	2	RR		
		Number of anaemia cases treated successfully	2	RR		
		Number of children with Pneumonia treated	2	RR		
		Proportion of cases requiring DEIC services out of screened	2	RR		
		Percentage of children on exclusive breastfeeding attending OPD	2	RR	up to 6 months of age	
		Number of children with severe & moderate anaemia treated	2	RR		
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Patient Satisfaction Score	2	RR	Parent- attendant group only	
		Waiting time at nutrition counselling centre	2	RR		
		Waiting time at paediatric clinic	2	RR		
		waiting time at drug dispensing counter dedicated for paediatric OPD	2	RR		
		Waiting time at registration counter	2	RR		
		Average door to drug time	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Paediatrics Ward			6
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assesses	
Type of Assessment (Internal/External)		Action plan Submission Date	

Paediatrics Ward Score Card

Area of Concern wise Score			MusQan Paediatrics Ward Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	

	Signature of Assessors					
	Date					

Reference No.	Measurable Element	Checkpoint	Compliance Full/Partial/No	Assessment Method	Means of verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	The facility provides Curative Services					
ME A1.4	The facility provides Paediatric Services	Availability of dedicated paediatric ward	2	SI/OB	(1)Assessment, investigation & treatment of admitted sick children. (2) Monitoring and supportive care for sick children (3) Early identification & referral of children at higher centre (for services not covered under the scope of DH) Give non compliance if paediatric care is given in general male/ female ward	
		Availability of diarrhoea treatment unit	2	SI/OB	(1) Assessment for dehydration (2) Management according to degree of dehydration (3)Rational use of drugs in children with diarrhoea/dysentery (4) Counselling on feeding, danger signs, prevention of diarrhoea	
		Availability of isolation rooms	2	SI/OB	Segregation and management of children with infectious diseases (source isolation)	
ME A1.14	Services are available for the time period as mandated	Availability of nursing care service 24*7	2	SI/PI		
ME A1.17	The facility provides Intensive care Services	Availability of High dependency unit	2	SI/OB	(1) Close , monitoring and treatment to children who have potential to be physiologically unstable (2) Management of children requiring constant oxygen therapy, cardiorespiratory monitoring, inotropic support. (3) Hospital has established linkage for referral and management with tertiary care unit (Paediatric Intensive Care Unit; PICU) if the condition of child deteriorates	
ME A1.18	The facility provides Blood bank & transfusion services	Availability of blood transfusion services	2	SI/RR		
Standard A2	The facility provides RMNCHA Services					
ME A2.4	The facility provides Child health Services	Indoor Management of Acute respiratory infections	2	SI/RR	ARI/Bronchitis, Asthmatics, Pneumonia	
		Indoor Management of Severe Diarrhoea	2	SI/RR	Severe dehydration & shock	
		Indoor Management of childhood illness	2	SI/RR	Meningitis, Liver diseases, convulsions disorders, childhood malignancies, vision & hearing impairment, severe anaemia, Goitre, Pyrexia of unknown reason.	
		Indoor Management of Severe Acute Malnutrition	2	SI/RR	Including vitamin & micronutrient deficiency	
		Management of bones & joints conditions	2	SI/RR	Subluxation of elbow, Rickets, Developmental dysplasia of hip, open & close reduction of bones	
		Management of emergency conditions in children	2	SI/RR	Accidental poisoning, Comma, convulsions, stings, bites, poisoning, paediatric surgical conditions	
Standard A3	The facility Provides diagnostic Services					
ME A3.1	The facility provides Radiology Services	Availability of X ray services	2	OB/RR	(1) Check for functional X ray services for indoor patients (2) Check services are available at night (3) Check records no. of paediatric cases seen in past three months to avail X-Ray services for Chest, Skull, Spine, Abdomen, bones & Dental etc	
		Availability of USG services	2	OB/RR	(1) Check for functional USG services (2) Check records no. of paediatric cases seen in past three months to avail USG services (3)Availability of USG services for neonatal head- using probe for anterior fontanel to check oedema	
ME A3.2	The facility Provides Laboratory Services	Availability of laboratory services	2	RR/OB	Complete blood profile, CSF analysis, urine & stool analysis (Routine & Microscopy), sickle cell anaemia, thalassemia, culture sensitivity, Wilda ,Elisa, RA factor, LFT ,KFT, serum electrolyte, serum calcium, serum bilirubin, BUN, Elisa for TB, Immunoglobin profile, Clotting time etc.	
ME A3.3	The facility provides other diagnostic services, as mandated	Availability of services for Lumber puncture & fundoscopy	2	RR/SI		
Standard A4	The facility provides services as mandated in national Health Programmes/ state scheme					
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Indoor management of Vector Borne Diseases	2	SI/RR	Indoor management of malaria, Chikungunya in endemic areas. Check the records for management of cases in last one year	
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Indoor management of paediatric tuberculosis	2	SI/RR		
ME A4.12	The facility provides services as per Rashtriya Bal Swasthya Karykram	Availability of management services of 4 D's (Defects at birth, Deficiencies, Childhood	2	SI/RR	1. Linkages with DEIC for rehabilitative care 2. Management of developmental dysplasia of hip, congenital	
Standard A5	The facility provides support services					
ME A5.1	The facility provides dietary services	Availability of dietary services	2	SI/OB		
ME A5.2	The facility provides laundry services	Availability of laundry services	2	SI/OB		
ME A5.3	The facility provides security services	Availability of functional security services	2	SI/OB		
ME A5.4	The facility provides housekeeping services	Availability of Housekeeping services	2	SI/OB	including waste disposal	
ME A5.7	The facility has services of medical record department	Availability of services for maintenance & storage of clinical records	2	SI/OB		
Standard A6	Health services provided at the facility are appropriate to community needs.					
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of indoor services as per local prevalent disease	2	SI/RR	Acute encephalitis Syndrome (AES), endosulfane, arsenic poisoning ,haemophilia etc in children. Give full compliance if no such disease exist in area	
	Area of Concern - B Patient Rights					
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities					
ME B1.1	The facility has uniform and user-friendly signage system	Availability departmental &directional signage	2	OB	Numbering, main department and internal sectional signage. Directional signages are given from the entry of the facility	
ME B1.2	The facility displays the services and entitlements available in its departments	Information regarding services are displayed	2	OB	Visiting hours and visitor policy are displayed, Entitlement under RBSK, PMJAY or any state specific scheme are displayed,	

		Necessary Information regarding services provided is displayed	2	OB	Name of doctor and Nurse on duty are displayed and updated. Contact details of referral transport / ambulance displayed	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges for services are displayed	2	OB	User charges if any, are displayed and communicated to parent-attendants.	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC Material is displayed	2	OB	Breast feeding, immunization schedule, Management of diarrhoea using Zn & ORS, Pneumonia prevention, nutrition requirement of children, hand washing, Eat Healthy & Eat safe etc	
		No display of poster/ placards/ pamphlets/videos in any part of the Health facility for the promotion of breast milk substitute , feeding bottles, teats or any product as mentioned under IMS Act	2	OB	Check Paediatric ward, HDU, waiting areas etc.	
		No display of items and logos of companies that produce breast milk substitute, feeding bottles, teats or any product as mentioned under IMS Act	2	OB	1. Check in paediatric wards , waiting areas, HDU etc. 2. Check staff is not using pen, note pad, pen stand etc. which have logos of companies' producing breast milk substitute etc.	
		No information, counselling and educational material is provided to mothers and families on Formula Feed	2	PI/SI	During counselling Mothers and families has been specially educated about ill effects of breast milk substitutes/ formula feed	
ME B1.6	Information is available in local language and easy to understand	Signages and information are available in local language	2	OB	Check all information for patients/ visitors are available in local language	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Discharge summary is given to the patient	2	RR/OB	Check discharge summary provides 1. Information on follow up 2. Diet to be followed at home 3. Contact number for emergency 4. Collaboration for community based care	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Cots in Paed .ward are large enough for stay of mother with child	2	OB	Check Paediatric size cots are not used, As mother/ care giver has to stay along with baby through out the treatment days	
		Availability of Breast feeding corner	2	OB	Check availability of demarcated area for breastfeeding corner along with curtains for privacy & seating arrangement	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair /stretcher for easy access to paed. Ward	2	OB		
		Availability of ramps and railing	2	OB	If not located on the ground floor availability of the ramp / lift If ramp is available check it is at least 120 cm width, gradient not steeper than 1:12	
		Availability of disable friendly toilet	2	OB	Wide , placed at lower level, supported with bars & door of toilet is opening outside	
		Availability of children friendly toilet	2	OB	Children friendly- low WC seats; washbasins at appropriate height, lever operated taps	
ME B2.4	There is no discrimination on basis of social and economic status of the patients	Check care to child is not denied or deferred due to religion, caste, ethnicity, language, paying capacity, educational level & disease conditions	2	OB/PI		
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen at examination room /area	2	OB	Bracket screen	
		Availability of screen/curtain at breastfeeding corner	2	OB	(1) Secondary curtain/ screen is used to create a visual barrier in breastfeeding area	
		Curtains / frosted glass have been provided at windows	2	OB	Check all the windows are fitted with frosted glass or curtains have been provided	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB	(1) Check records are not lying in open and there is designated space for keeping records with limited access. (2) Records are not shared with anybody without permission of parents & appropriate hospital authorities	
		No information regarding patient's identity and details are unnecessary displayed on records	2	SI/OB	Specially HIV or any such cases	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB	Check that staff is not providing care in undignified manner such as yelling, scolding , shouting, blaming and using abusive language etc	
		Child is not left unattended or ignored during care	2	OB/PI	Check that children are left alone at any point of care. Either HCW or their parents/ guardian are available with them	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV status of child is not disclosed except to staff that is directly involved in care	2	PI/ OB	Check if HIV status is not displayed / written at bed side or records etc	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Paed. ward has system in place to take informed consent from patient relative whenever required	2	PI/RR	Check General Consent is taken in case sheet	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Parents/ relatives are communicated about child condition to at least once in day	2	PI	Check parents/ relatives of admitted baby is communicated about child condition, treatment plan and any changes at least once in day	
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re addressal and whom to contact is displayed	2	OB	Check the completeness of the Grievance redressal mechanism , from complaint registration till its resolution	
Standard B5	**The facility ensures that there are no financial barrier to access, and that there is financial protection given from the cost of hospital services.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Indoor treatment is free	2	PI/SI	For RBSK, PMJAY or any state specific scheme patient	
		Availability of free blood, diagnostic & drugs	2	PI/SI	For JSSK, RBSK patient etc	
		Availability of free transport services	2	PI/SI	Availability of Free referral vehicle/Ambulance services.	
		Availability of free stay & Diet	2	PI/SI	(1) For both parent-attendant & Child (2) Availability two meals per paediatric bed per shift (breakfast, lunch & dinner).	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.	2	PI/SI		
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	If any other expenditure occurred it is reimbursed from hospital	2	PI/RR		
		Area of Concern - C Inputs				
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space in wards as per patient load	2	OB	(1) Check there is no cluttering of beds (2) The space between 2 rows of beds is 5 feet and space between two beds 3.5-4.00 feet. Clearance of bedhead from the wall is 1 feet and 2 feet from the opposite bed.	
ME C1.2	Patient amenities are provide as per patient load	Functional toilets with running water and flush are available	2	OB	1 Water Closet for every 6 Indoor beds & 2 washbasin up to 24 persons	
		Functional bathroom with running water are available	2	OB	1 bathroom for every 6 indoor beds	
		Availability of potable drinking water	2	OB	In paediatric ward /in its vicinity	
		Availability of sitting arrangement for patient attendant	2	OB	Availability shaded waiting area for attendant with functional toilet & hand washing facility	

		Availability of bedside lockers & call bell	2	OB	Switches for all beds with indicator lights and location indicator in the nurses' duty station specially if cubicle arrangement is followed	
ME C1.3	Departments have layout and demarcated areas as per functions	Availability of dedicated nursing station	2	OB		
		Demarcated area for Examination & Treatment	2	OB		
		Availability of isolation room	2	SI/OB	Separate room/s, preferably close to paediatric ward	
		Availability of Doctor's & nurses Duty room	2	OB		
		Availability of ancillary area	2	OB	Stores, dirty utility areas	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment	2	OB	of both staff and equipment	
		Corridors are wide enough for patient, visitor and trolley/ equipment movement	2	OB	Corridor should be 3 meters wide	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	Availability of IPD beds as per case load	2	OB	(1) 8-10% of hospital beds are allocated for paediatric ward	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Location of nursing station & patient beds enables easy & direct observation of patient	2	OB		
		Arrangement of different section ensures unidirectional flow	2	OB	Unidirectional flow of goods and services.	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1					DELETED	
ME C2.2					DELETED	
ME C2.3					DELETED	
ME C2.4					DELETED	
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Paediatric ward has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI	Check the fire exits are clearly visible and routes to reach exit are clearly marked. Check there is no obstruction in the route of fire exits. Staff is aware of assembly points .	
ME C3.2	The facility has adequate fire fighting Equipment	Paediatric ward has installed fire Extinguisher that is either Class A , Class B, C type or ABC type	2	OB	Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR	Staff is aware of RACE (Rescue, Alarm, Confine & Extinguish) & PASS (Pull, Aim, Squeeze & Sweep)	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Paediatrician	2	OB/RR	Check for on call during evening and night shifts also.	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of general duty doctor	2	OB/RR	Trained for managing paediatric cases & providing paediatric care	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of nursing staff	2	OB/RR	As per patient load (One nurse for 4-6 functional beds)	
ME C4.5	The facility has adequate support / general staff	Availability of ward attendant & security guard	2	SI/RR	Availability of mamta/ ayahs, Sanitary worker & security guard	
Standard C5	**The facility provides drugs and consumables required for assured services.**					
ME C5.1	The departments have availability of adequate medicines at point of use	Availability of antibiotics	2	OB/RR	Ampicillin, Gentamicin, ,Cefotaxime, Ceftriaxone, benzyl pencillin,cloxacillin, cephalosporin, ciprofloxacin cotrimoxazole, Doxycycline,Metrindazol, Albendazole	
		Availability of oral medicines	2	OB/RR	Syrup Chloroquine, artesunate (Anti malarial medicines), Paracetamol, Vitamin A, IFA tablets, Salbutamol, Frusemide tablets, Anti TB medicines, Iron syrup, adrenaline, calcium gluconate , digoxin, Manitol,Nebuliser solution of salbutamol	
		Availability of parental medicines	2	OB/RR	Ringer's lactate, normal saline , glucose 5%, 10 % & 25%, corticosteroid IV,Furosemide IV, diazepam IM/ IV, cephalosporins IV, Calcium gluconate, Vit K, Potassium chloride, Sodium bicarbonate, Magnesium sulphate inj, Antihistaminic inj, Ranitidine inj.	
ME C5.2	The departments have adequate consumables at point of use	Consumables for Paediatric ward	2	OB/RR	Plastic / disposable syringes · IV cannulas (22G and 24G) · Scalp vein set No. 22 and 24 · IV infusion sets (micro infusion), infusion pump for drip, simple rubber catheter, Nasal prongs, masks	
		Resuscitation consumables	2	OB/RR	Nasogastric tube (8,10,12FG) Suction catheter (6,8,10 FG) Uncuffed tracheal tube (all sizes) Oropharyngeal airway, self inflating bags for resuscitation 250&500ml	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained	2	OB/RR	Normal Saline (NS),Glucose 25%,Ringer Lactate (RL),Dextrose 5%,Potassium Chloride,Calcium Gluconate,Sodium Bicarbonate,Inj Pheniramine,Inj Hydrocortisone Hemisuccinate/ Hydrocortisone Sodium Succinate ,Inj Phenobarbitone,Inj Phenytoin,Inj Diazepam,Inj Midazolam,Salbutamol Respiratory,Ipratropium Respirator solution for use in nebulizer,Inj Dopamine,I.V Infusion set,I.V Cannula (20G/22G/24G/26G) & Nasal Cannula(Infant, Child, Adult) & oxygen	
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	Weighing machine(infant & adult), Stadiometer for height, Infantometer for length, paediatric & adult stethoscope, plus oximeter. BP apparatus with paediatric cuff, multipara monitor, Thermometer, torch ,	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of instrument for treatment & procedures	2	OB	Nebulizer, spacer with mask for administration of metered doses, otoscope, ophthalmoscope, dressing tray, nebulizer	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments	2	OB	Glucometer, Urine Dipsticks, RDT for malaria, Typhoid, Dengue & portable x ray (may be shared with main hospital)	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.	2	OB	Face masks (3 type; Neonate, Infant and paediatric type) Self-inflating ventilation bag (all sizes), Laryngoscope, Suction machines Oxygen supply, ET tube (different sizes)	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning & disinfection	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush,	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of patient beds with attachments &accessories	2	OB	Prop up facility Hospital graded mattress, Bed side locker , IVstand, Bed pan, bed rail	
		Availability of Fixtures	2	OB	Electrical fixture for equipment like suction, X ray view box, cool white fluorescent light/CFL or LED ,	
		Availability of furniture	2	OB	Cupboard, nursing counter, table for preparation of medicines, chair, Call bell	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1					DELETED	

ME C7.7					DELETED	
ME C7.8					DELETED	
ME C7.9					DELETED	
	Area of Concern - D Support Services					
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	Weighting machine, Infantometer, suction machine etc	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	(1) Check log book is maintained & it shows time taken to repair equipment. (2) Backup of critical equipment such as suction machine, nebuliser & pulse oximeter is available (3) Check staff is aware of Contact details of the agencies/ person responsible for maintenance	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	BP apparatus, thermometers weighting scale etc. are calibrated. Check for calibration stickers & records	
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas					
ME D2.1	There is established procedure for forecasting and indenting medicines and consumables	There is established system of timely indenting of consumables and medicines at nursing station	2	SI/RR	1. Stock is updated on defined intervals 2. Requisition are timely placed based on consumption pattern	
		medicines are intended in Paediatric dosages/formulations only	2	OB/RR		
		Forecasting of medicines and consumables is done scientifically based on consumption	2	RR/SI	Staff is trained for forecast the requirement using scientific system	
ME D2.3	The facility ensures proper storage of medicines and consumables	medicines are stored in containers/tray/crash cart and are labelled	2	OB		
		Empty and filled cylinders are labelled & kept separately	2	OB	1. Flow meter, humidifier, cylinder keys & updated data sheet is available with in use of cylinders.	
ME D2.4	The facility ensures management of expiry and near expiry medicines	Expiry dates' of medicines are maintained	2	OB/RR	Records for expiry and near expiry medicines are maintained for drug stored in department & emergency tray	
		No expired drug found	2	OB/RR	Check drug sub store & emergency tray	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock in paediatric ward	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time	
		Department maintained stock and expenditure register of medicines and consumables	2	RR/SI	Check stock and expenditure register is adequately maintained	
ME D2.6	There is a procedure for periodically replenishing the medicines in patient care areas	There is no stock out of vital and essential medicines	2	SI/RR	There is procedure for replenishing medicines in emergency tray and sub stores maintained in department	
ME D2.7	There is process for storage of vaccines and other medicines, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records are maintained	2	OB/RR	Check for temperature charts are maintained and updated periodically. Refrigerators meant for storing medicines should not be used for storing eatables	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic medicines	Check narcotic and psychotropic medicines are kept in lock & key	2	OB/RR		
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at nursing station & patient care areas	2	OB	150 Lux at patient bedside along with Provision of natural light. Illumination of 100 Lux in ward. Illumination level at nursing station- 150-300 Lux.	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Visitor policy is defined & implemented	2	OB/PI	(1) Only one female/ family members allowed to stay with the child, Visiting hour are fixed and practiced (2) There is no overcrowding in the ward	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area nursing station/duty room	2	PI/OB	Room kept between 25° - 30° C (to the extent possible) Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Safe measures used for re-warming children	2	SI/OB	Check availability of Blankets to cover the children/ functional room heaters	
		Side railings has been provided to prevent fall of patient	2	OB		
ME D3.4	The facility has security system in place at patient care areas	Identification band for all children	2	OB		
		Security arrangement in Paediatric Ward	2	OB/SI	Functional CCTV is installed (may be shared with main hospital)	
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place	2	SI		
Standard D4	The facility has established Programme for maintenance and upkeep of the facility					
ME D4.1	Exterior & Interior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB	Check building is plastered, painted/ whitewashed in uniform colour	
		Interior walls of ward are brightly painted and decorated	2	OB	Check walls are painted with cartoon characters/ animals/ plants/ under water/ jungle themes etc	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof tops, sinks, patient care and circulation areas are Clean	2	OB	1. All area are clean with no dirt,grease,littering and cobwebs. 2. Surface of furniture and fixtures are clean 3. Cleanliness and maintenance of child zone including their swings and toys is ensured	
		Toilets are clean with functional flush and running water	2	OB	Check toilet seats, floors, basins etc are clean and water supply with functional cistern	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB	Window panes , doors and other fixtures are intact	
		Patients beds are intact and painted	2	OB	Mattresses are Intact and clean	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the ward	2	OB	Check if any obsolete article including equipment, instrument, records, drugs and consumables	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB	(1) No lizard, cockroach, mosquito, flies, rats, bird nest etc. (2) Anti Termite treatment on wooden items on defined intervals	
Standard D5	The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Check for round the clock piped water supply with overhead tank	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in patient care areas	2	OB/SI	Check availability of power back with 1-2 outlets connected to generator supply, check for functional UPS /emergency lights	
StandardD6	Dietary services are available as per service provision and nutritional requirement of the patients.					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of all children done specially high risk cases	2	RR/SI	1. Check nutritional Assessment is done to provide age appropriate diet by dietician/ nutrition counsellor / doctor. 2. Special nutritional advice is given for cases like diarrhoea, mild under nutrition & disease conditions / specific food intolerance etc 3. Check caregiver/ mother of all children below two years are directed to the counselling centre for breastfeeding & age-appropriate counselling.	
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check the procedure for requisition of different type of diet from ward to kitchen	2	OB/RR	(1) Check dietary requirement of children of various ages are taken into consideration in menu/ diet chart of the hospital (2) Check the menu includes choices that are appropriate to the different cultural needs of children and their families	
		Check for the adequacy and frequency of diet as per nutritional requirement	2	OB/PI	Ask attendant/ patient whether they are satisfied with the Quality & quality of food provided	

		Check facility provide diet for child parents/ guardian staying along with baby	2	PI/RR	Check for Two meals / paediatric bed/ shift is ordered	
ME D6.3		Check paediatric ward is not supplied with the same food as adults	2	PI/SI	Give non compliance if same adult food is provided to children in paediatric ward	
		Check standard procedures are followed for transportation & distribution of diet	2	RR/SI	1. Check food is transported in covered trolley from kitchen/pantry to ward, 2. Food is distributed away from clinical area, 3. Distribution staff adhere to their PPE 4. Check utensil provided are not broken & chipped off. 5. Check the condition of trolley whether it is clean and free from	
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Clean Linens are provided for all occupied bed	2	OB/RR	Check adequate availability of Blankets, draw sheet, bed sheets, pillow with pillow cover and mackintosh.	
		Child friendly bright coloured and soft linen is used	2	OB/RR	Check linen used in paediatric ward is having cartoon characters/ animals/ plants/ jungle themes etc.	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled	2	PI/RR	Ask parents whether the linen is changed as soon as it gets soiled	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR	1. Check linen is clean, stains free & not torn, 2. Check what action is taken in case the linen is torn/ still stained/ unclean.	
Standard D10	**The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	Availability of valid No objection Certificate from fire safety authority	2	RR	Shared with main hospital building	
		Availability of authorization for handling Bio Medical waste from pollution control board	2	RR	Shared with main hospital building	
		Availability of certificate of inspection of electrical installation	2	RR	Shared with main hospital building	
		Availability of licence for operating lift	2	RR	Shared with main hospital building	
ME D10.2					DELETED	
ME D10.3					DELETED	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB	As per hospital dress code	
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.2	There is a system of periodic review of quality of out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/Laundry/Security/Maintenance) provided are done by designated in-house staff.	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration & admission	2	RR	Check for that patient demographics like Name, age, Sex, UID Chief complaint, etc. are recorded in admission records	
ME E1.3	There is established procedure for admission of patients	There is established criteria for admission	2	SI/RR	Check the criteria is defined for admission based on age, clinical sign & symptoms , patient condition, etc & followed	
		There is no delay in treatment because of admission process	2	SI/RR/OB	Admission is done by written order of a qualified doctor. Time of admission is recorded in patient record.	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Procedure to cope with surplus patient load	2	OB/SI	1. Check for provision of extra beds 2. Check no two children are treated at one bed	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Criteria for initial assessment is defined & practiced	2	RR/SI	(1) Check process of initial assessment, triage, identification of emergency, priority & non urgent signs are defined & followed. (2) Check time for initial assessment done is recorded in BHT	
		Patient History, Physical Examination & Provisional Diagnosis is done and recorded	2	RR	Check BHT :- 1. General condition including vital signs are documented 2. Patient H/O is taken & documented 3. Provisional diagnosis is made & written 4. Initial treatment to start is recorded	
		Initial assessment and treatment is provided immediately	2	RR/SI	Initial assessment is documented preferably within 2 hours	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for assessment of stable & critical patient	2	RR/OB	Check BHT for adherence on frequency of assessment	
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identifed through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during departmental transfer	2	SI/RR	Check process followed to transfer/ handover the patient to & from OT, HDU, NRC, emergency etc	
		There is a procedure for consultation of the patient to other specialist with in the hospital	2	RR/SI	Check the process followed in case child require referral to any speciality including DEIC	
		Paediatric ward/ emergency has established criteria for discharge/transfer to High dependency unit	2	RR/SI	Children requiring close supervision, monitoring & supervision, significant potential for physiologically unstable, management of children requiring consent oxygen supply, cardio respiratory monitoring, inotropic support etc	
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.	Patient referred with referral slip	2	RR/SI	A referral slip/card is provide to patient when referred to another health care facility. Check reason for referral are clearly mentioned.	
		Advance communication is done with higher centre	2	RR/SI	1. Referral vehicle is arranged 2. Referral in and out register is maintained	
		There is a system of follow up of referred patients	2	SI/RR	Referred paediatric cases are followed up for appropriate care, completion of treatment & outcome	

		Facility has functional referral linkages with lower facilities	2	RR	(1) Check for referral cards filled from lower facilities (2) ANM of nearby PHC/HWC is informed about discharge follow ups	
ME E3.3	A person is identified for care during all steps of care	Duty Doctor and nurse is assigned for each patients	2	RR/SI		
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification before any clinical procedure	2	OB/SI	(1) Identification tags are used for children less than 5 yrs. (2) There is system in place to identify the patient before drug administration or performing any clinical procedure	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained	2	RR	Check treatment chart are updated and drugs given are marked in. Co relate it with drugs and doses prescribed. Dispensing feed, time of oral drugs, supervision of intravenous fluids etc is recorded	
		There is a process to ensure the accuracy of verbal/telephonic orders	2	SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR	Nursing Handover register is maintained	
		Hand over is given bed side	2	SI/RR	Check staff follows SBAR protocol (situation, background, assessment and recommendation)	
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately	2	RR/SI	Check for nursing note register. Notes are adequately written	
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals for stable & critical patients are monitored and recorded periodically	2	RR/SI	Check for TPR chart, I/O chart, any other vital required is monitored viz lower chest indrawing, coma score or level of consciousness (AVPU: [Alert, Responding to voice, responding to pain, unconscious), temperature and body weight	
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/ SI	Check the measure taken to prevent new born theft, sweeping ,baby fall, adverse events following drugs/vaccine etc.	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI	Triage is done and provide emergency treatment keeping in mind the ABCD steps: Airway, Breathing, Circulation, Coma, Convulsion, and Dehydration.	
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	The facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only	2	RR	Check all the drugs in case sheet and discharge slip are written in generic name only.	
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use	2	RR	STG for Management of Pneumonia, Diarrhoea, ARI/Bronchitis Asthmatic, Severe acute malnutrition, vitamin deficiencies and micronutrient deficiencies, Haematological	
		Check staff is aware of the drug regimen and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per treatment protocols &Check for rational use of antibiotics	
		Availability of drug formulary	2	SI/OB	Staff is aware of formulary	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Check complete medication history including over-the- counter medicines is taken and documented	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome	
		Complete medication history is documented and communicated for each patient at the time of discharge	2	SI/RR	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary"	
		Patients are engaged in their own care	2	PI/SI	"1. Clinician/Nurse counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge"	
Standard E7	**The facility has defined procedures for safe drug administration**					
ME E7.1	There is process for identifying and cautious administration of high alert drugs	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride, Opioids, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist & primaquine not to be given to infants etc	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nurses and doctor.	
ME E7.2	Medication orders are written legibly and adequately	There is process to ensure that right doses of drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided	
		Every Medical advice and procedure is accompanied with date , time and signature	2	RR	Verify case sheets of sample basis	
		Check medication orders are legible & easily comprehendible by the clinical staff	2	RR/SI	Verify case sheets of sample basis	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI	Check for any open single dose vial with left over content intended to be used later on. In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Check 1. Staff is aware of ADR 2. Check for availability of ADR formats 3. Check when is the last ADR reported /Nil reporting	
ME E7.4	There is a system to ensure right medicine is given to right patient	IV Fluid and drug dosages are calculated according to body weight	2	SI/RR	Check for calculation chart	
		Drip rate and volume is calculated and monitored	2	SI/RR	Check the nursing staff how they calculate Infusion and monitor it	
		Administration of medicines done after ensuring 6R's	2	SI/OB	Check Staff follows 6Rs's practice Right patient, Right drugs , Right route, Right time, Right Dosage and after administration, Right documentation.	
ME E7.5	Patient is counselled for self drug administration	Patient attendant's are advice by doctor/nurse about the dosages and timings .	2	PI/SI	Dose & advice is described in vernacular. It is not given directly in hand of relative/patient	
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Day to day progress of patient is recorded in BHT	2	RR	Check at least 2 times/ day notes are recorded in case sheet	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT	2	RR	Check treatment is prescribed in Case records and nursing records (Medication orders, treatment plan, lab investigations)	
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/treatment registers	2	RR	Treatment given is recorded in treatment chart /register	
ME E8.4	Procedures performed are written on patients records	Procedures performed are written on patients records	2	RR	1. Procedures performed (If any) are well explained prior to the patient attendant like ryles tube insertion/ drainage bag maintenance/ nebulization/ Resuscitation, blood transfusion etc 2. Procedure performed viz. Nebulization, Resuscitation, blood transfusion etc are documented	
ME E8.5	Adequate form and formats are available at point of use	Standard Format for bed head ticket/ Patient case sheet available as per state guidelines	2	RR/OB	TPR chart, IO chart, Growth chart , BHT, continuation sheet, Discharge card, Facility specific child death review format - 1. Check for adequate availability of the forms 2. Check for completeness in the filled forms	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, OT register, Diet register, Linen register, Drug intend register, Patient Attendant record that is staying with the patient, Handover register etc	

		All register/records are identified and numbered	2	RR	Unique identification number is given & staff is able to retrieve previous register/records	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB	(1) Records of discharged cases are kept in MRD/ department sub store (2) Check records are retrieval in case of re admission (3) Copy of records is given to next kin only with permission from authorised staff only	
Standard E9	**The facility has defined and established procedures for discharge of patient.**					
ME E9.1	Discharge is done after assessing patient readiness	Paed. HDU has established criteria to transfer to step down	2	SI/RR	Criteria for transfer to step down: Respiratory distress improves, babies on antibiotics for completion of therapy, children who are otherwise stable.	
		Paediatric ward has established criteria for discharge	2	SI/RR	Primary illness is resolved, All infections and other medical complications have been treated, baby maintain temp, baby is accepting mothers milk/feed, Child is provided with micronutrients Immunization is updated etc	
		Discharge is done by a responsible and qualified doctor after assessment in consultation with treating doctor	2	SI/RR	Discharge is done in consultation with treating doctor	
		Patient / attendants are consulted before discharge	2	PI/SI	Time of discharge is communicated to patient in prior	
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary adequately mentions patients clinical condition, treatment given, Nutritional status and follow up	2	RR/PI	See for discharge summary, referral slip provided.	
		Discharge summary is give to all patients	2	SI/RR	Including LAMA/Referral patient	
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge	2	SI/PI	Advice includes the information about the nearest health centre for further follow up. Counsel mother for treatment, follow up, feeding, discharge timings are explained prior	
ME E9.4	The facility has established procedure for patients leaving the facility against medical advice, absconding, etc	Declaration is taken from the LAMA patient	2	RR/PI		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.2	Emergency protocols are defined and implemented	Staff is aware of process & steps for emergency management of sick children	2	SI/RR	(1) Triage - ETAT protocol - keeping in mind ABCD steps (2) Ascertaining the group of baby - Emergency, Priority and non urgent. (2) After identification of emergency & priotize sign- prompt emergency treatment is to be given to stabilize before transfer to ward/HDU or refer	
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR	Role and responsibilities of staff in disaster are defined Mock drills have conducted from time to time	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB	Protocols are defined & followed for sample collection & transfer timely from ward to lab for testing	
ME E12.3	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different tests	2	SI/RR	(1) Critical values are defined and intimated timely to treating medical officer (2) List of Normal reference ranges are available in Paed. Ward	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.9	There is established procedure for transfusion of blood	Patient's identification is confirmed & Consent is taken before transfusion	2	RR	Check whether staff follows the protocol for patient identification and cross validates it with written advice	
		Protocol of blood transfusion is monitored & regulated	2	RR	Blood is kept on optimum temperature before transfusion. Blood transfusion is monitored and regulated by qualified person	
		Blood transfusion note is written in patient records	2	RR	Blood bag details sticker is pasted in case file, patient monitoring status is recorded in case sheet	
		Paediatric blood transfusion bags are used for transfusion	2	RR	Check for adequate availability and utilization of paediatric blood bags	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR	Check - Staff is aware of the protocol to be followed in case of any transfusion reaction	
Standard E15	**The facility has defined and established procedures of Operation theatre services**					
ME E15.2	The facility has established procedures for Preoperative care	Patient evaluation before surgery is coordinated and recorded	2	RR/SI	Vitals , Patients fasting status etc. is managed & informed to OT.	
ME E15.4	The facility has established procedures for Post operative care	Staff is aware of the care protocol of children returned back from surgery	2	SI/RR	1. Staff frequently assess the surgical site in case of any redness, discharge the case in charge is informed immediately. 2. Staff counsel the mother on the techniques of feeding infant post surgery 3. Diet - Soft, mashed diet to be provided to children post surgery. Do not give hard, crunchy foods In cases of cleft lip and cleft palate: General & Specific care directed by Orthodontics viz. Mouth care is maintained post surgery use gauze lock and mouthwash for cleaning. Don't use brush for 3 weeks . Use the arm string/ restrain to avoid thumb/ finger sucking etc	
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives	2	SI	Bad news/adverse event/ poor prognosis are disclosed in quite & private setting	
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note is written as per child death review guidelines	2	RR	Child death are recorded as per CDR guideline. Death note including efforts done for resuscitation. Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**					
ME E20.1	The facility provides immunization services as per guidelines	Immunization services are provided as immunization schedule	2	SI/RR	Check MCP card is available & updated. Mother /care provider is counselled and directed to immunize the child	
ME E20.2	Triage, Assessment & Management of new-borns, infant & children having emergency signs are done as per guidelines	Triage of sick children is done as per protocols	2	SI/RR	Screening of sick child is done to prioritize management as per classification : Emergency sign, priority sign & non urgent sign. All emergency & priority sign are stabilize and child is referred to HDU / higher centre for management	
		Staff is aware of emergency signs in Sick child	2	SI/RR	Obstructed or absent breathing, severe respiratory distress, central cyanosis, signs of shock (cold hands, capillary refill time longer than 3 s, high heart rate with weak pulse, and low or unmeasurable blood pressure),coma, convulsions signs of severe dehydration in a child with diarrhoea	
		Staff is aware of priority signs in Sick child	2	SI/RR	Tiny infant: any sick child aged < 2 months, Temperature: child is very hot, Trauma or other urgent surgical condition, severe Pallor , Poisoning ,severe Pain ,Respiratory distress, Restless, continuously irritable or lethargic, visible severe wasting, Oedema of both feet & major burn	
		Assessment & Management of airway due to breathing obstructions/failure	2	SI/RR	Assess airway & breathing- severe respiratory distress, central cyanosis & obstructed/absent breathing (any of sign positive)- Check (1) if foreign body aspirated. Manage airway in choking child. Check staff is aware of management of choking child, by back slap, chest thrust (infant) back blow (child >1 yr.) (2) If no foreign body is aspirated -Manage air way, give oxygen & keep child warm. Proceed for full investigation & treatment	

		Assessment & management of hypoxaemia	2	SI/RR	(1) Early signs confusion, restlessness & shortness of breath. (2) Determine oxygen level using pulse oximeter. (3) Oxygen supplementation - when child is in respiratory distress & SPo2 is <90%. Child with emergency signs but with out respiratory distress receive oxygen therapy- if SPo2 is <94%. (4) Investigate for underlying cause - viz. Asthma, Pneumonia, Anaemia, ARDS etc	
		Assessment & management of circulation failure cases	2	SI/RR	Cold body with capillary refill longer than 3 sec/ fast & weak pulse. Any sign positive. Check for any bleeding, give oxygen & keep child warm. If malnourishment seen: child is lethargic /unconscious- Insert IV line & Give IV glucose, if child is not lethargic & unconscious- give glucose orally/nasogastric tube, proceed for full investigation & further treatment.	
		Management of coma/convulsion in children	2	SI/RR	Coma/convulsion: Manage the airway, if convulsing, give diazepam rectally,Postion the child (if head & neck trauma is suspected), give IV glucose	
ME E20.7	Management of children presenting with fever, cough/ breathlessness is done as per guidelines	Management of Child with Bronchial Asthma	2	SI/RR	Initial Treatment Salbutamol inhalation 2.5 mg/dose (5 mg/ml solution), by nebuliser every 20 minutes x 3 / Salbutamol inhalation by MDI-Spacer 4 puffs (100mcg/puff) at 2-3 min interval. This course is repeated every 20 minutes x3 / Inj Adrenaline 0.01 ml/kg (maximum of 0.3 ml) of 1:1000 solution subcutaneous every 20 minutes x 3 <u>In case of Moderate to Severe attack Additional -</u> Oxygen Start Steroids; Prednisolone 2mg/kg/day in divided doses **Reassess 30-60 mins If not improve -** Continue bronchodilator 1-2 hly and Ipratropium 8hly; Continue steroids, Give one dose of Mag. Sulph, /aminophylline	
		Staff is aware of sign & symptoms of severe pneumonia in children 2 months to 5 yrs.	2	SI/RR	Cough or difficulty in breathing in children with at least one of the following condition : (1) Central Cyanosis or oxygen saturation <90% (2) Server respiratory distress (laboured of very fast breathing (RR<70 per minute) or severe lower chest indrawing or head nodding or stridor or grunting) (3) Sign of pneumonia with general danger sign (inability to breastfed or lethargy or reduced level of consciousness or convulsions)	
		Management of Severe pneumonia in children 2 month to 5 yrs.	2	SI/RR	Antibiotics: Ampicillin 50mg/kg or Benzyl penicillin 50,000U/Kg IM or IV every 6 hrs. Gentamicin7.5 mg/Kg IM or IV once in a day Give Cloxacillin or Amoxicillin+ clavulanic acid if Staphylococcal infection is suspected (presence of skin pustules or boil) Give Ceftriaxone with vancomycin in case of septic shock) If child does not show signs of improvement with in 48hrs,switch to Gentamicin7.5 mg/Kg IV once in a day combined with Ceftriaxone 100mg/kg IV divided in to 2 doses or cloxacillin 50mg/kg IV 8 hrly. Shift to oral dose as soon as child is able to take it orally, except those with shock or complicated pneumonia where longer parenteral therapy is advised. Duration_ Clinical response with in 48 hrs- 7 days Clinical response after 48 hrs- 10days	
		Staff is aware of Oxygen therapy given for severe pneumonia in children 2 months to 5 yrs.	2	SI/RR	Oxygen saturation <90% - give oxygen to all children or <94% with other emergency sign like shock etc.) Use nasal prongs as preferred method of oxygen delivery to young infant. Use pulse oximeter to guide the oxygen therapy (keep oxygen saturation >90%). If pulse oximeter is not available- continue the oxygen until clinical sign of hypoxia (inability to breastfed or breathing rate > or equal to 70/min) are no longer present.	
		Management of child presenting with severe anaemia	2	SI/RR	Give a blood transfusion to: all children with an EVF ≤ 12% or Hb ≤ 4 g/dl & less severely anaemic children (EVF > 12–15%; Hb 4–5 g/dl) with any of the condition: shock, impaired consciousness, respiratory acidosis (deep, laboured breathing),heart failure, very high parasitaemia (> 20% of red cells parasitized). Give 10 ml/kg packed cells or 20 ml/kg whole blood over 3–4 h. Check the respiratory rate and pulse rate every 15 min. If one of them rises, transfuse more slowly. Give a daily iron–folate tablet or iron syrup for 14 days	
		Staff is aware of indications for blood transfusion due to severe anaemia	2	SI/RR	All children with Hb ≤4 gm/dl, Children with Hb 4–6 gm/dl with any of the following: – Dehydration – Shock – Impaired consciousness – Heart failure – Deep and laboured breathing – Very high parasitaemia (>10% of RBC)	
		Staff is aware of blood transfusion protocols	2	SI/RR	If packed cells are available, give 10 ml/kg over 3–4 hours preferably. If not, give whole blood 20 ml/kg over 3–4 hours.	
		Management of children with seizures	2	SI/RR	(1) Children presenting with acute seizures IV diazepam or IV lorazepam may be used. In case, IV access is not available non-parenteral routes of administration of benzodiazepines is used. Options include rectal diazepam, oral or intranasal midazolam and rectal or intranasal lorazepam. (2) In children with established status epilepticus, i.e. seizures persisting after two doses of benzodiazepines, IV valproate, IV phenobarbital or IV phenytoin can be used, with appropriate monitoring. (3) Check continuous anticonvulsant medications (phenobarbital or valproate) is not used for febrile seizures.	
ME E20.8	Management of children with severe Acute Malnutrition is done as per guidelines	Management of child presented in shock with severe malnourishment	2	RR	(1) Insert IV line, weight the child, give IV fluid 15ml/kg over 1 hr. Use one of the following solutions : – Ringer's lactate with 5% glucose (dextrose); – Half-strength Darrow's solution with 5% glucose (dextrose); – 0.45% NaCl plus 5% glucose (dextrose). (2)Measure the pulse rate, volume and breathing rate at every 5–10 min. (3) If there are signs of improvement (pulse rate falls, pulse volume increases or respiratory rate falls) and no evidence of pulmonary oedema – repeat IV infusion at 15 ml/kg over 1 h; then – switch to oral or nasogastric rehydration & initiate re-feeding with starter F-75./ If the child fails to improve after two IV boluses of 15 ml/kg, – give maintenance IV fluid (4 ml/kg per h) initiate re-feeding with starter F-75 & start IV antibiotic treatment	
ME E20.9	Management of children presenting diarrhoea is done per guidelines	Assessment & Management severe dehydration cases	2	SI/RR	Diarrhoea plus two of signs are positive viz. lethargy, sunken eyes, very slow skin pinch & unable to drink or drink very less. If no severe malnutrition give fluids rapidly & start diarrhoea treatment. If severe malnourishment do not insert IV, proceed for full assessment & treatment.	

		Treatment of child presenting with severe dehydration	2	SI/RR	(1) Start IV fluids immediately. While the drip is being set up, give ORS solution if the child can drink. (2) Start isotonic solutions: Ringer's lactate solution and normal saline solution (0.9% NaCl) is given. Give 100 ml/kg of the chosen solution. If age <12 month: first give 30ml/kg in 1 hr & repeat if radial pulse is weak & then 70ml/kg in 5 hrs. If age is more than or equal to 12 month, first give 30ml/kg in 30min & repeat if radial pulse is weak & then 70ml/kg in 2.5 hrs)	
		Staff is aware of Care of children with Developmental Dysplasia of Hip	2	SI/RR	1. Management in child up to 4 months - Application of Pavlik Harness 2. Management of Child above 4 years - Closed Reduction and hip spica application 3. Follow-up with the patient referred back from tertiary hospitals 4. Frequent Skin care	
ME E20.10	Facility ensures optimal breast feeding practices for new born & infants as per guidelines	Communication and counselling the mothers for exclusive breastfeeding up to 6 months	2	PI/OB	1. Staff support the mother by providing adequate privacy and explaining the benefits of exclusive breastfeeding 2. Staff is aware and follow the protocol for management of cracked nipples, inverted nipples engorged breast etc.	
		Staff counsel the mother for complementary feeding as per IYCF guidelines	2	PI/OB	Awareness is generated for complementary feeding from 6 months of age till two years of age	
		Communication and counselling on optimal infant & young child feeding practices for sick babies	2	PI/SI	For children born prematurely or with low birth weight, one to one counselling session should be conducted with the mother/caregiver and follow up visits to the centre requested.	
		Breast milk substitutes are not promoted for newborn or infant unless medically indicated	2	PI/OB	Ask Parents about the counselling	
Standard E23	**The facility provides National health Programme as per operational/Clinical Guidelines**					
ME E23.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Management of child presenting with uncomplicated malaria	2	SI/RR	For P. vivax, give a 3-day course of artemisinin-based combination therapy. For P. falciparum (with the exception of artesunate plus sulfadoxine–pyrimethamine) combined with primaquine at 0.25 mg base/ kg, taken with food once daily for 14 days. Give oral chloroquine at a total dose of 25 mg base/kg, combined with primaquine.	
		Admission criteria is defined for dengue cases	2	SI/RR	1. Child having high fever, poor oral intake, or any danger signs (Bleeding, red spots or patches on the skin, bleeding from nose or gums, black-coloured stools, heavy menstruation/vaginal bleeding, Frequent vomiting, Severe abdominal pain, Drowsiness, mental confusion or seizures, pale, cold or clammy hands and feet, Difficulty in breathing) 2 If platelet count < 100,000 /cu.mm or rapidly decreasing trend. 3 If haematocrit is rising trend.	
		Staff follows the management protocol for Dengue management.	2	SI/RR	1. Encourage oral fluids. If not tolerated, start intravenous isotonic fluid therapy with or without dextrose at maintenance. Give only isotonic solutions. Start with 5 ml/kg/hour for 1–2 hours, then reduce by 2ml/kg/hour every 2 hours till 2ml/kg/hr provided there is clinical improvement and haematocrit is appropriately improving. IV fluids are usually required for 1-2 days. 2. Reassess the clinical status and repeat the haematocrit after 2 hours. If the haematocrit remains the same, continue with the same rate for another 2–4 hours and reassess. If the vital signs/haematocrit is worsening increase the fluid rate and refer immediately. 3. Switch to oral as soon as tolerated, total fluid therapy usually 24-48 hrs, titrated to adequate urine output.	
		Staff frequently assess the child during the management	2	SI/RR	1. Temperature, Pulse, blood pressure and respiration-every hour (or more often) until stable subsequently 2 hourly. 2. Hourly fluid balance sheet recording the type of fluid and the rate and volume of its administration to evaluate the adequacy of fluid replacement. 3. Chest X-ray, ultrasound abdomen, electrolytes 12-24 hrly as when clinically indicated	
		Discharge criteria is defined for dengue cases	2	SI/RR	1. Absence of fever for at least 24 hrs. 2. Return of appetite. 3. Clinical improvement. 4. Good urine output. 5. Stable haematocrit. 6. 2 days after recovery from shock 7. No respiratory distress from pleural effusion and ascites	
ME E23.11	The facility provide services under National viral Hepatitis Control Programme	Staff is aware of clinical presentation of Acute Hepatitis	2	SI/RR	Signs of Jaundice, unexplained weight loss, loss of appetite, fatigue etc Acute case - elevations in the concentration of alanine and aspartate aminotransferase levels (ALT and AST); values up to 1000 to 2000 international units/L are typically seen during the acute phase with ALT being higher than AST. Chronic is clinically salient	
		Staff is aware of the treatment regimen of HBV Chronic Infection	2	SI/RR	Entecavir (in children 2 years of age or older and weighing at least 10kg. the oral solution should be given to children with a body weight up to 30kg) Recommended once-daily dose of oral solution (mL) Body weight (kg) Treatment –naïve persons* 10 to 11 - 3 >11 to 14 - 4 >14 to 17 - 5 >17 to 20 6 >20 to 23- 7 >23 to 26- 8 >26 to 30 - 9 >30 to - 10mL (0.5 mg) / 0.5 mg tablet once daily Renal function should be monitored annually in persons on long-term tenofovir or entecavir therapy, and growth monitored carefully in children	
		Staff is aware of the treatment regimen for HCV	2	SI/RR	Children with cirrhosis compensated- (pugh A) Sofosbuvir(400mg) + Velpatasvir(100mg) for 84 days(12 wks.) once a day. Children with cirrhosis (Pugh B and C) - decompensated- Sofosbuvir(400mg) + Velpatasvir (100mg) & Ribavirin(600-1200mg**) for 84 days(12 wks.) once a day Ribavirin based on body weight	
	Area of Concern - F Infection Control					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.1	The facility has functional infection control committee	Infection control committee is in place	2	SI/RR	Shared with main hospital. Check paediatrician is part of the committee	
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces such as examination tables, injection tray, isolation wards etc.	
ME F1.3	The facility measures hospital associated infection rates	There is procedure for collection & reporting of incidences of HAI cases	2	SI/RR	(1) Patients are observed for any sign and symptoms of HAI & reported (2) Check there are defined criteria and format for reporting HAI & staff is aware of it (3) Check there is system at place to collate & analyse the data & feed is given to departments	

ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization & periodic check-up of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	(1) Hand washing and infection control audits done at periodic intervals (2) There is designated person for coordinating infection control activities	
ME F1.6	The facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR	(1) There is system for reporting Anti Microbial Resistance with in the facility (2) Policy Includes Rational Use of Antibiotics (3) Check facility measure antibiotic consumption rate & paediatric ward is aware of it	
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing with running Water Facility at Point of Use	2	OB	1. Check for availability of wash basin near the point of use. 2. Check the regularity of water supply.	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	1. Check for availability/ Ask staff if the supply is adequate and uninterrupted. 2. Availability of Alcohol based Hand rub	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps & Hand washing sink	2	OB	Check wash basin is wide and deep enough to prevent splashing and retention of water	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration & check staff awareness about when to wash the hands	
		Mothers are aware of importance of washing hands	2	SI/PI	Mothers are aware of importance of washing hands .Washing hands after using the toilet/ changing diapers and before feeding children.	
		Mothers/care giver adhere to hand washing practices with soap	2	PI/OB	Ask for demonstration	
ME F2.3	The facility ensures standard practices and materials for antisepsis	Availability Use of Antiseptic Solutions	2	OB		
Standard F3	**The facility ensures standard practices and materials for Personal protection**					
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Availability of PPE (Gloves, mask, apron & caps)	2	RR/SI	1.Check if staff is using PPEs. 2. Ask staff if they have adequate supply. 3. Verify with the stock/Expenditure register	
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable PPE	2	OB/SI	No reuse of gloves, Masks, caps and aprons etc.	
		Compliance to correct method of wearing and removing the gloves & Other PPEs	2	SI	Ask for demonstration.	
Standard F4	**The facility has standard procedures for processing of equipment and instruments**					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of examination and procedural surfaces	2	SI/OB	Ask staff how they decontaminate Examination table , Patients Beds Stretcher/Trolleys/ Examination table etc. (Wiping with 1% Chlorine solution)	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like Stethoscope, Dressing Instruments, Examination Instruments, Blood Pressure Cuff etc (Soaking in 1 % Chlorine Solution, Wiping with 1% Chlorine Solution or 70% Alcohol as applicable Contact time for decontamination of instruments	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Cleaning of instruments	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Staff know how to make chlorine solution	2	SI/OB		
		Toys washed regularly, and after each child uses	2	SI/OB	Check records for decontamination and washing of toys	
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	1. Ask staff about temperature, pressure and time for autoclaving. 2. Ask staff about method, concentration and contact time required for chemical sterilization. 3.Check records	
		Staff is aware of storage time for autoclaved items	2	OB/SI	Check staff is aware of how long autoclaved items can be stored. Also, autoclaved items are stored in dry, clean, dust free, moist free environment	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant & cleaning as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade disinfectant & detergent solution	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Spill management protocols are implemented	2	SI/RR	1. Check availability of Spill management kit , 2. Staff is trained for managing small & large spills , 3. Check protocols are displayed	
		Cleaning of patient care area with detergent solution	2	SI/RR	Three bucket system is followed	
		Standard practice of mopping and scrubbing are followed	2	OB/SI	1. Unidirectional mopping from inside out is followed. 2. Staff is trained for preparing cleaning solution as per standard procedure. 3. Cleaning equipment like broom are not used in patient care areas	
ME F5.4	The facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed	2	OB/SI	1. Check there is a separate area for infectious patients like chicken pox, measles, diarrhoea cases . 2. Check staff is aware of barrier and reverse barrier nursing Give non compliance if Diarrhoea or infectious disease cases are kept in corridors or with general patients	
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation	2	OB		
		Availability of Non chlorinated colour coded plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI		
		Segregation of infected plastic waste in red bin	2	OB		
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2	OB		
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters and puncture proof box	2	OB	(1) Check if needle cutter has been used or just lying idle. (2) it should be available near the point of generation like nursing station	
		Availability of post exposure prophylaxis	2	OB/SI	1. Staff knows what to do in case of needle stick injury. 2. Staff is aware of whom to report 3. Check if any reporting has been done 4. Also check PEP issuance register	
		Glass sharps and metallic implants are disposed in Blue colour coded puncture proof box	2	OB	Includes used vials, slides and other broken infected glass	
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled & staff is aware of when to empty the bin	2	SI/OB	Bins should not be filled more than 2/3 of its capacity	
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		

		Staff aware of mercury spill management	2	SI/RR	Check whether department is replacing mercury products with digital products (Aspire for mercury free)	
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1					DELETED	
ME G1.2					DELETED	
Standard G2	**The facility has established system for patient and employee satisfaction**					
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals	Client satisfaction survey is done on monthly basis	2	SI/RR	Feedback is taken from parents/guardians	
ME G2.2	The facility analyses the patient feed back, and root-cause analysis	Analysis of low performing attributes is undertaken	2	SI/RR		
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients	Action plan is prepared and improvement activities are undertaken	2	SI/RR		
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments	There is a system of daily round by matron/hospital manager/ hospital superintendent for monitoring of services	2	SI/RR	Findings /instructions during the visit are recorded and actions are taken	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5					DELETED	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR	Check that SOP for management of departmental services has been prepared and is formally approved	
		Current version of SOP are available with process owner	2	OB/RR	Check current version is available with the departmental staff	
		Work instruction/clinical protocols are displayed	2	OB	Child safety, formula for calculation of paediatric doses , CPR, nutritional requirements with growth charts, Appropriate feeding practices, Summary of the 10 steps of successful breastfeeding, lactation position and milk expression protocol, etc. are displayed	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented Procedure for receiving and initial assessment of the patient	2	RR	Review the SOP has adequately cover procedure for reception, triage initial assessment, admission & investigation of the patient	
		Department has documented procedure for reassessment of the patient as per clinical condition	2	RR	Review the SOP has adequately cover procedure for reassessment, follow up and referral of patient	
		Department has documented procedure for general patient care processes	2	RR	Review the SOP has adequately cover procedure of management of hypothermia, hypoglycaemia, dehydration, electrolyte imbalance, feeding recommendation as per IMNCI, micronutrient supplementation. SOP also cover protocols to be used for paediatric dose preparation as per defined criteria	
		Department has documented procedure for specific processes to the department	2	RR	Department has documented procedure for emergency triage, assessment and treatment. Documented procedure for Management of fever, cough, breathlessness, pneumonia, diarrhoea and malnutrition, documented procedure for blood transfusion, documented procedure for requisition and reporting of diagnostics, documented procedure for end of life care	
		Department has documented procedure for support services & facility management.	2	RR	Review the SOP has adequately cover procedure of nutritional assessment & age appropriate diet, provision of micronutrient supplementation etc. SOP also covers support services such as equipment maintenance, calibration, housekeeping, security, storage and inventory management etc	
		Department has documented procedure for safety & risk management	2	RR	Check availability of risk management record/register to identify risk & action taken to mitigate them	
		Department has documented procedure for ensuring patients rights including consent, privacy confidentiality & entitlement	2	RR	Check availability of documented procedure for taking consent, maintenance of privacy during physical examination. Due care is taken in examining older female child (she should be examined in the presence of a relative or a female staff even if it is not a medico legal case), confidentiality & entitlements various Health Schemes	
		Department has documented procedure for infection control & bio medical waste management	2	RR	Review SOP adequately cover description of Hand Hygiene, personal protection, environmental cleaning, instrument sterilization, asepsis, Bio Medical Waste management, surveillance and monitoring of infection control practices	
		Department has documented procedure for quality management & improvement	2	RR	Review SOP for procedure to constitute quality circles, their regular meetings, development of quality objectives, steps to be take to achieve objectives and their monitoring & measurement mechanisms	
		Department has documented procedure for data collection, analysis & use for improvement	2	RR	1. Check the availability of updated Risk Management Framework. 2. Check the components of physical, fire, operational and pt safety are covered. 3. Review the updated mitigation plan.	
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1					DELETED	
ME G5.2					DELETED	
ME G5.3					DELETED	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4					DELETED	
ME G6.2					DELETED	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					

ME G9.4					DELETED	
					DELETED	
ME G9.5					DELETED	
Standard G9	Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risks are done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre defined criteria at least once in three month.	
Standard G10	The facility has established clinical Governance framework to improve quality and safety of clinical care processes					
ME G10.3					DELETED	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical and referral audits	2	SI/RR	(1) Random referral slips are audited (2) The reasons of the referral is clearly mentioned (3) Referral is written by authorized competent person (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct child death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct prescription audits	2	SI/RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings	
		All non compliance are enumerated recorded for medical and referral audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for prescription audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical and referral audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per prescription audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
		Check the mapping of existing clinical practices processes is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks					
ME H1.1	Facility measures productivity Indicators on monthly basis	Total admissions	2	RR		
		Bed Occupancy Rate	2	RR		
		Proportion of admissions by gender	2	RR		
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Referral Rate	2	RR		
		Discharge Rate	2	RR		
		Relapse rate	2	RR		
		Percentage of children with emergency signs received initial treatment in emergency	2	RR		
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average length of Stay	2	RR		
		Case fatality rate in Paed. Ward	2	RR		
		No of adverse events per thousand patients	2	RR		
		% of infants exclusively breastfed from admission to discharge	2	RR		
		No. of cases treated for severe Anaemia	2	RR		
		No. of cases treated for pneumonia with shock	2	RR		
		No. of cases treated for severe dehydration	2	RR		
		Percentage of viral hepatitis cases managed	2	RR		
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate	2	RR		
		Parent/caregiver Satisfaction Score	2	RR	In Paed. Ward	

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Checklist for Special Newborn Care Unit	7

Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assesses	
Type of Assessment (Internal/External)		Action plan Submission Date	

SNCU Score Card

Area of Concern wise Score			MusQan SNCU Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference	ME Statement	Checkpoint	Compliance/Full/ Partial/No	Assessment Method	Means of verification	Remarks
	Area of Concern - A Service Provision					
Standard A2	Facility provides RMNCHA Services					
ME A2.3	The Facility provides Newborn health Services	Management of low birth weight infants <1800 gm and preterm	2	SI/RR		
		Prevention of infection including management of newborn sepsis	2	SI/RR		
		Management of Neonatal Jaundice	2	SI/RR	Phototherapy for new born	
		Management of Neonatal Asphyxia	2	SI/RR		
		Emergency Management of Newborn Illnesses	2	SI/RR	ETAT , Resuscitation	
		Management of Hypothermia	2	SI/RR	Maintenance of Warmth , Breast feeding/feeding support and Kanaaroo Mother care (KMC)	
		Lactation support & Management Services	2	SI/RR/OB	Counselling, Storage, promotion & support for optimal feeding practices	
		Provision for follow up of high risk babies discharged from the SNCU	2	SI/RR/OB	(1) On fixed Day- for routine examination i.e. anthropometry, growth, developmental screening (2) Valid referral linkage inhouse or with higher centre equipped with developmental/ interventional facilities	
Standard A3	Facility Provides diagnostic Services					
ME A3.2	The Facility Provides Laboratory Services	SNCU has side lab /Linkage for laboratory investigation.	2	SI/OB	(1) Serum bilirubin, Plasma glucose, Serum creatinine, Complete Blood count, Platelet, C reactive protein, Prothrombin time, Blood gas analysis with PH measurement analysis, Serum Creatinine (2) Check availability of services specially at night.	
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme					
ME A4.12	The facility provides services as per Rashtriya Bal Swasthya Karykram	Identification of the New born for Birth Defects & referral for management	2	SI/RR	(1) Neural tube defects, down's syndrome, cleft lip & palate, developmental dysplasia of hip, Club foot, congenital cataract, deafness, heart diseases, retinopathy of prematurity, Linkage with DEIC for rehabilitative care (2) All the birth defects are identified and complete accurate records are uploaded SEAR-NBBD database (online)	
	Area of Concern - B Patient Rights					

Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental signages	2	OB	(1) Numbering, main department and internal sectional signage, Restricted area signage displayed. (2) Directional signages are given from the entry of the facility	
ME B1.2	The facility displays the services and entitlements available in its departments	Necessary Information regarding services provided is displayed	2	OB	(1) Name of doctor and Nurse on duty are displayed and updated. (2) Contact details of referral transport / ambulance displayed. (3) Entitlements under JSSK, RBSK, or any relevant scheme are displayed	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	Display of information for education of mother /relatives	2	OB	Display of pictorial information/ chart regarding expression of milk/ techniques for assisted, feeding , KMC, complimentary feeding, Nutrition requirement of children , hand washing & Breastfeeding policy etc.	
		Parents/family attendants are educated for providing care to their admitted sick new-born	2	PI/OB	As per family participatory care guidelines	
		Counselling aids are available for education of parents/ guardian	2	OB	Audio Visual Films, Scrolls, Job Aids, mama's breast model etc are available to provide counselling for lactation, nutrition	
		No display of poster/ placards/ pamphlets/videos in any part of the Health facility for the promotion of breast milk substitute , feeding bottles, teats or any product as mentioned under IMS Act	2	OB	Check in Immunization, paediatric OPDs , waiting areas/ outside SNCU etc.	
		No display of items and logos of companies that produce breast milk substitute, feeding bottles, teats or any product as mentioned under IMS Act	2	OB	1. Check in SNCU Complex including waiting areas 2. Check staff is not using pen, note pad, pen stand etc. which have logos of companies' producing breast milk substitute etc.	
		No information, counselling and educational material is provided to mothers and families on Formula Feed	2	OB	During counselling Mothers and families are specially educated about ill effects of breast milk substitutes.	
ME B1.6	Information is available in local language and easy to understand	Signages and information are available in local language	2	OB	Check all information for patients/ visitors are available in local language	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Privacy is maintained in breast feeding and KMC room/area	2	OB	(1) Screens / Partition has been provided between mothers (2) Visual privacy is maintained in milk expression area	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB	(1) Check records are not lying in open and there is designated space for keeping records with limited access. (2) Records are not shared with anybody without written permission of parents & appropriate hospital authorities	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	OB/PI	Check staff is not providing care in undignified manner such as yelling, scolding, shouting and using abusive language to mother in SNCU and MNCU	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	SNCU has system in place to take informed consent from parent/ guardian/ relative whenever required	2	SI/RR	Check BHT/ Pt file General Consent form is taken and signed.	
ME B4.2	Patient is informed about his/her rights and responsibilities	Check mothers of inborn and outborn baby have been allotted space to stay especially in case of long stay of sick newborn.	2	OB/PI	Also check provision for their stay and diet	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	SNCU has system in place to involve patient /relatives in decision making as per Family Participatory guidelines	2	PI	Check parents/ relatives of admitted baby is communicated about newborn condition, treatment plan and any changes at least once in day	
ME B4.5	Facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re addressal and whom to contact is displayed	2	OB	Check the completeness of the Grievance redressal mechanism , from complaint registration till its resolution	
Standard B5	**The facility ensures that there are no financial barrier to access, and that there is financial protection given from the cost of hospital services.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Check all services including drugs, consumables, diagnostics and blood are provided free of cost	2	PI/SI	Ask mother or attendants if they have paid for any services or any informal fees given to service providers	
		Availability of free transport services	2	PI/SI	Availability of Free drop back, availability of Free referral vehicle/Ambulance services	
		Availability of free stay & Diet to mother	2	PI/SI	Check with mother about stay facility (specially mother of outborn newborn) Check with mother if she is getting adequate meal at least 3 times	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.	2	PI/SI	Ask parent attendants/guardians if they purchased any drug/consumable from outside	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.		PI/SI	Ask parent attendants/guardians if they got any diagnostic investigation done from outside	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	System of reimbursement exist in case any expenditure incurred in the treatment	2	PI/SI/RR		
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space in SNCU without cluttering	2	OB	(1) Floor area of 50 sq. ft per bed is required for patient care area with additional 50 sq. ft for ancillary area. (2) Additional space is required for step down area. (3)Space between 2 adjacent beds in SNCU should be 4 ft. Space between wall and beds is 2 ft	
		Adequate space in MNCU as per the load	2	OB	As per MNCU guideline	
ME C1.2	Patient amenities are provide as per patient load	Availability adequate waiting area for patient relatives	2	OB	Waiting areas are along with toilet, Drinking water, seating arrangement, TV for entertainment & Health Promotion activities , Tea/coffee vending machine	
		Availability of space for mothers of admitted sick newborn to stay	2	OB	Check availability of beds, bathing facility, toilets and diet supply	
ME C1.3	Departments have layout and demarcated areas as per functions	SNCU has earmarked triage area	2	OB	Demarcated reception and resuscitation area	
		SNCU has newborn care area	2	OB	To accommodate at least 20 radiant warmer, separate outborn may not required if strict asepsis is followed	
		SNCU has designated area for infected cases as isolation ward	2	OB	(1) Varicella, Diarrhoea (2) Strict asepsis protocol are followed	
		Clean area for mixing intravenous fluids and Medications/ fluid preparation area	2	OB	Area is clean & entry to area is restricted	
		SNCU has a designated follow-up area	2	OB	For counselling during discharge and imparting FPC training	
		Mother's area for expression of breast milk/ Breast feeding, gowning area & Handwashing area	2	OB	SNCU has system in place to call mother's of baby for feeding	
		SNCU Complex has designated space for MNCU	2	OB	(1) Part of SNCU complex/ Area in close proximity (2) Check Stepdown and KMC unit amalgamated as part of MNCU	
		Dedicated space for support services	2	OB	Autoclaving room, washing area, change room & Dirty Utility , Dining area	
		Demarcated ancillary area	2	OB	Doctors duty room Unit stores & Side Lab	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy movement	2	OB		
		Check availability of buffer zone beyond the door of SNCU	2	OB	Check entry is restricted - visitors are not allowed without permission	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	Availability of adequate patient care units as per case load	2	OB		
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Check maternity complex & SNCU is in close proximity	2	OB	SNCU is easily accessible from labour room, maternity ward and obstetric OT	
		Arrangement of different section ensures unidirectional flow	2	OB	Unidirectional flow of goods and services.	
Standard C2	**Facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	SNCU does not have temporary connections and loosely hanging wires	2	OB	Switch Boards other electrical installations are intact	
		SNCU has mechanism for periodical check / test of all electrical installation by competent electrical Engineer	2	OB/RR	SNCU has system for power audit of unit at defined intervals and records of same is maintained	
		10 central Voltage stabilize outlets are available with each warmer in main SNCU, Step down area and triage room	2	OB/RR	50% of each should be 5amp and 50% should be 15 amp to handle load of equipment	

		SNCU has earthling system available	2	OB/RR	(1) SNCU has three phased stabilized power supply to protect the equipment from electrical damage. (2) Wall mounted digital display is available in SNCU to show earth to neutral voltage. (3) Earth resistance should be measured twice in a year and logged. Normal range 3-5 V (if exceed to report immediately)	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the SNCU are non slippery and even	2	OB	The floor of the SNCU complex is made of anti-skid material.	
		Windows/ ventilators if any are intact and sealed	2	OB		
Standard C3	**Facility has established program for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	SNCU has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI	Check the fire exits are clearly visible and routes to reach exit are clearly marked. Check there is no obstruction in the route of fire exits. Staff is aware of assembly points & policy to evacuate SNCU in case of fire	
ME C3.2	The facility has adequate fire fighting Equipment	SNCU has installed fire Extinguisher that is either Class A , Class B, C type or ABC type	2	OB	Check the expiry date for fire extinguishers are displayed as well as due date for next refilling is clearly mentioned	
		SNCU has provision of Smoke and heat detector & fire alarm	2	OB	SNCU has electrical and automatic fire alarm system or alarm system sounded by actuation of any automatic fire extinguisher	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR	Staff is aware of RACE (Rescue, Alarm, Confine & Extinguish) &PASS (Pull, Aim, Squeeze & Sweep)	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of fulltime Paediatrician	2	OB/RR	At least one paediatrician/ FBNC trained medical officer per shift	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	3 per shift	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability technician for side lab	2	OB/SI	1 technician (if side lab is available). Give full compliance if there is functional linkage with Hospital's lab and lab tech is available at night even	
ME C4.5	The facility has adequate support / general staff	Availability of SNCU support staff	2	SI/RR	Availability of sanitary staff and ayahs, Security staff & data entry operator	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate medicines at point of use	Availability of Antibiotics	2	OB/RR	Ampicillin, Cefotaxime, Gentamycin, Amikacin, Piperacillin, Meropenem	
		Availability of antiepileptic medicines (AEDs)	2	OB	Lorazepam, Phenytoin and Phenobarbitone	
		Availability of analgesics and antipyretics	2	OB/RR	Paracetamol	
		Availability of IV Fluids & medicines for electrolyte imbalance	2	OB/RR	5%, 10%, 25% Dextrose Normal saline, Inj. Potassium Chloride 15%, Isolyte-P, distilled water. Inj. Calcium Gluconate 10%	
		Availability of Supplements	2	OB/RR	Vit D, Calcium, Phosphorus, multivitamin & iron	
ME C5.2	The departments have adequate consumables at point of use	Availability of consumables for new born care	2	OB/RR	Gauze piece and cotton swabs, Diapers, Baby ID tag, cord clamp, mucus sucker, Gauze piece and cotton swabs.	
		Availability of syringes and IV Sets /tubes	2	OB/RR	Neoflon 24 G , micro drip infusion set with &without burette, BT set, Suction catheter, PT tube, feeding tube, pedia drip set	
		Availability of consumables for mother/family attendant	2	OB/RR	Gowns (disposable /autoclavable) while entering inside SNCU and also while providing KMC	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained	2	OB/RR	Inj.Adrenaline (1:10000) Inj. Naloxone Sodium Bicarbonate Injection Aminophylline Phenobarbitone (Injection +oral) Injection Hydrocortisone,Inj.Dexamethasone, Inj. Phenytoin, Vit K , Caffeine citrate	
Standard C6	**Facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	Multipara monitor , Thermometer, Weighing scale, pulse oximeter, Stethoscope (binaural, neonate),stethoscope (paediatric), Infantometer , Measuring tape, fluxmeter	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of diagnostic instruments for side laboratory	2	OB	Availability of services in side lab; Micro hematocrit,Multistix,Bilirubinometer,Microscope,Dextrometer, Glucometer, test stripes, 26 gauge needle or lancet, alcohol for skin preparation	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Functional Critical care equipment for Resuscitation.	2	OB	Infusion pumps,Oxygen cylinder/central line/Oxygen concentrator, oxygen hood, Self inflating Bag and masks (Size 00, 0 & 1) 250 ml &500 ml, laryngoscope (with 0 &1 size straight blades) , ET tubes, suction machine	
		Functional Patient care units	2	OB	20 Radiant warmers -servo controlled with oxygen & suction and 6 phototherapy machine	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of neonatal transport equipment	2	OB	Transport incubator with temp probes, digital thermometer, oxygen cylinder with flowmeters, oxygen tubing adapter, oxygen hood, neonatal size masks & cannula, resuscitation bags, nasal prong, endotracheal tubes, mucus suction trap, feeding tube, infusion pump etc	
		Availability of equipment for cleaning, washing sterilization and disinfection	2	OB	Buckets for mopping, Separate mops for ward and circulation area, duster, waste trolley, Deck brush, washing machine, Autoclave	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of furniture & fixture	2	OB	Cupboard, nursing counter, table for preparation of medicines, chair, furniture at breast feeding room, X ray view box.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Facility based New Born Care (FBNC) training	2	SI/RR	To all Medical Officers and Nursing Staff posted at SNCU -4 days class room training followed by 14 days observership at recognized collaborating centre	
		NRP module training for updated protocols of neonatal resuscitation	2	SI/RR	To all Medical Officers and Nursing Staff posted at SNCU	
		ETAT training	2	SI/RR	All the staff working in SNCU	
		Training on IYCF	2	SI/RR	Especially for lactation failure or breast problems like engorgement, mastitis etc, and provide special counselling to mothers with less breast milk, low birth weight babies, sick new-born, undernourished children, adopted baby, twins and babies born to HIV positive mothers. At least two service providers trained in advanced lactation management and IYCF counselling skills should be available to deal with difficult and referred cases.	
		Biomedical Waste Management& Infection control and hand hygiene ,Patient safety	2	SI/RR	Check training records	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Check facility has system of on job monitoring and training	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		SNCU staff is provided with refresher training	2	SI/RR	Check with training records the SNCU staff have been provided refresher training at least once in every 12 month on care of normal and sick newborn at time of birth & beyond & Breast feeding support	
		Nursing staff is skilled to train parent-attendants for providing care to the sick newborn	2	SI/ PI	As per family participatory care guidelines	
	Area of Concern - D Support Services					
Standard D1	**Facility has established program for inspection, testing and maintenance and calibration of equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	Radiant warmer, Phototherpy units suction machine, Oxygen concentrator, pulse oximeter/ Multipara monitor	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	Check for breakdown & Maintenance record in the log book Back up for critical equipment. Label Defective/Out of order equipment and stored appropriately until it has been repaired.	
		Staff is skilled for cleaning, inspection & trouble shooting of the equipment malfunction	2	SI/RR	(1) Staff is trained for use, preventive maintenance and trouble shooting of equipment such as radiant warmers, infusion pump, oxygen concentrator, bag &mask, weighting machine, phototherapy unit. (2) There is procedure to check timely replacement of lights in Phototherapy unit.	

		Check the skill of staff for maintenance & trouble shooting of oxygen concentrator	2	SI/ OB	**Maintenance-** Coarse filter- Ensure it is dust free & wash daily Zeolite granule- change after 20,000 hrs Bacterial filter- change every yr. **Trouble Shooting-** Machine is too noisy- May be coarse filter is blocked- wash filter daily. Machine or room gets heated- Machine is near wall- Keep away from wall or outside the room for free circulation of air Yellow light is not going off- desired oxygen conc. is not reached- may be due to high humidity or flow rate is more, so decrease flow rate. Compressor heats up- Malfunctioning of compressor- Look at fan, it may be jammed, & hence need repair. If central oxygen supply is used - Check staff is aware of it maintenance & trouble shooting	
		Check the skill of staff for maintenance & trouble shooting of phototherapy units	2	SI/RR	Low irradiance : Due to tubes old, flickering, black ends, bulbs covered with dust or dirty reflectors)	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	(1) BP apparatus, thermometers, weighing scale , radiant warmer etc are calibrated . (2) Check for records /calibration stickers. (3) There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due.	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipment are readily available with SNCU staff.	2	OB/SI	Check operating and trouble shooting instructions of equipment are available in SNCU	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs	2	SI/RR	Stock level are daily updated Requisition are timely placed well before reaching the stock out level. Check with stock and indent registers.	
		Drugs are indented & supplied in Paediatric dosages only	2	OB/RR/SI	Check drugs are available in paediatric doses/formulation	
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled	2	OB	Check drugs and consumables are kept at allocated space in Crash cart/ Drug trolleys and are labelled. Look alike and sound alike drugs are kept separately	
		Empty and filled cylinders are labelled and updated	2	OB	Empty and filled cylinders are kept separately and labelled, flow meter is working and pressure/ flow rate is updated in the checklist	
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry and near expiry dates are maintained	2	OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray and drug stored at department	
		No expiry drug found	2	OB/RR	In SNCU sub store as well as drug/emergency trays	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	At least once in a week- minimum buffer stock is maintained. Minimum stock and reorder level are calculated based on consumption in a week accordingly	
		Department maintained stock and expenditure register of drugs and consumables	2	RR	Check stock and expenditure register is adequately maintained	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is procedure for replenishing drug tray /crash cart	2	SI/RR	There is no stock out of drugs and Procedure for replenishing drug in place	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records are maintained	2	OB/RR	Check for temperature charts are maintained and updated periodically. Refrigerators meant for storing drugs should not be used for storing other items such as eatables	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination patient care unit & nursing station	2	OB	200 Lux at the plane of infant bed, adjustable Ambient lightening at least 50 to more than 600 Lux. Illumination level at nursing station- 150-300 Lux Light source is glare free or veiling reflections	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Visitor policy is defined & implemented	2	OB/SI	(1) One trained female family member allowed to stay with the new born in step down after undertaking all universal precaution measures like bathing, wearing gowns, mask, head cap etc. (2) Entry to SNCU is restricted, (3) Visiting hour are fixed and practiced	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	SNCU has system to control temperature and humidity and record of same is maintained	2	SI/RR	Temperature inside main SNCU should be maintained at (28+/- 2^{0}C), round O clock preferably by thermostatic control. Relative humidity of 30-60% should be maintained	
		SNCU has procedure to check the temperature of radiant warmer ,phototherapy units, baby incubators etc.	2	SI/RR	Each equipment used should have servo controlled devices for heat control with cut off to limit increase in temperature of radiant warmers beyond a certain temperature or warning mechanism for sounding alert/alarm when temp increases beyond certain limits	
		SNCU has system to control & monitor sound level	2	SI/RR	Control the sound producing activities and gadgets (like telephone sounds, staff area and equipment). Should not keep beeping at high volume (Not more than 45 db and peak intensity should not be more than 80 db)	
		SNCU has system of switching off light when not performing any activity /at night	2	OB		
ME D3.4	The facility has security system in place at patient care areas	New born identification band and foot prints are used	2	OB/RR	There is procedure for handing over the baby to mother/father/Legal Guardian	
		Check security arrangement at SNCU are robust	2	OB	Restriction Signage, security guard in each shift, functional CCTV camera, define & practice procedure for handing over the baby to mother/father	
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior & Interior of the facility building is maintained appropriately	Interior & exterior of patient care areas are plastered & painted & building are white washed in uniform colour	2	OB	Wall and Ceiling of SNCU is painted and made of white wall tiles, with seamless joint, and extending up to the ceiling.	
ME D4.2	Patient care areas are clean and hygienic	Walls & sinks are cleaned as per schedule	2	OB	(1) At least once a day (2) With hospital grade disinfectant	
		Mopping of SNCU is done as per schedule	2	OB/ RR	(1) At least 3 times in a day	
		Floors, walls, roof, roof tops, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs. Surface of furniture and fixtures are clean	
		Toilets are clean with functional flush and running water	2	OB	Check toilet seats, floors, basins etc are clean and water supply with functional cistern has been provided.	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB	Check for patient care as well as auxiliary areas	
		Window panes , doors and other fixtures are intact	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the SNCU	2	OB	Check for any obsolete article including equipment, instrument, records, drugs and consumables	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB	No lizard, cockroach, mosquito, flies, rats, bird nest etc.	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Availability of 24X7 Running water & hot water facility.	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in patient care areas	2	OB/SI	Check for 24X7 availability of power backup including dedicated UPS and emergency light	
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen and vacuum supply	2	OB		
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done specially for mother of admitted baby	2	RR/SI		
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check for the adequacy and frequency of diet as per nutritional requirement	2	OB/RR	(1) Check diet is provided to all mothers (both inborn or outborn babies) (2) Check that all items fixed in diet menu is provided	
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	SNCU has facility to provide sufficient and clean linen for each parent -attendant	2	OB/RR	Check linen is clean, stains free & not torn.	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled	2	OB/RR		
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen	2	SI/RR	Quantity of linen is checked before sending it to laundry. Cleanliness & Quantity of linen is checked received from laundry. Records are maintained	
		Check dedicated closed bin is kept for storage of dirty linen	2	OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	(1) Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc) (2) Check FPC roster of nurses for providing training to Parent/ attendant	

ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB	As per hospital administration or state policy. Check SNCU doctors and nurses follow the dress code	
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number & patient demographic records are generated during process of registration & admission	2	RR	Check for that patient UID & demographics like Name, age, Sex, Chief complaint, etc. are recorded	
ME E1.3	There is established procedure for admission of patients	Admission criteria for SNCU is defined & followed	2	SI/RR	Baby weight <1800 or more >4 Kg, gestation- <34 weeks, perinatal asphyxia, apnoea, refusal to feed, respiratory distress(Rate >60/min,severe jaundice, hypothermia <35.4 deg C & hyperthermia >37.5 deg C, central cyanosis, shock (CFT>3 sec)bleeding, abdominal distension, diarrhoea & major malformation	
		There is no delay in admission of patient	2	SI/RR/OB	Time of admission is recorded in patient record, Admission is done by written order of a qualified doctor	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Procedure to cope with surplus patient load	2	OB/SI		
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all admitted patient done as per standard protocols	2	RR/SI	Check availability & use of assessment criteria like triage of sick new born, Kramer's criteria for assessment of Jaundice, Silverman Anderson Score for assessment of severity of respiratory distress and Ballard score for assessing gestation of new born etc.	
		Patient History, Physical Examination & Provisional Diagnosis is done and recorded	2	RR	Check bed head ticket	
		Initial assessment and treatment is provided immediately	2	RR/SI	Initial assessment is documented preferably within 2 hours	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for assessment of stable patients & critical patients	2	RR/OB	There is fix schedule of reassessment as per protocols. Reassessment finding are recorded in BHT	
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identifed through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer	There is procedure of taking over of new born from labour , OT/ Ward to SNCU	2	RR/SI	Check continuity of care is maintained while transferring/ hand overing the patient	
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.	Check pre referral stabilization is done	2	SI/ RR/ OB	(1) Check baby is stabilized w.r.t Temp. (skin to skin care- cover the baby- Transport incubator), Oxygenation: Airway & breathing, perfusion (HR, CRT temp), Sugar. (2) Check 1st dose of antibiotics -inj Ampicillin & gentamicin is given. Also, Vit K is given if not administrated earlier	
		Patient referred with referral slip	2	RR/SI	(1) A referral slip/ Discharge card is provide to patient when referred to another health care facility . (2) Referral slip includes demographic details, History of patient, examination findings, management done , drugs administered, any procedure done, reason for referral, (3) Detail of referral centre including whom to contact and signature of approving medical officer	
		Reason for referral is clearly stated and referral is written by authorized competent person (Paediatrician or Medical Officer on duty)	2	RR/ SI	(1) Verify with referral records that reasons for referral were clearly mentioned (2) SNCU staff confirms the suitability of referral with higher centres to ascertain that case can be managed at higher centre and will not require further referrals	
		Advance communication is done with higher centre & Referral vehicle is being arranged	2	SI/PI/RR	(1) Check SNCU staff facilitates arrangement of ambulance for transferring the patient to higher centre . (2) Patient attendant are not asked to arrange vehicle by their own (3) Check if SNCU staff checks ambulance preparedness in terms of necessary equipment, drugs, accompanying staff in terms of care that may be required in transit	
		Referral checklist & Referral in/ Out register is maintained for all referred cases	2	SI/RR	(1) Referral check list is filled before referral to ensure all necessary steps have been taken for safe referral (2) Check referral records has information regarding advance communication, transport arrangement, accompanying care provider, reason for referral , time taken for referral etc. along with demographics, date & time of admission, date & time of referral, and follow up	
		There is a system of follow up of referred patients	2	SI/RR	(1) Check that SNCU staff take follow up of referred cases for timely arrival and appropriate care provided at higher centre. (2) Outcome and deficiencies if any should be recorded in referral out register & analysed for improvement	
		Facility has functional referral linkages to lower facilities	2	SI/RR	(1) Check for referral cards filled from lower facilities (2) CHW of nearby PHC/HWC is informed about discharge for follow ups	
ME E3.3					DELETED	
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification of baby before any clinical procedure	2	OB/SI	Identification tags are used for new-borns	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained	2	RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.	
		There is a process to ensue the accuracy of verbal/telephonic orders	2	SI/RR	Verbal orders are rechecked before administration. Verbal orders are documented in the case sheet	
		Parent/ attendants are encouraged to provide basic care to the newborn	2	PI/SI	Breastfeeding, KMC, cleaning of baby can be undertaken by trained parent/attendant under the supervision of doctor/ nurse	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR	Nursing Handover register is maintained	
		Hand over is given bed side	2	SI/RR	(1) Handover is given during the shift change explaining the condition, care provided and any specific care if required. (2) Check SBAR (situation, background, assessment and recommendation) protocols are followed	
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately	2	RR/SI	Check for nursing note register. Notes are adequately written	
ME E4.5	There is procedure for periodic monitoring of patients	Vital are monitored for stable & critical patients and recorded periodically	2	RR/SI	Check for TPR chart, Phototherapy chart, any other vital required is monitored	
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Measures are taken to protect new born from any harm	2	OB/SI	Check the measure taken to prevent new born theft/swapping ,baby fall, baby charring, adverse drug events etc	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI	New born with emergency & priority signs assessed & immediate treatment is given	
Standard E6	**Facility ensures rationale prescribing and use of medicines**					

ME E6.1	The facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only	2	RR	Check prescriptions are not written with brand name	
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use	2	RR	Essential newborn care, Newborn Resuscitation, management of hypothermia. LBW, Fluid management, hypoglycaemia, neonatal jaundice, ETAT etc	
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per protocols and &Check for rational use of drugs	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Check complete medication history including over-the-counter medicines is taken and documented	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome	
		Patients are engaged in their own care	2	PI/SI	"1. Clinician/Nurse counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge"	
Standard E7	**The facility has defined procedures for safe drug administration**					
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride, Dopamine, dobutamine, Hydrocortisone, Phenytoin, Phenobarbitone, Adrenergic agonist, Opioids, Anti thrombolytic agent etc. as applicable	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nurses and doctor.	
ME E7.2	Medication orders are written legibly and adequately	There is process to ensure that right doses of drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided	
		Every Medical advice and procedure is accompanied with date , time and signature	2	RR	Verify case sheets of sample basis	
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI	Verify case sheets of sample basis	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI	Check for any open single dose vial with leftover content intended to be used later on .In multi dose vials, needle is not left in the seotum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Check if adverse drug reaction form is available in SNCU and its reporting is in practice.	
ME E7.4	There is a system to ensure right medicine is given to right patient	Fluid, drug & dosages are calculated according to body weight	2	SI/RR	Check for calculation chart	
		Drip rate and volume is calculated and monitored	2	SI/RR	Check the nursing staff how they calculate Infusion and monitor it	
		Check Nursing staff is aware 7 R's of Medication and follows them	2	SI/OB	Administration of medicines done after ensuring right patient, right drugs , right route, right time, Right dose , Right Reason and Right Documentation	
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	New born's progress is recorded as per defined assessment schedule	2	RR	Check BHT is updated following each reassessment	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan are written on BHT and all drugs are written legibly in case sheet.	2	RR	(1) Check Medication order, treatment plan, lab investigation & nursing charts are recorded adequately (2) Check change in treatment plan is also mentioned in case new born's condition deteriorate	
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/treatment registers	2	RR	Treatment given is recorded in treatment chart	
ME E8.4	Procedures performed are written on patients records	Procedure performed are recorded in BHT	2	RR	Resuscitation, blood transfusion, suctioning, phototherapy etc	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available	2	RR/OB	Availability of formats for neonatal case sheet, Treatment Charts, TPR Chart , Intake Output Chart, Investigation sheet, Community follow up card, BHT/ newborn case record , treatment continuation sheet, Discharge card, nomographs, congenital anomaly if any. etc Check forms & formats are being used	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, Diet register, Linen register, Drug indent register etc	
		All register/records are identified and numbered	2	RR	Check records are numbered and labelled legibly	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB	(1) Records of discharged cases are kept in MRD/ department sub store (2) Check records are retrieval in case of re admission (3) Copy of records is given to next kin only with permission from authorised staff only	
Standard E9	**The facility has defined and established procedures for discharge of patient.**					
ME E9.1	Discharge is done after assessing patient readiness	High risk identification checklist is available & filled at time of discharge	2	SI/RR	Checklist having information regarding babies birth weight, gestational age, perinatal asphyxia, small for date, hypoglycaemia, neonatal seizures, sepsis with meningitis, shock requiring vasopressor support, total serum bilirubin in exchange range, suboptimal home environment etc.	
		SNCU has established criteria for discharge	2	SI/RR	Criteria for transfer to home: Primary illness is resolved, baby maintain temp without radiant warmer, baby is accepting mothers milk, documented weight gain for consecutive 3 days, & wt. is more than 1.5 Kg, baby haemodynamically stable (normal CFT and strong peripheral pulses)	
		Discharge is done by a responsible and qualified doctor after assessment	2	SI/RR	Discharge is done in consultation with treating doctor	
		New-born/ attendants are consulted before discharge	2	PI/SI	Time of discharge is communicated to patient in prior	
		Follow up plan for assessment & specific interventions is scheduled after discharge of high risk babies	2	RR/SI	Check suggested schedule along with follow up protocols is available & used	
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary adequately mentions patient clinical condition, treatment given and follow up	2	RR/PI	See for discharge summary, referral slip provided.	
		Discharge summary is give to patients going in LAMA/Referral patient	2	SI/RR		
ME E9.3	Counselling services are provided as during discharges wherever required	Parent/attendants are trained & confident to provide care after discharge	2	PI/SI	Training has been given for nutrition, immunisation, understanding baby cues and addressing the issues. Ask parent /attendant if they have been trained	
		Check with mother/attendant the key points explained during counselling	2	PI	Breastfeed infant exclusively, keep infant warm, keep cord clean and dry, importance and correct method of handwashing & danger signs*. (*Danger signs: Refusal to feed; Fast or difficult breathing, Cold or Hot to touch, jaundice involving palms and soles Pallor/Cyanosis, Abdominal distension, Abnormal movements, Bleeding from any site or Diarrhoea with blood in stool)	
ME E9.4	The facility has established procedure for patients leaving the facility against medical advice, absconding, etc	Declaration is taken from parent's/ guardian of the LAMA patient	2	RR/SI		
Standard E10	**The facility has defined and established procedures for intensive care.**					
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubation, and care of patients on ventilation and subsequently on its removal	Criteria are defined for endotracheal intubation	2	RR/SI	(1) To suction trachea in presence of meconium when newborn is not vigorous (2) if positive pressure ventilation is not resulting into adequate clinical improvement (3)To improve efficacy of ventilation after several minutes of bag & mask ventilation or ineffective bag & mask ventilation (4)To facilitate chest compressions and ventilation and to maximize the efficiency of each ventilation (5) for special cases like giving endotracheal medication & suspected diaphragmatic hernia	
		Staff is trained for intubating newborn	2	SI/OB	Ask for demonstration Steps to follow : (1) Stabilize the new born's head in sniffing position, deliver free flow of oxygen during procedure (2) Slide laryngoscope over right side of tongue, pushing the tongue to left side of mouth & advancing the blade until the tip lies beyond the base of the tongue. (3) Lift the blade slightly, raise entire blade not just tip (4) Look for landmarks, vocal cords should appear as vertical stripes of each side of glottis or inverted 'v' (5) Suction if required for visualization (6) Insert the tube into right side of mouth with the curve of the tube lying in horizontal plane (7) If cords are closed, wait them to open. Insert the tip of endotracheal tube until vocal cord guide is at the level of cords (8) Hold the tube firmly against the babies palate while removing laryngoscope	

		Staff is aware of indications of correct placement of endotracheal tube	2	SI/OB	(1) Improved vital signs (2) Breath sounds over both lung fields (3) No gastric distention (4) Vapours in tube during exhalation (5) Chest movement in each breath (6) Direct visualization of tube passing between vocal cords	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.2	Emergency protocols are defined and implemented	Staff is aware of process & steps for emergency management of sick neonate	2	SI/RR	(1) Triage - ETAT protocol - keeping in mind ABCD steps (2) Ascertaining the group of baby - Emergency, Priority and non urgent. (2) After identification of emergency & priotize sign- prompt emergency treatment is to be given to stabilize.	
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR	Role and responsibilities of staff in disaster are defined Mock drills have conducted from time to time	
ME E11.4	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement	SNCU has provision of Ambulances to refer the case to higher centre	2	SI/RR	Check ambulance/ vehicle used for neonatal transport have following requirements: (1) Secure fixation for transport incubator (2) Secure fastening of other equipment (e.g. Monitoring equipment) (3) Independent power source to supplement equipment batteries to ensure uninterrupted operation of the equipment	
		Ambulance has provision/ method for maintenance of Warm chain while referring baby to higher centre	2	SI/RR	Ambulance/transport vehicle have adequate arrangement for Oxygen therapy, mechanical ventilation, resuscitation/ essential supplies kit and emergency drug kit	
		Transfer of patient in Ambulance /patient transport vehicle is accompanied by trained medical Practitioner	2	SI/RR	Check Constant vigilance (maintaining TOPS_ temp. oxygen, perfusion & sugar) during journey.	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB	Protocols are defined & followed for sample collection. Also check procedure to transfer to lab (if need to send to inhouse/outsource lab.)	
ME E12.3	There are established procedures for Post-testing Activities	SNCU has defined critical values of various lab test	2	SI/RR	(1) Critical values are defined and intimated timely to treat medical officer (2) List of Normal reference ranges as per available in NRC	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.9	There is established procedure for transfusion of blood	Patient's identification is confirmed & Consent is taken before transfusion	2	RR		
		Protocol of blood transfusion is monitored & regulated	2	RR	Blood is kept on optimum temperature before transfusion. Blood transfusion is monitored and regulated by qualified person	
		Blood transfusion note is written in patient records	2	RR	Blood bag details sticker is pasted in case file, patient monitoring status is recorded in case sheet	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR	Check - Staff is aware of the protocol to be followed in case of any transfusion reaction	
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1	Death of admitted patient is adequately recorded and communicated	SNCU has system for conducting grievance counselling of parents in case of newborns' mortality	2	SI	Bad news/adverse event/ poor prognosis are disclosed in quite & private setting	
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note is written as per new born death review guidelines	2	RR	New born death are recorded as per CDR guideline. Death note including efforts done for resuscitation is noted in patient record. Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	
ME E16.3	The facility has standard operating procedure for end of life support	Parents/ guardians are informed clearly about the deterioration in health condition of Patients	2	SI/RR	(1) Provide clear & honest information in supporting & caring manner (2) Avoid negative comments about parents, referring physician. (3) There is a procedure to allow parents to observe patient in last hours	
ME E16.4	The facility has standard procedures for conducting post-mortem, its recording and meeting its obligation under the law	Parent's consent is taken if autopsy required	2	PI/ SI/ RR	Check there is process to call parents after a month to explain findings of autopsy & if required to discuss the possibility of the problem occurring in next baby.	
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**					
ME E20.1	The facility provides immunization services as per guidelines	Immunization services are provided as immunization schedule	2	SI/RR	Check MCP card is available & updated. Mother /care provider is counselled and directed to immunize the child	
ME E20.2	Triage, Assessment & Management of newborns having emergency signs are done as per guidelines	Rapid assessment of sick neonates is done for prioritizing management in SNCU	2	SI/RR	Staff is aware of Triage or sorting categories to prioritize management i.e EPN (Emergency sign, priority sign & non urgent sign)	
		Staff is aware of emergency signs in Sick new born & action required	2	SI/RR	(1) Hypothermia temp.< 35.5^{0}C, (2) Apnoea or gasping breathing, Severe respiratory distress rate > 70/min , severe retraction, grunt, (3) Central cyanosis, shock, cold periphery, CFT>3 sec, weak or fast pulse, (4) coma, convulsion &encephalopathy. Action: Urgent intervention, Stabilize and admit in SNCU	
		Staff is aware of priority signs in Sick new born & action required	2	SI/RR	(1) Weight less than 1800 g (tiny neonates) or >3800g. (2) Temp. 36.5 ^{0}C -35.5^{0}C, (3) Lethargy/irritable/restless/jittery (4) refusal to feed (5) respiratory distress rate > 60, no or minimal retraction, (6) abdominal distention,(7) severe jaundice appear in <24hrs/stains palms and soles/lasts >2 weeks, severe pallor, (8) bleeding from any site, (9)congenital malformation, Action: immediate assessment, attended on priority & need to be admitted in SNCU	
		Staff is aware of non urgent signs signs in Sick new born & action required	2	SI/RR	(1)Minor birth trauma, (2) superficial infection,(3) minor malformation, (4)possetting, (5) transitional stools, (6) jaundice. Action Assess & treat as per neonate's requirement	
		Staff is competent in Management of emergency signs	2	SI/RR	Check for Temp., Airway breathing, circulation, coma or convulsation, Severe dehydration & hypoglycaemia (1) Cold to touch (Abdomen): Re warm under radiant warmer, assess the temp every half an hour (2) Apnoea or gasping breathing : Manage airway, administer Positive pressure ventilation with bag & mask (3) Central cyanosis or Severe respiratory distress, lower chest drawing, grunting& ,give oxygen, monitor oxygen saturation with pulse oximeter (3) Capillary filling time >3, weak or fast pulse>160: Give 10ml/kg normal saline over 20- 30 min, repeat the bolus, if circulation does not improve, (4) Convulsion: Manage airway, check & correct hypoglycaemia, if convulsion continue give IV calcium, if convulsion still continue give anticonvulsant. (5) Diarrhoea plus any two sign (a) Lethargy (b) Sunken eyes (c) Very slow skin pinch - Insert IV line & began giving fluids rapidly, make sure neonate is warm	
		Staff is able to demonstrate steps of new born resuscitation	2	SI/RR	(1) Provide the warmth, Position the head & clear the air way, suction first mouth & then nose ,Reposition & stimulate breathing , Evaluate respiration, heart rate & oxygenation. (2) If still not breathing, use correct size mask, ensure proper seal, squeeze 2-3 times & observe the chest rise, if chest rise is adequate, ventilate for 30 sec & re assess, if chest rise is not adequate, take step to improve ventilation. (3) Assess heart rate after 30 sec of ventilation, if less than 100/min & not breathing well, continue ventilation with oxygen.	
ME E20.3	Management of Low birth weight new-borns including pre term and Small for gestational age as per guidelines	Staff is able to identify Low birth weight newborn	2	SI/RR	Newborn baby can be LBW : **(1) Preterm(<37 weeks) & (2) SGA (if the weight is below the 10 percentile on the chart gestational age.** LBWs can be identified from LMP, USG (first trimester) & Expended Ballard score (EBS) and other physical maturity signs like skin, ear cartilage, breast nodule, sole creases and external genetalia	

		Staff is aware of clinical presentation of LBW	2	SI	Feeding problem, asphyxia, hypothermia, RDS, Apnoeic spells, Intraventricular haemorrhage, hypoglycaemia, hyperbilirubinemia, infection and retinopathy of prematurity (ROP) etc.	
		Staff is aware of management protocols of babies < 1800 gm (34 weeks)	2	SI/RR	Use of Overhead radiant warmer or incubator to keep baby warm. Regular monitoring of axillary temp at least once every 6-8hrs . Planning the nutrition and fluids of babies considering type of feeding, quantity , frequency and modality of feeding	
		Staff is aware of frequency & type of feeding to LBW	2	SI/RR	LBW babies should fed with mother's milk every 2 hrs. starting immediately after birth. Ensure LBW babies receive 'hind milk'. Multi fortified breast milk should be given to pre term <32 weeks / 1500 gm, who fail to gain weight despite of breastfeeding **Minimum entral feeds** : Small volume of expressed breastmilk i.e. 12 to 24 ml/kg/day given every 1-3 hours delivered intra gastric.	
		Check staff is aware of importance of hind milk	2	SI	Comes towards end of feed, rich in fat content and provide more energy . LBW babies with poor weight gain may fed with expressed hind milk.	
		Check guidelines for mode and quantity of providing fluids and feeds to babies is available & followed	2	SI/RR	Guidelines for modes requirements (i.e. Based on Birth weight in gm and age (weeks). Guidelines for fluid requirement of neonate (ml/kg/day) _ (based on Birth weight)	
		Check total daily requirement is estimated as per guidelines	2	SI/RR	Check quantity given is monitored & charted	
		Check staff skill for various techniques/modes of feeding to LBW	2	SI/RR	Techniques: **Minimum entral feeds** : Small volume of expressed breastmilk i.e. 12 to 24 ml/kg/day given every 1-3 hours delivered intra gastric. **Non nutritive sucking**: In premature or small babies - to develop sucking behaviour & improve digestion of feed **Gavage feeds:** Using feeding catheter - baby is fed with 10 ml syringe (without plunger) attached toward outer end of tube & milk is allowed to trickle by gravity. The baby should be placed in left lateral position for 15-20min to avoid regurgitation. **Katori Spoon Feed:** Feeding with spoon or paladai, specially neonates with gestation of 30-32 weeks or more are in position to swallow. Take required amount of expressed breast milk in katori, place the baby in semi upright posture. Fill the spoon with milk, a little short of brim, place it at lips of the baby and let the milk flow into babies mouth slowly, the baby will actively swallow the milk	
		Check fluid and nutritional supplementation is fulfilled as per requirement	2	OB/SI	Fluid requirement: First day of fluid requirement range from 60-80 ml/kg. Daily increment - approx. 15ml/kg till 150ml/kg is reached. **Nutritional Supplementation_ Vit K** : All LBW<1000gm - receive 0.5 mg IM of Vit K at birth & all other 1mg IM. All LBW who are exclusively breastfed should receive 400IU daily of vit K from first day of life to once baby start accepting full feeds & supplementation will continue until 6 month. 800-1000IU for small babies (<1500gm) **Multivitamin drops:** 0.3 ml/day from 2 week of age **All LBW receive calcium and phosphorus** at 120-140 mg/kg/day & 60-90 mg/kg/day respectively. & continue till 40wk post conceptual **Iron Supplementation**_ 2-3mg/kg/day at 6-8 wks. and as early as 2wks in <1500gm	
		Check the records to monitor intake & output to prevent fluid overload	2	SI/RR	(1) IV-fluids are given are compared with prescribed volume & recorded in fluid monitoring chart every 2 hrly. (2) Measure blood glucose every 6-8hrs and take action for low (<45mg/dl) or high (150mg/dl) blood glucose (3) Daily monitoring : of weight, urine output, frequency of passage of urine, sign of overhydration.	
		Staff infusion site is inspected frequently	2	SI	If there is redness and swelling seen at any time stop the infusion remove the cannula and establish new IV line in d/f vein	
		Check Growth is monitored in LBW babies	2	SI/RR	Babies checked for weight (daily), head circumference(weekly) and length (fort-nightly). Fenton's growth chart is used for pre term babies. WHO growth chart is used from corrected age of 40 weeks	
		Precautions are taken to protect LBW baby from hypothermia	2	SI/RR	Heat loss is minimized by kangaroo-care and a cap on the head and socks on the feet	
		Staff is aware of assessment & grading of hypothermia	2	SI/RR	Normal Axillary temp- 36.5 -37.5 ^{o}C Cold Stress- 36.4- 36^{o}C Moderate Hypothermia- 35.9- 32^{o}C Severe Hypothermia- <32^{o}C. Assessment through Axillary temp., Skin temperature (using radiant warmer probe) and Human touch.	
		Staff is aware of clinical conditions in which baby can exhibit signs of hypothermia	2	SI	LBW, preterm babies, hypoglycemia,sclerema, DIC and internal bleeding Hypothermic babies show signs of lethargy, irritability, poor feeding, tachypnoea/apnoea etc.	
		Staff is aware of management of mild hypothermia (temp <35.5- 36.4^{o}C)	2	SI/RR	(1) Provide KMC to re warm baby with mild hypothermia or warm the room using radiant heater or other heating devices if KMC is not possible. (2) Cover adequately & ensure to replace cold clothes with warm clothes (3) Keep room warm (26-28^{o}C) & draught free (4) Continue breastfeeding (5) Monitor temp . & capillary filling time during re earning. Watch for apnoea and hypoglycaemia . (6) Monitor axillary temp every 1/2hr till it reaches 36.5 ^{o}C, then hourly for next 4 hrs, 2 hrly for 12 hrs thereafter 3 hrly as routine	
		Staff is aware of management of severe hypothermia (temp <35.5^{o}C)	2	SI/RR	Remove cold clothes from baby and replace with warm clothes Place under radiant warmer or one may use room heater or other means to warm baby monitor temp every 15-30 min, monitor BP, HR, temp & glucose as needed. Additional - Start IV 10% dextrose, if perfusion is poor, give 10ml/kg of ringer lactate or normal saline. Give Vit K -1mg I/M & provide oxygen & monitor SPO_2. Assess for sepsis	
		Staff is able to demonstrate the process of Kangaroo mother care Protocols	2	SI	Counsel the mother and take consent for initiating KMC. Give mother/care taker front open loose shirt or blouse Guide the mother/ care taker to sit in semi reclining position on chair or bed Unbutton top 2-3 buttons and slip baby with only napkin, socks and cap on, into shirt Ensure skin to skin contact b/w baby and care taker Baby should be in frog like position with head turned to one side and placed between mother's breast Tie a string at belt level to prevent the baby from slipping down Cover mother and baby dyad with woollen or sheet Encourage frequent breastfeeding	

		Staff is able to access the clinical definition and symptoms of hypoglycaemia is new-borns	2	SI	**Blood glucose level less than 45mg/dl** in all new-borns **Symptoms of hypoglycaemia:** (1) Jitteriness, irritability (2) Lethargy, limpness (3) Weak or high pitched cry (4) Poor feeding , vomiting (5) Tachycardia (>180/min) (6) Sweating (7) Hypothermia (8) Poor respiratory effort or apnoea, tachypnoea (9) Cyanosis (10) Seizures or coma	
		Staff is skilled for technique of estimating blood sugar using regent strips in neonates	2	SI	Common site- Heel. (1) Ensure heel is not cold. Heel can be warmed by holding it in hand for few minutes (2) Prepare the site with 70% Isopropyl alcohol. Allow to dry. (3) Make needle stick puncture of posterolateral aspect of heel & avoid making deep puncture. (4) Follow instructions on reagent strip bottle for obtaining blood sample analysis. (5) If blood glucose is low send blood sample to lab for confirmation	
		Staff is competent in management of hypoglycaemia	2	SI/RR	(1)Establish IV line, infuse bolus of 2ml/kg body weight of 10% dextrose over 1min. (2) If an IV line can not be established quickly, give 2ml/kg body weight of 10% dextrose orogastric tube (3) Start infusion of dextrose containing fluid at daily maintenance volume acc. to baby's age so as to provide a glucose infusion rate (GIR) of 6mg/kg/min (4) If glucose remain below 45mg/dl GIR is increased in steps of 2mg/kg/min to max. of 12mg/kg/min (5) Check blood glucose 30 min after starting the infusion of glucose or any GIR. if blood glucose is above 45mg/dl, continue glucose infusion at this rate and recheck blood glucose 1hr later. With 2 blood glucose values in normal range, the frequency of glucose monitoring is reduced to 6 hrly. (6) If blood glucose is less than 25mg/dl, repeat the bolus of dextrose and GIR as needed. (7) if the blood glucose b/w 25-45mg/dl, do not give dextrose bolus but increase GIR. The upper conc. of dextrose sol. which can be infused safely through peripheral vein is 15%. Conc. higher than this necessitate central line placement & referral	
		Staff is aware of frequency of blood glucose measurement after blood glucose return to normal	2	SI/RR	(1) Every 8 hrs as long as baby require IV fluid. If the baby is no longer required or is not receiving IV fluid, measure blood glucose every 12 hrs for 24 hrs	
		Charts/guidelines are readily available & followed in SNCU for estimating glucose infusion rates in neonates	2	SI/RR	Infusion rates with birth weight more than or equal to 1500gm using Mixture of D10 & D25. Infuse ion rates with birth weight less than 1500 gm using mixture of D10 & D25	
		Discharge & follow up protocols are followed LBW babies	2	SI/RR	(1) Consistently demonstrate weight again for 3 consecutive days (2) Mother should be confident in feeding the neonate (3) The required nutritional supplements started (4)BCG, Hep. B and OPV is given to baby (5) Methods of temperature regulation viz. KMC and other skills are taught to mother and adequately practices in hospital (6) Mother/parents are available to identify danger sign	
		Check important information like ROP screening and hearing evaluation is given to parents/mother of LBW babies	2	SI/RR	LBW (32 weeks/<1500gm) are advised for ROP screening at 1 month of postnatal age and hearing evaluation at 40 weeks corrected gestational age	
ME E20.4	Management of neonatal asphyxia is done as per guidelines	Staff is aware of clinical presentation of asphyxia	2	SI	Asphyxiated babies evolve neurological manifestation viz seizures, hypotonia, come or Hypoxic ischemic encephalopathy (HIE) within 72 hrs of life Evidence of multi organ system dysfunction (manifested as difficult breathing or renal failure or feeding intolerance or hepatic dysfunction or haematological abnormalities) in immediate neonatal period	
		Grading of hypoxic ischaemic encephalopathy (HIE) is done & recorded on case sheet	2	SI/RR	Using Levene's grading HIE - assessment of consciousness, tone ,seizure activities and autonomic disturbances like sucking & respiration - Severity is decided. Check sequential grading is done every 8-12 hrs to assess the progression of HIE	
		Initial stabilization & management of asphyxia cases is done as per protocols	2	SI/RR	(1) Maintenance of temperature (keep the baby under radiant warmer & temp is maintained at normal range) perfusion, ventilation (monitoring of oxygen saturation-SPO2 maintained b/w 90-94%) and normal Metabolic state including glucose, calcium and acid base balance (IV fluids, enteral feeding, glucose monitoring, management of hypocalcaemia & administration of vit K 1mg IM) (2) Early detection & management of complications must be done to prevent extension of cerebral injury	
		Clinical monitoring or bed side tests of asphyxiated babies is performed	2	SI/RR	(1) Levene's staging for neurological status (2) Downe's Score for respiratory status (3) Cardiovascular status- i.e. heart rate, colour, CRT, peripheral pulses, non- investive BP (4) Abdominal circumferences- to rule out ileus (5) Urine output - to check for serum electrolytes, blood urea & serum creatinine (6) Monitoring of Blood surger	
		Clinical monitoring is performed & updated in case sheet at defined intervals	2	SI/RR	(1) Levene's staging -every 8hrs (2) Downe's Score -every 2-3 hrs (3) Cardiovascular status- i.e. heart rate, colour, CRT, peripheral pulses, non- investive BP (4) Abdominal circumferences- to rule out ileus (5) Urine output - measured daily-- should not be <1ml/kg/hr (6) Monitoring of Blood surger every 6-8hrs during the first 24 hrs	
		Staff is aware of two major clinical manifestation results due to asphyxia	2	SI	(1) Neonatal Shock (2) Neonatal Seizures	
		Staff is skilled to identify shock	2	SI	(1) Unexplained Tachycardia- (HR>160/min) (2) Capillary refill time (CRT)- >3 seconds	
		Staff is aware of technique to check CRT & its interpretation	2	SI/RR	Gentle pressure is applied by the tip of finger on central part of the body such as chest for 3-5 seconds by slowly counting from 1 to 5. this result in to blanching and area refill & it become pink after the tip of finger is lifted. Normal CRP is <3 sec. A prolonged CRT indicates poor circulation and tissue perfusion.	
		Staff is skilled to manage neonatal shock	2	SI/RR	(1) Supportive Care : (a) Maintain TBAC (b) Hypoxia: Maintain SPO2- 90-94% (c) Hypoglycaemia- Maintain normal blood glucose- (>45 mg/dl) (d) Hypothermia- Maintain temp _ 36.5-37.5 ^{O} C (2) Fluid resuscitation: infuse fluid bolus of 10ml/kg or normal saline over 20-30 min. (3) Administration of Inotropes	
		Staff is competent to assess improvement	2	SI/RR	Check: (1) Improvement in CRT (2) Decrease in heart rate by at least 10 beats/min. (3) Improvement in pulse volume and an increase in urine output over next 4-6 hrs (is sign of improvement)	
		Staff is competent to identify when to start vasopressors	2	SI/RR	If signs for poor perfusion persists despite 2 fluid boluses-Start vasopressor along with supportive care. Most commonly used vasopressor in neonates is dopamine	
		Staff is aware of dose of dopamine	2	SI/RR	(1) Starting dose- 5-10 microgram/kg/min (2) If no improvement occurs- the dose can be increased by increments of 5 microgram/kg/min every 20-30 min to max of 20microgram/kg/min	

		Staff is aware of next line of treatment if shock persists after max dose of dopamine	2	SI/RR	Dobutamine - Dose same as dopamine Hydrocortisone -1mg/kg of hydrocortisone can be given as initial dose and then depending upon response , it can be given 8-12 hrly in dose of 1mg/kg/dose for 2-3 days	
		Staff is aware of further line of treatment in case baby is unresponsive to shock	2	SI/RR	(1) Consider blood transfusion if Hb< 12gm% (2) Consider referral after stabilization of temperature, oxygenation and blood glucose	
		Staff is aware of therapeutic end points for babies suffering from neonatal shock	2	SI/RR	CRT <3 sec, Normal Heart rate, normal pulse, warm extremities, normal BP and urine output >1ml/kg/hr	
		Staff is competent in method of weaning from inotropes	2	SI/RR	Once hypotension improves (BP normal for 4-6hrs) & tissue perfusion improves, inotropes should be tapered slowly @5microgm/kg/min every 1-2 hrly provided neonate maintain the list of therapeutic end point	
		Staff is aware of causes of neonatal Seizures	2	SI	Asphyxia (Most common), birth injuries, meningitis, intracranial bleeding or due to metabolic problems like hypoglycaemia, hypocalcaemia, and hypo or hypernatremia	
		Staff knows d/f in spasm due to tetanus and jitteriness	2	SI	**Spasm due to tetanus**: Appear after 48hrs, Involuntary contraction of muscles, fists often persistently and tightly clenched, Trismus opisthotonus, triggered by touch, light & sound and Baby is conscious throughout, often crying with pain. **Jitteriness**: Provoked by stimulus, abolished by restraining, Not associated with autonomic changes, examination of neonatal is normal b/w seizure episodes & EEG is normal	
		Staff is aware of diagnostic approach for seizure	2	SI	In sick babies: blood glucose, serum ionized calcium, serum sodium & Sepsis screen. Detailed history is taken and examination is done after initial acute management to determine the underlying cause.	
		Staff is skilled to provide treatment of neonate with seizures	2	SI/RR	**1st Step:** Resuscitate if needed : In thermoneutral environment ensure TABC. Start oxygen if required IV access should be secured and blood sample drawn for blood count, blood sugar, serum calcium & electrolytes **Step 2**: If blood sugar less than 45mg/dl correct hypoglycaemia by a bolus of 2ml/kg 10% dextrose followed by maintenance infusion of 6-8 mg/kg/min **3rd step**: Estimate calcium levels. Consider giving 10% calcium gluconate 2ml/kg IV over 5-10min **4th Step**: Anti convulsant drug (ACD); ACD given if seizures persists even after correction of hypoglycaemia and hypocalcaemia	
		Staff is aware of 1st and 2nd line ACD along with their doses	2	SI/RR	**1st Line ACD**: Inj Phenobarbitone20mg/kg IV over 20min. If baby has no further seizures don to start maintenance. If seizures persists after initial phenobarbitone infusion, administer boluses of 5mg/kg put total 40 mg/kg. **2nd Line ACD:** Inj Phenytoin or Fosphenytoin 20mg/kgIV over 20 min if seizures are not controlled with Phenobarbitone. Assess seizures control after the infusion. If seizures persists then **Lorazepam** 0.05- 0.10 mg/kg IV may be infused. Once the seizures are controlled, start maintenance dose of 3-4mg/kg day after 12 hrs of loading dose of phenobarbitone and phenytoin	
		Staff is aware of therapeutic action for neonate with seizures	2	SI/RR	(1) Transient metabolic problem i.e. hypoglycaemia, hypocalcaemia, dyselectrolytemia- Treat the cause , stop ACD immediately if started (2) Seizures controlled with 1st bolus of phenobarbitone- No maintenance ACD, observe for 48 hrs if seizures re occur (3) Seizures controlled with multiple dose of phenobarbitone- Start maintenance dose phenobarbitone. Stop once seizure free for 48hrs (4) Difficult to control seizures- Stop Phenytoin if seizures free for 48 hrs, continue maintenance dose phenobarbitone, Assess neurological status : if normal-Stop phenobarbitone, If abnormal -may continue oral maintenance phenobarbitone	
		Staff is competent to identify conditions when to refer the neonatal asphyxia cases to higher centre	2	SI/RR	(1) when baby need respiratory support - as PPV required for 5min or longer (2) Onset of seizures within 12 hrs- refractory seizures (uncontrolled with phenobarbitone & phenytoin) (3) Severe HIE & unable to restore oral feeds within 1 week- (4) Shock unresponsive to vasopressor	
		Post discharge & follow up advice is given as per protocols	2	SI/RR	To attend follow up clinic for monitoring of their growth & development and to identify post asphyxia sequelae and development delays.	
ME E 20.5	Management of sepsis is done as per guidelines	Staff is aware of classification of neonatal sepsis	2	SI	Early onset sepsis (EOS): where sign & symptoms of sepsis appear within 72 hrs of birth due to pathogens in maternal genital tract or delivery area, respiratory distress due to congenital pneumonia. Late onset of Sepsis (LOS): where sign appear after 72 hrs of age due to pathogens from hospital or community. LO is commonly presented as Septicaemia, pneumonia, or meningitis	
		Staff is aware of signs of neonatal sepsis	2	SI	(1) Clinical picture is **highly variable. Sign & symptom are minimal, subtle or non specific.** (2) Clinical manifestation of neonatal sepsis : Lethargy, refuse to suckle, poor cry or high pitched cry or excessive cry, comatose, and. Distension, diarrhoea, vomiting, hypothermia, poor perfusion, sclera, poor weight gain, shock, bleeding, renal failure, cyanosis, tachypnoea, chest retraction, grunt, apnoea, fever, seizures, neck retraction, bulging fontanel etc.	
		Staff is competent to identify clinical manifestation of meningitis	2	SI	fever, seizures, blank look, high pitched cry to excessive crying/irritability, neck retraction & bulging fontanel	
		Laboratory investigations are performed to confirm neonatal sepsis	2	SI/RR	Direct method: Isolation of micro-organism from blood, CSF, urine or pus. Indirect method: Leukopenia (TLC< 5000/cu mm), Neutropenia (ANC< 1800/cu mm), Immature neutrophil to total neutrophil ratio (>0.2), Micro ESR(>15mm 1st hour) positive C Protein. Any of the 2 or more test come positive indicate sepsis. Lumber puncture : must be performed in all cases with late onset of sepsis	
		Supportive care is provided to manage new borns	2	SI/RR	Maintain TABC Ensure SPO_2 -90-94% Maintain normoglycemia Administer inj vit K 1mg IV , if there is active bleeding from any site Avoid enteral feed if hemodynamically compromised & start feed as hemodynamically stable. Consider exchange transfusion if there is sclerema	
		Appropriate antibiotics are given according to age and weight of the baby	2	SI/ RR	Correct dose and frequency is given as per antibiotic therapy of neonatal sepsis Antibiotic therapy should cover the common bacteria viz, E .coli, Staphylococcus aureus and Klebsiella Pneumonia Every new born unit must have its own antibiotic policy based on profile of pathogen & local sensitivity pattern	
		Staff administer antibiotic as per protocols for confirmed Sepsis	2	SI/RR	1. Give Injection ampicillin and gentamicin, as first line of treatment. 2. Give cloxacillin (if available) instead of ampicillin, if there are extensive skin pustules or abscesses, as these might be signs of Staphylococcus infection. 3. Antibiotics should be given slowly, after dissolving in 5-10 ml fluid using a microdrip set or infusion pump. 4. Never mix two antibiotics in same syringe.	

		Check algorithm & treatment charts for management of neonatal sepsis is available & practices	2	SI/RR	Antibiotic schedule & dosage including frequency, route and duration is available & used	
		Staff provide antibiotic as per protocols for confirmed meningitis	2	SI/RR	Check availability charts for prescribing antibitotics for meningitis. Check charts reflect following information: Weight <2kg Inj Cefotaxime- 12 hrly (0-7 days of age) or 8 hrly (>7days of age), IV, for 3 weeks Inj Amikacin-24hrly (0-7 days of age) or 24 hrly (>7days of age), IV, for 3 weeks Weight >2kg Inj Cefotaxime- 8 hrly (0-7 days of age) or 6 hrly (>7days of age), IV, for 3 weeks Inj Amikacin-24hrly (0-7 days of age) or 24 hrly (>7days of age), IV, for 3 weeks. 2nd line treatment: Inj Meropenem- 8 hrly (0-7 days of age) or 8 hrly (>7days of age), IV, for 3 weeks nj Amikacin-24hrly (0-7 days of age) or 24 hrly (>7days of age), IV, for 3 weeks	
		The response to treatment is monitored	2	SI/RR	Empirical upgradation can be considered if there is no clinical improvement by 48hrs of institution of antibiotic or there is sign of deterioration	
		Staff assess the clinical presentation of possible serious bacterial infection among children of 0-59 days	2	SI/RR	Pneumonia in 0-59 days children - difficult to diagnose as per clinical conditions Possible serious bacterial infections can be pneumonia, septicaemia, or meningitis. Essential Features: (1) Baby not able to feed or (2) Convulsion or (3) Fast breathing (RR-> 60/min) or (4) Severe chest indrawing or (5) Axillary temp > or equal to 37.5 ^{o}C (or feel hot to touch) (6) or Axillary tem <35.5 oC (or feel cold to touch) or movement only when stimulated or no movement at all	
		Management of Possible serious bacterial infections	2	SI/RR	Hospitalise, Maintain nutrition & hydration, Give Oxygen (if SpO2 <90). Check availability charts for prescribing antibitotics for serious bacterial infections. Check dose, duration, frequency is given as per indicated	
		Staff is competent to identify conditions that do not require antibiotic for management	2	SI	Meconium strained amniotic fluid, meconium aspiration syndrome, Mild respiratory distress, perinatal asphyxia, Asymptomatic neonates with present of 1-2 risk factors of EOS, jaundice and prematurity	
		Staff is competent to identify when to refer the baby	2	SI/RR	If condition worsen or no improvement after 48hrs (1) Respiratory failure requiring mechanical ventilation (2) Unresponsive shock (3) Persistent convulsions (4) DIC (5) Baby require exchange transfusion (& facility is not available	
ME E20.6	Management of jaundice is done as per guidelines	Staff is aware of alert sign of neonatal pathological jaundice	2	SI	Clinical Jaundice in first 24 hrs of life or Total serum bilirubin (TSB) increasing by 5mg/dl/day or 0.5mg/dl/hr or TSB >15mg/dl to Conjugated serum bilirubin >2mg/dl or clinical jaundice persisting for > 14 days in term and > 21 days in preterm infants	
		Staff is aware of causes of onset of Jaundice within 24 hrs of age	2	SI	(1) Haemolytic disease of newborn: RH, ABO and minor group incompatibility,(2) Infection: Intrauterine viral-bacterial, malaria (3) G6PD deficiency	
		Staff is aware of causes of onset of Jaundice after 24 hrs of age	2	S	Physiological, Polycythaemia, Concealed haemorrhage, Sepsis, neonatal hepatitis, metabolic disorder	
		Clinical assessment of severity of Jaundiced neonate is done as per Kramer's criteria	2	SI/RR	Kramer's criteria: Jaundice limited to face: Serum Bilirubin-about 6mg/dl, Jaundice extended to trunk- 9mg/dl, Extended to abdomen-12mg/dl. Extended to legs -15mg/dl & Extended to feet & hand-19-20mg/dl	
		Staff is aware of features of acute bilirubin encephalopathy	2	SI	Hypotonia, lethargy, high pitched cry, poor suck, hypertonia of external muscles, irritability, fever, seizures, opisthotonus, shrill cry, apnoea, coma	
		Staff is aware of Jaundice evaluation protocols	2	SI	Blood sample is taken for TSB estimation. Plotting of values on AAP charts on bilirubin nomogram	
		Management of Jaundice is done as per protocols	2	SI/RR	Management directed toward reducing level of bilirubin & preventing CNS toxicity. Prevention of hyperbilirubinemia: by early & frequent feeding Reduction of bilirubin: Achieved by phototherapy and /or exchange transfusion	
		Normogram is used to imitate phototherapy & exchange transfusion	2	SI/RR	Check normogram is available & practiced for new born more than 35 week	
		Guidelines for phototherapy & exchange transfusion is readily available and being followed	2	SI/RR	For new born <35 week	
		Staff is aware of precautions to be taken while giving phototherapy to baby	2	SI/RR	Baby should be naked eyes & genitals should be covered. New born should be kept at distance of more than 45 cm below light source.Frquent feeding every 2 hours ? change in posture is promoted, once under phototherapy serum bilirubin must be monitored every 12 hrs or earlier if required	
		Check baby is monitored through out the phototherapy	2	RR/SI	Check the records baby's temperature is measured every 4 hourly to monitor for hypo/hyperthermia Check weight is taken daily Frequent breast feeding Increase in allowance for fluid, (if there is any evidence of dehydration) Position is changed frequently, after each feed (Low birth weight babies can have their socks, caps and mittens on, while under phototherapy)	
		Check the availability & use of fluxmeter	2	RR	Use Fluxmeter to check for and ensure optimal irradiance in phototherapy units	
ME E20.7	Management of children presenting with fever, cough or respiratory distress is done as per guidelines	Staff is aware of common causes of hyperthermia	2	SI	(1) Sepsis (2) Envt. too hot for baby (3) Wrapping the baby in too many layers of clothes, esp. in hot humid climate (4) Keeping newborn close to heater/hot water bottle (5) Leaving the under heating devices i.e. radiant warmer, incubator, phototherapy that is not functioning properly and/to not check regularly	
		Staff is aware and follow management protocols of hyperthermia	2	SI	**Examine every hyperthermic baby for infection** (1) If temp. is above 39^{o}C, the neonate should be undressed and sponged with tepid water at app. 35^{o}C until temperature is below is below 38 ^{o}C (2) If temp. is 37.5- 39^{o}C- Undressing & exposing to room temp is usually all that is necessary. (3) If due too envt. temperature: move baby to colder environment & using loose & light clothes. (4) If due to device- remove the baby from source of heat (5) Give frequent breastfeeds to replace fluids. if the baby cannot breastfeed, give EBM. If does not tolerate feeds, IV fluids may be given (6) Measures the temp. hourly till it become normal	
		Staff is able to identify the babies with respiratory distress	2	SI/RR	(1) RR >60 breaths per min (2) Severe chest in drawing (3) Grunting (4) Apnoea or gassing	
		Staff is aware of common causes of respiratory distress in newborn	2	SI	(1) Pre Term : RDS, Congenital pneumonia, hypothermia & hypoglycaemia (2) Term: Transient tachypnoea of newborn (TTNB), meconium aspiration, pneumonia, asphyxia (3) Surgical cases: Diaphragmatic hernia, Trachea - oesophageal fistula, B/L choanal atresia (4) other causes: Congenital heart disease, acidosis, inborn errors of metabolism	
		Detailed antenatal & perinatal history is taken based on causes of respiratory distress & recorded	2	SI/RR	H/O gestation, onset of distress, previous preterm babies with RDS, antenatal steroid prophylaxis, rupture of membranes >24 hrs, intrapartum fever, meconium asphyxia, maternal diabetes mellitus, poor feeding, lethargy, convulsion, h/o excessive frothing	
		Objective assessment of severity of respiratory distress is done & recorded	2	SI/RR	Using Downe's score and status is recorded in BHT	

		Staff is aware of parameters & interpretation of Downe's Score	2	SI/RR	Parameter: RR, Cyanosis, Air entry, Grunt and retraction. Score 1-6= RDS Score >6- Impending respiratory failure	
		Detailed examination of babies representing with RDS is done and recorded	2	SI/RR	(1) Severity of RDS- Assessed by Downe Score (2) Neurological status: Activity or altered sensorium (3) CRT (4) Hepatomegaly (5) Central Cyanosis or low oxygen saturation (6) Features of sepsis (7) Evidences of malformation	
		Staff is competent to identify conditions when to order chest X ray	2	SI	(1) All babies with moderate to severe respiratory distress- to identify underlying causes (2) Babies with mild respiratory distress observed for few hrs- if distress does not settle in 4-6 hrs or baby continues to need supplementary oxygen	
		Staff follow support management protocols for all sick newborn	2	SI/RR	(1) Maintain body temp. (2) Give Oxygen with oxygen hood or nasal prongs to achieve appropriate oxygen saturation. Titrate oxygen delivery, targeting oxygen saturation of 90-94% (3) EBM by gavage feeding (4) Give IV fluids if baby does not accept Breast feed (5) Maintain blood glucose, if low treat hypoglycaemia	
		Staff is competent in management of apnoeic baby	2	SI/RR	(a) Maintain temperature (b) Stimulate to breathe by rubbing the back or flicking the sole. If does not begin to breathe, provide PPV with bag & mask immediately (c) Check blood glucose (d) Administer caffeine citrate/Aminophylline if baby is pre term with no other evident cause of apnoea (d) If apnoeic spells are recurrent, obtain sepsis screen along with blood culture and initiate treatment for sepsis	
		Staff is competent in specific management of moderate to severe respiratory distress	2	SI/RR	Start nasal CPAP and/or organize transfer for assisted ventilation	
		Staff is aware of duration to administer antibiotics	2	SI/RR	(1) If baby show clinical improvement- sepsis screen is negative and blood culture is sterile stop antibiotic after 48 hrs (2) if baby show clinical improvement but sepsis screen is positive & culture is negative give antibiotic for 5-7days (3) Id culture is positive for Gram positive cocci (GPC) give antibiotic for 7 -10days & for Gram negative bacilli (GNB) for 10-14 days Antibiotic may be modified based in clinical response and blood culture sensitivity pattern	
		Staff is skilled to provide oxygen therapy	2	SI/RR	(1) Pulse oximeter is used to check oxygen saturation -should be maintained b/w 90-94% (2) Saturation below 90% should be treated using oxygen supplementation. Ensure at NO TIME babies under supplemental oxygen should have oxygen saturation above 95% (3) Nasal prongs & head box is used to deliver oxygen. Adjust flow of oxygen 0.5-2.0 L/min with Nasal prongs to achieve target saturation. Adjust the flow of oxygen (3-5L/min) to achieve desired oxygen saturation	
		Staff is competent in oxygen weaning protocols	2	SI/RR	Once baby's oxygen saturation on pulse oximeter is 90-94%, gradually wean oxygen. Reduce the oxygen flow rate by 1/2litre/min every few minutes to observe the oxygen saturation. If oxygen saturation remain in normal range gradually remove oxygen.	
		Staff is competent to identify when to refer the baby	2	SI/RR	(1) If baby with breathing difficulty needs CPAP or mechanical ventilation (2) persistent central cyanosis or low oxygen saturation despite oxygen supplementation (3) Repeated apnoeic spells Always stabilize before referral & transport	
		Discharge & follow up advice is given as per protocols	2	PI/RR	Babies with respiratory distress should be seen 48hrs after discharge, either at hospital or during home visit by ASHA. Counselling of parents for exclusive breastfeeding, temp maintenance and immunization Should be done	
ME E20.10	Facility ensures optimal breast feeding practices for new born & infants as per guidelines	SNCU promotes initiation of breastfeeding within half an hour after birth	2	PI/ SI	Check with mother when she has provided breastmilk to baby after delivery	
		Check colostrum is given to baby & staff is aware of its importance	2	SI	Women produce colostrum in first few days after delivery. It is thick yellowish in colour & contain antibodies, white blood cells and other anti infective proteins. Importance: Help to fight diseases that baby is likely to be exposed after delivery. Help to clear baby's gut of meconium. Clear bilirubin from the gut & also help to prevent hyperbilirubinemia	
		No ghutti, gripe water , honey or any other milk is given to baby		OB/PI		
		SNCU ensures exclusive breastfeeding to babies during their stay in SNCU unless clinically indicated	2	PI/SI	(1) Check with mother how frequently she breastfed her admitted baby (At least 8 times per day (EBM or DHM) (2) No formula feeding unless prescribed by doctor	
		Check process in place to assess the milk intake among admitted babies	2	SI/PI	(1) By counting no. of wet diapers per day (6-8 time/day) (2) Weight gain (20-30 gm a day in 1st 3-4 months after regaining birthweight	
		Check records are maintained to monitor intake of babies	2	SI/RR		
		Staff is aware & practice assisted feeding techniques for babies unable to take feed	2	SI/RR	Gavage feeding, katori-spoon feeding /paladai feeding/ gastric tube	
		Check SNCU provide assistance in positioning & attaching the baby to mother's breast	2	SI/PI	Check with mother if she has been taught/ guided to position & attach the baby	
		Check staff& mothers are aware of signs of proper position	2	SI/PI	(1) Baby's body is well supported (2) The head, neck & body of baby are kept in same plane (3) Entire body of baby faces the mother (4) Baby's abdomen touches mother's abdomen	
		Check staff & mothers are aware of signs of proper attachment	2	SI/PI	(1) Baby's mouth is wide open (2) lower lip turned outwards (3) Baby's chin turned towards mother's breast (4) Majority of areola is inside the baby's mouth	
		Check poster of proper positioning & attachment is displayed in Breastfeeding area in SNCU	2	RR	Poster explain Signs of proper positioning, attachment and suckling. Also explain disadvantages of not following proper positioning & attachment	
		Staff is aware of breastfeeding problems & its management	2	SI/PI	(1) Inverted/flat nipples - Treatment- A 20ml plastic syringe can be used to draw out nipple gently (2) Sore nipple, due to incorrect attachment or frequent washing with soap & water or pulling the baby off while he is still sucking- Treatment- Correct positioning & attachement.Apply hind milk after feed & nipple should be aired, to allow healing in between feeds. In case of fungal infection suspected- refer to specialist or provide anti fungal medication (3) Breast engorgement- Treatment - Ensuring early & frequent feeding & correct attachment. Apply local warm water packs & analgesics (paracetamol) . Milk should be gently expressed to soften the breast. (4) Breast abscess- treatment- treated with analgesics & antibiotics. The abscess is to incised & drained. (5) Reduced milk supply: if baby is not gaining weight- Ask mother to feed more frequently especially during night. Make sure proper attachment & back massage is useful for stimulating lactation	
		SNCU provides extra support to establish breastfeeding in mother's having pre term & LBW babies	2	SI/PI	(1) SNCU ensures mother has begin the expression of milk within 6 hrs of delivery. (2) Encourage the mother's to repeat expression of milk 8-10 times per day to maintain flow of production & to feed the baby (3) The baby should put in breast every 2-3 hrs for feeding or non nutritive suckling (NNS) (4) SNCU ensures preterm milk is given to pre term babies	

		Check mother is encouraged to visit, touch and care her baby	2	SI/PI	Ask mother how often she visits her baby in SNCU	
		Check mothers are encouraged to learn milk expression	2	SI/PI	Both manual and through breast pump. Check instructions are displayed in milk expression room. Functional electrical pumps are available	
		SNCU has provision to collection, & storage breast milk	2	SI/OB	Check availability of milk expression room & refrigerator to store milk	
		SNCU has system to label & identify the expressed milk or milk received from CLMC	2	SI/OB	(1) Unique ID of baby, date of expression of milk or Date & time of opening the DHM bottle	
		Expressed milk/ DHM is stored at recommended temperature	2	SI/OB	Milk is immediately transferred to a refrigerator at the temperature of +2˚C to +4˚C for storage. EBM can be kept at room temp for 8 hours & in refrigerator for 24 hrs	
		SNCU promote feeding of breastmilk for pre term, low birth & sick new born	2	PI/RR	Check Bed head tickets whether mother milk or milk substitute is prescribed for admitted new born. Give non compliance if milk substitute is prescribed (untill clinically indicated)	
		Check breastfeeding policy is displayed	2	RR	Mentioning 10 steps of successful breastfeeding. Check Staff is able to explain at least 3 components of breastfeeding policy	
		Check SNCU promotes breastfeeding during follow up visits	2	RR/OB	(1) Exclusive during 6 months (2) initiate complemtary feeding after 6 months & (3) continue breastfeeding up to 2 yrs. and bevond	
		Check SNCU has linkage with Comprehensive lactation management centre	2	SI/PI	Inhouse or outsourced for ensuring breastmilk to the babies	
ME E20.11					DELETED	
	Area of Concern - F Infection Control					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
ME F1.3	The facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection	2	SI/RR	Patients are observed for any sign and symptoms of HAI. HAI reporting formats are available. Staff Know whom to report & action are taken on feed back.	
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization & periodic check-up of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals for Staff as well as mothers/care givers visiting regularly	
		Check each person enter SNCU after hand washing & gowning	2	OB		
ME F1.6	The facility has defined and established antibiotic policy	Check doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing with running Water Facility at Point of Use	2	OB	At least 1 wash basin for every 5 beds	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted. Availability of Alcohol based Hand rub	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps	2	OB	Hand washing sink is wide and deep enough to prevent splashing and retention of water	
		Separate Handwashing facilities are available for parent/ attendant	2	OB/SI	Only parents who follow the hygiene practices are allowed to provide care to their sick newborn	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	(1) Ask for demonstration (2) Staff aware of when to hand wash	
		Check each person enter SNCU after hand washing & gowning	2	OB/ PI	Ask for demonstration - mothers/guardian aware Steps of HW.	
		Mothers/care giver adhere to hand washing practices with soap	2	PI/OB	Mothers are aware of importance of washing hands .Washing hands after using the toilet/ changing diapers and before feeding children.	
Standard F3	**The facility ensures standard practices and materials for Personal protection**					
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Clean gloves are available at point of use	2	OB/SI	Handwashing b/w each patient & change of gloves	
		Availability of Mask caps & shoe cover	2	OB/SI		
		Availability of gown/ Apron & mask	2	OB/SI	Staff, visitors and parent/attendants	
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the gloves & other PPEs	2	SI	Ask for demonstration.	
		Mother's/parents are allowed to entre SNCU after gowning only	2	SI		
Standard F4	**The facility has standard procedures for processing of equipment and instruments**					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , Patients Beds Stretcher/Trolleys etc. (Wiping with 1% Chlorine solution	
		Cleaning of instruments	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB	Staff is trained for preparing cleaning solution as per standard procedure	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ new-born care area	
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Disinfection of instruments is done as per protocols	2	SI/OB	Achieve within 20 min contact period with 2% glutaraldehyde	
		Disinfection of individual items & utensils is done before use	2	SI/OB	(1) Individual item like stethoscope, thermometer measuring taps, probe should be done with 70% isopropyl alcohol daily or whenever used for another baby. (2) Cup spoon and paladai are boiled for at least 15 min before use /after every feed	
		Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/Chemical Sterilization	
		Autoclaving of instruments is done as per protocols	2	OB/SI	Ask staff about temperature, pressure and time	
		Chemical sterilization of instruments/equipment is done as per protocols	2	OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization(4hrs contact period), also how long the glutaraldehyde is active once prepared	
		Staff is aware of storage time for autoclaved items	2	OB/SI	Check staff is aware of how long autoclaved items can be stored. Also, autoclaved items are stored in dry, clean, dust free, moist free environment	
		Autoclaved dressing material & linen are used for SNCU	2	OB/SI		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Functional area of the department are arranged to ensure infection control practices	Facility layout ensures separation of routes for clean and dirty items	2	OB	Facility layout ensures separation of general traffic from patient traffic	
		There is separation between in born and out born unit	2	OB		
		Entry in SNCU is restricted	2	OB	Check there is no overcrowding inside the SNCU. Hospital staff without having a valid reason are not allowed in SNCU	
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde etc	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant, detergent solution, Lysol 5% or 3% phenol	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Spill management protocols are implemented	2	SI/RR	Check avaialbity of Spill management kit ,staff is trained for managing small & large spills , check protocols are displayed	
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out. Use of three bucket system for mopping.	
		Cleaning equipment like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment or activity leading to dispersion of dust particles in air should be avoided	
		External foot wares are restricted	2	OB	Check foot ware are changed before entry in SNCU	
ME F5.4	The facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases	2	OB/SI	Check babies with diarrhoea, pyoderma, or any other contagious disease should not be admitted inside SNCU	
ME F5.5	The facility ensures air quality of high risk area	SNCU has system to maintain ventilation and its environment should be dust free	2	OB	Ventilation can be provided in two ways: exhaust only and supply-and-exhaust. Exhaust fans pull stale air out of the unit while drawing fresh air in through cracks, windows or fresh air intakes. Exhaust-only ventilation is a good choice for units that do not have existing ductwork to distribute heated or cooled air	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					

ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB		
		Availability of Non chlorinated plastic colour coded plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI		
		Segregation of infected plastic waste in red bin	2	OB		
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2	OB		
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutter & Puncture proof container	2	OB	(1) Check if needle cutter has been used or just lying idle. (2) it should be available near the point of generation like nursing station	
		Availability of post exposure prophylaxis	2	OB/SI	1. Staff knows what to do in case of needle stick injury. 2. Staff is aware of whom to report 3. Check if any reporting has been done 4. Also check PEP issuance register	
		Glass sharps and metallic implants are disposed in Blue colour coded puncture proof box	2	OB	Includes used vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI	Bins should not be filled more than 2/3 of its capacity	
		Disinfection of liquid waste before disposal	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1					DELETED	
ME G1.2					DELETED	
Standard G2	**The facility has established system for patient and employee satisfaction**					
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals	Patient relative satisfaction survey done on monthly basis	2	RR		
ME G2.2	The facility analyses the patient feed back, and root-cause analysis	Analysis of low performing attributes is undertaken	2	RR		
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients	Action plan is prepared and improvement activities are undertaken	2	RR		
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Findings /instructions during the visit are recorded	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5					DELETED	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR	Check that SOP for management of services has been prepared and is formally approved	
		Current version of SOP are available with process owner	2	OB/RR	Check current version is available	
		Work instruction/clinical protocols are displayed	2	OB	WI for phototherapy, Grading and management of hypothermia, Expression of milk, KMC, Management of hypoglycaemia, housekeeping protocols, Administration of commonly used drugs, assessment of neonatal sepsis, Assessment of Jaundice, Temperature maintenance etc	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	SNCU has documented procedure for ensuring patients rights including consent, privacy, confidentiality & entitlement	2	RR	Review the SOP has adequately cover procedure for taking consent, maintenance of privacy, confidentiality & entitlements	
		SNCU has documented breastfeeding policy	2	RR	Review the SOP has adequately explaining implementation of 10 steps of breastfeeding	
		SNCU has documented procedure for safety & risk management	2	RR	Check availability of risk management record/register to identify risk & action taken to address them	
		SNCU has documented procedure for support services & facility management.	2	RR	Documented procedure for preventive- break down maintenance and calibration of equipment, Maintenance of infrastructure, inventory management & storage, retaining ,retrieval of SNCU records	
		SNCU has documented procedure for general patient care processes	2	RR	Availability of documented criteria & procedure for triage, admission, training and engagement of parent-attendants in care provision, assessment & re assessment, referral & discharge of the patient	
		SNCU has documented procedure for specific processes to the department	2	RR	SNCU has documented procedure for key clinical processes including resuscitation, thermoregulation of new born, ,drugs,intravenous,and fluid management and nutrition management of new born	
		SNCU has documented procedure for infection control & bio medical waste management	2	RR	Check availability of documented procedure for infection control practices& BMW	
		SNCU has documented procedure for quality management & improvement	2	RR	Check availability of documented procedure for departmental quality activities viz: nomination of department Nodal officer, internal assessments, audits, patient satisfaction survey, internal & external quality assurance processes,	
		SNCU has documented procedure for data collection, analysis & use for improvement	2	RR	Check availability of documented departmental Data set need to be measured monthly & procedure for their collection, analysis & improvement	
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1					DELETED	
ME G5.2					DELETED	
ME G5.3					DELETED	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4					DELETED	
ME G6.5					DELETED	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1					DELETED	
					DELETED	
ME G7.2					DELETED	
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality reivew, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ prgoress notes-	
		Check the patient /family participate in the care evalution	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits	2	SI/RR	Check medical audit records (a) Completion of the medical records i.e Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission	

		There is procedure to conduct newborn death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct referral audits	2	SI/RR	Check for -valid sample size, data is analysed, poor performing attributes are identified and improvement initiatives are undertaken	
		All non compliance are enumerated recorded for medical audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for newborn death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for referral audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per newborn death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per referral audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	Percentage of babies weighting less than 1800gm are admitted to SNCU	2	RR	No. of babies weighting less than 1800gm admitted / Total admission in SNCU in Month	
		Bed Occupancy Rate	2	RR		
		Proportion of female babies admitted	2	RR		
		No. of FPC sessions conducted in a month	2	RR	FPC register	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Percentage of very low birth weight babies survived	2	RR	No. of very low birth weight babies (< 1200 gm)/No. of Low birth+ Very low birth babies	
		Down time Critical Equipment	2	RR		
		Referral Rate	2	RR		
		Survival rate	2	RR	Discharge rate	
		Average waiting time for initiation of treatment	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Percentage of new-born deaths among inborn weighting 2500gm or more	2	RR		
		Percentage of new-born deaths among out-born weighting 1200 to 1800g	2	RR		
		Recovery rate	2	RR		
		Antibiotic use rate	2	RR		
		Average length of stay	2	RR		
		Percentage of new-born survived following Resuscitation	2	RR		
		Adverse events are reported	2	RR	Baby theft, wrong drug administration, needle stick injury, absconding patients etc	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate	2	RR		
		Parent/ care giver Satisfaction Score	2	RR		

National Quality Assurance Standards for District Hospitals	Version: DH/NQAS-2020/00
Checklist for Operation Theatre	9

Assessment Summary

Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Operation Theatre Score Card

Area of Concern wise Score			Operation Theatre Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No.	ME Statement	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.2	The facility provides General Surgery services	Availability of General Surgery procedures	2	SI/OB	Appendectomy, Intestinal Obstruction, Perforation, Tongue Tie, Inguinal Hernia, haemorrhoidectomy, Abscess drainage (perianal), Liver abscess, Cholecystectomy, superficial tumour excision.	
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Gynaecology procedures	2	SI/OB	(a) D & C, Hysterectomy, Cervical Cautery, Bartholin cyst excision, explorative laparotomy (uterine perforation, twisted ovarian), sling operation, haematocolpus drainage colpotomy (b) Lump excision, Simple mastectomy, Mammary fistula excision, Abscess drainage (breast)	
ME A1.4	The facility provides Paediatric Services	Availability of Paediatric Surgery procedure	2	SI/OB	I&D, Pepuceal Dilation, Meatomy, Gland Biopsy, Reduction Paraphimosis, Brachial/Thyroglossal Cyst and Fistula, Inguinal Herniotomy, Neonatal Intestinal Obstruction	
ME A1.5	The facility provides Ophthalmology Services	Availability of Ophthalmic Surgery procedures	2	SI/OB	Cataract Extraction with IOL, Canthotomy, Paracentesis, Enucleation, Glaucoma surgery, Conjunctival Cyst,	
ME A1.6	The facility provides ENT Services	Availability of ENT surgical procedure	2	SI/OB	Nose, Ear and Throat surgical procedures Packing, therapeutic removal of granulation (nasal, aural, oropharynx), Mastoid abscess, myringoplasty, endoscopic sinus surgery, Antral Puncture, Fracture Reduction, Mastoid Abscess I & D, periauricular sinus excision, stitching of CLW (nose & ear)	
ME A1.7	The facility provides Orthopaedics Services	Availability of Orthopaedic surgical procedures	2	SI/OB	Open and Closed Reduction, Nailing and Plating, Amputation, Disarticulation of Hip and Shoulder	
ME A1.10	The facility provides Dental Treatment Services	Availability of Oral surgery procedures	2	SI/OB	Trauma Including Vehicular Accidents , Fracture Wiring	
ME A1.14	Services are available for the time period as mandated	OT Services are available 24X7	2	SI/RR		
ME A1.16	The facility provides Accident & Emergency Services	Availability of Emergency OT services as and even when required	2	SI/OB	Check the number of emergency surgeries conducted in last 3 months	
Standard A2	Facility provides RMNCHA Services					
ME A2.4	The facility provides Child health Services	Availability of Paediatric surgical Procedure under RBSK	2	SI/OB	Developmental Dysplasia of the Hip, Congenital Cataract, cleft lip and palate	

Standard A3	**Facility Provides diagnostic Services**					
ME A3.1	The facility provides Radiology Services	Availability of portable x-ray machine	2	SI/OB	Check availability of functional C arm for 300 and above beds	
ME A3.2	The facility Provides Laboratory Services	Availability of point of care diagnostic test	2	SI/OB	Blood gas analyser& USG	
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**					
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of Reconstructive Surgery	2	SI/OB	Reconstruction of hand (tendon repair), polio surgery	
		Availability of Amputation Surgery	2	SI/OB		
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are played	
		Signage for restricted area are displayed	2	OB		
		Zones of OT are marked	2	OB		
ME B1.2	The facility displays the services and entitlements available in its departments	Information regarding services are displayed	2	OB	Display doctor/ Nurse on duty and updated OT schedule displayed	
		OT schedule displayed	2	OB		
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female staff if a male doctor examination/ conduct surgery of a female patients	2	OB/SI	Availability of female staff in pre and post operative room	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the OT	2	OB		
		Availability of ramps with railing	2	OB	At least 120 cm width, gradient not steeper than 1:12	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen between OT table	2	OB		
		Patients are properly draped/covered before and after produce	2	OB		
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB		
		No information regarding patient identity and details are unnecessary displayed	2	SI/OB		
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and Confidentiality of HIV cases	2	SI/OB		
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Consent is taken before major surgeries	2	SI/RR		
		Anaesthesia Consent for OT	2	SI/RR		
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient attendant is informed about clinical condition and treatment been provided	2	PI/SI		
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free medicines and consumables are available	2	PI/SI	JSSK	
		All surgical procedure are free of cost as per entitlements	2	PI/SI	PMJAY beneficiaries/ state scheme etc	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.	2	PI/SI		
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Surgical services are free for BPL patients	2	PI/SI/RR		
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space for accommodating surgical load	2	OB		
		Availability of OT for elective major surgeries	2	OB	100-200 -1OT, 200-300-2, 300-400 -3	
		Availability of OT for Emergency surgeries	2	OB	Emergency OT 1	
		Availability of OT ophthalmic/ENT	2	OB	Ophthalmic/ENT- 1	
		Waiting area for attendants	2	OB		
ME C1.2	Patient amenities are provide as per patient load	Functional toilets with running water and flush are available	2	OB	In the OT waiting area for patient relatives/ in the vicinity of OT	
		Availability of drinking water	2	OB	Check for availability of Hot water facility	
		Availability of seating arrangement	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions	Demarcated of Protective Zone	2	OB		
		Demarcated Clean Zone	2	OB		
		Demarcated sterile Zone	2	OB		
		Demarcated disposal Zone	2	OB		
		Availability of Changing Rooms	2	OB		
		Availability of Pre & post Operative Room	2	OB		
		Availability of Scrub Area	2	OB		
		Availability of Autoclave room/ TSSU	2	OB		
		Availability of dirty utility area	2	OB		
		Availability of store	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for movement of trolleys	2	OB	2-3 meters	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	OT tables are available as per load	2	OB	Hydraulic OT Tables As per case load at least two for 100 - 200 bedded DH and 4 for More than 200 beds	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods and services	2	OB	No cris cross of infectious and sterile goods	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	OT does not have temporary connections and loosely hanging wires	2	OB		
		Adequate electrical socket provided for safe and smooth operation of equipment	2	OB	Power boards are marked as per phase to which it belongs	
		Availability of three phase electricity supply	2	OB		

		OT has mechanism for periodical check / test of all electrical installation by competent electrical Engineer	2	OB		
		Wall mounted digital display is available in OT to show earth to neutral voltage	2	OB		
		Quality output of voltage stabilizer is displayed in each stabilizer as per manufacturer guideline	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the ward are non slippery and even	2	OB		
		Walls and floor of the OT covered with joint less tiles	2	OB		
		Windows/ ventilators if any in the OT are intact and sealed	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	OT has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	OT room has installed fire Extinguisher that is Class A , Class B, C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies' for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Obg & Gynae Surgeon	2	OB/RR	As per case load	
		Availability of general surgeon	2	OB/RR	As per case load	
		Availability of Orthopaedic Surgeon	2	OB/RR	As per case load	
		Availability of ophthalmic surgeon	2	OB/RR	As per case load	
		Availability of ENT surgeon	2	OB/RR	As per case load	
		Availability of anaesthetist	2	OB/RR	As per case load	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	As per patient load , at least two	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of OT technician	2	OB/SI		
ME C4.5	The facility has adequate support / general staff	Availability of OT attendant/assistant	2	SI/RR		
		Availability CSSD/ TSSU Asstt.	2	SI/RR		
		Availability of Security staff	2	SI/RR		
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Medical gases	2	OB/RR	Availability of Oxygen Cylinders / Piped Gas supply, Nitrogen	
		Availability of Anti-Infective medicines - Antibiotics, Antifungal	2	OB/RR	Inj. Ampillicin, Inj. metronidazole Inj. Gentamycin,	
		Availability of Antihypertensive medicines	2	OB/RR	Injectable preparations	
		Availability of analgesics and antipyretics	2	OB/RR	Tab Paracetamol, Ibuprofen, Inj. Diclofenac, Sodium plasma expender	
		Availability of Solutions Correcting Water, Electrolyte Disturbances and Acid-Base Disturbances	2	OB/RR	IV fluids, Normal saline, Ringer lactate,	
		Availability of anaesthetic agents	2	OB/RR	As per the State's EML - Topical agents: Lignocaine, Xylocaine Inhaled agents: Halothane, Nitrous oxide. Injectable: Barbiturates (Thiopental, Thiamylal, methohexital, Benzodiazepines)	
		Availability of other medicines	2		Tab B complex, Inj. Betamethasone, Inj. Hydralazine, Methyldopa, HIV drugs	
		Availability of emergency drugs	2	OB/RR	Inj. Magnesium sulphate 50%, Inj. Calcium Gluconate 10%, Inj. Dexamethasone, Inj. Hydrocortisone Succinate, Inj. Diazepam, Inj. Pheniramine maleate, Inj Corboprost, Inj. Pentazocine, Inj. Promethazine, Betamethason, Inj. Hydrazaline, Nifedipine, Methyldopa, Ceftriaxone	
ME C5.2	The departments have adequate consumables at point of use	Availability of dressings and Sanitary pads	2	OB/RR		
		Availability of syringes and IV Sets	2	OB/RR		
		Availability of Antiseptic Solutions	2	OB/RR	Ethyl Alcohol, Povidone Iodine Solution	
		Availability of consumables for new born care	2	OB/RR		
		Availability of personal protective equipment	2	OB/RR		
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency drug tray is maintained in OT in pre and post operative room	2	OB/RR		
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Thermometer, Pulse Oxy meter, Multiparameter , PV Set	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional General surgery equipment	2	OB	Diathermy (Unit and Bi Polar), Proctoscopy set, general Surgical Instruments for Piles, Fistula, & Fissures. Surgical set for Hernia & Hydrocele, Cautery	
		Availability of functional orthopaedic surgery equipment	2	OB	C arm, check OT table is C arm compatible, Thomas Splint, IM Nailing Set, SP Nailing, Compression Plating Kit, Dislocation Hip Screw Fixation	
		Availability of Ophthalmic surgery equipment	2	OB	Operating Microscope, IOL Operation Set, Ophthalmoscope Keratometer, A Scan Biometer	
		Availability of functional ENT surgery equipment	2	OB	Operating Microscope, ENT Operation set, Mastoid Set, Tracheotomy set, Microdrill System set	
		Operation Table with Trendelenburg facility	2	OB		
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments	2	OB	Portable X-Ray Machine, Glucometer, HIV rapid diagnostic kit, USG and Blood gas analyser	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments Resuscitation	2	OB	Ambu bag, Oxygen, Suction machine , laryngoscope scope, Defibrillator (Paediatric and adult) , LMA, ET Tube	
		Availability of functional anaesthesia equipment	2	OB	Boyles apparatus, Bains Circuit or Soda lime absorbent in close circuit	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
		Availability of equipment for storage of sterilized items	2	OB	Instrument cabinet and racks for storage of sterile items	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning	2	OB	Buckets for mopping, Separate mops for patient care area and circulation area duster, waste trolley, Deck brush	
		Availability of equipment for CSSD/TSSU	2	OB	Autoclave Horizontal & Vertical, Steriliser Big & Small	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of functional OT light	2	OB	Shadow less Major & Minor, Ceiling and Stand Model, Focus Lamp	
		Availability of attachment/ accessories with OT table	2	OB	Hospital graded mattress , IVstand, Bed pan	
		Availability of Fixtures	2	OB	Trey for monitors, Electrical panel for anaesthesia machine, cardiac monitor etc, panel with outlet for Oxygen and vacuum, X ray view box.	
		Availability of furniture	2	OB	Cupboard, table for preparation of medicines, chair, racks,	

Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Advance Life support	2	SI/RR	ALS and CPR by recognized agency to all category of staff.	
		OT Management	2	SI/RR	OT scheduling, maintenance, Fumigation, Surveillance, equipment-operation and maintenance, infection control, surgical procedures and emergency protocols.	
		Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Training on processing/sterilization of equipment	2	SI/RR		
		Patient Safety	2	SI/RR	Assessment, action planning, PDCA, 5S & use of checklist	
		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for resuscitation and intubation	2	SI/RR		
		Nursing Staff is skilled for maintaining clinical records	2	SI/RR		
		Staff is Skilled to operate OT equipment	2	SI/RR		
		Staff is skilled for processing and packing instrument	2	SI/RR		
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	(1) Check log book is maintained & it shows time taken to repair equipment. (2) Backup of critical equipment (3) Check staff is aware of Contact details of the agencies/ person responsible for maintenance	
		There has system to label Defective/Out of order equipment and stored appropriately until it has been repaired	2	OB/RR		
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR		
		Periodic cleaning, inspection and maintenance of the equipment is done by the operator	2	SI/RR		
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	Boyles apparatus, cautery, BP apparatus, autoclave etc.	
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	2	OB/ RR		
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipment are readily available with staff.	2	OB/SI		
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs	2	SI/RR	Stock level are daily updated Indent are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled	2	OB	Check drugs and consumables are kept at allocated space in Crash cart/ Drug trolleys and are labelled. Labelled with drug name, drug strength and expiry date. Look alike and sound alike drugs are kept separately from their identical one in look or sound.	
		Empty and filled cylinders are labelled	2	OB	Flow meter , humidifier, key & updated data sheet is available with in use cylinders	
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray	2	OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray FIRST EXPIRY and FIRST OUT (FEFO) is in practice	
		No expired drug found	2	OB/RR	Check drug sub store & emergency tray	
		Records for expiry and near expiry drugs are maintained for drug stored at department	2	RR	Records for expiry and near expiry drugs are maintained for drug stored at department FIRST EXPIRY and FIRST OUT (FEFO) is in practice	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time	
		Department maintained stock register of drugs and consumables	2	RR/SI	Check record of drug received, issued and balance stock in hand and are maintained	
		Drugs are categorized in Vital, Essential and Desirable	2	OB/RR	Check all Vital drugs are available	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is procedure for replenishing drug tray /crash cart	2	SI/RR	Procedure for replenishing drug in place	
		There is no stock out of drugs	2	OB/SI	Random stock check of some drugs	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day are maintained	2	OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day. Refrigerators meant for storing drugs should not be used for storing other items such as eatables.	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic and psychotropic drugs are kept in lock and key	2	OB/SI	Separate prescription for narcotic and psychotropic drugs by a registered medical practioner	
		Anaesthetic agents are kept at secure place	2	OB/SI		
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at OT table	2	OB	100000 lux	
		Adequate Illumination at pre operative and post operative area	2	OB		
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry to OT is restricted	2	OB		
		Warning light is provided outside OT and its been used when OT is functional	2	OB/SI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature is maintained and record of same is kept	2	SI/RR	20-25OC, ICU has functional room thermometer and temperature is regularly maintained	
		Humidity is maintained at desirable level	2	SI/RR	50-60%	
		Positive pressure is maintained in OT	2	SI/RR		
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at OT	2	OB		
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		

ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		OT Table are intact and without rust	2	OB	Check Mattresses are intact and clean	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the OT	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No pests are noticed	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
		Availability of Hot water supply	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OT	2	OB/SI	2 tier backup with UPS	
		Availability of UPS		OB/SI		
		Availability of Emergency light	2	OB/SI		
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen, nitrogen and vacuum supply	2	OB		
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	OT has facility to provide sufficient and clean linen for surgical patient	2	OB/RR	Drape, draw sheet, cut sheet and gown	
		OT has facility to provide linen for staff	2	OB/RR		
		Availability of Blankets, draw sheet, pillow with pillow cover and mackintosh	2	OB/RR		
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed after each procedure	2	OB/RR		
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR		
		Check dedicated closed bin is kept for storage of dirty linen	2	OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	There is procedure for Pre Operative assessment	2	RR/SI	Physical examination, results of lab investigation, diagnosis and proposed surgery	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
		Check treatment / care plan is documented	2	RR	The care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, discharge plan etc	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure of handing over & receiving patient	2	SI/RR	form OT to ward and ICU/HDU	
		There is a procedure for consultation of the patient to other specialist with in the hospital	2	RR/SI		
ME E3.3	A person is identified for care during all steps of care	Duty Doctor and nurse is assigned for each patients	2	RR/SI		
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure	2	OB/SI	Patient id band/ verbal confirmation etc.	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	There is a process to ensue the accuracy of verbal/telephonic orders	2	SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR		
		Nursing Handover register is maintained	2	RR		
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for use of cardiac monitor/multi parameter	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Check the measure taken to prevent new born theft, sweeping and baby fall	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI	HIV, Infectious cases	
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only	2	RR		
ME E6.2	There is procedure of rational use of drugs	Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per STG	
		Availability of drug formulary	2	SI/OB		
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Patient's name, prescription details and medical history is taken before surgery. Check complete medication history including over-the- counter medicines is taken and documented	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for the best possible clinical outcome"	
Standard E7	**Facility has defined procedures for safe drug administration**					

ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride, Opioids, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc. as applicable	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor	
		There is process to ensure that right doses of high alert drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided	
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR		
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI		
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI		
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content intended to be used later on	
		Check for separate sterile needle is used every time for multiple dose vial	2	OB	In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events	
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them	2	SI/RR	Administration of medicines done after ensuring right patient, right drugs, right route, right time, Right dose, Right Reason and Right Documentation	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Records of Monitoring/ Assessments are maintained	2	RR	PAC, Intraoperative monitoring	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT	2	RR	Treatment prescribed in nursing records (Manually/e-records)	
ME E8.4	Procedures performed are written on patients records	Operative Notes are Recorded	2	RR	Name of person in attendance during procedure, Pre and post operative diagnosis, Procedures carried out, length of procedures, estimated blood loss, Fluid administered, specimen removed, complications etc. (Manually/e-records)	
		Anaesthesia Notes are Recorded	2	RR	(Manually/e-records)	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available	2	RR/OB	Consents, surgical safety check list	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	OT Register, Schedule, Infection control records, autoclaving records etc	
		All register/records are identified and numbered	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	RR		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.3	There are established procedures for Post-testing Activities	OT is provided with the critical value of different test	2	SI/RR		
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.8	There is established procedure for issuing blood	Availability of blood units in case of emergency with out replacement	2	RR/SI	The blood is ordered for the patient according to the MSBOS (*Maximum Surgical Blood Order Schedule*)	
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR		
		Patient's identification is verified before transfusion	2	SI/OB		
		blood is kept on optimum temperature before transfusion	2	RR		
		Blood transfusion is monitored and regulated by qualified person	2	SI/RR		
		Blood transfusion note is written in patient recorded	2	RR		
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR		
Standard E14	**Facility has established procedures for Anaesthetic Services**					
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up	There is procedure to ensure that PAC has been done before surgery	2	RR/SI		
		There is procedure to review findings of PAC	2	RR/SI		
		Minimum PAC for emergency cases	2	RR/SI	in emergency & life saving conditions, surgery may be started with General physical examination of the patient & sending the sample for lab. Examination	
ME E14.2	Facility has established procedures for monitoring during anaesthesia	Anaesthesia plan is documented before entering into OT	2	RR		
		Anaesthesia Safety Checklist is used for safe administration of anaesthesia	2	RR	Check use of WHO Anaesthesia Safety Checklist	
		Anaesthesia equipment are checked before induction	2	RR	Sufficient reserve of gases. Vaporizers are connected, Laryngoscope, ET tube and suction App are ready and clean	
		Food intake status of Patient is checked	2	RR/SI		
		Patients vitals are recorded during anaesthesia	2	RR	Heart rate , cardiac rate , BP, O2 Saturation,	
		Airway security is ensured	2	RR/SI	Breathing system is securely and correctly assembled	
		Potency and level of anaesthesia is monitored	2	RR/SI		
		Anaesthesia note is recorded	2	RR	Check for the adequacy	
		Any adverse Anaesthesia Event is recorded and reported	2	RR		
ME E14.3	Facility has established procedures for Post Anaesthesia care	Post anaesthesia status is monitored and documented	2	RR/SI		
Standard E15	**Facility has defined and established procedures of Surgical Services**					
ME E15.1	Facility has established procedures OT Scheduling	There is procedure OT Scheduling	2	RR/SI	Schedule is prepared in consonance with available OT house and patients requirement	
ME E15.2	Facility has established procedures for Preoperative care	Patient evaluation before surgery is done and recorded	2	RR/SI	Vitals , Patients fasting status etc.	
		Antibiotic Prophylaxis given as indicated	2	RR/SI		
		Tetanus Prophylaxis is given if Indicated	2	RR/SI		
		There is a process to prevent wrong site and wrong surgery	2	RR/SI	Surgical Site is marked before entering into OT	
		Surgical site preparation is done as per protocol	2	RR/SI	Cleaning , Asepsis and Draping	
ME E15.3	Facility has established procedures for Surgical Safety	Surgical Safety Check List is used for each surgery	2	RR/SI	Check for Surgical safety check list has been used for surgical procedures	
		Sponge and Instrument Count Practice is implemented	2	RR/SI	Instrument, needles and sponges are counted before beginning of case, before final closure and on completing of procedure	
		Adequate Haemostasis is secured during surgery	2	RR/SI	Check for Cautery and suture legation practices	
		Appropriate suture material is used for surgery as per requirement	2	RR/SI	Check for what kind of sutures used for different surgeries . Braided Biological sutures are not used for dirty wounds, Catgut is not used for closing fascial layers of abdominal wounds or where prolonged support is required	
		Check for suturing techniques are applied as per protocol	2	RR/SI		

ME E15.4	Facility has established procedures for Post operative care	Post operative monitoring is done before discharging to ward	2	RR/SI	Check for post operative operation ward is used and patients are not immediately shifted to wards after surgery	
		Post operative notes and orders are recorded	2	RR/SI	Post operative notes contains Vital signs, Pain control, Rate and type of IV fluids, Urine and Gastrointestinal fluid output, other medications and Laboratory investigations	
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1	Death of admitted patient is adequately recorded and communicated	Death note is written on patient record	2	RR		
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note including efforts done for resuscitation is noted in patient record	2	RR	Includes both maternal and neonatal death	
		Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	2	RR/SI		
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
ME F1.3	Facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection	2	SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .	
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
		Periodic medical check-up of the staff	2	SI/RR		
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps	2	OB		
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB		
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Adherence to Surgical scrub method	2	SI/OB	procedure should be repeated several times so that the scrub lasts for 3 to 5 minutes. The hands and forearms should be dried with a sterile towel only.	
		Staff aware of when to hand wash	2	SI		
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
		Proper cleaning of perineal area before procedure with antisepsis	2	SI		
		Check Shaving is not done during part preparation/delivery cases	2	SI		
		Check sterile field is maintained during surgery	2	OB/SI	Surgical site covered with sterile drapes, sterile instruments are kept within the sterile field.	
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
		Sterile s gloves are available at OT and Critical areas	2	OB/SI		
		Use of elbow length gloves for obstetrical purpose	2	OB/SI		
		Availability of gown/ Apron	2	OB/SI		
		Availability of Caps	2	OB/SI		
		Personal protective kit for infectious patients	2	OB/SI	HIV kit	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps, Aprons	
Standard F4	**Facility has standard Procedures for processing of equipment and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like OT Table, Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like ambubag, suction canulae, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/HLD/Chemical Sterilization	
		High level Disinfection of instruments/equipment is done as per protocol	2	OB/SI	Ask staff about method and time required for boiling	
		Chemical sterilization of instruments/equipment is done as per protocols	2	OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization	
		Formaldehyde or glutaraldehyde solution replaced as per manufacturer instructions	2	OB/SI		
		Autoclaved linen are used for procedure	2	OB/SI		
		Autoclaved dressing material is used	2	OB/SI		
		Instruments are packed according for autoclaving as per standard protocol	2	OB/SI		
		Autoclaving of instruments is done as per protocols	2	OB/SI	Ask staff about temperature, pressure and time	
		Regular validation of sterilization through biological and chemical indicators	2	OB/SI/RR		
		Maintenance of records of sterilization	2	OB/SI/RR		
		There is a procedure to ensure the traceability of sterilized packs	2	OB/SI/RR		
		Sterility of autoclaved packs is maintained during storage	2	OB/SI	Sterile packs are kept in clean, dust free, moist free environment.	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					

ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic	2	OB	Faculty layout ensures separation of general traffic from patient traffic	
		Zoning of High risk areas	2	OB		
		Facility layout ensures separation of routes for clean and dirty items	2	OB		
		Floors and wall surfaces of ICU are easily cleanable	2	OB		
		CSSD/TSSU has demarcated separate area for receiving dirty items, processes, keeping clean and sterile items	2	OB		
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI		
		Cleaning equipment like broom are not used in patient care areas	2	OB/SI		
		Use of three bucket system for mopping	2	OB/SI		
		Fumigation/carbolization as per schedule	2	SI/RR		
		External footwares are restricted	2	OB		
ME F5.4	Facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases	2	OB/SI		
ME F5.5	Facility ensures air quality of high risk area	Positive Pressure in OT	2	OB/SI		
		Adequate air exchanges are maintained	2	SI/RR		
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins & Plastic bags at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids,dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2	OB		
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters & puncture proof, leak proof, temper proof white container for segregation of sharps	2	OB	See if it has been used or just lying idle.	
		Availability of post exposure prophylaxis & Protocols	2	OB/SI	Ask if available. Where it is stored and who is in charge of that. Also check PEP issuance register Staff knows what to do in condition of needle stick injury	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI	Not more than two-third.	
		Disinfection of liquid waste before disposal	2	SI/OB	Through Local Disinfection	
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		
		Staff aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF	
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the OT	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Check for entries in Round Register	
ME G3.2	Facility has established external assurance programs at relevant departments		2			
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI		
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2		Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2		Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2		Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	processing and sterilization of equipment,	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for scheduling the Surgery and its booking	2	RR		
		Department has documented procedure for pre operative procedure, in-process check and post operative care	2	RR		

		Department has documented procedure for pre operative anaesthetic check up	2	RR		
		Department has documented procedure for post operative care of the patient	2	RR		
		Department has documented procedure for operation theatre asepsis and environment management	2	RR		
		Department has documented procedure for OT documentation.	2	RR		
		Department has documented procedure for reception of dirt packs and issue of sterile packs from TSSU	2	RR		
		Department has documented procedure for maintenance and calibration of equipment	2	RR		
		Department has documented procedure for general cleaning of OT and annexes	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check that the patient /family participate in the care evalution	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is the procedure to conduct surgical audits	2	SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission	
		There is procedure to conduct death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		All non compliance are enumerated and recorded for surgical audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non-compliance are enumerated and recorded for death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per surgical audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	

		Check the mapping of existing clinical practices processes is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	No. of Major surgeries done per 1 lakh population	2	RR		
		No. of emergency surgeries done	2	RR		
		Proportion of other emergency surgeries done in the night	2	RR		
		No. of elective surgeries performed	2	RR		
		CSSD/TSSU productivity index	2	RR	No. of packs sterilized against the no. of surgeries	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime critical equipment	2	RR		
		Skin to skin time	2	RR		
		No of major surgeries per surgeon	2	RR		
		Proportion emergency surgeries	2	RR		
		Cycle time for instrument processing	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Surgical Site infection Rate	2	RR	No. of observed surgical site infections*100/total no. of Major surgeries	
		Proportion of cases with post surgical complications	2		Complication grading using Clavien-Dindo scale. All the cases with complication more than graded >2 on the Clavien-Dindo scale	
		No of adverse events per thousand patients	2	RR		
		Incidence of re-exploration of surgery	2	RR		
		% of environmental swab culture reported positive	2	RR		
		Perioperative Death Rate	2	RR	Deaths occurred from pre operative procedure to discharge of the patient	
		Proportion of General Anaesthesia to spinal anaesthesia	2	RR		
		Proportion of PAC done out of total elective surgeries	2	RR		
		No. of autoclave cycle failed in Bowie dick test out of total autoclave cycle	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Operation Cancellation rates	2	RR	(a) No. of cancelled operation*1000 /total operation done Planned operations cancelled due to any reason like clinical, non clinical (theatre), or by patient	
		Average time taken to conduct the emergency surgery	2	RR	Time taken from presentation in emergency department to non-elective surgery conducted	

National Quality Assurance Standards			Version: DH/NQAS-2020/00
Checklist for Maternity Operation Theatre			10
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assesses	
Type of Assessment (Internal/External)		Action plan Submission Date	

Operation Theatre Score Card

Area of Concern wise Score			Operation Theatre Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No.	ME Statement	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.14	Services are available for the time period as mandated	OT Services are available 24X7	2	SI/RR	Check with OT records that OT services were functional in 24X7 and surgeries are being conducted in night hours	
ME A1.16	The facility provides Accident & Emergency Services	Availability of Emergency OT services as and when required	2	SI/OB		
ME A1.17	The facility provides Intensive care Services	Availability of Maternity HDU/ICU services in the facility	2	SI/OB		
Standard A2	Facility provides RMNCHA Services					
ME A2.1	The facility provides Reproductive health Services	Availability of Post partum sterilization services	2	SI/OB	tubal ligation	
ME A2.2	The facility provides Maternal health Services	Availability of Elective C-section services	2	SI/RR	Check services are available and are being utilized	
		Availability of Emergency C-section services	2	SI/RR	Check services are available and are being utilized	
		Management of MTP	2	SI/OB	Surgical management	
ME A2.3	The facility provides New-born health Services	Availability of New born resuscitation& essential new born care	2	SI/OB	Dedicated Functional New born Care services in Operation theatre	

Standard A3	**Facility Provides diagnostic Services**					
ME A3.2	The facility Provides Laboratory Services	Availability of point of care diagnostic test	2	SI/OB	Glucometer, RDK , Blood grouping	
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage, Restricted area signage displayed. Directional signages are given from the entry of the facility	
ME B1.2	The facility displays the services and entitlements available in its departments	Information regarding services are displayed	2	OB	Display doctor/ Nurse on duty and updated OT schedule displayed	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**					
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	OT is easily accessible	2	OB	Availability of Wheel chair or stretcher for easy Access. Door is wide enough for passage of trolley and staff.	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Patients are properly draped/covered before and after procedure	2	OB	Look patients are covered while transferred from ward to OT and vice-versa.	
		Visual Privacy is maintained between two OT Tables	2	OB	Preferably only one OT table should be placed in theatre, if it is not possible because of high case load adequate visual privacy should be provided through screens of multiple patients are present in same OT	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB	In drawers/Amirah; preferably with lock facility.	
ME B3.3	The facility ensures the behaviour of staff is dignified and respectful, while delivering the services	Behaviour of OT staff is dignified and respectful	2	OB/PI	Check that OT staff is not providing care in undignified manner such as yelling, scolding , shouting, blaming and using abusive language	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Pregnant women is not left unattended or ignored during care in the OT	2	OB/PI	Check that care providers are attentive and empathetic to the pregnant women at no point of care they are left alone.	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Consent is taken for surgical procedures	2	SI/RR	written consent with details of the procedure with potentials risks and complication. Should be signed by patient/next of kin and one witness	
		Separate consent is taken for Anaesthesia procedure	2	SI/RR	written consent with details of the anaesthesia with potentials risks and complication. Should be signed by patient/next of kin and one witness	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	All surgical procedure are free of cost for JSSK beneficiaries	2	PI/SI	free drugs, consumables , blood, referral etc.	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space for accommodating surgical load	2	OB	OT around 40 Square meter. Two OT tables are not kept in one OT	
ME C1.3	Departments have layout and demarcated areas as per functions	Demarcated Protective Zone	2	OB	Reception, waiting area, stretcher/Trolley bay, Pre and post operative rooms,	
		Demarcated Clean Zone	2	OB	Doctor's and Nurse's room, Anaesthesia room, equipment room, emergency exit.	
		Demarcated sterile Zone	2	OB	Operating room, Scrub station, Anaesthesia station,	
		Demarcated disposal Zone	2	OB	Disposal corridor, janitor closet	
		Availability of Changing Rooms	2	OB	Separate for male and females	
		Availability of demarcated Pre & post Operative Room /area	2	OB	Can be in a single room with a partition.	
		Availability of earmarked area for new born Corner	2	OB	Functional warmer, resuscitation apparatus, suction/mucous extractor, O2 cylinder, weighing scale and sterile gloves.	
		Availability of Scrub Area	2	OB	Height around 96 cm with elbow taps/sensors, both hot and cold water available. Sink is deep and wide enough to avoid spoiling. Scrub area should not be inside the OT room.	
		Availability of TSSU /CSSD	2	OB	Dedicated areas with provision of Washing, Packing , Autoclaving the instruments and linen	
		Availability of store	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for movement of trolleys	2	OB	7 to 10 feet.	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB	Intercom should connects Operation theatre to key areas like ICU, Blood Bank, SNCU, Lab, Accident and emergency, wards, Administration	
ME C1.6	Service counters are available as per patient load	OT tables are available as per load	2	OB	Hydraulic OT Tables As per case load at least two	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods and services	2	OB	Services are designed in a way, that there is no criss cross in moment of sterile & no sterile supplies & equipment etc.	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	OT does not have temporary connections and loosely hanging wires	2	OB	No extension cord or multi-plugs	
		Availability of three phase electricity supply	2	SI/OB	Check electricity bill or Power Distribution Board. Meter have three wires coming out (with one neutral).	
ME C2.4	Physical condition of buildings are safe for providing patient care	Walls and floor of the OT covered with joint less tiles	2	OB	made of anti-skid & Epoxy flooring	
		Windows/ ventilators if any in the OT are intact and sealed	2	OB	No broken glass, gap or cracks in window/ventilator.	
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	OT has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI	Check the fire exits are clearly visible and routes to reach exit are clearly marked	
ME C3.2	The facility has adequate fire fighting Equipment	Labour room has installed fire Extinguishers & expiry is displayed on each fire extinguisher	2	OB	Class A , Class B, C type or ABC type. Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR	staff should be able to demonstrate how to open the extinguisher and operate it. PASS (Pull the pin, Aim at the base of fire, Sway from side to side)	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					

ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Obs. & Gynae Surgeon	2	OB/RR	100 beds 2, 200 beds-3, 3oo beds-4, 400 beds-5 and 500 beds-6	
		Availability of anaesthetist	2	OB/RR	At least One	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	As per patient load , at least two	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of OT technician	2	OB/SI	One per shift.	
ME C4.5	The facility has adequate support / general staff	Availability of OT attendant/assistant & TSSU assistant	2	SI/RR	1 each	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of medical gases	2	OB/RR	Availability of Oxygen, nitrogen Cylinders / Piped Gas supply.	
		Availability of drugs for local anaesthesia	2	OB/RR	Procaine, lignocaine, bupivacaine, Xylocaine jelly	
		Availability of drugs for general anaesthesia	2	OB/RR	Inhaled agents-Halothane, nitrous oxide. Injectable: Barbiturates (Theopental, Thiamylal, methohexital, Benzodiazepines (diazepam, Lorazepam, Midazolam), Ketamine, Etomidate, Propofol . Neostigmine, Naloxone, Flumazenil, Sugammadex-as per EDL/State guidelines.	
		Availability of opioid analgesics.	2	OB/RR	Fentanyl, Sufentanil, Morphine, Buprenorphine, Levorphanol, Methadone-As per EDL/State guidelines.	
		Availability of muscle relaxants drugs	2	OB/RR	Succinylcholine, Vecuronium, Mivacurlum, Tubocarine as per EDL/state guidelines	
		Availability of emergency drugs	2	OB/RR	Inj Magsulf 50%, Inj Calcium gluconate 10%, Inj Dexamethasone, inj Hydrocortisone, Succinate, Inj diazepam, inj Pheneramine maleate, inj Corboprost, Inj Fortwin, Inj Phenergen, Betameathazon, Inj Hydrazaline, Nefidepin, Methyldopa,ceftriaxone	
		Availability of other drugs	2	OB/RR	Antibiotics, Analgesics, Uterotonic drugs, IV fluids and anithypertensive drugs as per EDL/ state guidelines	
ME C5.2	The departments have adequate consumables at point of use	Availability of dressings Material	2	OB/RR	Adequate quantity of sterile pads, gauze, bandages , Antiseptic Solution.	
		Availability of syringes and IV Sets	2	OB/RR	In adequate quantity as per load.	
		Availability of consumables for new born care	2	OB/RR	Cord Clamp, mucous sucker, airway, NG Tube, Suction catheter, IV cannula, paed IV set and Bag and Mask (0 & 1 no.)	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency drug tray is maintained in OT in pre and post operative room	2	OB/RR	Every tray is labelled with name and number of drugs and consumables along with their date of expiry.	
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Thermometer, Pulse Oxy meter, Multiparameter , PV Set, torch & wall clock.	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional instruments for Gynae and obstetrics	2	OB	LSCS Set, Cervical Biopsy Set, Proctoscopy Set, Hysterectomy set, D&C Set	
		Availability of functional equipment/ Instruments for New Born Care	2	OB	Radiant warmer, Baby tray with Two pre warmed towels/sheets for wrapping the baby, mucus extractor, bag and mask (0 &1 no.), sterilized thread for cord/cord clamp, nasogastric tube	
		Availability of functional General surgery equipments	2	OB	Diathermy (Unit and Bi Polar), Cautery	
		Operation Table with Trendelenburg type	2	OB	OT Table hydraulic major and OT table hydraulic minor	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments	2	OB	Glucometer, HIV rapid diagnostic kit, USG, ABG machine	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments Resuscitation for new born & Mother	2	OB	Resuscitation bag (Adult & paediatrics) Ambu bag, Oxygen, Suction machine , laryngoscope scope, Defibrillator (Paediatric and adult) , LMA, ET Tube	
		Availability of functional anaesthesia equipment	2	OB	Boyles apparatus, Bains Circuit or Soda lime absorbent in close circuit ,AGSS (Anaesthesia gas scavenging system)	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage of drugs & Instruments	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley, Instrument cabinet and racks for storage of sterile items	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning	2	OB	Three Bucket system for mopping, Separate mops for patient care area and circulation area duster, waste trolley, Deck brush	
		Availability of equipment for TSSU	2	OB	Autoclave Horizontal & Vertical, Steriliser Big & Small	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of functional OT light	2	OB	Shadow less Major & Minor, Ceiling and Stand Model, Focus Lamp	
		Availability of Fixtures	2	OB	Tray for monitors, Electrical panel for anaesthesia machine with minimum 6 electrical sockets (2= 15 amp power point), panel with outlet for Oxygen and vacuum, X ray view box.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Advance Life support	2	SI/RR	ALS and CPR by recognized agency to all category of staff.	
		Training on OT Management	2	SI/RR	OT scheduling, maintenance, Fumigation, Surveillance, equipment-operation and maintenance, infection control, surgical procedures and emergency protocols.	
		Biomedical Waste Management& Infection control and hand hygiene ,Patient safety	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
		Training on Quality Management	2	SI/RR	Assessment, action planning, PDCA, 5S & use of checklist	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	look for MOU and visit records of the empanelled agency.	
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	Back up for critical equipment. Label Defective/Out of order equipment and stored appropriately until it has been repaired	

		Staff is skilled for cleaning, inspection & trouble shooting in case equipment malfunction	2	SI/RR	E.g. when to change water of batteries, when to oil, change fuse, replace filters etc.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated	2	OB/ RR	Boyles apparatus, cautery, BP apparatus, autoclave etc. There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipment are readily available with staff.	2	OB/SI	If operator doesn't understand English, then instructions should be in local language.	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs	2	SI/RR	Stock level are daily updated Requisition are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart are labelled	2	OB	Away from direct sunlight and temperature is maintained as per instructions of manufacturer.	
		Empty and filled cylinders are labelled & kept separately	2	OB	Each cylinder is provided with a checklist & flow meter and key for opening the cylinder	
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray	2	OB/RR	Records for expiry and near expiry drugs are maintained for drug stored at department. No expired drugs found	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	At least one week of minimum buffer stock is maintained all the time in the labour room. Minimum stock and reorder level are calculated based on consumption in a week accordingly	
		Department maintained stock and expenditure register of drugs and consumables	2	RR/SI	Check that records are regularly updated	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is procedure for replenishing drug tray /crash cart	2	SI/RR	There is no stock out of drugs	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records are maintained	2	OB/RR	Check for temperature charts are maintained and updated periodically	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic ,psychotropic & Anaesthetic agents are kept in lock and key	2	OB/SI	Under direct supervision of anaesthetist	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at OT table	2	OB	100000 lux	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Warning light outside the OT is switched on when OT is functional	2	OB/SI	Only persons required in OT are allowed to enter the OT	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature & humidity is maintained and record of same is kept	2	SI/RR	20-25^{0}C, ICU has functional room thermometer and temperature is regularly maintained. 50-60% humidity	
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at OT	2	OB	Restricted Signage, security guard, CCTV camera	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Department is painted/whitewashed in uniform colour &plastered & painted	2	OB	Painted in soothing colours Not bright colours.	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof tops, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB	Look for dirt above OT light, behind stationary equipment etc.	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB	check corners, false ceiling.	
		OT Table are intact and without rust	2	OB	Mattresses are intact and clean	
		No unnecessary items in sterile zone	2		No slabs, almirah, storing unnecessary items like drums, equipment, Instruments etc Items not required for immediate procedures are kept out of sterile zone	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the OT	2	OB	No partial compliance.	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB	Check for no stray animal in and around OT. Also no lizard, cockroach, mosquito, flies, rats etc.	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Availability of Hot water supply	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OT	2	OB/SI	2 tier backup with UPS	
		Availability of UPS & Emergency light	2	OB/SI	Check their functionality.	
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen, nitrogen and vacuum supply	2	OB	Cylinders are provided with trolleys to prevent fall and injuries.	
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	OT has facility to provide sufficient and clean linen for surgical patient	2	OB/RR	Drape, draw sheet, cut sheet and gown	
		OT has facility to provide linen for staff	2	OB/RR	OT dress, gown. Separate OT dress for OT staff.	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed after each procedure	2	OB/RR	Bed sheets, draw sheets and Macintosh.	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR	OT tech/Nurse checks Number of linen, cleanliness, whether it is turned or stained	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB	Check staff is wearing dress as per their dress code.	
	Area of Concern - E Clinical Services					
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	There is procedure for Pre Operative assessment	2	RR/SI	Physical examination, results of lab investigation, X-Rays, diagnosis and proposed surgery	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	

Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure of handing over from OT to Maternity Ward, HDU and SNCU	2	SI/RR	Transfer Register is maintained.	
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure	2	OB/SI	Patient id band/ verbal confirmation etc. At least two identifiers are used.	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR	Handover register is maintained	
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for use of cardiac monitor/multi parameter	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Check the measure taken to prevent new born theft, sweeping of baby or fall	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI	HIV, Infectious cases	
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for Case Sheet if drugs are prescribed under generic name only	2	RR	Check at least 5 case sheets selected randomly	
ME E6.2	There is procedure of rational use of drugs	Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check if drugs are prescribed as per STG in at least 5 case sheets selected randomly	
		Check Case Sheet that drugs are prescribed as per STG	2	RR	Check if drugs are prescribed as per STG in at least 5 case sheets selected randomly	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Check complete medication history including over-the- counter medicines is taken and documented	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome	
Standard E7	**Facility has defined procedures for safe drug administration**					
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride, Opioids, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc. as applicable	
		Maximum dose of high alert drugs are defined and communicated & there is process to ensure that right doses of high alert drugs are only given	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor. A system of independent double check before administration, Error prone medical abbreviations are avoided	
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR	Look for pre-op, Procedure and Post op notes and instructions.	
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI	Ask OT/Ward staff to read the orders written by doctor.	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI	Check for any open single dose vial with left over content intended to be used later on. In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events, Check for ADR forms and records.	
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them	2	SI/RR	Administration of medicines done after ensuring right patient, right drugs , right route, right time, Right dose , Right Reason and Right Documentation	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Records of Monitoring/ Assessments are maintained	2	RR	PAC, Intraoperative monitoring	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on Case Sheet	2	RR	Treatment prescribed in nursing records	
ME E8.4	Procedures performed are written on patients records	Operative Notes are Recorded	2	RR	Name of person in attendance during procedure, Pre and post operative diagnosis, Procedures carried out, length of procedures, estimated blood loss, Fluid administered, specimen removed, complications etc.	
		Anaesthesia Notes are Recorded	2	RR	notes includes Anaesthesia type, induction, airway, intubation, inhalation agents, epidural, spinal, allergies, IV lines, IV fluids, regional block.	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available	2	RR/OB	Consent forms, Anaesthesia form, surgical safety check list	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	OT Register, Schedule, Infection control records, autoclaving records etc	
		All register/records are identified and numbered	2	RR	Register are labelled and numbered.	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	RR	Records are kept in place without seepage, moisture, termite, pests.	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan & their role and responsibilities of staff is defined	2	SI/RR	Ask role of staff in case of disaster.	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB	Including Specimen for HPE & biopsy. Name, Age, Sex, date, UHID	
ME E12.3	There are established procedures for Post-testing Activities	OT is provided with the critical value of different test	2	SI/RR	Critical values are displayed.	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.8	There is established procedure for issuing blood	Availability of blood units in case of emergency with out replacement	2	RR/SI	The blood is ordered for the patient according to the MSBOS (Maximum Surgical Blood Order Schedule)	
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR	Duly signed by patient/next of kin	
		Patient's identification is verified before transfusion	2	SI/OB	At least two identifiers are used.	
		Protocol of blood transfusion is monitored & regulated	2	RR	blood is kept on optimum temperature before transfusion. Blood transfusion is monitored and regulated by qualified person	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR	After transfusion, Reaction form is returned back to blood bank, even when there is no reaction.	
Standard E14	**Facility has established procedures for Anaesthetic Services**					
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up	There is procedure to ensure that PAC has been done before surgery	2	RR/SI	There is procedure to review findings of PAC	
		Minimum PAC for emergency cases	2	RR/SI	in emergency & life saving conditions, surgery may be started with General physical examination of the patient & sending the sample for lab. Examination	
ME E14.2	Facility has established procedures for monitoring during anaesthesia	Anaesthesia plan is documented before starting surgery	2	RR	Type of anaesthesia planned-local/general/spinal/epidural. Time is mentioned on all entries of anaesthesia monitoring sheet	

		Anaesthesia Safety Checklist is used for safe administration of anaesthesia	2	RR	Check use of WHO Anaesthesia Safety Checklist	
		Anaesthesia equipment are checked before induction	2	RR	Sufficient reserve of gases. Vaporizers are connected, Laryngoscope, ET tube and suction App are ready and clean	
		Food intake status of Patient is checked	2	RR/SI	Time of last food intake is mentioned	
		Patients vitals are recorded during anaesthesia	2	RR	Heart rate , cardiac rate , BP, O2 Saturation, temperature, Respiration rate.	
		Airway security is ensured	2	RR/SI	Breathing system of anaesthesia equipment that delivers gas to the patient is securely and correctly assembled and breathing circuits are clean	
		Potency and level of anaesthesia is monitored	2	RR/SI	Recorded in the Anaesthesia Record Form.	
		Anaesthesia note is recorded	2	RR	Check for the adequacy, signed, complete, and post anaesthesia instructions.	
		Any adverse Anaesthesia Event is recorded and reported	2	RR	Reduced level of consciousness, reparatory depression, malignant hyperpyrexia, bone marrow depression, life threatening pressure effect, anaphylaxis	
ME E14.3	Facility has established procedures for Post Anaesthesia care	Post anaesthesia status is monitored and documented	2	RR/SI	Check for anaesthetic notes & post operating instructions in post operative room & area	
Standard E15	**Facility has defined and established procedures of Surgical Services**					
ME E15.1	Facility has established procedures OT Scheduling	List of Elective Surgeries for the day is prepared and displayed outside OT.	2	RR/SI	Surgery list is prepared in consonance with availability of the OT hours and patients requirement.	
		Surgery list is complete in all respect	2	OB/SI	Day, date and time of surgeries. Name, Age, Gender of patients. Clear description of the procedure (name of procedure which side,) Name of the surgeon & anaesthetist. Major or minor case.	
		Operation list is sent to OT well in advance	2	RR/SI	By 12:00 hours, a day before the surgery.	
		Surgery list is informed to surgeon and ward sister.	2	RR/SI	Verify the surgery register/email	
		The operation list does not exceed the time allocated to it.	2	RR/SI	This does not refer to the time during an operation of an individual patient	
ME E15.2	Facility has established procedures for Preoperative care	Patient evaluation before surgery is done and recorded	2	RR/SI	Vitals , Patients fasting status etc.	
		Antibiotic Prophylaxis and Tetanus given as indicated	2	RR/SI	As per instructions of surgeon/anaesthetist.	
		Surgeries planned under local anaesthesia/Regional Block sensitivity test is done	2	RR/SI	lidocaine sensitivity test	
		There is a process to prevent wrong site and wrong surgery	2	RR/SI	Surgical Site is marked before entering into OT	
		No shaving of the surgical site	2	SI/RR	Only clipping on the day of surgery in OT is done	
		Skin preparation before surgery is done.	2	SI/RR	Bathing with soap and water prior to surgery in ward.	
		Skin preparation is done as per protocol	2	RR/SI	Prepare the skin with antiseptic solution (Chlorhexidine gluconate and iodine), starting in the centre and moving out to the periphery. This area should be large enough to include the entire incision and an adjacent working area.	
		Draping is done as per protocol	2	SI/OB	Scrub, gown and glove before covering the patient with sterile drapes. Leave uncovered only the operative field and those areas necessary for the maintenance of anaesthesia.	
ME E15.3	Facility has established procedures for Surgical Safety	Surgical Safety Check List is used for each surgery	2	RR/SI	Check for Surgical safety check list has been used for surgical procedures	
		Sponge and Instrument Count Practice is implemented	2	RR/SI	Instrument, needles and sponges are counted before beginning of case, before final closure and on completing of procedure & documented	
		Adequate Haemostasis is secured during surgery	2	RR/SI	Check for functional Cautery, use of artery forceps and suture ligation techniques	
		Appropriate suture material is used for surgery as per requirement	2	RR/SI	For closing abdominal wall or ligating blood vessel use non-absorbable sutures (braided suture, nylon, polyester etc). absorbable sutures in urinary tract. Braided Biological sutures are not used for dirty wounds, Catgut is not used for closing fascial layers of abdominal wounds or where prolonged support is required	
		Check for suturing techniques are applied as per protocol	2	RR/SI	Braided sutures for interrupted stiches. Absorbable and non-absorbable monofilament sutures for continuous stiches.	
ME E15.4	Facility has established procedures for Post operative care	Post operative monitoring is done before discharging to ward	2	RR/SI	Check for post operative operation room /area is used and patients are not immediately shifted to wards after surgery	
		Post operative notes and orders are recorded	2	RR/SI	Post operative notes contains Vital signs, Pain control, Rate and type of IV fluids, Urine and Gastrointestinal fluid output, other medications and Laboratory investigations	
		Information & instructions are given to nursing staff before shifting the patient to the ward from the OT	2	RR/SI	Instructions given by surgeon and anaesthetist.	
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note including efforts done for resuscitation is noted in patient record	2	RR	Includes both maternal and neonatal death. Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	
Standard E18	**Facility has established procedures for Intranatal care as per guidelines**					
ME 18.3	Facility staff adheres to standard procedures for routine care of new-born immediately after birth	Wipes the baby with a clean pre-warmed towel and wraps baby in second pre-warmed towel;	2	SI/OB	Check staff competence through demonstration or case observation	
		Performs delayed cord clamping and cutting (1-3 min);	2	SI/OB	Check staff competence through demonstration or case observation	
		Initiates breast-feeding soon after birth	2	SI/OB	Check staff competence through demonstration or case observation	
		Records birth weight and gives injection vitamin K	2	SI/OB	Check staff competence through demonstration or case observation	
ME E18.4	There is an established procedure for assisted and C-section deliveries per scope of services.	Pre operative care and part preparation	2	SI/RR	Check for Haemoglobin level is estimated , and arrangement of Blood, Catheterization, Administration of Antacids Proper cleaning of perineal area before procedure with antisepsis	
		Proper selection Anaesthesia technique	2	SI/RR	Check Both General and Spinal Anaesthesia Options are available. Ask for what are the criteria for using spinal and GA. Regional block and epidural anaesthesia used wherever required/indicated	

		Intraoperative care	2	SI/RR	Check for measures taken to prevent Supine Hypotension (Use of pillow/Sandbag to tilt the uterus), Technique for Incision, Opening of Uterus, Delivery of Foetus and placenta, and closing of Uterine Incision	
		Post operative care	2	SI/RR	Frequent monitoring of vitals, Strict IO charting, Flat bed without pillow for SA, NPO depending on type of anaesthesia and surgery.	
ME 18.5	Facility staff adheres to standard protocols for identification and management of Pre Eclampsia / Eclampsia	Management of PIH/Eclampsia	2	SI/RR	Ask for how to secure airway and breathing, Loading and Maintenance dose of Magnesium sulphate , Administration of anti Hypertensive Drugs	
ME 18.6	Facility staff adheres to standard protocols for identification and management of PPH.	Postpartum Haemorrhage	2	SI/RR	IV fluids, parental oxytocin and antibiotics, manual removal of placenta, blood transfusion, B-lynch suturing, surgery	
		Ruptured Uterus	2	SI/RR	Put patient in left lateral position, maintain Airway, breathing and circulation, IV Fluid, antibiotics, urgent laparotomy and hysterectomy.	
ME 18.7	Facility staff adheres to standard protocols for Management of HIV in Pregnant Woman & Newborn	Provides ART for seropositive mothers/ links with ART centre	2	SI/RR	Check case records and Interview of staff	
		Provides syrup Nevirapine to new-borns of HIV seropositive mothers	2	SI/RR	Check case records and Interview of staff	
ME 18.10	There is Established protocol for new-born resuscitation is followed at the facility.	New born Resuscitation	2	SI/RR	Ask Nursing staff to demonstrate Resuscitation Technique	
Standard E19	**Facility has established procedures for postnatal care as per guidelines**					
ME E19.1	Facility staff adheres to protocol for assessment of condition of mother and baby and providing adequate postpartum care	Prevention of Hypothermia	2	SI/RR	Skin contact, Kangaroo mother care, radiant warmer, warm clothes.	
ME E19.2	Facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding	Initiation of Breastfeeding with in 1 Hour	2	PI/SI	Shall be initiated as early as possible and exclusive breast feeding	
ME E19.5	The facility ensure adequate stay of mother and new born in a safe environment as per standard protocols	There is established criteria for shifting new born to SNCU	2	SI/RR	only the new born requiring intensive care should be transferred to SNCU	
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
ME F1.3	Facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection	2	SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .	
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization medical check-up of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR	Antibiotics prescribed are in line with Antibiotic Policy.	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing with running Water Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps	2	OB	elbow /foot operated or sensor	
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB	Tap should be approx. 96 cm from the ground.	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adequate preparation for surgical scrub.	2	OB/SI/RR	Check Finger nails of staff. They should not reach beyond finger tip. No nail polish or artificial nails. All jewellery on the fingers, wrists and arms should be removed. Adjust water to a comfortable temperature.	
		Adherence to Surgical scrub method	2	SI/OB	Procedure should be repeated several times so that the scrub lasts for 3 to 5 minutes. Hands must always be kept above elbow level. The hands and forearms should be dried with a sterile towel only.	
		Use of antibiotic soap/liquid	2	SI/OB	Check adequate quantity of antibiotic soap/Chlorhexidine solution is available and used.	
		Staff aware of when to hand wash	2	SI	Ask for 5 moments of hand washing	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB	Povidone iodine solution	
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
		Check sterile field is maintained during surgery	2	OB/SI	Surgical site covered with sterile drapes, sterile instruments are kept within the sterile field.	
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipment's as per requirements	Sterile gloves are available at OT and Critical areas	2	OB/SI	In adequate quantity, as per load	
		Availability of Masks	2	OB/SI	In adequate quantity, as per load	
		Availability of Caps & gown/ Apron	2	OB/SI	In adequate quantity, as per load	
		Personal protective kit for infectious patients	2	OB/SI	Disposable surgery kit for HIV patients	
		Availability of gum boots	2	OB/SI	In adequate quantity, as per load	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI/RR	Check Autoclaving/sterilization records.	
		Compliance to correct method of wearing and removing the gloves	2	SI	Adherence to standard technique so that sterile area is not in contact with unsterile at any given point of time.	
		Compliance to standard technique of wearing and removing of gown	2	SI	Adherence to standard technique so that sterile area is not in contact with unsterile at any given point of time.	
Standard F4	**Facility has standard Procedures for processing of equipment's and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and clean in of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like OT Table, Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution)	

		Cleaning of instruments after use	2	SI/OB	Ask staff how they clean the instruments like ambubag, suction canulae, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable)	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ sterile area	
		Staff know how to make disinfectant solution	2	SI/OB	Carbolic acid, chlorine solution, glutaraldehyde or any other disinfectant used	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment's	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/Chemical Sterilization	
		Chemical sterilization of instruments/equipment's is done as per protocols	2	OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization.	
		Glutaraldehyde solution is changed as per manufacturer instructions	2	OB/SI	Date of preparation & due date of change of solution is mentioned on container and staff is aware of When to change the chemical.	
		Autoclaved linen and Dressing are used for procedure	2	OB/SI	Gowns, draw sheets , Cotton, Gauze, bandages. Etc.	
		Instruments are packed as per standard protocol	2	OB/SI	Check for Window of autoclave drum is closed, drum is not filled more than 3/4th, instruments are not hinged,	
		Autoclaving of instruments is done as per protocols	2	OB/SI	Ask staff about temperature, pressure and time	
		Regular validation of sterilization through chemical indicators	2	OB/SI/RR	Indicators (temperature sensitive tape) that change colour after being exposed to certain temperature.	
		Regular validation of sterilization through biological indictor	2	OB/SI/RR	Bacillus Thermophilus spores are used, for measuring biological performance of autoclaving process. Performed monthly. Label the spore ampule, place in horizontal position, kept at the bottom or farthest part of autoclave	
		Maintenance of records of sterilization	2	OB/SI/RR	Autoclave Register have column: Date, Time started, Time finished, Temp, pressure, Autoclave tape, spore test,	
		There is a procedure to ensure the traceability of sterilized packs	2	OB/SI/RR	Each Sterilized pack is marked with Date/Time of sterilization, contents, name/signature of the Technician,	
		Sterility of autoclaved packs is maintained during storage	2	OB/SI	Sterile packs are kept in clean, dust free, moist free environment.	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Functional area of the department are arranged to ensure infection control practices	Facility layout ensures separation of routes for clean and dirty items	2	OB	Facility layout ensures separation of general traffic from patient traffic. Separate disposal zone	
		CSSD/TSSU has demarcated separate area for receiving dirty items, processes, keeping clean and sterile items	2	OB	Sterile & unsterile store are separately.	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid , fumigation material	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Spill management protocols are implemented	2	SI/RR	spill management kit. staff training, protocol displayed	
		Mercury Spill management Kit is available	2	SI/OB	Hospital should aspire to be mercury free. If used than Hg spill management kit should be available with gloves, cap, mask, goggles, polybag, Plastic container & torch.	
		Cleaning of patient care area with detergent solution	2	SI/RR	Washing of floor with luke warm water and detergent.	
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Use of three bucket system for mopping	
		Cleaning equipment's like broom are not used in patient care areas	2	OB/SI	Look in janitors closet	
		Fumigation as per schedule	2	SI/RR	check that Formalin is not used. safer commercially available disinfectants such as Bacillicidal are used for fumigation	
		External footwears are restricted	2	OB	adequate numbers are available at the entrance	
		Entry to sterile zone is permitted only after hand washing, change of clothes, gowning & PPE	2	OB/SI	only persons really required are allowed to enter the sterile zone	
ME F5.5	Facility ensures air quality of high risk area	Positive Pressure in OT	2	OB/SI	OT to have an independent air handling unit with controlled ventilation such that the lay-up room and the OT table is under positive pressure	
		Adequate air exchanges are maintained	2	SI/RR	Independent AHU also allows to maintain required number of Air exchange side. 20-25.	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins & Plastic bags at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters & puncture proof, leak proof, temper proof white container for segregation of sharps	2	OB	See if it has been used or just lying idle.	
		Availability of post exposure prophylaxis & Protocols	2	OB/SI	Ask if available. Where it is stored and who is in charge of that. Also check PEP issuance register Staff knows what to do in condition of needle stick injury	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Includes used vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI	Not more than two-third.	
		Disinfection of liquid waste before disposal	2	SI/OB	Through Local Disinfection	
	Area of Concern - G Quality Management					

Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the operation theatre	2	SI/RR	Check if quality circle formed and functional in the OT	
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system of daily round by matron/hospital manager/ hospital superintendent/ OT in charge for monitoring of services	2	SI/RR	Check for entries in Round Register.	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or prevalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR	Can be prepared by junior surgeon and approved by HOD/OT in charge	
		Current version of SOP are available with process owner	2	OB/RR	Look for version.	
		Work instruction/clinical protocols are displayed	2	OB	processing and sterilization of equipment's,	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for ensuring patients rights including consent, privacy, confidentiality & entitlement	2	RR	Check SOP for adequacy	
		Department has documented procedure for safety & risk management	2	RR	Check SOP for adequacy	
		Department has documented procedure for support services & facility management.	2	RR	Check SOP for adequacy	
		Department has documented procedure for general patient care processes	2	RR	Check SOP for adequacy	
		Department has documented procedure for specific processes to the department	2	RR	Check SOP for adequacy	
		Department has documented procedure for infection control & bio medical waste management	2	RR	Check SOP for adequacy	
		Department has documented procedure for quality management & improvement	2	RR	Check SOP for adequacy	
		Department has documented procedure for data collection, analysis & use for improvement	2	RR	Check SOP for adequacy	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR	Ask staff how they carry out a specific activity.	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1					DELETED	
ME G5.2					DELETED	
ME G5.3					DELETED	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.4					DELETED	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1					DELETED	
ME G7.2					DELETED	
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes	2		Check parameter are defined & implemented to review the clinical care i.e. through peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check the patient /family participate in the care evaluation	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co-ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is a procedure to conduct C-section audits	2	SI/RR	Check with audit reports	
		All non compliance are enumerated & recorded for c-section audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per c-section audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or prevalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	

		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
		Check the mapping of existing clinical practices processes is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks					
ME H1.1	Facility measures productivity Indicators on monthly basis	C-Section Rate	2	RR	Total LSCS done x 100/Total deliveries conducted (Normal +LSCS)	
		Percentage of C-Sections done in the night	2	RR	Total C-Section done in night x 100/Total surgeries conducted (Day Night)	
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime critical equipment	2	RR	Sum total of time Elapsed between when equipment had problem and when the problem is sorted out for critical equipment.	
		No of C-Section per OBG surgeon	2	RR	Total number of C-Section done/No. of OBG Surgeon available	
		Percentage of elective C-Sections	2	RR	No. of elective LSCS x 100/Total LSCS (Elective + Emergency)	
		No of drug stock out in the month	2	RR		
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Surgical Site infection Rate	2	RR	No. of observed surgical site infections*100/total no. of Major surgeries	
		No of adverse events per thousand patients	2	RR	No of Adverse events reported x 1000/total no of patient treated in OT	
		% of environmental swab culture reported positive	2	RR	No. of swab culture reported positive x 100/Total no. of swab sent for culture	
		Perioperative Death Rate	2	RR	Deaths occurred from pre operative procedure to discharge of the patient	
		Percentage of C-Sections conducted using Safe Surgery Checklist	2	RR	No. of C- Section Conducted using safe surgery checklist *100/Total no. C-Section Conducted	
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Operation Cancellation rates	2	RR	No. of cancelled operation*1000 /total operation done	

1
2

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Intensive Care Unit			**12**
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Intensive Care Unit Score Card

Area of Concern wise Score			Intensive Care Unit Score
A	Service Provision	**100%**	**100%**
B	Patient Rights	**100%**	
C	Inputs	**100%**	
D	Support Services	**100%**	
E	Clinical Services	**100%**	
F	Infection Control	**100%**	
G	Quality Management	**100%**	
H	Outcome	**100%**	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No	ME Statement	Checkpoint	Compliance Full/Partial/No	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	**Facility Provides Curative Services**					
ME A1.1	The facility provides General Medicine services	Availability of Intensive care services for medical cases	2	SI/OB	Major medical cases like CVA,Haematomas, CAD, Haemoptysis, Snake bite, Br. Asthma Poisoning etc	ICU caters all the departments.
ME A1.2	The facility provides General Surgery services	Availability of Intensive care services for Surgical cases	2	SI/OB	Major surgical cases including trauma	
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Intensive care services for Gynae and obstetrics cases	2	SI/OB	If ICU services are not available then facility ensure linkages (Partial Compliance)	
ME A1.14	Services are available for the time period as mandated	Availability of ICU services 24X7	2	SI/RR		
ME A1.17	The facility provides Intensive care Services	Availability of Intensive care services.	2	SI/OB	Intubation, Tracheotomy, Mechanical Ventilation, short term cardio respiratory support, Defibrillation, CPR, Mobilization, Chest Tube, ventilator	
Standard A3	**Facility Provides diagnostic Services**					
ME A3.1	The facility provides Radiology Services	Availability of Portable X ray services	2	SI/OB		
		Availability of USG services	2	SI/OB		
ME A3.2	The facility Provides Laboratory Services	Functional side laboratory services are available	2	SI/OB	ABG & Electrolyte	
ME A3.3	The facility provides other diagnostic services, as mandated	Functional ECG Services are available	2	SI/OB	12 lead ECG	
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**					
ME A4.8					DELETED	
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed	
		Restricted area signage are displayed	2	OB		
ME B1.2	The facility displays the services and entitlements available in its departments	Services provision in ICU are displayed	2	OB		
		Services not available in ICU are displayed	2	OB		
		Names of doctor and nursing staff on duty are displayed and updated	2	OB		
		Important numbers including ambulance, blood bank and referral centres displayed	2	OB		
ME B1.4					DELETED	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC material displayed in waiting area	2	OB		
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Discharge summary is given to the patient	2	OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female staff if a male doctor examination a female patients	2	OB/SI		

ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the ICU	2	OB		
		ICU is connected to lift/ramp	2	OB	for easy , safe and fast transport of bed/trolley of critically sick patient	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen/curtain at the examination and procedural area	2	OB		
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB		
		No information regarding patient identity and details are unnecessary displayed	2	SI/OB		
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV cases	2	SI/OB		
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent for ICU	2	SI/RR	Admission, intubation, blood transfusion	
		Consent for Invasive procedure	2	SI/RR		
ME B4.3	Staff are aware of Patients rights responsibilities	Staff is aware of patients rights and responsibilities	2	SI		
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	ICU has system in place to communicate with patient/ their family member the nature and seriousness of the illness at least once in day	2	PI/SI	Ask patients relative about whether they have been communicated about the treatment plan and progress	
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re addressal and whom to contact is displayed	2	OB		
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	ICU services are free for beneficiaries	2	PI/SI	PMJAY, JSSK and any other beneficiary	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not incurred expenditure on purchasing drugs or consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not incurred expenditure on diagnostics from outside.	2	PI/SI		
ME B5.4					DELETED	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.6	There is an established procedure for 'end-of-life' care	End of life policy & procedure are available and followed	2	SI/RR	The policy clearly defines the procedures for managing critical cases in the ward, HDU/ICU, brain-dead patients, conscious patients with serious diseases like motor neurons and brought-in dead cases. It also includes: (a) Patient and family have the right to be informed about their condition and make choices about the treatment (b) Withhold or withdraw life-sustaining treatment (c) Organ donation as per NOTTO &India's Governing organ donation law (d) All the decisions should be transparent and documented	
		Staff is educated & trained for end of life care	2	SI/RR		
		The patient's Relatives informed clearly about the deterioration in the health condition of Patient.	2	SI/RR	Periodic update on the patient's condition is given to the family.	
		Policy & procedures like DNR , DNI etc for critical cases are in consonance with legal requirement	2	SI/RR	Patient right "Do not resuscitate" or " Do not intubate"/ allow natural death are respected	
		The is a standard procedure for removal of life-sustaining treatment as per law	2	SI/RR	(1) Check about the policy and practice for removing life support (2)Patient or family is involved in decision-making, and patient's or family's choice is respected	
		There is a procedure to allow patient relative/Next of Kin to observe patient in last hours	2	SI/OB		
		Staff is aware of events indicating that conversations about end-of-life care need to start with patient or family	2	RR/SI	(a) a patient living with or diagnosed with life-limiting illness (b) a patient who is likely to die in the short or medium term is admitted, or deteriorates during their admission (c) a patient is dying where Patient (or family member, if the patient lacks capacity) expresses interest in discussing end-of-life care (d) a previously well person who has suffered an acute life-threatening event or illness is admitted (e) unexpected, significant physical deterioration occurs	
		Hospital has documented policy for pain management	2	SI/OB		
		Screening of the patient for pain	2	SI/RR	Symptomatic treatment is given to the patient to prevent complications to extent possible	
		Pain alleviation measures or medication is initiated & titrated as per need and response	2	SI/RR		
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient	2	RR/SI	Consequences of LAMA are explained to patient/relative	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	ICU has adequate space as per requirement	2	OB	Space requirement in ICU is 100-125 sq. feet area per bed in patient care area including space for storage and duty room etc	
		Availability of adequate waiting area	2	OB		
ME C1.2	Patient amenities are provide as per patient load	Availability of seating arrangement	2	OB		
		Availability of cold Drinking water	2	OB		
		Availability of functional toilets	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions	ICU has single entry and exit	2	OB	There is no thoroughfare through ICU	
		Central nursing station is available in ICU	2	OB	All monitors/ patients must be observable from nursing station either directly or through central monitoring station	
		ICU has designated Isolation room	2	OB		
		Availability of Ancillary area	2	OB	Ancillary area includes: Nursing station, clean and dirty utility area, Unit stores, Hand washing and gowning area,	
		ICU has dedicated change room for staff	2	OB	Separate doctor and nurse change room are available	
		ICU has dedicated counselling room	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for easy movement of Trolleys	2	OB	2-3 Meters	
		There is sufficient space between two bed to provide bed side nursing care and movement	2	OB		
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		

ME C1.6	Service counters are available as per patient load	Availability of ICU beds as per load	2	OB		
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services	2	OB	There is separate nursing station for each ward	
		There is a separate nursing station	2	OB	Location of nursing station and patients beds enables easy and direct observation of patients	
		ICU is in Proximity of OT and has functional linkage with OT	2	OB		
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment's , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	ICU building does not have temporary connections and loose hanging wires	2	OB		
		ICU has mechanism for periodical check / test of all electrical installation by competent electrical Engineer	2	OB/RR		
		ICU has dedicated earthling pit system available	2	OB/RR		
		Wall mounted digital display is available in ICU to show earth to neutral voltage	2	OB		
		Quality output of voltage stabilizer is displayed in each stabilizer as per manufacturer guideline	2	OB		
		Power boards are marked as per phase to which it belongs	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the ICU are non slippery and even	2	OB		
		Windows/ ventilators if any in the OT are intact and sealed	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	ICU has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	OPD has installed fire Extinguisher that is Class A , Class B C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB		
		ICU has provision of Smoke and heat detector	2	OB/RR		
		ICU has electrical and automatic fire alarm system or alarm system sounded by actuation of any automatic fire extinguisher	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of full time intensivist	2	OB/RR		
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor	2	OB/RR	Duty doctor in 1: 5 ratio	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff as per requirement	2	OB/RR/SI	As per guideline	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of paramedic staff	2	OB/SI	1: 5 ratio	
ME C4.5	The facility has adequate support / general staff	Availability of ICU attendant	2	SI/RR		
		Availability Security staff	2	SI/RR	1 in each shift	
		Availability of housekeeping staff	2	SI/RR		
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Analgesics/Antipyretics/Anti Inflammatory	2	OB/RR	As per DG--ESIC RC List	
		Availability of Anti Infectives -Antibiotics, Antifungal, Antiprotozoal	2	OB/RR	As per DG--ESIC RC List	
		Availability of Infusion Fluids	2	OB/RR	As per DG--ESIC RC List	
		Availability of Drugs acting on Cardiovascular System	2	OB/RR	As per DG--ESIC RC List	
		Availability of drugs action on Central Nervous system, Peripheral Nervous System	2	OB/RR	As per DG--ESIC RC List	
		Availability of dressing material and antiseptic liquid/lotion	2	OB/RR	As per DG--ESIC RC List	
		Drugs for Respiratory System	2	OB/RR	As per DG--ESIC RC List	
		Hormonal Preparation and Anti- Hormonal Preparation	2	OB/RR	As per DG--ESIC RC List	
		Availability of Medical gases	2	OB/RR	Availability of Oxygen Cylinders	
ME C5.2	The departments have adequate consumables at point of use	Availability of disposables	2	OB/RR	examination gloves, Syringes,	
		Resuscitation Consumables / Tubes	2	OB/RR	Masks, Ryles tubes, Catheters, Chest Tube, ET tubes etc	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency and resuscitation tray are maintained	2	OB/RR		
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	Bed side monitor, pulse oximeter, thermometer, BP apparatus, ECG	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of dressing tray for ICU Surgical Ward	2	OB		
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments	2	OB	ABG Machine, Glucometer,	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of Functional Intensive care equipment and instruments	2	OB	Ventilator, Infusion pump, C-PAP,	
		Availability of Functional Resuscitation equipment's	2	OB	Bag and mask, laryngoscope, ET tubes, fibro optic bronchoscope Oxygen cylinder/central line, oxygen hood, Trey for procedures like central line, Defibrillator (Ambu bag)	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment's for cleaning	2	OB	Buckets for mopping, Separate mops for patient care area and circulation area duster, waste trolley, Deck brush	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of specialized ICU bed	2	OB	ICU bed (shock proof -fibre).	
		Availability of attachment/ accessories with patient bed	2	OB	Over bed tables, Head end panel, IV stand, Bed pan, bed rail,	
		Availability of Fixtures	2	OB	Trey for monitors, Electrical panel with bed, bedhead panel with outlet for Oxygen and vacuum, X ray view box.	
		Availability of furniture	2	OB	Cupboard, nursing counter, table for preparation of medicines, chair.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Bio Medical waste Management	2	SI/RR		
		Infection control and hand hygiene	2	SI/RR		
		Advance life support Training	2	SI/RR		
		Patient safety	2	SI/RR		

		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled to operate ICU equipments	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for resuscitation and intubation	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Nursing staff is skilled identifying and managing complication	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Nursing Staff is skilled for maintaining clinical records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	(1) Check log book is maintained & it shows time taken to repair equipment. (2) Backup of critical equipment such as Ventilator, Infusion pump, C-PAP,etc. is available (3) Check staff is aware of Contact details of the agencies/ person responsible for maintenance	
		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired	2	OB/RR		
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR		
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator	2	SI/RR		
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR		
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	2	OB/ RR		
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.	2	OB/SI	Check the down time of equipments	
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs at nursing station	2	SI/RR	Stock level are daily updated Indents are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled	2	OB	Away from direct sunlight and temperature is maintained as per instructions of manufacturer.	
		Empty and filled cylinders are labelled	2	OB		
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray	2	OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray FIRST EXPIRY and FIRST OUT (FEFO) is in practice	
		No expired drug found	2	OB/RR	Check the drug expiry of drug sub store	
		Records for expiry and near expiry drugs are maintained for drug stored in ICU	2	RR	Check the record of expiry and near expiry drug	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time	
		Department maintained stock register of drugs and consumables	2	RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated	
		Drugs are categorized in Vital, Essential and Desirable	2	OB/RR	Check all Vital drugs are available	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established system for replenishing drug tray /crash cart	2	SI/RR		
		There is no stock out of drugs	2	OB/SI	Check stock of some vital drugs	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for temperature charts are maintained and updated twice a daily.	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic ,psychotropic drugs are kept separately in lock and key	2	OB/SI	Separately kept, away from other drugs and labelled	
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at nursing station	2	OB	General Patient Care - 200-50 Lux Procedure Spot Light - 1500 Lux	
		Adequate illumination in patient care unit	2	OB		
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry to ICU is restricted	2	OB		
		Visiting hour are fixed and practiced	2	OB/PI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature is maintained in ICU and record of same is kept	2	SI/RR	20-25OC, ICU has functional room thermometer and temperature is regularly maintained	
		Humidity is maintained in ICU and record of same is maintained	2	SI/RR	50-60%	
		ICU has system to maintain its ventilation and its environment is dust free	2	SI/RR		
		ICU has system to control the sound producing activities and gadgets' (like telephone sounds, staff area and equipments)	2	SI/RR		
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at ICU	2	OB		
		Identification band for all	2	OB	Check mechanism at place to track the patient based on UID	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	The facility has established Programme for maintenance and upkeep of the facility					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform color	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Patients beds are intact and painted	2	OB	Mattresses are intact and clean	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the ICU	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No rodent/pests are noticed	2	OB		

Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in ICU	2	OB/SI	Power back for all critical equipments	
		Availability of UPS	2	OB/SI		
		Availability of Emergency light	2	OB/SI		
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen and vacuum supply	2	OB		
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor	2	RR/SI		
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check for the adequacy and frequency of diet as per nutritional requirement	2	OB/RR	Check that all items are as per clinical advice	
		Check for the Quality of diet provided in ICU	2	PI/SI	Ask patient/staff weather they are satisfied with the Quality of food	
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	There is procedure of requisition of different type of diet from ward to kitchen	2	RR/SI		
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Clean Linens are provided for all occupied bed	2	OB/RR		
		Gown is provided to all patients	2	OB/RR		
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled	2	OB/RR		
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR		
		Check dedicated closed bin is kept for storage of dirty linen	2	OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration	2	RR		
		Patient demographic details are recorded in admission records	2	RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.	
ME E1.3	There is established procedure for admission of patients	There is established criteria for admission at ICU	2	SI/RR	Criteria based on Vital sign, Laboratory value/ Diagnostic values and Physical finding	
		There is no delay in admission of patient	2	SI/RR/OB		
		Admission is done on written order by authorized doctor	2	SI/RR/OB		
		Time of admission is recorded in patient record	2	RR		
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Procedure cope with surplus patient load	2	OB/SI	Check for admission criteria. Check for linkage with higher facilities	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all admitted patient done as per standard protocols	2	RR/SI	Assessment criteria of different kind of medical /surgical conditions is defined and practiced	
		Patient History is taken and recorded	2	RR		
		Physical Examination is done and recorded wherever required	2	RR		
		Provisional Diagnosis is recorded	2	RR		
		Initial assessment and treatment is provided immediately	2	RR/SI		
		Initial assessment is documented preferably within 1 hours	2	RR		
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation	2	RR/OB		
		For critical patients admitted in the ward there is provision of reassessments as per need	2	RR/OB		
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure for hand over for patient transferred from ICU to IPD /OT/HDU	2	SI/RR	Check for how hand over is given from ICU to ward and vice versa etc.	
		Check for the procedure if patient is to be consulted with other specialist	2	RR/SI	Check for the procedure for calling specialist on call to ICU for opinion /advice. Is there any list of specialist with phone no. available	
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	Patient referred with referral slip	2	RR/SI		
		Reason for referral is clearly stated and referral is written by authorized competent person (Medical Officer on duty)	2	RR/ SI	(1) Verify with referral records that reasons for referral were clearly mentioned (2) ICU staff confirms the suitability of referral with higher centres to ascertain that case can be managed at higher centre and will not require further referrals	

		Advance communication is done with higher centre & Referral vehicle is being arranged	2	SI/PI/RR	(1) Check ICU staff facilitates arrangement of ambulance for transferring the patient to higher centre (2) Patient attendant are not asked to arrange vehicle by their own (3) Check if ICU staff checks ambulance preparedness in terms of necessary equipment, drugs, accompanying staff in terms of care that may be required in transit	
		Referral in or referral out register is maintained	2	RR	(1) Referral check list is filled before referral to ensure all necessary steps have been taken for safe referral (2) Check referral records has information regarding advance communication, transport arrangement, accompanying care provider, reason for referral , time taken for referral etc. along with demographics, date & time of admission, date & time of referral, and follow up	
		Facility has functional referral linkages to facilities	2	SI/RR	Check the mechanism of referral linkages to lower/higher facilities	
		There is a system of follow up of referred patients	2	RR		
ME E3.3	A person is identified for care during all steps of care	Doctor and nurse is designated for each patient admitted to ICU ward	2	RR/SI	Treating doctor is designated	
		There is established procedure for co ordination of care between duty doctor and treating doctor/specialist	2	RR/SI	Duty doctor takes round with treating doctor	
		Patient condition is reviewed during hand over between duty doctors	2	RR/SI		
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure	2	OB/SI	Patient id band/ verbal confirmation/Bed no. etc.	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained	2	RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.	
		There is a process to ensue the accuracy of verbal/telephonic orders	2	SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR		
		Nursing Handover register is maintained	2	RR		
		Hand over is given bed side	2	SI/RR		
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately	2	RR/SI	Check for nursing note register. Notes are adequately written	
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for TPR chart, IO chart, any other vital required is monitored	
		Critical patients are monitored continually	2	RR/SI	Check for use of cardiac monitor/multi parameter	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Unconscious and comatose patient, stupors patient, patient with suppressed immune system	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI		
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only	2	RR		
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use	2	RR		
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per STG	
		Availability of drug formulary	2	SI/OB		
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Check complete medication history including over-the- counter medicines is taken and documented	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome	
		Complete medication history is documented and communicated for each patient at the time of discharge	2	SI/RR	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary	
		Patients are engaged in their own care	2	PI/SI	1. Clinician/Nurse/Paramedics counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse/Pharmacist highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge	
Standard E7	**Facility has defined procedures for safe drug administration**					
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride, Uploads, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc. as applicable	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor	
		There is process to ensure that right doses of high alert drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are not used	
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR		
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI		
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI		
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content indented to be used later on	
		Check for separate sterile needle is used every time for multiple dose vial	2	OB	In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events	
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them	2	SI/RR	Administration of medicines done after ensuring right patient, right drugs, right route, right time, Right dose, Right Reason and Right Documentation	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Patient progress is recorded as per defined assessment schedule	2	RR	(Manually/e-records)	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT	2	RR	Treatment prescribed in nursing records (Manually/e-records)	

ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/treatment registers	2	RR	Treatment given is recorded in treatment chart (Manually/e-records)	
ME E8.4	Procedures performed are written on patients records	Procedure performed are recorded in BHT	2	RR	Mobilization, resuscitation etc (Manually/e-records)	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available	2	RR/OB	Check for the availability of ICU slip, Requisition slips etc.	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, OT register, Diet register, Linen register, Drug intend register	
		All register/records are identified and numbered	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB		
Standard E9	**The facility has defined and established procedures for discharge of patient.**					
ME E9.1	Discharge is done after assessing patient readiness	ICU has established criteria for discharge of the patient	2	SI/RR	Patient is shifted to ward/step down after assessment	
		Assessment is done before discharging patient	2	SI/RR		
		Discharge is done by an authorised doctor	2	SI/RR		
		Patient / attendants are consulted before discharge	2	PI/SI		
		Treating doctor is consulted/ informed before discharge of patients	2	SI/RR		
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided	2	RR/PI	See for discharge summary, referral slip provided.	
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up	2	RR		
		Discharge summary is give to patients going in LAMA/Referred out	2	SI/RR		
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge	2	PI/SI		
		Time of discharge is communicated to patient before hand	2	PI/SI		
Standard E10	**The facility has defined and established procedures for intensive care.**					
ME E10.1	The facility has established procedure for shifting the patient to step-down/ward based on explicit assessment criteria	ICU has procedure for step down of the patient.	2	RR/SI	Step down of the patient is planned by on duty doctor in consultation with treating doctor	
ME E10.2	The facility has defined and established procedure for intensive care	ICU has protocols for pain management	2	RR/SI		
		ICU has protocol for sedation	2	RR/SI		
		ICU has procedure for starting Central lines	2	RR/SI		
		ICU has protocol for early eternal nutrition	2	RR/SI		
		Protocol for Care of unconscious paraplegic patients is available	2	RR/SI	Prevention of decubitus in ICU patient	
		ICU has protocol for management of anaphylactic shock	2	RR/SI		
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubating, and care of patients on ventilation and subsequently on its removal	ICU has criteria defined for non invasive ventilation in case of respiratory failure	2	RR/SI	C -PEP and V -PEP	
		Criteria for intubation	2	RR/SI		
		Criteria for extubating	2	RR/SI		
		Criteria of tracheotomy	2	RR/SI		
		ICU has protocols for care and Monitoring of patient on ventilator	2	RR/SI	Monitoring include subjective responses, physiological responses, blood gas measurement	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.3	There are established procedures for Post-testing Activities	ICU has critical values of various lab test	2	SI/RR		
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.8	There is established procedure for issuing blood	There is a procedure for issuing the blood promptly for life saving measures	2	RR/SI		
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR		
		Patient's identification is verified before transfusion	2	SI/OB		
		Blood is kept on optimum temperature before transfusion	2	RR		
		Blood transfusion is monitored and regulated by qualified person	2	SI/RR		
		Blood transfusion note is written in patient recorded	2	RR		
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR		
Standard E14	**Facility has established procedures for Anaesthetic Services**					
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up	Pre anaesthesia check up is conducted for elective / Planned surgeries	2	SI/RR		
	Maternal & Child Health Services					
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1	Death of admitted patient is adequately recorded and communicated	ICU has procedure to inform patient relatives about poor prognostic status of inpatient	2	SI		
		ICU has system for conducting bereavement support of patient's relative in case of mortality	2	RR/SI		
		Death note is written on patient record	2	RR		
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note including efforts done for resuscitation is noted in patient record	2	SI/RR		
		Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	2	SI/RR		
		The body of deceased is handled with respect and dignity	2	SI/RR/OB		
		Socio-cultural beliefs of patient 's family are identified and respected	2	SI/RR/OB		
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
ME F1.3	Facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection	2	SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .	
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
		Periodic medical check-ups of the staff	2	SI/RR		
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	FNBC guideline: Each unit should have at least 1 wash basin for every 5 beds	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply. Hand rub dispenser are provided adjacent to bed	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	

		Availability of elbow operated taps	2	OB		
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB		
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Mask	2	OB/SI		
		Availability of gown/ Apron	2	OB/SI	Staff and visitors	
		Availability of shoe cover	2	OB/SI	Staff and visitors	
		Availability of Caps	2	OB/SI	Staff and visitors	
		Personal protective kit for infectious patients	2	OB/SI		
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps and Aprons	
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Cleaning & Decontamination of patient care Units	2	SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , Patients Beds Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like abusage, suction cannula, Airways, Face Masks, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/HLD/Chemical Sterilization	
		High level Disinfection of instruments/equipments is done as per protocol	2	OB/SI	Ask staff about method and time required for boiling	
		Autoclaving of instruments is done as per protocols	2	OB/SI	Ask staff about temperature, pressure and time	
		Chemical sterilization of instruments/equipments is done as per protocols	2	OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization	
		Autoclaved linen are used for procedure	2	OB/SI		
		Autoclaved dressing material is used	2	OB/SI		
		There is a procedure to ensure the traceability of sterilized packs	2	OB/SI		
		Sterility of autoclaved packs is maintained during storage	2	OB/SI	Sterile packs are kept in clean, dust free, moist free environment.	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic	2	OB		
		Facility layout ensures separation of routes for clean and dirty items	2	OB		
		Floors and wall surfaces of ICU are easily cleanable	2	OB		
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
		Use of three bucket system for mopping	2	OB/SI		
		Fumigation/carbonization as per schedule	2	SI/RR		
		External foot wares are restricted	2	OB		
ME F5.4	Facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases	2	OB/SI		
ME F5.5	Facility ensures air quality of high risk area	Negative pressure is maintained in Isolation	2	OB/SI		
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.	
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI/OB		
		Disinfection of liquid waste before disposal	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2			

		Staff is aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF	
	Area of Concern - G Quality Management					
Standard G1	The facility has established organizational framework for quality improvement					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Intensive Care Unit	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G3	Facility have established internal and external quality assurance programs wherever it is critical to quality.					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Check for entries in Round Register	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	Admission and discharge criteria, Intubation protocol, CPR	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for receiving, initial assessment, admission, clinical assessment & reassessment of patient in icu	2	RR	registration, consultation, Procedures, assessment of patient , counselling, Monitoring etc.	
		Department has documented procedure for discharge of the patient	2	RR		
		ICU has documented procedure nursing care for critical patient	2	RR		
		ICU has documented procedure for collection, transfer and reporting the sample to laboratory	2	RR		
		ICU has documented procedure for nutrition in critical illness	2	RR		
		ICU has documented procedure for key clinical protocols	2	RR		
		ICU has documented procedure for preventive- break down maintenance and calibration of equipments	2	RR		
		ICU has documented system for storage, retaining, retrieval of records	2	RR		
		ICU has documented procedure for purchase of External services and supplies	2	RR		
		ICU has documented procedure for Maintenance of infrastructure of SNCU	2	RR		
		ICU has documented procedure for thermoregulation	2	RR		
		ICU has documented procedure for drugs,intravenous,and fluid management of patient	2	RR		
		ICU has documented procedure for counselling of the patient attendant	2	RR		
		ICU has documented procedure for infection control practices	2	RR		
		ICU has documented procedure for inventory management	2	RR		
		ICU has documented procedure for entry of visitor in ICU	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages					
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	Facility seeks continually improvement by practicing Quality method and tools.					
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
		Advance quality improvement method	2	SI/OB	Six sigma, lean.	

ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
Standards G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits	2	SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission	
		There is procedure to conduct death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct referral audits	2	SI/RR	Check for -valid sample size, data is analysed, poor performing attributes are identified and improvement initiatives are undertaken	
		All non compliance are enumerated & recorded for medical audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated & recorded for newborn death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated & recorded for referral audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per death audit record's findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per prescription audit record findings	2	SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
		Check the mapping of existing clinical practices processes is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate	2	RR		
		Proportion of BPL patients admitted	2	RR		
		Number of the patients screened for pain	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime critical equipments	2	RR		
		Transfer Rate	2	RR		
		Re admission rate	2	RR		
		Patient's fall rate	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average length of stay	2	RR		
		Risk Adjusted Mortality Rate/Standard Mortality Rate	2	RR		
		No of Pressure Ulcer developed per thousand cases	2	RR		

		No of adverse events per thousand patients	2	RR	Injection room : Post exposure prophylaxis, medication error, patient fall.	
		UTI rate	2	RR		
		VAP rate	2	RR		
		Adverse events are identified	2	RR	Injection room : Post exposure prophylaxis, medication error, patient fall.	
		Reintubation Rate	2	RR		
		Culture Surveillance sterility rate	2	RR	% of environmental swab culture reported positive	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate	2	RR		
		Patient Satisfaction Score	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Indoor Patient Department			13
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Indoor Patient Department Score Card

Area of Concern wise Score			IPD Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No/	ME Statement	Checkpoints	Compliance	Assessment Method	Means of verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	The facility provides Curative Services					
ME A1.1	The facility provides General Medicine services	Availability of general medicine indoor services	2	SI/OB		
		Availability of isolation ward services	2	SI/OB		
ME A1.2	The facility provides General Surgery services	Availability of surgery ward/beds	2	SI/OB		
		Availability of burn ward	2	SI/OB		
ME A1.5	The facility provides Ophthalmology Services	Availability of ophthalmology indoor services	2	SI/OB		
ME A1.7	The facility provides Orthopaedics Services	Availability of Orthopaedics indoor services	2	SI/OB	In IPHS 2022, beds provision is there for Orthopaedic inpatient services	
ME A1.9	The facility provides Psychiatry Services	Availability of Psychiatry Indoor services	2	SI/OB	(a) Assessment by doctor, availability of doctor on call (b) Availability of emergency care round the clock (c) Psycho social interventions	Applicable to only few location
ME A1.12	The facility provides Physiotherapy Services	Availability of Indoor Physiotherapy Procedures	2	SI/OB	Physiotherapy advices for IPD patient, Physiotherapy procedures like tractions (Lumbar & Cervical), Short Wave Diathermy, Electrical stimulator with TENS, Ultra sonic therapy, Paraffin wax bath, Infra red therapy, Ultraviolet therapy, Electric Vibrator, Vibrator belt message, Post polio exercises, Obesity exercises, cerebral Palsy massage, Breathing exercises & Postural Drainage	
ME A1.14	Services are available for the time period as mandated	Availability of nursing services 24X7	2	SI/OB		
ME A1.16	The facility provides Accident & Emergency Services	Availability of accident & trauma ward	2	SI/OB		
Standard A4	The facility provides services as mandated in national Health Programmes/ state scheme					
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of Indoor services for Management	2	SI/RR	Malaria Kalaazar Dengue & Chikunguna AES/Japanese Encephalitis as prevalent locally	
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Indoor treatment of TB patients requires hospitalization	2	SI/RR		
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Inpatient Management of severely ill cases	2	SI/RR		

ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Inpatient care for cases require hospitalization	2	SI/RR		
ME A4.5	The facility provides services under National Programme for prevention and control of Blindness as per guidelines	Availabily of Ophthalmic ward	2	SI/OB		
ME A4.7					DELETED	
ME A4.15					DELETED	
Standard A6	**Health services provided at the facility are appropriate to community needs.**					
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of indoor Services as per local prevalent disease	2	SI/RR		
	Area of Concern - B Patient Rights					
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed. Directional signages are given from the entry of the facility	
		Display of layout/floor directory	2	OB		
		Visiting hours and visitor policy are displayed	2	OB		
		All signages are in uniform colour scheme	2	OB		
ME B1.2	The facility displays the services and entitlements available in its departments	List of services available are displayed	2	OB		
		Entitlement under different national health program	2	OB		
		List of drugs available are displayed and updated	2	OB		
		Contact details of referral transport / ambulance displayed	2	OB		
ME B1.4	User charges are displayed and communicated to patients effectively	User charges if any displayed	2	OB		
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	Relevant IEC material displayed at wards	2	OB		
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Discharge summary is given to the patient	2	RR/OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical , economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Separate male & female wards	2	OB	Where ever male and female are kept in same wards male and female area are demarcated	
		Male and female toilets are demarcated	2	OB/SI		
		Access to toilet should not go through opposite sex patient care area	2	OB		
		Male attendants are not allowed to stay at night in female ward	2	OB/SI		
		There is no discrimination with transgender patients	2	SI/PI		
		No unnecessary /non-essential disclosure of a person's trans status	2	SI/PI/RR		
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the ward	2	OB		
		Availability of ramps with railing	2	OB	At least 120 cm width, gradient not steeper than 1:12	
		Availability of specially able toilet	2	OB		
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screens / Curtains	2	OB	Bracket screen	
		Examination/ Dressing of patient is done in enclosed area	2	OB		
		Curtains / frosted glass have been provided at windows	2	OB	Check all the windows are fitted with frosted glass or curtains have been provided	
		No two patients are treated on one bed	2	OB		
		Partitions separating men and women are robust enough to prevent casual overlooking and overhearing	2	OB		
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	SI/OB		
		No information regarding patient identity and details are unnecessary displayed	2	SI/OB		
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	OB/PI		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV status of patient is not disclosed except to staff that is directly involved in care	2	SI/OB		
Standard B4	**The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	General Consent is taken before admission	2	SI/RR		
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient is informed about clinical condition and treatment been provided	2	PI		
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re redressal and whom to contact is displayed	2	OB		
Standard B5	**The facility ensures that there are no financial barrier to access, and that there is financial protection given from the cost of hospital services.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Stay in wards is free for entitled patients under NHP and state scheme	2	PI/SI		
		Drugs and consumables under NHP are free of cost	2	PI/SI		
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.	2	PI/SI		
ME B5.4					DELETED	
ME B5.6					DELETED	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.6	There is an established procedure for 'end-of-life' care	Staff is educated & trained for end of life care	2	SI/RR		
		The patient's Relatives informed clearly about the deterioration in the health condition of Patient.	2	SI/RR	Periodic update on the patient's condition is given to the family.	
		Policy & procedures like DNR , DNI etc for critical cases are in consonance with legal requirement	2	SI/RR	Patient right "Do not resuscitate" or " Do not intubate"/ allow natural death are respected	
		Hospital has documented policy for pain management	2	SI/OB		
		Screening of the patient for pain intensity	2	SI/RR	Using pain assessment scales /tools	
		Check the pain characteristics	2	SI/RR	In terms of Location, frequency, duration, radiation etc. - Post operating, neuralgia, arthralgia or myalgia	
		Pain alleviation measures or medication is initiated & titrated as per need and response	2	SI/RR		
		Patient & family are educated on various pain management techniques wherever appropriate	2		Specially in chronic cases	
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient	2	RR/SI	Consequences of LAMA are explained to patient/relative	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space in wards with no cluttering of beds	2	OB	Distance between centres of two beds – 2.25 meter	
ME C1.2	Patient amenities are provide as per patient load	Functional toilets with running water and flush are available as per strength and patient load of ward	2	OB	one toilet for 12 patients	
		Functional bathroom with running water are available as per strength and patient load of ward	2	OB		
		Availability of drinking water	2	OB		
		Patient/ visitor Hand washing area	2	OB		
		Adequate shaded waiting area is provide for attendants of patient	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions	Availability of Dedicated nursing station	2	OB		
		Availability of Examination room	2	OB		

		Availability of Treatment room	2	OB		
		Availability of Doctor's and Nurse Duty room	2	OB		
		Availability of Store	2	OB	Drug &Linen store	
		Availability of clean and Dirty utility room	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	There is sufficient space between two bed to provide bed side nursing care and movement	2	OB	Space between two beds should be at least 4 ft and clearance between head end of bed and wall should be at least 1 ft and between side of bed and wall should be 2 ft	
		Corridors are wide enough for patient, visitor and trolley/ equipment movement	2	OB	Corridor should be 3 meters wide	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	There is a separate nursing station for each ward	2	OB	Location of nursing station and patients beds in enables easy and direct observation of patients	
		Availability of IPD beds as per load	2	OB		
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Surgical wards has functional linkages with OT	2	OB		
		Location of nursing station and patients beds enables easy and direct observation of patients	2	OB		
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	IPD building does not have temporary connections and loosely hanging wires	2	OB	Switch Boards other electrical installations are intact	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the ward are non slippery and even	2	OB		
		Windows have grills and wire meshwork	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Ward has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	IPD has installed fire Extinguisher that is Class A , Class B, C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of specialist doctor on call	2	OB/RR		
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor at all time	2	OB/RR		
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff	2	OB/RR/SI	As per patient load	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of dresser in surgical ward	2	OB/SI/RR		
ME C4.5	The facility has adequate support / general staff	Availability of ward attendant/ Ward boy	2	SI/RR		
		Availability Security staff	2	SI/RR		
Standard C5	**The facility provides drugs and consumables required for assured services.**					
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Non-opioid Analgesics/Antipyretics/Anti Inflammatory medicines	2	OB/RR	As per DG-ESIC RC List	
		Availability of Anti - Infective Medicines - Antibiotics, Antifungal	2	OB/RR	As per DG-ESIC RC List	
		Availability of Solutions Correcting Water, Electrolyte Disturbance and Acid-base Disturbance	2	OB/RR	As per DG-ESIC RC List	
		Availability of medicines acting on Cardiovascular System	2	OB/RR	As per DG-ESIC RC List	
		Availability of medicines acting on Central Nervous System/Peripheral Nervous System	2	OB/RR	As per DG-ESIC RC List	
		Availability of dressing material and antiseptic liquid/cream/ lotion	2	OB/RR	As per DG-ESIC RC List	
		Medicines for Respiratory System	2	OB/RR	As per DG-ESIC RC List	
		Hormonal Preparation and other Endocrine Medicines	2	OB/RR	As per DG-ESIC RC List	
		Availability of Medical gases	2	OB/RR	Availability of Oxygen Cylinders	
ME C5.2	The departments have adequate consumables at point of use	Availability of dressing material in surgical wards	2	OB/RR	As per DG-ESIC RC List	
		Availability of syringes and IV Sets /tubes	2	OB/RR		
		Availability of Antiseptic Solutions	2	OB/RR	As per DG-ESIC RC List	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Availability of emergency drug tray	2	OB/RR		
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Thermometer, fetoscope, baby and adult weighing scale, Stethoscope , Doppler	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of dressing tray for Surgical Ward	2	OB		
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments	2	OB	Glucometer	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.	2	OB	Adult bag and mask, Oxygen, Suction machine, Airway, nebulizer, suction apparatus , LMA, Laryngoscope, ET tube	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of attachment/ accessories with patient bed	2	OB	Hospital graded mattress, Bed side locker , IVstand, Bed pan	
		Availability of Fixtures	2	OB	Spot light, electrical fixture for equipment like suction, X ray view box	
		Availability of furniture	2	OB	cupboard, nursing counter, table for preparation of medicines, chair.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Patient Safety	2	SI/RR		
		Basic Life Support	2	SI/RR		
		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Nursing staff is skilled for maintaining clinical records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR	BP apparatus, thermometers etc are calibrated	

Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs at nursing station	2	SI/RR	Stock level are daily updated Indents are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled	2	OB	Away from direct sunlight and temperature is maintained as per instructions of manufacturer.	
		Empty and filled cylinders are labelled	2	OB		
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray	2	OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray FIRST EXPIRY and FIRST OUT (FEFO) is in practice	
		No expiry drug found	2	OB/RR		
		Records for expiry and near expiry drugs are maintained for drug stored at department	2	RR	Check the record of expiry and near expiry drug in drug sub store	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time	
		Department maintained stock register of drugs and consumables	2	RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established system for replenishing drug tray /crash cart	2	SI/RR		
		There is no stock out of drugs	2	OB/SI	Check stock of some vital drugs	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for temperature charts are maintained and updated twice a daily.	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic ,psychotropic drugs are kept separately in lock and key	2	OB/SI	Separate prescription for narcotic and psychotropic drugs. Separately kept, away from other drugs and labelled	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at nursing station	2	OB		
		Adequate illumination in patient care areas	2	OB	Potable spot light and it is used whenever it is required	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Visiting hour are fixed and practiced	2	OB/PI		
		There is no overcrowding in the wards during to visitors hours	2	OB		
		One family members is allowed to stay with the patient	2	OB/SI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area	2	PI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation in nursing station/duty room	2	SI/OB	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4	The facility has security system in place at patient care areas	Security arrangement in IPD	2	OB/SI		
		Identification band for all	2	OB	Check mechanism at place to track the patient based on UID	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Patients beds are intact and painted	2	OB	Mattresses are intact and clean	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the ward	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in patient care areas	2	OB/SI		
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**					
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor	2	RR/SI		
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check for the adequacy and frequency of diet as per nutritional requirement	2	OB/RR	Check that all items fixed in diet menu is provided to the patient	
		Check for the Quality of diet provided	2	PI/SI	Ask patient/staff weather they are satisfied with the Quality of food	
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	There is procedure of requisition of different type of diet from ward to kitchen	2	RR/SI	diet for diabetic patients, low salt and high protein diet etc	
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Clean Linens are provided for all occupied bed	2	OB/RR		
		Gown are provided at least to the cases going for surgery	2	OB/RR		
		Availability of Blankets, draw sheet, pillow with pillow cover and mackintosh	2	OB/RR		
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled	2	OB/RR		
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry	2	SI/RR		
		Check dedicated closed bin is kept for storage of dirty linen	2	OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB		
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration	2	RR		
		Patient demographic details are recorded in admission records	2	RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.	
ME E1.3	There is established procedure for admission of patients	There is no delay in admission of patient	2	SI/RR/OB		
		Admission is done by written order of a qualified doctor	2	SI/RR/OB		
		Time of admission is recorded in patient record	2	RR		
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	There is provision of extra Beds	2	OB/SI		
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all admitted patient done as per standard protocols	2	RR/SI	The assessment criteria for different clinical conditions are defined and measured in assessment sheet	
		Patient History is taken and recorded	2	RR		
		Physical Examination is done and recorded wherever required	2	RR		

		Provisional Diagnosis is recorded	2	RR		
		Initial assessment and treatment is provided immediately	2	RR/SI		
		Initial assessment is documented preferably within 2 hours	2	RR		
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for assessment of stable patients	2	RR/OB		
		For critical patients admitted in the ward there is provision of reassessment as per need	2	RR/OB		
		There is system in place to identify and manage the changes in Patient's health status	2	SI/RR	Criteria is defined for identification, and management of high-risk patients and patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process	2	SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	
		Check treatment/care plan is prepared as per patient's need	2	RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	SI/RR	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients from one department to other department	2	SI/RR		
		There is a procedure for consultation of the patient to other specialist with in the hospital	2	RR/SI		
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.	Patient referred with referral slip	2	RR/SI		
		Advance communication is done with higher centre	2	RR/SI		
		Referral vehicle is being arranged	2	SI/RR		
		Referral in or referral out register is maintained	2	RR		
		Facility has functional referral linkages to lower facilities	2	SI/RR	Check for referral cards filled from lower facilities	
		There is a system of follow up of referred patients	2	RR		
ME E3.3	A person is identified for care during all steps of care	Duty Doctor and nurse is assigned for each patients	2	RR/SI		
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure	2	OB/SI	Patient id band/ verbal confirmation/Bed no. etc.	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained	2	RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.	
		There is a process to ensue the accuracy of verbal/telephonic orders	2	SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period	
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift	2	SI/RR		
		Nursing Handover register is maintained	2	RR		
		Hand over is given bed side	2	SI/RR		
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately	2	RR/SI	Check for nursing note register. Notes are adequately written	
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically	2	RR/SI	Check for TPR chart, IO chart, any other vital required is monitored	
		Critical patients are monitored continually	2	RR/SI		
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm	2	OB/SI	Unstable, irritable, unconscious. Psychotic and serious patients are identified	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI		
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	The facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only	2	RR		
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are availble at point of use	2	RR		
		Check staff is aware of the drug regime and doses as per STG	2	SI/RR	Check BHT that drugs are prescribed as per STG	
		Availability of drug formulary	2	SI/OB		
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient	2	RR/OB	Nurse confirms patient's name, prescription details and medical history before drug administration at bed-side, during transfer of care and at the time of discharge	
		Established mechanism for Medication reconciliation process	2	SI/RR	1. Medication Reconciliation is carried out by a trained and competent health professional during the patient's admission, interdepartmental transfer or discharged 2. Medicine reconciliation includes Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements, potentially interactive food items, herbal preparations, and recreational drugs"	
		Medicine are reviewed and optimised as per individual treatment plan	2	SI/RR	1. Medication review is performed for some groups like patients taking multiple medicines, people with chronic or long term conditions, older people, etc. 2. Medicines are optimised as per individual treatment plan for best possible clinical outcome	
		Complete medication history is documented and communicated for each patient at the time of discharge	2	SI/RR	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary"	
		Patients are engaged in their own care	2	PI/SI	"1. Clinician/Nurse counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge"	
Standard E7	**The facility has defined procedures for safe drug administration**					
ME E7.1	There is process for identifying and cautious administration of high alert drugs	High alert drugs available in department are identified	2	SI/OB	Electrolytes like Potassium chloride, Opioids, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc.	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor	
		There is process to ensure that right doses of high alert drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided	

ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature	2	RR		
		Check for the writing, It comprehendible by the clinical staff	2	RR/SI		
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration	2	OB/SI		
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content intended to be used later on	
		Check for separate sterile needle is used every time for multiple dose vial	2	OB	In multi dose vial needle is not left in the septum	
		Any adverse drug reaction is recorded and reported	2	RR/SI	Adverse drug event trigger tool is used to report the events	
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them	2	SI/RR	Administration of medicines done after ensuring right patient, right drugs, right route, right time, Right dose, Right Reason and Right Documentation	
ME E7.5	Patient is counselled for self drug administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings	2			
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Day to day progress of patient is recorded in BHT	2	RR	(Manually/e-records)	
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT	2	RR	Treatment prescribed inj nursing records (Manually/e-records)	
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/treatment registers	2	RR	Treatment given is recorded in treatment chat (Manually/e-records)	
ME E8.4	Procedures performed are written on patients records	Any procedure performed written on BHT	2	RR	Dressing, mobilization etc (Manually/e-records)	
ME E8.5	Adequate form and formats are available at point of use	Standard Format for bed head ticket/ Patient case sheet available as per state guidelines	2	RR/OB	Availability of formats for Treatment Charts, TPR Chart , Intake Output Chat Etc.	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, OT register, Diet register, Linen register, Drug intend register	
		All register/records are identified and numbered	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB		
Standard E9	**The facility has defined and established procedures for discharge of patient.**					
ME E9.1	Discharge is done after assessing patient readiness	Assessment is done before discharging patient	2	SI/RR		
		Discharge is done by a responsible and qualified doctor after assessment in consultation with treating doctor	2	SI/RR	Discharge is done in consultation with treating doctor	
		Patient / attendants are consulted before discharge	2	PI/SI		
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided	2	RR/PI	See for discharge summary, referral slip provided.	
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up	2	RR		
		Discharge summary is give to patients going in LAMA/Referral	2	SI/RR		
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge	2	SI/PI	Advice includes the information about the nearest health centre for further follow up. Counsel mother for treatment, follow up, feeding, discharge timings are explained prior	
		Time of discharge is communicated to patient in prior	2	PI/SI		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.3	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different tests	2	SI/RR		
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR		
		Patient's identification is verified before transfusion	2	SI/OB		
		blood is kept on optimum temperature before transfusion	2	RR		
		Blood transfusion is monitored and regulated by qualified person	2	SI/RR		
		Blood transfusion note is written in patient recorded	2	RR		
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR		
Standard E14	**The facility has established procedures for Anaesthetic Services**					
ME E14.1	The facility has established procedures for Pre-anaesthetic Check up and maintenance of records	Pre anaesthesia check up is conducted for elective / Planned surgeries	2	SI/RR		
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communication of death to relatives	2	SI		
		Death note is written on patient record	2	RR		
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible	2	SI/RR		
		Death note including efforts done for resuscitation is noted in patient record	2	RR		
	National Health Program					
Standard E23	**The facility provides National health Programme as per operational/Clinical Guidelines**					
ME E23.6	The facility provides services under Mental Health Programme as per guidelines	Management of mental illness as per guidelines	2	SI/RR	(a) Treatment of mental illness symptoms & associated condition	
		Psychosocial support is provided	2	SI/RR	(a) Basic psycho education about treatment adherence (b) Motivation enhancement (c) Reduction of high risk behaviour (d) Relapse prevention (e) Counselling for occupational rehab. (d) Patient support group / individual counselling	
ME E23.7	The facility provides services under National Programme for the health care of the elderly as per guidelines	Geriatric Care is provided as per Clinical Guidelines	2	SI/RR	(a) Linkage with specialists like medicine, ortho, health., ENT services (b) Referral services to Regional Geriatric centre/MC	
ME E23.8	The facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines	Management of Myocardial infarction & stroke	2	SI/RR	As per treatment protocols	
		Management of admitted diabetes cases as per guidelines	2	SI/RR	As per treatment protocols	
		Chemotherapy follow up in cancer cases	2	SI/RR	Chemotherapy support or services provided as per state mandate	
		Counselling the identified cases for self care	2	PI/RR	Counsel the patient for monitoring of their BP (using digital BP apparatus) , sugar (using glucometer) , self-care for ulcers etc	
ME E23.9	The facility provide service for Integrated disease surveillance Programme	Weekly reporting of Presumptive cases on form "P" from IPD	2	SI/RR	(a) Submitted to District surveillance officer (b) Data is submitted manually or through IHIP (integrated health information platform)	
ME E 23.12	Facility provide services under National program for pallative care	Management of pain as per guidelines	2	SI/RR	(a) Treatment of symptoms, associated condition & referral to the linkage (b) Pain management by the staff trained in pain & pallative care	

		Psychosocial support is provided	2	SI/RR	(a) Basic psycho education about treatment adherence (b) Motivation enhancement (c) Reduction of high risk behaviour (d) Relapse prevention (e) Recreation facility (d) Patient support group / individual counselling	
	Area of Concern - F Infection Control					
Standard F1	The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection					
ME F1.3	The facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection	2	SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .	
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
		Periodic medical check-ups of the staff	2	SI/RR		
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	The facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use along with elbow operated tap	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
ME F2.3	The facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3	The facility ensures standard practices and materials for Personal protection					
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps and Aprons	
Standard F4	The facility has standard procedures for processing of equipment and instruments					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , Patients Beds Stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like Stethoscope, Dressing Instruments, Examination Instruments, Blood Pressure Cuff etc (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement	2	OB/SI	Autoclaving/HLD/Chemical Sterilization	
		High level Disinfection of instruments/equipments is done as per protocol	2	OB/SI	Ask staff about method and time required for boiling	
		Autoclaved dressing material is used	2	OB/SI		
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention					
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
ME F5.4	The facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases	2	OB/SI		
Standard F6	The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.					
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.	
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		

		Staff is aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF	
	Area of Concern - G Quality Management					
Standard G1	**Facility has established organizational framework for quality improvement**					
ME G1.1	Facility has a quality team in place	Quality circle has been formed in the IPD	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G2	**The facility has established system for patient and employee satisfaction**					
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals	Patient satisfaction survey done on monthly basis	2	RR		
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system daily round by Hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Check for entries in Round Register	
ME G3.2	The facility has established external assurance programmes at relevant departments		2			
ME G3.3	The facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	Patient safety, CPR	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for receiving and initial assessment of the patient	2	RR		
		Department has documented procedure for admission, shifting and referral Of patient	2	RR		
		Department has documented procedure for requisition of diagnosis and receiving of the reports	2	RR		
		Department has documented procedure for preparation of the patient for surgical procedure	2	RR		
		Department has documented procedure for transfusion of blood	2	RR		
		Department has documented procedure for maintenance of rights and dignity of Patient	2	RR		
		Department has documented procedure for record eminence including taking consent	2	RR		
		Department has documented procedure for counselling of the patient at the time of discharge	2	RR		
		Department has documented procedure for environmental cleaning and processing of the equipment	2	RR		
		Department has documented procedure for sorting, and distribution of clean linen to patient	2	RR		
		Department has documented procedure for end of life care	2	RR		
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1	The facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	The facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	The facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1	The facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
		Advance quality improvement method	2	SI/OB	Six sigma, lean.	
ME G7.2	The facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes	2	SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	

		Check regular ward rounds are taken to review case progress	2	SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	SI/RR	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co- ordination is reviewed	2	SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits	2	SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission	
		There is procedure to conduct death audits	2	SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct referral audits	2	SI/RR	Check for -valid sample size, data is analysed, poor performing attributes are identified and improvement initiatives are undertaken	
		All non compliance are enumerated & recorded for medical audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated & recorded for newborn death audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated & recorded for referral audits	2	SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	SI/RR	Check the drugs prescribed are available in EML or part of drug formulary	
		Check the updated/latest evidence are available	2	SI/RR	Check when the STG/protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.	
		Check the mapping of existing clinical practices processes is done	2	SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate of Medical Wards	2	RR		
		Bed Occupancy Rate for surgical wards	2	RR		
		Number of the patients screened for pain	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Referral Rate	2	RR		
		Bed Turnover rate	2	RR		
		Discharge rate	2	RR		
		No. of drugs stock out in the ward	2	RR		
		Percentage of in-patients with complete screening for nutritional needs	2	RR		
		Patient's fall rate	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average length of stay for Medical wards	2	RR		
		Average length for surgical wards	2	RR		
		Time taken for initial assessment	2	RR		
		Medication error per 1000 patient days	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate	2	RR		
		Patient Satisfaction Score	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Blood Bank			14
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Blood Bank Score Card				
Area of Concern wise Score			Blood Bank Score	
A	Service Provision	100%	100%	
B	Patient Rights	100%		
C	Inputs	100%		
D	Support Services	100%		
E	Clinical Services	100%		
F	Infection Control	100%		
G	Quality Management	100%		
H	Outcome	100%		

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No.	ME Statement	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1.	Facility Provides Curative Services					
ME A1.14.	Services are available for the time period as mandated	Blood bank services available 24X7	2	SI/RR		
ME A1.18.	The facility provides Blood bank & transfusion services	Blood bank has facility of whole blood collection and storage	2	SI/OB		
.		Blood Bank has facility for Blood Components preparation	2	SI/OB	PRC, Platelets Concentrate, FMP, Plasma& Single donor Cryo Precipitate	
.		Blood bank has emergency stock of blood	2	SI/OB	For A+, B+, O+ and O-	
		Provision of blood donation camps	2	SI/OB	As per the procedure laid down by the National Blood Transfusion Council	
Standard A2	Facility provides RMNCHA Services					
ME A2.2	The facility provides Maternal health Services	Availability of transfusion services	2	SI/OB		
Standard A3	Facility Provides diagnostic Services					
ME A3.2	The facility Provides Laboratory Services	Availability of screening and cross matching services	2	SI/OB		
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme					
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of platelets for management of Dengue cases	2	SI/RR		
Standard A6.	Health services provided at the facility are appropriate to community needs.					

ME A6.1.	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Blood Bank provides blood components for thalassemia, dengue, haemophilia etc. as per local need	2	SI/RR		
	Area of Concern - B Patient Rights					
Standard B1.	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1.	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed	
ME B1.2.	The facility displays the services and entitlements available in its departments	List of services available are displayed	2	OB		
.		Blood bank has displayed of Information regarding donors eligibility	2	OB		
		Blood bank has displayed information regarding number of blood units available	2	OB		
ME B1.4.	User charges are displayed and communicated to patients effectively	User services charges in r/o blood are displayed at entrance	2	OB		
ME B1.5.	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC material is available in blood bank to provide information and to promote blood donation	2	OB		
ME B1.6.	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
Standard B2.	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**					
ME B2.3.	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of ramp or alternate for easy access to the blood bank	2	OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available	
Standard B3.	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1.	Adequate visual privacy is provided at every point of care	Privacy at blood donation and counselling room	2	OB		
ME B3.2.	Confidentiality of patients records and clinical information is maintained	Blood Bank has system to ensure the confidentiality of results of screening test done	2	SI/OB	Blood bank staff do not discuss the lab result outside. reports are kept in secure place	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB		
ME B3.4.	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Confidentiality and privacy of HIV patients	2	SI/OB		
Standard B4.	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1.	There is established procedures for taking informed consent before treatment and procedures	Blood bank is taking informed consent of donor	2	SI/RR	In consent form, procedure of donation is explained along with informing the donor regarding testing of blood is mandatory for safety of recipient	
ME B4.3.	Staff are aware of Patients rights responsibilities	Awareness of staff on donor rights and donor responsibilities	2	SI	About the confidentiality and privacy of donor information	
ME B4.4.	Information about the treatment is shared with patients or attendants, regularly	Pre donation counselling is done before donation	2	PI/SI/RR	Procedure include preparation of venepuncture site, use of blood bags and anticoagulant solution, collecting sample for laboratory test	
.		Post donation counselling for sero reactive donors	2	PI/SI	Post donation counselling also include counselling on HIV/ Hept B for which blood bank may refer the donor to ICTC /SACS/ MTC	
ME B4.5.	The facility has defined and established grievance redressal system in place	Availabilty of complaint box and display of process for grievance re addressal and whom to contact is displayed	2	OB		
Standard B5.	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1.	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free blood for Pregnant woman, Mothers and New Borns	2	PI/SI		
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing blood from outside.	2	PI/SI		
ME B5.4.	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Free blood for BPL patients	2	PI/SI/RR		
	Area of Concern C: Inputs					
Standard C1.	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1.	Departments have adequate space as per patient or work load	Blood bank has adequate space as per requirement	2	OB	Space required is more than 100 sq meters	
		Availability of waiting area in blood bank	2	OB		
ME C1.2.	Patient amenities are provide as per patient load	Separate toilet facilities for male & female are available	2	OB		
		Seating arrangement in waiting area	2	OB		
ME C1.3.	Departments have layout and demarcated areas as per functions	Dedicated examination room	2	OB		
.		Dedicated Blood collection room	2	OB		
.		Dedicated transfusion transmissible infection (TTI) lab	2	OB		
.		Availability of refreshment cum rest room	2	OB		
.		Dedicated sterilization area	2	OB		
.		Dedicated store cum record room	2	OB		
.		Availability of Duty room for staff	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff and equipments	2	OB		
ME C1.5.	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6.	Service counters are available as per patient load	Adequate Donor couches/ donor units as per load	2	OB		
ME C1.7.	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Blood bank layout ensures smooth flow of donor and services	2	OB		
Standard C2.	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	Blood bank does not have temporary connections and loosely hanging wires	2	OB		
.		Adequate electrical socket provided for safe and smooth operation of lab equipments	2	OB/RR		
ME C2.4	Physical condition of buildings are safe for providing patient care	Work benches are chemical resistant	2	OB		
		Floors of the Laboratory are non slippery and even	2	OB		
		Windows have grills and wire meshwork	2	OB		
Standard C3.	**The facility has established Programme for fire safety and other disaster**					
ME C3.1.	The facility has plan for prevention of fire	Blood bank has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
.		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
		Blood bank has plan for safe storage and handling of potentially flammable materials.	2	OB		
ME C3.2.	The facility has adequate fire fighting Equipment	Blood Bank has installed fire Extinguisher that is Class A , Class BC type or ABC type	2	OB/RR		

.		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3.	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4.	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1.	The facility has adequate specialist doctors as per service provision	Availability of dedicated blood bank medical officer	2	OB/RR	MBBS doctor with one year experience	
ME C4.3.	The facility has adequate nursing staff as per service provision and work load	Availability of dedicated Nursing Staff	2	OB/RR/SI		
ME C4.4.	The facility has adequate technicians/paramedics as per requirement	Availability of dedicated Blood Bank Technician round the clock	2	SI/RR		
ME C4.5.	The facility has adequate support / general staff	Availability of housekeeping staff	2	SI/RR		
		Availability of security staff	2	SI/RR		
Standard C5.	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1.	The departments have availability of adequate drugs at point of use	Departments have availability of adequate emergency drugs at point of use	2	OB/RR	Inj Adrenaline,Inj Deriphylline,Inj Dexamethasone ,Inj Chlorpheniramine,Inj Metochlorpromide	
		Availability Laboratory materials	2	OB/RR	Evacuated Blood collection tubes, Swabs, Syringes, Glass slides, Glass marker/paper stickers	
ME C5.2.	The departments have adequate consumables at point of use	Availability of Reagents /Kits for lab	2	OB/RR	Standard Grouping Sera Anti A, Anti B & Anti D ,VDRL/RPR Kit for Syphillis,RDK/ ELISA for Malarial Antigen, ELISA kit for Hep B &C, ELISA kit for HIV1 & 2, malarial parasite stains	
Standard C6.	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1.	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	Adult Weighing machine, BP apparatus , clinical thermometer	
ME C6.3.	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of laboratory equipment & instruments for laboratory	2	OB	Microscope with water bath, ELISA reader with washer, RH viewer, Sahli's Haemoglobino meter/Others	
ME C6.4.	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.	2	OB	Adult bag and mask and Oxygen	
ME C6.5.	Availability of Equipment for Storage	Check for availability of storage equipments for blood products	2	OB	Blood bags refrigerator with thermo graph and alarm device, Insulated carrier boxes with ice packs, Blood bag weighting machine, deep freezer, Platelets agitators	
ME C6.6.	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
ME C6.7.	Departments have patient furniture and fixtures as per load and service provision	Availability of beds/Couches in blood bank	2	OB	Blood collection bed, recovery beds	
		Availability of attachment/ accessories	2	OB	Hospital graded Mattress, bed sheet, blanket, and bed side table	
		Availability of Fixtures	2	OB	Electrical fixture for equipments lab and storage equipments	
		Availability of furniture	2	OB	cupboard, counter for issuing blood, work benches for lab, chair.	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Patient Safety	2	SI/RR		
		Basic Life Support	2	SI/RR		
		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for operating the equipments	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
.	**Area of Concern - D Support Services**					
Standard D1.	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1.	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
.		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
.		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired	2	OB/RR		
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR		
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator	2	SI/RR		
ME D1.2.	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR		
.		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	2	OB/ RR		
.		Blood bank has system to update correction factor after calibration wherever required	2	SI/RR	Check for records	
.		Each lot of reagents has to be checked against earlier tested in use reagent lot or with suitable reference material before being placed in service and result should be recorded.	2	SI/RR		
ME D1.3.	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.	2	OB/SI		
Standard D2.	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1.	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and reagents	2	SI/RR	Stock level are daily updated Indent are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	Reagents and consumables are kept away from water and sources of heat, direct sunlight	2	OB/RR	Check the storage conditions of reagents, blood,etc.	
		Reagents are labelled appropriately	2	OB/RR	Reagents label contain name, concentration, date of preparation/opening, date of expiry, storage conditions and warning	
ME D2.4.	The facility ensures management of expiry and near expiry drugs	Expiry dates' of the blood bags are maintained	2	OB/RR		
		No expired blood is found in storage	2	OB/RR		
		Records for expiry and near expiry blood are maintained	2	RR	Check the record of expiry and near expiry drug in drug substore	

ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock of reagents	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time	
		Department maintained stock register of reagents	2	RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procdeure for replenishing drug tray /crash cart	2	SI/RR		
		There is no stock out of reagents	2	OB/SI	Check some stock of reagent	
ME D2.7.	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators used for storing lab reagents are kept as per storage requirement and records twice a day are maintained	2	OB/RR	Check for temperature charts are maintained and updated twice a day for refrigerators used storing lab reagents	
.		Regular Defrosting is done	2	SI/RR		
Standard D3.	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1.	The facility provides adequate illumination level at patient care areas	Adequate illumination at work station in laboratory	2	OB	Illumination level of blood bank is as per recommendation/ sufficient to carry out blood bank activities	
		Adequate illumination at donation area	2	OB		
ME D3.2.	The facility has provision of restriction of visitors in patient areas	Entry is restricted in storage and lab area of the blood bank	2	OB		
ME D3.3.	The facility ensures safe and comfortable environment for patients and service providers	Temperature is maintained and record of same is kept	2	SI/RR	Air conditioned blood collection room, blood group serology lab, testing lab for Transfusion Transmissible Diseases, refreshment cum rest room	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4.	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2.	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3.	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Patients beds are intact and painted	2	OB	Mattresses are intact and clean	
ME D4.5.	The facility has policy of removal of condemned junk material	No condemned/Junk material in the lab	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5.	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
ME D5.2.	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in Blood Bank	2	OB/SI		
		Availability of UPS	2	OB/SI		
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Blood bank provides Linen for donors	2	OB/RR	Blankets	
Standard D10.	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					
ME D10.1.	The facility has requisite licences and certificates for operation of hospital and different activities	Blood bank has valid license under Rule 122(G) Drug and cosmetic act	2	RR		
Standard D11.	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1.	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2.	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3.	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, technician and support staff adhere to their respective dress code	2	OB		
Standard D12.	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
.	**Area of Concern - E Clinical Services**					
Standard E1.	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1.	The facility has established procedure for registration of patients	Unique identification number is given to each donor during process of registration	2	RR		
		Donors demographic details are recorded	2	RR	Check for that patient demographics like Name, age, Sex, Address etc.	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	There is procedure for assessment of patient before donation	2	RR/SI	Initial assessment is recorded	
Standard E3.	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1.	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during departmental transfer	2	SI/RR		
.		There is a procedure consultation of the patient to other specialist with in the hospital	2	SI/RR		
ME E3.2.	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	There is procedure for referral of cases for which requested blood group is not available	2	SI/RR		
.		Facility has functional referral linkages to blood storage unit	2	SI/RR		
Standard E4.	**The facility has defined and established procedures for nursing care**					
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Procedure to handover test/ results during shift change	2	RR/SI		
		Handover register is maintained	2	RR		
Standard E8.	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Records of donor assessment is maintained	2	RR	(Manually/e-records)	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available	2	RR/OB	Format for consent, requisition form, blood transfusion reaction form, referral slip	
ME E8.6.	Register/records are maintained as per guidelines	Blood bank records are labelled and indexed	2	RR	(Manually/e-records)	
.		Records are maintained for blood bank	2	RR	Records includes daily group wise stock register, daily temperature recording of temperature dependent equipment, stock register of consumables and non consumables, documents of proficiency testing, records of equipment maintenance, records of recipient, compatibility records, transfusion reaction records, donors records etc.	
ME E8.7.	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB	Blood bank has facility to store records for 5 year	

Standard E11.	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3.	The facility has disaster management plan in place	Blood bank has system of coping with extra demand of blood in case of disaster	2	SI/RR		
		Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
Standard E13.	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.1.	Blood bank has defined and implemented donor selection criteria	Blood bank has defined criteria for donor selection	2	RR/SI	Based on Physical examination, Medical history, condition that affects safety of recipients, donation intervals,	
.		Blood bank ensures that blood is taken from voluntary donors only	2	RR/PI/SI		
		Pre donation counselling is done before donation	2	RR/PI		
		Check for questionnaire is available in local language for taking pre donation information	2	OB/RR		
ME E13.2.	There is established procedure for the collection of blood	Blood bank has standardized procedure for collection of blood from donor	2	RR/SI	Procedure include preparation of venepuncture site, use of blood bags and anticoagulant solution, collecting sample for laboratory test	
.		Instructions for collection and handling the collected blood are communicated to those responsible for collection	2	RR/SI	Mostly numeric or alpha numeric label should be used for tracing	
.		Blood bank has identified procedure for labelling of blood bag/blood component /pilot tubes	2	RR/OB		
.		Blood bank has system to trace of unit of blood /component from source to final destination	2	RR/SI	Blood should be kept at 4oC to 6oC except if it is used for component preparation it will be stored at 22oC until platelet are separated	
.		Blood bank has system to maintain temperature of collected blood immediately after donation	2	RR/SI		
.		Blood bank has system in place to monitor the transportation of the blood from camp site	2	RR/SI		
ME E13.3.	There is established procedure for the testing of blood	Determination of ABO group is done by recommended methods	2	RR/SI	Tube or Microplate or gel technology	
		Determination of Rh (D) Type done as per recommended method	2	RR/SI	Check for the protocol/ Algorithm followed for determining RH + or RH- Blood type	
		Laboratory tests for Infectious diseases done as per recommended method	2	RR/SI	or infectious diseases (VDRL/RPR/TPHAfor syphilis, ELISA/Rapid test for Hep A, Hep B, HIV and Malaria for malarial parasite	
		There is provision of Quarantine Storage untested blood	2	RR/OB/SI	Check for untested blood is stored in different refrigerator	
		Blood units with reactive test result area kept separately	2	RR/OB/SI	In dedicate secure area with biohazard sign until disposal	
		Sterility of Blood units checked with adequate sample size	2	RR/OB/SI	Check Sterility is checked at least for 1% of blood unit collected or 4 per month which ever higher by appropriate culture method	
ME E13.4	There is established procedure for preparation of blood component	Sterility of Blood component is insured during processing	2	SI/RR	Check for use of aseptic method and availability of Sterile pyrogen free disposable bags and solutions	
		Transfusion time limits are adhered one frozen component have been thawed	2	SI/RR	Within 6 hours	
		Blood components are prepared as per technical standards	2	SI/RR	Check availability and adherence to NACO standards	
		Approximate volume of the component is indicated on bag	2	RR		
ME E13.5.	There is establish procedure for labelling and identification of blood and its product	Blood bank has system to ensure that final blood bags are labelled only after all mandatory testing is completed.	2	RR/SI		
.		Blood bank has system of identification traceability of its products	2	RR/SI	Blood bags are Identified with a numeric or alpha numeric system / Barcode	
.		Blood bank has system to the affix the product information on bag, after processing	2	RR/SI	Name of product, numeric information, date of collection and expiry, amount of anticoagulant and approximate blood collected, Name, address and manufacturing license number of collecting facility, storage temperature and expiry date	
		Instruction for transfusion are printed on label	2	RR/SI		
.		Blood bank has colour coded scheme for differentiate ABO groups	2	RR/SI	Blood group O -blue, Blood group A- yellow, Blood group B- Pink, Blood group AB- White	
ME E13.6	There is established procedure for storage of blood	Check for refrigerators or freezers for blood storage are not used for storing other items	2	OB	Lab reagents etc.	
		Check for refrigerators used for blood storage are kept at recommended temperature	2	OB/RR	Check records that temperature is maintained at 4c + 2 C	
		Storage temperature is monitored at every 4 hours	2	OB/RR	Check the records	
		Alarm system has been provided with refrigerator	2	RR/SI		
		Adequate alternate storage facility available	2	RR/SI		
		Shelf life of blood and components is adhered as per NACO protocols	2	RR/SI		
ME E13.7.	There is established the compatibility testing	Blood bank has system to testing and cross matching the recipient blood	2	RR/SI	Testing of recipient blood includes Determination ABO type, Rh (D) type, detection of unexpected antibodies etc.	
		There is established procedure for selection of blood and components for transfusion	2	RR/SI	Check for practice in case of ABO type specific groups are not available. Issue of blood to RH+ and Negative recipient	
		There is established procedure for re cross matching in case of massive transfusion	2	RR/SI		
		Paediatric blood collection bags are available	2	RR/SI		
ME E13.8.	There is established procedure for issuing blood	Blood bank has system to testing and cross matching the recipient blood	2	RR/SI	Testing of recipient blood includes Determination ABO type, Rh (D) type, detection of unexpected antibodies etc.	
.		Instructions for collection and handling blood sample of recipient are communicated to those responsible for collection	2	RR/SI	Blood sample collection vial is label with Patient Name, identification no, name of hospital, ward/bed number, date time , Phlebotomist signature	
.		Blood bank has system to confirm that information on transfusion requisition form and recipients blood sample label is same	2	RR/SI		
.		Blood bank has system to retain recipient and donor blood sample for 7 days at specified temperature (2-8 c) after each transfusion	2	RR/SI		
.		Blood bank has system to issue the blood along with cross matching report	2	RR/SI		
.		Blood bank has system to identify the person who is performing the cross matching test and issue the blood	2	RR/SI	Record of same should be available	
.		Blood bank has procedure to issue the blood in case of its urgent requirement	2	RR/SI		
ME E13.10.	There is a established procedure for monitoring and reporting Transfusion complication	Transfusion reaction form is provided when blood is issued	2	RR/SI		

.		Blood bank has system of detection, reporting and evaluations of transfusion errors	2	RR/SI		
	Area of Concern - F Infection Control					
Standard F1.	Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection					
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
ME F1.4.	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxid etc	
		Periodic medical checkups of the staff	2	SI/RR		
.ME F1.5.	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
Standard F2.	Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis					
ME F2.1.	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use	
.		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
.		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
.		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps	2	OB		
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB		
ME F2.2.	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
.		Staff aware of when to hand wash	2	SI		
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3.	Facility ensures standard practices and materials for Personal protection					
ME F3.1.	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available at point of use	2	OB/SI	All personal use gloves while drawing sample, examining and disposable of the samples	
.		Availability of lab aprons/coats	2	OB/SI		
.		Availability of Masks	2	OB/SI		
ME F3.2.	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps and Aprons	
Standard F4.	Facility has standard Procedures for processing of equipments and instruments					
ME F4.1.	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate work benches (Wiping with 0.5% Chlorine solution	
.		Proper Decontamination of instruments after use	2	SI/OB	Decontamination of instruments and reusable of glassware are done after procedure in 1% chlorine solution/ any other appropriate method	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2.	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Disinfection of reusable glassware	2	SI/OB	Disinfection by hot air oven at 160 oC for 1 hour	
Standard F5.	Physical layout and environmental control of the patient care areas ensures infection prevention					
ME F5.2.	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Gluteraldehye, carbolic acid	
.		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3.	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
Standard F6.	Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.					
ME F6.1.	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
.		Availability of colour coded non chlorinated plastic bags	2	OB		
.		Segregation of different category of waste as per guidelines	2	OB/SI		
.		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2	OB		
ME F6.2.	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.	
.		Seggregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation.Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
.		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
.		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
ME F6.3.	Facility ensures transportation and disposal of waste as per guidelines	Disinfection of liquid waste before disposal	2	SI/OB		
.		Disposal of discarded blood bags as per guideline	2	SI/OB		
.		Check bins are not overfilled	2	SI		
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		
		Staff aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to lacate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF	

.	**Area of Concern - G Quality Management**					
Standard G1.	**The facility has established organizational framework for quality improvement**					
ME G1.1.	The facility has a quality team in place	Quality circle has been formed in the Blood Bank	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G2	**Facility has established system for patient and employee satisfaction**					
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	There is system to take feed back from clinician about quality of services	2	RR		
		Feedback from donor are taken on periodic basis	2	RR		
Standard G3.	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1.	Facility has established internal quality assurance program at relevant departments	Internal Quality assurance program is in place	2	SI/RR		
.		Standards are run at defined interval	2	SI/RR		
		Control charts are prepared and outliers are identified.	2	SI/RR		
		Corrective action is taken on the identified outliers	2	SI/RR		
ME G3.2.	Facility has established external assurance programs at relevant departments	Cross validation of lab test are done and reports are maintained	2	SI/RR	It includes participation of laboratory in inter laboratory comparison	
.		Corrective actions are taken on abnormal values	2	SI/RR	Blood bank takes corrective action when control criteria are not fulfilled in Interlaboratory comparisons and records of same is maintained	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4.	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1.	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
.		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	work instruction for screening of blood, storage of blood, maintaining blood and component in event of power failure	
ME G4.2.	Standard Operating Procedures adequately describes process and procedures	Blood bank has documented procedure for Donor selection and collection of blood from donor	2	RR		
.		Blood bank has documented procedure for testing of donated blood	2	RR		
.		Blood bank has documented procedure for preparation of blood components	2	RR		
.		Blood bank has documented procedure for storage, transportations of blood and issue of blood for transfusion	2	RR		
.		Blood bank has documented procedure for issue of blood in case of urgent requirement	2	RR		
.		Blood bank has documented procedure to address the transfusion reactions	2	RR		
.		Blood bank has documents procedure for calibration and maintenance of equipment	2	RR		
.		Blood bank has documented procedure for HAI and disposal of BMW	2	RR		
.		Blood bank has documented system for storage, retaining and retrieval of laboratory records, primary sample, Examination sample and reports of results.	2	RR		
.		Blood bank has documented system for internal and external Quality control of Equipments, reagent and tests	2	RR		
ME G4.3.	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5.	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1.					DELETED	
ME G5.2.					DELETED	
ME G5.3.					DELETED	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1.	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/RR	PDCA & 5S	
.		Advance quality improvement method	2	SI/OB	Six sigma, lean.	
ME G7.2.	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.	
ME G9.7					DELETED	
ME G9.8	Risks identified are analyzed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
.	**Area of Concern - H Outcome**					
Standard H1 .	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					

ME H1.1.	Facility measures productivity Indicators on monthly basis	No. of Blood unit issued per thousand population	2	RR	No. of Unit issued X1000/ Population of serving area	
.		% of units issued for the transfusion at facility	2	RR	No. of Unit issued for facility*100/Total no of units issued in the period	
.		No of voluntary donation done per thousand population	2	RR	No of Voluntary Donation X1000/Population of the serving area	
.		No. of units supplied to storage units	2	RR	Self Explanatory	
.		Blood donation camps held	2	RR	Self Explanatory	
.		Proportion of blood units issued in emergency cases out of total unit issued in month	2	RR		
		No of blood units issued for free of cost	2	RR	JSSK, Thalassemia , BPL	
Standard H2 .	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1.	Facility measures efficiency Indicators on monthly basis	Downtime critical equipments	2	RR	Time period for which equipment was out of order/Total no of working hours for equipments	
.		% of Blood Units discarded	2	RR	No of unit discarded *100/ Total no of unit collected	
.		% of unit issued against replacement	2	RR	No of unit issued on replacement *100/ Total no of unit issued	
.		% of unit tested seroreactive	2	RR	No of unit found sero reactiveX100/ No of unit tested	
Standard H3.	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1.	Facility measures Clinical Care & Safety Indicators on monthly basis	Blood transfusion reaction rate	2	RR	No of Blood Transfusion reactions 1000/ No of patient blood issued	
.		Adverse events are identifies and reported	2	RR	Chemical splash, Needle stick injuries. Major blood transfusion reaction, wrong cross matching, wrong blood issue	
.		Component to whole blood ratio	2	RR	No of component unit issued/No of whole blood issued	
.		Cross matched/ Transfused Ratio	2	RR	No of unit are cross matched on request/ No of unit actually transfused	
		% of single unit transfusion	2	RR	% of single use transfusion 100/ Total no of units transfused	
.		Number of adverse events per thousand patients	2	RR	Chemical splash, Needle stick injuries. Major blood transfusion reaction, wrong cross matching, wrong blood issue	
Standard H4.	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1.	Facility measures Service Quality Indicators on monthly basis	Time gap between issuing and requisition of blood in routine conditions	2	RR		
.		Time gap between issuing and requisition of blood in emergency conditions	2	RR		
.		Donor Satisfaction Score at Blood Bank	2	RR		
.		No of refusal cases	2	RR	No of requisition refused/ referred due to non availability of blood group or any other reason	

1
2

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Laboratory			15
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Laboratory Score Card

Area of Concern wise Score			Laboratory Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Standard	ME Statement	Checkpoint	Compliance Full/Partial/ No	udit Metho	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.14	Services are available for the time period as mandated	All lab services are available in routine working hours	2	SI/RR		
		Emergency lab services are available for selected tests of Haematology, Biochemistry and Serology 24X7	2	SI/RR	Check for: 1. Laboratory services are available at night 2. Look for number of lab tests performed at night	
Standard A3	Facility Provides diagnostic Services					
ME A3.2	The facility Provides Laboratory Services	Availability of Haematology services	2	SI/OB		
		Availability of Biochemistry services	2	SI/OB		
		Availability of Microbiology services	2	SI/OB		
		Availability of Cytology services	2	SI/OB		
		Availability of Histopathology services	2	SI/OB		
		Availability of Clinical Pathology services	2	SI/OB		
		Availability of Serology services	2	SI/OB		
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme					

ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Tests for Diagnosis of maleria (Smear and RDTK)	2	SI/OB		
		Tests for diagnosis of Dengue, Chikengunia	2	SI/OB		
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Availability of Designated Microscoy Center (AFB)	2	SI/OB		
		Availability or Linkage with CBNAAT	2			
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of Skin Smear Examination	2	SI/OB		
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability of blood test for NCD	2	SI/RR	Haemogram, BT CT, Fasting/PP Sugar, Lipid Profile, Blood Urea , LFT Kidney Function Test	
Standard A6	**Health services provided at the facility are appropriate to community needs.**					
ME A 6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Laboratory provides specific test for local health problems/diseases	2	SI/RR	Like Dengue, swine flu, Kala Azar, Lymphatic Filariasis,etc.	
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed	
		Restricted area signage are displayed	2	OB		
ME B1.2	The facility displays the services and entitlements available in its departments	List of services available are displayed at the entrance	2	OB		
		Timing for collection of sample and delivery of reports are displayed	2	OB		
ME B1.4					DELETED	
ME B1.5	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Lab Reports are provided to Patient in printed format	2	OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religiousand cultural needs, and there are no barrier on account of physical , economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Separate queue for females at lab	2	OB		
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Check the availability of ramp in lab building area /sample collection area	2	OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.2	Confidentiality of patients records and clinical information is maintained	Laboratory has system to ensure the confidentiality of the reports generated	2	SI/OB	Laboratory staff do not discuss the lab result outside. And reports are kept in secure place	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV positive reports/pregnancy reports are communicated as per NACO guidelines	2	SI/OB		
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed Consent is taken before HIV testing, Biopsy and any other invasive procedure	2	SI/RR	Before testing HIV patient is informed that test is voluntary and result will be disclosed to him/her only	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Pre test counselling is given before HIV testing	2	PI/SI/RR		
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free Diagnostic tests for Pregnant women, Infant and Children	2	PI/SI		
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not incurred expenditure on purchasing consumables from outside.	2	PI/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not incurred expenditure on diagnostics from outside.	2	PI/SI		
		Laboratory provides complete list of diagnostic test available to all department of the hospital	2	PI/SI		
ME B5.4					DELETED	
ME B5.5					DELETED	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Laboratory space is adequate for carrying out activities	2	OB	Adequate area for sample collection, waiting, performing test, keeping equipment and storage of drugs and records	
		Availability of adequate waiting area	2	OB		
ME C1.2	Patient amenities are provide as per patient load	Availability of sitting arrangement of sub waiting area	2	OB		
		Availability of patient calling system at lab	2	OB		
		Availability of functional toilets	2	OB		
		Availability of drinking water	2	OB		
ME C 1.3	Departments have layout and demarcated areas as per functions	Demarcated sample collection area	2	OB		
		Demarcated testing area	2	OB		
		Designated report writing area	2	OB		
		Demarcated washing and waste disposal area	2	OB		
		Availability of store	2	OB		
ME C 1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff and equipments	2	OB		
ME C 1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C 1.6	Service counters are available as per patient load	Availability of collection counters as per load	2	OB		
ME C 1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services	2	OB	Sample collection- Sample processing- Analytical area- reporting.	
Standard C 2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	Laboratory does not have temporary connections and loose hanging wires	2	OB		
		Adequate electrical socket provided for safe and smooth operation of lab equipments	2	OB/RR		
ME C2..4	Physical condition of buildings are safe for providing patient care	Work benches are chemical resistant	2	OB		

		Floors of the Laboratory are non slippery and even surfaces and acid resistent	2	OB		
		Windows have grills and wire meshwork	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Laboratory has plan for safe storage and handling of potentially flammable materials.	2	OB/SI		
		Department has sufficient fire exit with signage to permit safe escape to its occupant at time of fire	2	OB		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	Lab has installed fire Extinguisher that is Class A , Class B C type or ABC type	2	OB/RR		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of dedicated pathologist	2	OB/RR	For 100 bed - 1 , 200-1, 300-3, 400-3, 500-4.	
		Availability of dedicated Microbiologist	2	OB/RR	For 300-500 bed -1	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Lab Technician 24X7	2	SI/RR		
ME C4.5	The facility has adequate support / general staff	Availability of Lab assistant	2	SI/RR	In-house/Out-sourced	
		Availability of housekeeping staff	2	SI/RR		
		Availability of security staff	2	SI/RR		
Standard C 5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.2	The departments have adequate consumables at point of use	Availability of stains	2	OB/RR	Iodine Solution, Gram Romanowsky ,StainZiehl-neelsen, Acridine orange, Acridine orange (?)	
		Availability of reagents	2	OB/RR	Reagents for auto analyzers, ELISA Readers	
		Availability of other Chemicals	2	OB/RR	Acetone, Alcohol, distilled water, Microscope gel etc.	
		Availability Laboratory materials	2	OB/RR	Evacuated Blood collection tubes, Swabs, Syringes, Glass slides, Glass marker/paper stickers	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained	2	OB/RR		
Standard C 6	**The facility has equipment & instruments required for assured list of services.**					
ME C 6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Stethoscope at sample collection area	
ME C 6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of functional auto analyzers	2	OB	Auto/ Semi Auto analyzers according to need	
		Availability of functional haematology equipments	2	OB	Cell Counters/ Counting Chambers , Heamoglobinometer , ESR stands with tubes	
		Availability of functional Biochemistry Equipment	2	OB	Calorie meter, Blood Gas Analyzer, Electrolyte analyzer	
		Availability of functional equipments for sample processing	2	OB	Micropipettes , Centrifuge, Water Bath, Hot air oven.	
		Availability of functional Microscopy equipments	2	OB	Binocular Micro scope , FNAC, staining rack	
		Availability functional Histopathology equipments	2	OB	Microtome	
		Availability of functional Serology Equipments	2	OB	Elisa Reader, Elisa washer	
		Availability of functional Microbiology equipments	2	OB	Incubator , Inoculators, safety hood and bio safety cabinet	
ME C 6.5	Availability of Equipment for Storage	Availability of equipment for storage of sample and reagents	2	OB	Refrigerators	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
ME BC 6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of fixtures at lab	2	OB	Illumination at work stations, Electrical fixture for lab equipments and storage equipments	
		Availability of furniture	2	OB	Lab stools, Work bench's, rack and cupboard for storage of reagent ,Patient stool, Chair table	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Training on automated Diagnostic Equipments like auto analyzer	2	SI/RR		
		Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Training on Internal and External Quality Assurance	2	SI/RR		
		Laboratory Safety	2	SI/RR		
		Patient Safety	2	SI/RR		
		Basic Life Support	2	SI/RR		
		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled to run automated equipments	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for maintaining Laboratory records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D 1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	

		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired	2	OB/RR		
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR		
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator	2	SI/RR		
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR		
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	2	OB/ RR		
		Calibrators are available for Automated haematology analyzers	2	SI/RR		
		Laboratory has system to update correction factor after calibration wherever required	2	SI/RR		
		Each lot of reagents has to be checked against earlier tested in use reagent lot or with suitable reference material before being placed in service and result should be recorded.	2	SI/RR		
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.	2	OB/SI		
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and reagents	2	SI/RR	Stock level are daily updated Indent are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	Reagents and consumables are kept away from water and sources of heat, direct sunlight	2	OB/RR	Check the storage condition of reagents,etc.	
		Reagents are labelled appropriately	2	OB/RR	Reagents label contain name, concentration, date of preparation/opening, date of expiry, storage conditions and warning	
ME D2.4	The facility ensures management of expiry and near expiry drugs	No expired reagent found	2	OB/RR		
		Records for expiry and near expiry reagent are maintained	2	RR	Check the record of expiry and near expiry drug in drug substore	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock of reagents	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time	
		Department maintained stock register of reagents	2	RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procedure for replenishing drug tray	2	SI/RR		
		There is no stock out of reagents	2	OB/SI	Check the stock of some reagents	
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day. Refrigerators meant for storing drugs should not be used for storing other items such as eatables.	
		Regular Defrosting is done	2	SI/RR		
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at work station	2	OB		
		Adequate illumination at Collection area	2	OB	Testing areas, report writing area	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry is restricted in testing area	2	OB		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in collection area	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation testing area	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		In histopathology, for tissue processing separate room with fume hood is available	2	OB		
		Availability of Eye washing facility	2	OB		
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the lab	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Water use for analytical purpose should be of reagent grade	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in laboratory	2	OB/SI		
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement	Any positive report of notifiable disease is intimated to designated authorities	2	RR/SI		
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		

ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, technician and support staff adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique laboratory identification number is given to each patient sample	2	RR		
		Patient demographic details are recorded in laboratory records	2	RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	Laboratory has referral linkage for tests not available at the facility	2	RR/SI		
		Facility gets referred patients from lower level of facility	2	RR/SI	e.g.: linkage for disease surveillance and water testing	
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Procedure to handover test/ results during shift change	2	RR/SI		
		Handover register is maintained	2	RR		
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available	2	RR/OB	Printed formats for requisition and reporting are available	
ME E8.6	Register/records are maintained as per guidelines	Lab records are labelled and indexed	2	RR		
		Records are maintained for laboratory	2	RR	Test registers, IQAS/EQAS Registers, Expenditure registers, Accession list etc.	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Laboratory has adequate facility for storage of records	2	OB		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
ME E11.5	There is procedure for handling medico legal cases	Samples of medico legal cases are identified	2	SI/RR	Requisition and reports are marked with MLC and reports are handed over to authorized personnel only	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Requisition of all laboratory test is done in request form	2	RR/OB	Request form contain information: Name and identification number of patient, name of authorized requester, type of primary sample, examination requested, date and time of primary sample collection and date and time of receipt of sample by laboratory,	
		Instructions for collection and handling of primary sample are communicated to those responsible for collection	2	RR/SI		
		Laboratory has system in place to label the primary sample	2	RR/SI		
		Laboratory has system to trace the primary sample from requisition form	2	RR/SI		
		Laboratory has system to record the identity of person collecting the primary sample	2	RR/SI		
		Laboratory has system in place to monitor the transportation of the sample	2	RR/SI	Transportation of sample includes: Time frame, temperature and carrier specified for transportation	
ME E12.2	There are established procedures for testing Activities	testing procedure are readily available at work station and staff is aware of them	2	OB/RR		
		Laboratory has Biological reference interval for its examination of various results	2	OB/RR		
		Laboratory has identified critical intervals for which immediate notification is done to concerned physician	2	RR/SI		
ME E12.3	There are established procedures for Post-testing Activities	Laboratory has system to review the results of examination by authorized person before release of report	2	RR/SI		
		Laboratory has format for reporting of results	2	RR/OB		
		Laboratory has system to provide the reports within defined cycle time/ or each category of patient -routine and emergency	2	RR/SI		
		Laboratory results written in reports are legible without error in transcription	2	RR/SI		
		Laboratory has defined the retention period and disposal of used sample	2	RR/SI		
		Laboratory has system to retain the copies of reported result and promptly retrieved when required	2	RR/SI		
	National Health Programs					
Standard E23	**Facility provides National health program as per operational/Clinical Guidelines**					
ME E23.9	Facility provide service for Integrated disease surveillance program	Weekly reporting of Confirmed cases on form "L" from laboratory	2	SI/RR	(a) Submitted to District surveillance officer (b) Data is submitted manually or through IHIP (integrated health information plateform)	#Daily
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces	
		Technician is trained for taking and processing surface and air sample	2	SI/RR		
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxid etc	
		Periodic medical checkups of the staff	2	SI/RR		
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR		
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use	

		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps	2	OB		
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB		
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB		
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter	
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of lab aprons/coats	2	OB/SI		
		Availability of Masks	2	OB/SI		
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves and Masks.	2	OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps and Aprons	
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate work benches (Wiping with 0.5% Chlorine solution	
		Proper Decontamination of instruments after use	2	SI/OB	Decontamination of instruments and reusable of glassware are done after procedure in 1% chlorine solution/ any other appropriate method	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Staff know how to make chlorine solution	2	SI/OB		
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Disinfection of reusable glassware	2	SI/OB	Disinfection by hot air oven at 160 oC for 1 hour	
		Autoclaving for used culture media and other infected material	2	SI/OB		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Gluteraldehye, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
ME F5.4	Facility ensures segregation infectious patients	Precaution with infectious patients like TB	2	OB/SI		
ME F5.5	Facility ensures air quality of high risk area	Air quality in Lab	2	OB/SI	Negative Pressure for microbiology	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and solied waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids,dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vaccutainers with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.	
		Seggregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation.Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disinfection of liquid waste before disposal	2	SI/OB		
		Disposal of sputum cups as per guidelines	2	SI/OB		
		Check bins are not overfilled	2	SI		
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		

		Staff aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to lacate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF	
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Laboratory	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G2	**Facility has established system for patient and employee satisfaction**					
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	There is system to take feed back from clinician about quality of services	2	RR		
		Client/Patient satisfaction survey done on monthly basis	2	RR		
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1	Facility has established internal quality assurance program at relevant departments	Internal Quality assurance programme is in place	2	SI/RR		
		Standards are run at defined interval	2	SI/RR		
		Control charts are prepared and outliers are identified.	2	SI/RR		
		Corrective action is taken on the identified outliers	2	SI/RR		
		Internal Quality Control for Public Health lab is in place	2	SI/RR	Routine checking of equipments, new lots of regent, smear preparation, grading etc	
ME G3.2	Facility has established external assurance programs at relevant departments	Proficiency Test / EQUAS is done	2	SI/RR	For tests where Nationnal Proficiency Test program is available	
		External / Internal split testing is done	2	SI/RR	For test where PT program is not available	
		EQAs reporst are analysed and evaluated	2		Staff is aware of EQAS reporting system, how to evaluate, and compare	
		Corrective actions are taken on abnormal values/ Outliers	2	SI/RR		
		External quality assurance program implemented as per NTEP program	2	SI/RR	Onsite evaluation done Monthly Random Blinded rechecking (RBRC) done Monthly	
		External quality assurance program implemented for NVBDCP	2	SI/RR		
		External quality assurance under NACP	2	SI/RR		
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2		Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operting procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clincal protocols are displayed	2	OB	Work instruction for Internal Quality control,	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Laboratory has documented process for Collection, handling, transportation of primary sample	2	RR	Look for procedure for transportation of primary sample with specification about time frame, temperature and carrier	
		Laboratory has documented process on acceptance and rejection of primary samples	2	RR		
		Laboratory has documented procedure on receipt, labeling, processing and reporting of primary sample	2	RR		
		Laboratory has documented procedure on receipt, labeling, processing and reporting of primary sample for emergency cases	2	RR		
		Laboratory has documented system for storage of examined samples	2	RR		
		Laboratory has documented system for repeat tests due to analytical failure	2	RR		
		Laboratory has documented validated procedure for examination of samples	2	RR		
		Laboratory has documented biological reference intervals	2	RR		
		Laboratory has documented critical reference values and procedure for immediate reporting of results	2	RR		
		Laboratory has documented procedure for release of reports including details of who may release result and to whom	2	RR		
		Laboratory has documented internal quality control system to verify the quality of results	2	RR		
		Laboratory has documented External Quality assurance program	2	RR		
		Laboratory has documented procedure for calibration of equipments	2	RR		
		Laboratory has documented procedure for validation of results of reagents ,stains , media and kits etc. wherever required	2	RR		
		Laboratory has documented system of resolution of complaints and other feedback received from stakeholders	2	RR		
		Laboratory has documented procedure for examination by referral laboratories	2	RR		

		Laboratory has documented system for storage, retaining and retrieval of laboratory records, primary sample, Examination sample and reports of results.	2	RR		
		Laboratory has documented system to control of its documents	2	RR		
		Laboratory has documented procedure for preventive and break down maintenance	2	RR		
		Laboratory has documented procedure for internal audits	2	RR		
		Laboratory has documented procedure for purchase of External services and supplies	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
		Advance quality improvement method	2	SI/OB	Six sigma, lean.	
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analyzed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	No. of HIV test done per 1000 population	2	RR		
		No. of VDRL test done per 1000 population	2	RR		
		No. of Blood Smear Examined per 1000 population	2	RR		
		No. of AFB Examined per 1000 population	2	RR		
		No. of HB test done per 1000 population	2	RR		
		Lab test done per patients in 100 OPD	2	RR		
		Lab test done per patients100 IPD	2	RR		
		Percentage of lab test done at night	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	No of test not matched in validation	2	RR		
		Percentage of test not matched in Split test	2			
		VIS / Z scores or equivalent	2		Biochemistry & haematology	
		Down time of critical equipments	2			
		Turn around time for emergency lab investigations	2			
		Turn around time for routine lab investigations	2	RR		
		Lab test done per technician	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	% of critical values reported within one hour	2	RR		
		No of adverse events per thousand patients	2	RR		
		Test demography	2	RR	Proportion of Haematology, biochemistry, serology, Microbiology, cytology, clinical pathology	
		Report correlation rate	2	RR	Proportion of lab report co related with clinical examination	
		Proportion of false positive /false negative	2	RR	For Rapid diagnostic Kit test	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Waiting time at sample collection area	2	RR		
		Number of stock out incidences of reagents	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Radiology Department			16
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Radiology Score Card

Area of Concern wise Score			Radiology Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference no.	ME Statement	Checkpoint	Compliance Full/Partial/No	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	**Facility Provides Curative Services**					
ME A1.14	Services are available for the time period as mandated	All radiology services are available in routine working hours	2	SI/RR		
		Emergency radiology services are available for selected procedure 24X7	2	SI/RR	Check for: 1. Radiological services are available at night 2. Look for number of radiology test performed at night	
Standard A2	**Facility provides RMNCHA Services**					
ME A2.2	The facility provides Maternal health Services	Availability of USG services for Pregnant women	2	SI/OB		
Standard A3	**Facility Provides diagnostic Services**					
ME A3.1	The facility provides Radiology Services	Availability of X ray services	2	SI/OB	for chest, bones, skull, spine and abdomen.	
		Availability of special radio graph services	2	SI/OB	Barium Swallow, Barium enema, Barium meal, MMR (Miniature mass radiography) Chest, IVP, Mammography, C-arm	
		Availability of Dental X ray Services	2	SI/OB	Radio-vision-Graph (RVG) Digital dental X-ray, OPG services	
		Availability of ultrasound services	2	SI/OB	Pre natal diagnostic procedure: Ultrasonography with colour doppler, Fetoscopy	
		Availability of CT scan facility	2	SI/OB		
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed	
		Display of PNDT Notice at USG	2	OB	Notice in local language is displayed at entrance of USG department that All persons including the employer, employee or any other person associated with department shall not conduct or associate with or help in carrying out detection or disclosure of sex of foetus in any manner	
		Display of cautionary signage outside the X ray department	2	OB	Radiation hazard sign and caution for pregnant women and children	
ME B1.2	The facility displays the services and entitlements available in its departments	List of services available are displayed at the entrance	2	OB		
		Timing for taking X ray and collection of reports are displayed outside the X ray department	2	OB		
ME B1.4					DELETED	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Reports are provided to Patient in proper printed format	2	OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**					
ME B2.1	Services are provided in manner that are sensitive to gender	Female attendant should accompany female patients during radiological procedures	2	OB/SI		
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Check the availability of ramp in OPD/ X ray room	2	OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	X ray department has provision of privacy while taking X ray.	2	OB		
		USG department has provision of privacy while taking sonography	2	OB	provision of screen	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Radiology has system to ensure the confidentiality of the reports generated	2	RR/SI	Radiology staff do not discuss the lab result outside. And reports are kept in secure place	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI		
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					

ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Form F for USG under PNDT maintained for scan of pregnant woman	2	RR		
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free Diagnostic tests are available as per entitlement	2	PI/SI	Pregnant women, Infant and Children	
ME B5.3					DELETED	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Tests are free of cost for BPL patients	2	PI/SI		Aplicable to all
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Cashless investigation by empanelled lab for JSSK beneficiaries for test not available within the facility	2	PI/SI/RR		
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Room Size of X ray unit is as per AERB safety code	2	OB	The room housing X -ray equipment have appropriate area to facilitate easy movement of staff & proper patient positioning.	
		Availability of adequate waiting area	2	OB		
ME C1.2	Patient amenities are provide as per patient load	Attached toilet facility available	2	OB	For USG	
		Waiting area with sitting facility	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions	Entrance of X ray room is as per AERB layout guidelines	2	OB	Preferably one entrance with door having hydraulic mechanism to ensure that it is closed during procedure	
		Opening for Ventilation and natural light has been provided in X ray room as per AERB layout guidelines	2	OB	Windows should be above 2m from finished floor level outside the x ray. If no then shielding is provided is provided on the window up to 2 m	
		Positioning of chest stand as per AERB layout guidelines	2	OB	The chest stand should be located opposite to entrance door and control console	
		Positioning of control console as per AERB layout guidelines	2		Control console should be positioned as far away as possible from the X ray tube.	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for movement of trolleys and stretchers	2	OB	2-3 meters	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	No of X ray machines as per load	2	OB	Check for the adequacy X-ray machines as per load	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods and services	2	OB	No cris cross in the movement patient traffic and services flow Should be near emergency department	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	X-ray - does not have temporary connections and loosely hanging wires	2	OB	Switch Boards other electrical installation are intact	
		Adequate electrical socket provided for safe and smooth operation of lab equipment	2	OB		
		Stabilizer is provided for X-ray machine	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Radiology department are non slippery and even	2	OB		
		Positioning of mobile protective barrier as AERB layout guidelines	2	OB	Mobile protective barrier should to positioned in such as manner that the operator is completely shielded during exposure	
		Thickness of walls at X room are as AERB layout guidelines	2	OB/RR	The thickness is appropriate taking into consideration of (1) Distance from centre of patient table (2) type of shielding material (brick, concrete, steel, lead or any other material)	
		X ray department should not be located adjacent to patient care area	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Radiology has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	Radiology department has installed fire Extinguisher that is Class A , Class B C type or ABC type	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Radiologist	2	OB/RR	100-200 -1 200-400- 2 >400 - 3	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Radiographer	2	SI/RR	100-2, 200-3, 300-5, 400-7, 500-9	
ME C4.5	The facility has adequate support / general staff	Availability of housekeeping staff	2	SI/RR		
		Availability of security staff	2	SI/RR		
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.2	The departments have adequate consumables at point of use	Availability Consumables	2	OB/RR	X ray films, Developer, Fixer, USG gel, printing paper	
		Availability of personal protective equipment	2	OB/RR	Mobile protective barrier, Lead apron, Rubber hanging flaps, hand glove, lead shields.	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained	2	OB/RR		
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	TLD badges	TLD badges for all the technician
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of functional X-ray machines	2	OB	300 MA X ray machine & 100 MA X ray machine	
		Availability of functional Dental X-Ray Machine	2	OB	Radio-Visio-Graph (RVG) – digital dental X-Ray, Orthopantomogram (OPG)	
		Availability of functional Ultrasonography	2	OB	2 one general purpose & one for Obstetric purpose	
		Availability of functional Portable X-ray Machine	2	OB	60 MA X ray machine (Mobile)	
		Availability of functional CT-scan machine	2	OB		
		Availability of Accessories for X ray	2	OB	Cassettes X ray, Intensifying screen X ray, Lead letter (A-Z),Letter figures (0-9) and R & L (Manual). Computer, printer, x -ray holder/positioner, (Digital)	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of attachment/ accessories	2	OB	Bucky Stand	
		Availability of fixtures at radiology	2	OB	X-ray View box, Electrical fixture for equipment	
		Availability of furniture	2	OB	rack and cupboard , Chair table	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2		Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Daksha checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2		Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Training on radiation safety	2	SI/RR		
		Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Patient Safety	2	SI/RR		
		Basic Life Support	2	SI/RR		

		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Radiographers are skilled to operating equipment	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
Area of Concern - D Support Services						
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired	2	OB/RR		
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR		
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator	2	SI/RR		
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR		
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	2	OB/ RR		
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions and factor charts are available with the equipments	2	OB/SI		
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of X ray films, fixer and developers etc.	2	SI/RR	Stock level are daily updated Indent are timely placed	
ME D2.3	The facility ensures proper storage of drugs and consumables	There is separate storage area for undeveloped X ray films and personal monitoring devices	2	OB/RR	Check the storage area and its condition	
		X ray films/ Fixers, developer and consumables are kept away from water and sources of heat, direct sunlight	2		Storage condition - Kept away from direct sunlight, not in contact with damp wall, water, etc	
ME D2.4	The facility ensures management of expiry and near expiry drugs	No expired consumables is found	2	OB/RR	X ray films, USG jelly, contrast media, plate cleaner (fixer & developer - manual)	
		Records for expiry and near expiry are maintained	2	RR	Check the record of expiry and near expiry drug in drug sub store and are regular update	
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculation and maintaining buffer stock	2	SI/RR	X ray films, USG jelly, contrast media, plate cleaner, print paper roll (fixer & developer - manual)	
		Department maintained stock register in X ray & USG	2	RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procedure for replenishing drug tray /crash cart	2	SI/RR		
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at work station at X ray room	2	OB		
		Adequate illumination at workstation at USG	2	OB		
ME D3.2	The facility has provision of restriction of visitors in patient areas	Only one patient is allowed one time at X room	2	OB		
		Warning light is provided outside X ray room and its been used when unit is functional	2	OB/SI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Protective apron and gloves are being provided to relative of the child patient who escort the child for X ray examination/ immobilisation support is provided to children	2	OB/SI		
		X ray room has been kept closed at the time of radiation exposure	2	OB		
		Lead apron and other protective equipment's are available with radiation workers and they are using it	2	OB	Check TLD batch is worn below the lead apron	
		TLD badges are available with all staff of X ray department	2	OB	Records of its regular assessment is done by X ray department	
		Temperature control and ventilation in X ray room	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation USG	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the X-ray and USG	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI		
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in Radiology and USG room	2	OB/SI		
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	X ray department has registration from AERB.	2	RR		
		X ray department has layout approval	2	RR		
		X ray department has type approval of equipment with QA test report for X ray machine	2	RR		
		USG department has registration under PCPNDT	2	RR		
		Duplicate copy of Certificate of registration under Form B is displayed inside the department	2	OB		
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement	USG is taken by person Qualified as per PCPNDT	2	RR		
		X ray department has Radiological safety officer (RSO) approved by competent authority	2	RR	X ray department has certification from AERB for any person discharging duties and functions of RSO.	
		Records of submission of Form F to appropriate district authorities	2	RR		
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, technician and support staff adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					

ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient	2	RR		
		Patient demographic details are recorded in radiology/USG records	2	RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during transfer to X-Ray department/ USG room	2	SI/RR		
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	There is procedure for referral of patient for which services can not be provided at the facility	2	RR/SI		
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Radiology/ USG department identify vulnerable patients as per requirement	2	SI/RR	Check there is any system to give them preference for radiographic procedure	
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	Women in reproductive age are asked for pregnancy (LMP)before X-ray	2	OB/SI/RR	Notice in local language is displayed at entrance of X ray department asking every female to inform radiographer/radiologist whether she is likely to be pregnant	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available	2	RR/OB	Printed formats for requisition and reporting are available	
ME E8.6	Register/records are maintained as per guidelines	Radiology records are labelled and indexed	2	RR		
		Records are maintained for radiology	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Radiology has adequate facility for storage of records	2	OB		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
ME E11.5	There is procedure for handling medico legal cases	Procedure for handling of MLC	2	SI/RR	Requisition and reports are marked with MLC and reports are handed over to authorize person	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Requisition of all X ray examination is done in request form	2	RR/OB	Request form contain information: Name and identification number of patient, name of authorized requester, examination requested, type of X ray, date and time of X ray taken and date and time of receipt of X ray from X ray department	
		X ray has system to identify radiographer from who has taken X ray	2	RR/SI		
		X ray department has system in place to label X ray films	2	RR/SI		
		X ray department has system to trace back the recorded X ray film from requisition form	2	RR/SI		
		Records of type of X ray prescribed is made at the time of reception	2	RR/SI		
		Requisition of all USG examination is done in request form	2	RR/OB		
		USG department has system in place to label the USGs	2	RR/SI		
		Preparation of the patient is done as per requirement	2	RR/SI		
		Instructions to be followed by patient for USG are displayed in local language at reception	2	RR/SI		
ME E12.2	There are established procedures for testing Activities	X ray taking and processing procedure are readily available at work station and staff is aware of it	2	OB/RR		
		Necessary Instruction for taking X ray and its processing are displayed at work station in language understood by staff	2	OB/RR		
		X ray department has system in place to take X ray of patients in case of Emergency.	2	RR/SI		
		Radiographer is aware of operation of X ray machine	2	RR/SI		
		Necessary Instruction for USG Examination are displayed at work station in language understood by staff	2	OB/RR		
		USG of the patient is taken as per consultant requirement	2	OB/RR		
		USG department has system in place to take sonograph of patients in case of Emergency.	2	RR/SI		
ME E12.3	There are established procedures for Post-testing Activities	X ray department has format for reporting of results	2	RR/OB		
		X ray department has system to provide the reports within defined time intervals	2	RR/SI		
		USG department has format for reporting of results	2	RR/OB		
		USG report is signed by Radiologist/Sonologist	2	RR/OB		
		USG department has system to provide the reports within defined time intervals	2	RR/SI		
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxoid etc	
		Periodic medical check-ups of the staff	2	SI/RR		
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use along with availability of elbow operated tap	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipment's as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves and Masks.	2	OB/SI		
Standard F4	**Facility has standard Procedures for processing of equipment's and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate the procedure surface stretcher/Trolleys etc. (Wiping with 0.5% Chlorine solution	
		Staff know how to make chlorine solution	2	SI/OB		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipment's like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		

		Segregation of different category of waste as per guidelines	2	OB/SI		
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disposal of Fixer and Developer	2	SI/OB/RR		Facility has digitalised in most of the cases
		Area of Concern - G Quality Management				
Standard G1		**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Radiology	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G2		**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	There is system to take feed back from clinician about quality of services	2	RR		
		Patient satisfaction survey done on monthly basis	2	RR		
Standard G3		**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	Internal quality Assurance program is established in Radiology	2	SI/RR		
		Periodic QA of equipment by AERB authorized agencies	2	SI/RR	QA to be carried out at least once in 2 yrs. and also after any repairs having radiation safety implications	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4		**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work Instructions are displayed for radiation safety	2	OB	Factor chart, radiation safety, development for x-ray films	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for process of taking and handling X ray	2	RR		
		Department has documented procedure for acceptance and rejection of X ray taken	2	RR		
		Department has documented procedure for receipt, labelling , Processing and reporting of X ray	2	RR		
		Department has documented procedure for taking X ray in emergency conditions	2	RR		
		Department has documented procedure for quality control system to verify the quality of results	2	RR		
		Radiology has documented system for repeat X ray.	2	RR		
		Department has documented procedure for storage, retaining and retrieval of department records, and reports of results.	2	RR		
		Department has documented procedure preventive and break down maintenance	2	RR		
		Department has documented procedure for purchase of External services and supplies	2	RR		
		Department has documented procedure for inventory management	2	RR		
		Department has documented procedure for upkeep management of department	2	RR		
		Department has documented procedure for radiation safety of staff , patients and visitors	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5		**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6		**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7		**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
		Advance quality improvement method	2	SI/OB	Six sigma, lean.	
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standard G9		**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria	Check if periodic assessment of Physical and electrical safety risk is done using the risk assessment checklist	2	SI/RR	Verify with the assessment records. Comprehensive of physical and electrical safety should be done at least once in three month	
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
		Area of Concern - H Outcome				
Standard H1		**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	X ray done per 1000 OPD patient	2	RR		
		X ray done per 1000 IPD patient	2	RR		
		Ultrasound done per 1000 OPD patient	2	RR		
		Proportion of X ray done at night	2	RR		
		No. of dental X ray per 1000 dental OPD	2	RR		
		Proportion of BPL Patients screened	2	RR	X-ray, USG	
		Percentage of re-dos in imaging	2	RR	X-ray, USG (reason of image repeating is related to errors, mistakes or image quality)	
Standard H2		**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime for critical equipment	2	RR		
		Turn around time for X-Ray film development	2	RR		
		Proportion of waste of films	2	RR		
		Proportion of X ray rejected/repeated	2	RR		

		X ray done per radiographer	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Proportion of X rays for which report is signed by radiologist	2	RR		
		Proportion of scans for which F form is filled out of pregnant women scanned	2	RR		
		Examination Demography	2	RR	Proportion of General, Chest examination and specialised examination	
		Report correlation rate	2	RR	Proportion of radiology report co related with clinical examination/laboratory reports out of Total X ray reported	
		No of adverse events per thousand patients	2	RR		
		No of events of over limit of radiation exposure	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Average waiting time at radiology	2	RR		
		Average waiting time at USG	2	RR		
		Number of stock out incidences of x ray films	2	RR		

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Checklist for Pharmacy Department			17
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Pharmacy Score Card

Area of Concern wise Score			Pharmacy Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No	ME Statement	Checkpoint	Compliance Full/Partial/No	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.14	Services are available for the time period as mandated	Dispensary services are available in OPD hours	2	SI/RR		
		Facility ensure access to medicine store after OPD hours	2	SI/RR		
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme					
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of medicines under NVBDCP	2	SI/OB	Chloroquine, Primaquine, ACT (Artemisinin Combination Therapy)	
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Availability of medicines under NTEP	2	SI/OB		
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of medicines under NLEP	2	SI/OB	Rifampicin, Clofazimine, Dapsone	
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Availability of ARV medicines under NACP	2	SI/OB	Zidovudine, Stavudine, Lamivudine, Nevirapine in combination as per NACO	
		Availability of medicines for Paediatric HIV management	2	SI/OB	Paediatric Dosages FDC 6, FDC 10, Efavirenz, Cotrimoxazole	
Standard A5	Facility provides support services					
ME A5.6	The facility provides pharmacy services	Dispensing of Medicines and consumables for OPD Patients	2	SI/OB	Functional dispensary	

		Storage of medicines	2	SI/OB		
		Cold chain management services	2	SI/OB		
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages are displayed for easy access to Pharmacy/Generic medicine store	2	OB	Numbering, main department and internal sectional signage are displayed	
ME B1.2	The facility displays the services and entitlements available in its departments	Status of availability of medicines is updated daily	2	OB		
		Timing for dispensing counter of pharmacy are displayed	2	OB		
ME B1.4					DELETED	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of separate Queue for Male and female at dispensing counter	2	OB		
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Pharmacy has easy access for moment of goods	2	OB	Check for availability of ramp and goods trolley/ cart	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI		
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Method of Administration /taking of the medicines is informed to patient/ their relative by pharmacist as per doctors prescription in OPD Pharmacy	2	OB/SI		
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re addressal and whom to contact is displayed	2	OB		
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free medicines and consumables for all	2	PI/SI	JSSK, RBSK & PMJAY beneficiaries	
ME B5.2	The facility ensures that medicines prescribed are available at Pharmacy and wards	Pharmacy provides generic medicine list to all hospital department	2	SI/OB		
ME B5.4					DELETED	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Local purchase of stock out medicines/ Reimbursement of expenditure to the beneficiaries	2	PI/SI/RR		
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Hospital has allocated space for Pharmacy in OPD	2	OB	Minimum space required is 250sq F or 5% of average OPD X 0.8 sq m.	
		Dispensary has adequate waiting space as per load	2	OB		
ME C1.2	Patient amenities are provide as per patient load	Pharmacy has patients sitting arrangement as per requirement	2	OB		
		Dispensary counter has provision of shade	2	OB	If it is outside the hospital building	
ME C1.3	Departments have layout and demarcated areas as per functions	Dedicated area for keeping medical gases	2	OB		Manifold area
		Dedicated area for keeping inflammables	2	OB	Storage of sprit etc.	
		Demarcated are of keeping near expiry medicines	2	OB		
		Demarcated are of keeping expired medicines	2	OB		
		Demarcated area for keeping instruments and consumables	2	OB		
		Dedicated area for cold chain management	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff , medicines and carts	2	OB		
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	Adeqauate No of medicine dispensing counter as per load	2	OB		
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods in the Pharmacy .	2	OB	Receipt and Inspection area at one side and issue area on the other side	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	Pharmacy does not have temporary connections and loosely hanging wires	2	OB		
		Stabilizer is provided for cold chain room	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Windows of medicine store have grills and wire meshwork	2	OB		
		Floors of the Pharmacy department are non slippery and even	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Pharmacy has plan for safe storage and handling of potentially flammable materials.	2	OB/SI		
		Department has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB		
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB		
ME C3.2	The facility has adequate fire fighting Equipment	Pharmacy has installed fire Extinguisher that is Class A , Class B C type or ABC type	2	OB/RR		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Pharmacist	2	SI/RR		
ME C4.5	The facility has adequate support / general staff	Availability of security staff	2	SI/RR		
Standard C5	**Facility provides medicines and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate medicines at point of use	Non-opioid Analgesic, Anti-Pyretic and Nonsteroidal Anti-Inflammatory Medicines	2	OB/RR	As per DG-ESIC LIST	
		Anti-infective medicines - Antibiotics, Antifungal, Antiamoebic	2	OB/RR	As per DG-ESIC LIST	
		Antiseptic Liquid/Cream/lotion	2	OB/RR	As per DG-ESIC LIST	

		Solution Correcting Water, Electrolyte Disturbances and Acid-Base Disturbances and plasma expenders	2	OB/RR	As per DG-ESIC LIST	
		Anti-Allergic and Medicines used in Anaphylaxis	2	OB/RR	As per DG-ESIC LIST	
		Medicines acting on Digestive system - Anti Diarrhoeal, Anti-Ulcer, Anti - Emetic, Anti Constipation, Anti-Inflammatory	2	OB/RR	As per DG-ESIC LIST	
		Antidote and other Substances used in Poisoning	2	OB/RR	As per DG-ESIC LIST	
		Immunosuppressive Medicines	2	OB/RR	As per DG-ESIC LIST	
		Pain and Palliative Care Medicines	2	OB/RR	As per DG-ESIC LIST	
		Opioid Analgesic Medicines	2	OB/RR	As per DG-ESIC LIST	
		Medicines Affecting Blood	2	OB/RR	As per DG-ESIC LIST	
		Dermatological medicines (Topical)	2	OB/RR	As per DG-ESIC LIST	
		Ear, Nose and Throat (ENT) Medicines	2	OB/RR	As per DG-ESIC LIST	
		Dental Restorative Materials and Medicines	2	OB/RR	As per DG-ESIC LIST	
		Ophthalmological Medicines	2	OB/RR	As per DG-ESIC LIST	
		Availability of psychotherapeutic medicines	2	OB/RR	As per DG-ESIC LIST	
		Medicines acting on Cardiovascular system	2	OB/RR	As per DG-ESIC LIST	
		Medicines acting on Central/Peripheral Nervous system	2	OB/RR	As per DG-ESIC LIST	
		Medicines acting on Respiratory system	2	OB/RR	As per DG-ESIC LIST	
		Medicines acting on Urogenital system	2	OB/RR	As per DG-ESIC LIST	
		Medicines used on Obstetrics and Gynaecology	2	OB/RR	As per DG-ESIC LIST	
		Hormonal preparation and other Endocrine Medicines	2	OB/RR	As per DG-ESIC LIST	
		Immunological/Vaccine medicine and logistics	2	OB/RR	As per DG-ESIC LIST	
		Surgical accessories for Eye	2	OB/RR	As per DG-ESIC LIST	
		Vitamins, Mineral and nutritional supplement	2	OB/RR	As per DG-ESIC LIST	
		Dialysis Solution	2	OB/RR	As per DG-ESIC LIST	
		Prophylactic Iron, folic acid and deworming	2		As per DG-ESIC LIST	
ME C5.2	The departments have adequate consumables at point of use	Availability of Consumables	2	OB/RR	As per DG-ESIC LIST	
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.5	Availability of Equipment for Storage	Availability of Equipment for maintenance of Cold chain	2	OB	ILR, Deep Freezers, Insulated carrier boxes with ice packs, refrigerator	
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Storage furniture for medicine store	2	OB	Racks ,Cupboards, Sectional Drawer cabinet/ Shelves, Work table	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2		Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2		Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Inventory management	2	SI/RR		
		Cold chain management of ILR and deep freezer	2	SI/RR		
		Rational use of medicines	2	SI/RR		
		Prescription Audit	2	SI/RR		
		Patient Safety	2	SI/RR		
		Basic Life Support	2	SI/RR		
		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for estimation of the requirement and proper storage of the medicines	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for maintaining pharmacy records and bin cards	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR	Calibration of thermometers at cold chain room	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions for ILR/ Deep Freezers are available at cold chain room	2	OB/SI		
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines in pharmacy and patient care areas**					
ME D2.1	There is established procedure for forecasting and indenting medicines and consumables	Medicine store has process to consolidate and calculate the consumption of all medicines and consumables	2	RR/SI		
		Forecasting of medicines and consumables is done	2	RR/SI	Scientifically based on consumption pattern, disease prevelence, seasonality	
		Staff is trained for forecast the requirement using scientific system	2	RR/SI		
ME D2.2	The facility has establish procedure for procurement of medicines	Facility has a established procedures for local purchase of medicines in emergency conditions	2	RR/SI	10% of total budget	
		Hospital has system for placing requisition to district medicine store	2	RR/SI		
ME D2.3	The facility ensures proper storage of medicines and consumables	There is allocated place to store medicines in Pharmacy and medicine store	2	OB		
		All the shelves/racks containing medicines are labelled in pharmacy and medicine store	2	OB	Stock is arranged neatly in alphabetic order/ Therapeutic category with name facing the front and expiry date	
	LASA DRUGS	Medicines of similar name and multiple strength are stored separately	2	OB	E.g. Montelukast 5mg, Montelukast 10mg	LASA
		Heavy items are stored at lower shelves/racks	2	OB	Syrup cartons, reagents cartons are kept at the lower shelves	
		Fragile items are not stored at the edges of the shelves.	2	OB	Syrup bottles, glass ampoules, vials are not stored at the edge of the rack	
		Look Alike and Sound alike medicines are stored separately in patient care area and pharmacy	2	OB	LASA medicines kept away from their identical one in look or sound. Tall Man lettering method used for identification/labelling of LASA	
		High alert medicines are stored separately in patient care area and pharmacy	2	OB	High alert medicines are stored separately and labelled	

		There is separate shelf /rack/area for storage near expiry, expired, NSQ medicines in the drug store	2	OB		
		Pharmacy has system of inventory Management	2	OB/SI	DVDMS, E-Aushadhi, etc.	
		Medicines and consumables are stored away from water and sources of heat, direct sunlight, etc.	2	OB/RR	Medicines that are considered light-sensitive are stored in closed drawers.	
		Medicines are not stored at floor and adjacent to wall	2	OB	Pallets are provided if required to store at floor	
ME D2.4	The facility ensures management of expiry and near expiry medicines	Dispensing counter has system to check the expiry of medicines	2	RR/SI		
		Medicine store has system to check the expiry of medicines	2	RR/SI	DVDMS, E-Aushadhi, etc.	
		Medicine store has system to inform the patient care areas about near expiry/expired medicines	2	RR/SI		
		There is a system of periodic random quality testing of medicines	2	RR/SI		
ME D2.5	The facility has established procedure for inventory management techniques	Physical verification of inventory is done periodically	2	RR/SI	Stock audit sheet	
		Facility uses bin card system	2	RR/OB	Bin cards are used for each medicines and are updated regularly	
		First Expiry First Out (FEFO) System is established for medicines	2	OB	Storage - Near expiry medicines are stored in front and long expiry medicines are kept in back.	
		Stores has defined minimum stock for each category of medicine as per there consumption pattern	2	RR/OB	Minimum quantity/stock level of each category of drug is defined. E.g. Paracetamol 500mg 100 strips, etc.	
		Reorder level is defined for each category of medicines	2	RR		
		Medicine store has supply chain software for the management of innventory	2	OB/RR	DVDMS, E-Aushadhi, etc.	
		Medicines are categorized and stored	2	OB/RR	Medicines are stored and categorized in the store's shelves as per their consumption (Vital, Essential and Desirable, Fast Moving, slow moving)/ Alphabetically/Therapeutic category, etc.	
ME D2.6	There is a procedure for periodically replenishing the medicines in patient care areas	Hospital has established system to take medicines from store in case of emergency or if required urgently	2	RR/SI		
ME D2.7	There is process for storage of vaccines and other medicines, requiring controlled temperature	Check vaccines are kept in sequence	2	OB	(Top to bottom) : Hep B, DPT, DT, TT, BCG, Measles, OPV	
		Work instruction for storage of vaccines are displayed at point of use	2	OB		
		ILR and deep freezer have functional temperature monitoring devices	2	OB		
		There is system in place to maintain temperature chart of ILR	2	OB	Temp. of ILR: Min +2°C to 8°c in case of power failure min temp. +10°C . Twice a day temperature log are maintained	
		There is system in place to maintain temperature chart of deep freezers	2	OB	Temp. of Deep freezer cabinet is maintained between -15°C to -25°C. Twice a day temperature log are maintained	
		Check thermometer in ILR is in hanging position	2	OB		
		ILR and deep freezer has functional alarm system	2	SI/RR		
		Staff is aware of Hold over time of cold storage equipments	2	SI/RR		
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic medicines	Narcotic medicines are kept separetly in double lock	2	OB	As per Narcotic Drugs and Psycotropic Substances (NDPS) Act and Rules, Narcotic medicines are kept in double lock.	
		Empty ampoules/strips are returned along with narcotic administration detail sheet	2	OB/RR	Consumption of Narcotic drugs & psychotropic substances (NDPS) drugs by the wards and return back to the pharmacy	
		Hospital has system to discard the expired narcotic medicines	2	RR/SI	Discarded narcotic medicines are documented with witness.	
		Facility maintains the list of narcotic and psychotropic medicines available at facility	2	RR	List of NDPS drugs are maintained	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at medicine store	2	OB		
		Adequate Illumination at dispensing counter	2	OB		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in pharmacy	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at pharmacy	2	OB		
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the Pharmacy and medicine store	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in Pharmacy	2	OB/SI		
		Availability of power back for cold chain	2	OB/SI		
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	License for storing spirit	2	RR		
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Pharmacist adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					

ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E6	**Facility ensures rationale prescribing and use of medicines**					
ME E6.1	Facility ensured that medicines are prescribed in generic name only	Medicines are purchased in generic name only	2	RR/SI		
		Facility has essential medicine list as per State guideline(To substitute with ESIC guidelines)	2	OB		
		Facility provide list of medicines available to different departments as per essential medicine list	2	RR/SI		
		Facility has enabling order from state(MOLE/ESIC) for writing medicines in generic name only	2	RR/SI		
		There is system of conducting periodic prescription audit to ensure that only generic medicines are prescribed	2	RR/SI		
ME E6.2	There is procedure of rational use of medicines	Hospital has its own medicine formulary based on EML(ESIC)	2	RR/SI		
		medicine formulary is available with doctors and nurses/ clinical table	2	RR/SI		
		Hospital has system to review the medicine formulary as per EML(ESIC) at defined intervals	2	RR/SI		
		Hospital has system to review the prescription as per medicine formulary and STG	2	RR/SI		
Standard E7	**Facility has defined procedures for safe medicine administration**					
ME E7.1	There is process for identifying and cautious administration of high alert medicines	Pharmacy has list of high risk medicines are available	2	RR/SI		
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available	2	RR/OB	Bin cards, indent forms etc	
ME E8.6	Register/records are maintained as per guidelines	Pharmacy records are labeled and indexed	2	RR		
		Records are maintained for Pharmacy	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Pharmacy has adequate facility for storage of records	2	OB		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxid etc	
		Periodic medical checkups of the staff	2	SI/RR		
ME F1.6	Facility has defined and established antibiotic policy	Check for Pharmacist are aware of Hospital Antibiotic Policy	2	SI/RR		
		Pharmacist check the antibiotic consumption periodically	2	SI/RR		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of expired or discarded medicines in Yellow Bin	2		Pharmaceutical waste like antibiotics, cytotoxic medicines including all items contaminated with cytotoxic medicines along with glass or plastic ampoules, vials etc.	
		There is no mixing of infectious and general waste	2	OB		
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disposal of expired medicines as per state guidelines	2	SI/OB	Either sent back to manufacturer or disposed by incineration	
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Pharmacy	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G2	**Facility has established system for patient and employee satisfaction**					
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	Patient satisfaction survey done on monthly basis	2	RR		
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1	Facility has established internal quality assurance program at relevant departments	Physical verification of the inventory by Pharmacist/hospital manager at periodic intervals	2	SI/RR		
ME G3.2	Facility has established external assurance programs at relevant departments	Periodic and random sampling of the medicines for Quality Assurance	2	SI/RR	By medicine controller/State medicine quality Assurance	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality improvement (PDCA) project report	
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed	2	OB	Work instruction for storing medicines, Cold chain management	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for indent the medicines and items from district medicine warehouse	2	RR		
		Department has documented procedure for local purchase of medicines/ generic medicine stores	2	RR		
		Department has documented procedure for reception and storage of medicines and items	2	RR		
		Department has documented procedure for maintaining near expiry medicines at store and pharmacy and disposal of expired medicines	2	RR		
		Department has documented procedure for dispensing of medicines at Pharmacy	2	RR		

		Department has documented procedure of indenting the medicines to patient care area	2	RR		
		Department has documented procedure for issue of the medicines in emergency condition	2	RR		
		Department has documented procedure for maintenance of temperature of ILR/Deep freezer /refrigerators	2	RR		
		Department has documented procedure for storage of narcotic and psychotropic medicines	2	RR		
		Department has documented system for periodic random check and quality testing of medicines	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
		Advance quality improvement method	2	SI/OB	Six sigma, lean.	
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
ME G9.8	Risks identified are analyzed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	Percentage of medicines available against essential medicine list for OPD	2	RR		
		Percentage of medicines available against essential medicine list for IPD	2	RR		
		Expenditure on medicines procured throughlocal purchase for BPL patient	2	RR		
		Percentage of medicines procured locally	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Number of stock out situations in Vital category medicines	2	RR		
		% of medicines expired during the months	2	RR		
		Number of stock out medicines against EML	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Proportion of prescription found prescribing non generic medicines	2	RR		
		No of adverse medicine reaction per thosuand patients	2	RR		
		Antibiotic rate	2	RR	No. of antibiotic prescribed /No. of patient admiited or consulted	
		Percentage of irrational use of medicines/overprescription (Who will decide about rational or irrational)	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Turn Around time for dispensing medicine at Pharmacy	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Auxillary Services			18
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Auxillary Services Score Card

	Area of Concern wise Score		Auxillary Services Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference no	ME Statement	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A5	Facility provides support services					
ME A5.1	The facility provides dietary services	Availability of operational Kitchen	2	SI/OB	Functional Kitchen within the premise of the hospital	
ME A5.2	The facility provides laundry services	Availability of functional laundry	2	SI/OB	Arrangement of laundry services inhouse or outsourced	
ME A5.3	The facility provides security services	Availability of functional security services 24 X7	2	SI/OB		
ME A5.4	The facility provides housekeeping services	Availability of Housekeeping services 24X7	2	SI/OB		
ME A5.5		Availability of waste disposal services	2	SI/OB	Arrangement for disposal of Bio medical and general waste Inhouse or outsouced	
ME A5.6	The facility ensures maintenance services	Availability of maintenance services 24X7	2	SI/OB	Includes Physical infrastructure maintenance and equipment maintenance	
ME A5.8	The facility has services of medical record department	Availability of Medical record department	2	SI/OB		
	Area of Concern - B Patient Rights					
Standard B1	Facility provides the information to care seekers, attendants & community about the available services and their modalities					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental and directional signage for support service department	2	OB	Internal sectional signage are displayed	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Medical records are provided to patient/ Next to kin on request	2	RR/OB		
Standard B3	The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.					
ME B3.2	Confidentiality of patients records and clinical information is maintained	MRD has system to maintain Confidentiality of patient records	2	SI/RR	Patient records are not shared except the patient until it is authorized by law	

ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI		
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Availability of free diet	2	PI/SI		
ME B5.4					DELETED	For all patients
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization	Check hospital administration has defined protocols for data sharing	2		Check list of agencies with which data shared has routinely shred has been prepared . For any other agency a formal permission is sought from competent authorities before sharing the data including international agencies, press and NGOs.	
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research	Check hospital ensures that informed consent is taken from patient participating in any clinical or public Health research	2		Check for policy or practice	Applicable for Medical colleges and hospital running DNB cc
ME B6.9	There is an established procedure to issue of medical certificates and other certificates	Check hospital has documented policy for issuing medical certificates	2		Check for policy defines List of certificates can be issued by hospital Who can issue certificates Formats shall used for different certificates Record keeping of issued certificate procedures for issuing duplicate certificates	
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Dietary Department has adequate space as per requirement	2	OB		
		Laundry Department has adequate space as per requirement	2	OB	Minimum space requirement 10sq ft/bed	
		Medical record Department has adequate space as per requirement	2	OB	Minimum space requirement is 2.5 to 3,5 sq ft per bed	
ME C1.3	Departments have layout and demarcated areas as per functions	Check Dietary department has demarcated and dedicated area for various activities	2	OB	Layout as per functional flow that is receipt, storage, daily storage, preparation, Cooking area ,Service area, dish washing area, Garbage collection area and administrative area.	
		Check laundry department has demarcated and dedicated area for its various activities	2	OB	Layout as per functional flow that is from dirty end (receipt) to clean end (Issue). That is receipt, sorting, sluicing, washing, drying, ironing and issue	
		Availability of complaint box and display of process for grievance redressal and whom to contact is displayed	2	OB	Layout as per functional flow that is receipt, checking of completion of records, indexing and filling of records, storage.	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff , goods and food trolley in dietary department	2	OB		
		Availability of adequate circulation area for easy moment of staff, equipments and carts in laundry	2	OB		
		Availability of adequate circulation area in MRD	2	OB		
ME C1.5	The facility has infrastructure for intramural and extramural communication	All support services department are connected with intercom	2	OB		
ME C1.6	Service counters are available as per patient load	Unidirectional flow of goods and services in dietary services	2	OB		
		Unidirectional flow of goods and services in laundry services	2	OB		
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1					DELETED	
ME C2.3	The facility ensures safety of electrical establishment	Support services departments does not have temporary connections and loosely hanging wires	2	OB		
		Equipments in wet areas like Laundry and Kitchen are equipped with ground fault protection and designed for wet conditions	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Support services are non slippery and even	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster**					
ME C3.1	The facility has plan for prevention of fire	Building has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB/SI	dietary department laundry and Medical record department	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB	dietary department laundry and Medical record department	
		Dietary Department has plan for safe storage and handling of potentially flammable materials.	2	OB	Dietary Department	
ME C3.2	The facility has adequate fire fighting Equipment	Support services has installed fire Extinguisher that is Class A , Class B C type or ABC type are installed in adequate number at every strategic points	2	OB/RR	dietary department and Medical record department	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR	dietary department and Medical record department	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Dietician	2	SI/RR		
		Availability of MRD technician	2	SI/RR		
ME C4.5	The facility has adequate support / general staff	Availability of washer man(Landary personnel)	2	SI/RR	In-house/Out-sourced	
		Availability of Cook	2	SI/RR	In-house/Out-sourced	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.2	The departments have adequate consumables at point of use	Availability of consumables at dietary department	2	OB/RR	Cap, gowns, gloves, Detergent for cleaning of utensil and Soap for hand washing	
		Availability of consumables at laundry department	2	OB/RR	Detergent and disinfectant, Heavy utility gloves, apron.	

Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.6	Availability of functional equipment and instruments for support services	Availability of Equipments & utensils for Dietary department	2	OB	Refrigerator, LPG, food trolley and cooking utensils	
		Availability of Equipments for Laundry	2	OB	Washing machine, drier, Iron, Separate trolley for clean and dirty linen	
		Availability of Equipments for Medical record department	2	OB	Computer with scanner	
		Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of furniture and fixtures for Dietary department	2	OB	Exhaust fan, Storage containers, Work bench/slab, Utensil stand	
		Availability of furniture and fixtures for laundry department	2	OB	Stand/ Hanger for drying of linen, Iron table, Cupboard	
		Availability of furniture and fixtures for Medical record department	2	OB	Racks and cupboard, table, Sectional Drawer cabinet/ Shelves,	
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
		Training on Medical record Management	2	SI/RR		
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	MRD Staff is skilled for indexing and storage of Medical records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Laundry staff is skilled for segregating and processing of soiled and infectious linen	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.	2	OB/SI		
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**					
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at Kitchen	2	OB		
		Adequate Illumination at Laundry	2	OB		
		Adequate Illumination at Medical record department	2	OB		
ME D3.2	The facility has provision of restriction of visitors in patient areas	Hospital ensures unauthorised entry into dietary department is not permitted	2	OB/SI		
		Hospital ensures unauthorised entry into Laundry department is not permitted	2	OB/SI		
		Hospital ensures unauthorised entry into Medical record department is not permitted	2	OB/SI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in dietary department	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation in Laundry	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
		Temperature control and ventilation in Medical record Department	2	SI/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB	Dietary department, laundry and medical record department	
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB	Dietary department, laundry and medical record department	
		Window panes , doors and other fixtures are intact	2	OB	Dietary department, laundry and medical record department	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the Diet department	2	OB	Dietary department, laundry and medical record department	
		No condemned/Junk material in the Laundry	2	OB		
		No condemned/Junk material in the MRD	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds/pests	2	OB	Dietary department, laundry and medical record department	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Dietary and laundry department	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up	2	OB/SI	For Laundry, Diet and MRD department	
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**					
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Hospital has defined diet schedule for the patients.	2	RR/SI		

		Hospital has Special diet schedule for the critical ill patients suffering from Heart Disease, Hypertension, Diabetes, Pregnant Women, diarrhoea and renal patients	2	RR/SI		
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	Dietary department has system to calculate the number of diets to be prepared	2	RR/SI		
		Dietary department has procedure for procurement of perishable and non perishable items	2	OB/SI/RR	Time interval for procurement of Perishable and non perishable items is fixed	
		Perishable items are stored in the cold room or refrigerators.	2	OB	Like milk, cheese, butter, egg, vegetables, and fruits	
		Non perishable items are kept in racks/ storage container, in ventilated and rodent proof room	2	OB	All the food items are stored above floor level.	
		Food is prepared by trained staff, ensuring standards practices	2	OB/SI		
		There is a procedure for the distribution of the diet	2	SI/RR	Ensure diet is supplied at defined duration.	
		Distribution of the food is done in covered food trolleys	2	OB		
		Dietary department has system to check the quality of food provided to patient	2	RR/SI	There is designated person preferably nurse in Ward to check the Quality of food	
		Dietary department has procedure to collect and dispose of kitchen garbage at defined interval and place	2	OB/SI		
		There is practice of calculating and maintaining buffer stock in Kitchen	2	SI/RR		
		Department maintained stock and expenditure register in Kitchen	2	RR/SI		
		There is system to replenish raw food material	2	RR/SI		
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.1	The facility has adequate sets of linen	Hospital has sufficient set of linen available per bed	2	RR/SI	at least 5 sets for each functional bed	
		Hospital/ department has inventory of total linen available with category wise distribution in every area	2	RR/SI	Patient, staff and bed linen	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	Linen department has system for Periodic physical verification of linen inventory	2	RR/SI	To check the theft and pilferage	
		Linen department has separate trolley for distribution of clean linen and collection of dirty linen	2	OB		
		Linen are transported into closed leak proof containers /bags	2	OB		
		Infectious and non infectious linen are transported into separate containers / bags	2	OB/RR		
		Linen department has system of sorting of different category of linen before putting in to washing machine	2	OB/RR	Soiled, infected fouled type of linen	
		Linen department has procedure for sluicing of soiled, infected and fouled linen	2	OB/RR		
		Linen department has procedure to keep record of daily load received from each department	2	RR		
		Hospital has system/ designated person to check quality of washed linen	2	RR/SI		
		There is a fix time for collection for dirty linen and supply of clean linen	2	RR/SI		
		There is a system for verifying the quantity of linen received	2	RR/SI		
		There is procedure for condemnation of linen	2	RR/SI		
		There is system to check pilferage of linen from ward	2	RR/SI	Security guards keep vigil	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for Laundry department	2	RR/SI		
		There is designated in charge for Dietary department	2	RR/SI		
		There is designated in charge for MRD department	2	RR/SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Staff is adhere to their respective dress code	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.6	Register/records are maintained as per guidelines	All register/records are identified and numbered	2	RR		
		Diet Registers are maintained at Kitchen	2	RR		
		Laundry registers are maintained at laundry	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Hospital has procedure for collection, Compilation and maintenance of patient's records after discharge	2	RR	Manual/e-records	
		Medical record department has system to check for completion of records	2	RR	Checking the records as per checklist for completion	
		Medical record department has system for ICD coding /indexing the records	2	RR	As per ICD coding / indexing name, disease, diagnosis, physician and surgical procedure carried out	
		Medical record department has system to generate statistics for clinical use	2	RR	Submitting the reports to required health authorities (Birth death notification, notification of communicable diseases etc)	

		Medical record department has system to generate statistics for administrative use	2	RR	Hospital information system	
		Medical record department has system for filling and safe storage of records	2	RR	Give full compliance if system is in place for manual record management OR If the facility has e-records in place, check for 1. Password/finger print protected computer 2. Any restriction/firewall to protect the individual's information from misuse	
		Medical record department has procedure for retention/Preservation of records	2	RR	Retention is as per state guideline	
		Medical record department has procedure for destruction of old records	2	RR		
		Medical records department has system for retrieval of records	2	RR/SI	Give full compliance if system is in place for manual record management OR If the facility has e-records in place, check for 1. System is in place to define who all are authorized to access the patient e-records	
		Medical record department has procedure for production of records in Courts of law when summoned	2	RR/SI	In case of MLC	
		Medical records are issued to authorized personnel only	2	RR/SI	To patient/next kin to patient	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxid etc	
		Periodic medical checkups of the staff	2	SI/RR		
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility in kitchen	2	OB	Preferably in preparation and cooking area along with elbow operated tap	
		Availability of Running Water (Hot and cold)	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of soap with soap dish/ liquid antiseptic with dispenser	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available for distribution of food	2	OB/SI		
		Availability of apron	2	OB/SI		
		Availability of caps	2	OB/SI		
		Availability of Heavy duty gloves for laundry	2	OB/SI		
		Availability of gum boats for laundry	2	OB/SI		
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, caps and aprons.	2	OB/SI		
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Cleaning and decontamination of food preparation surfaces like cutting board	2	SI/OB	Ask the cleanliness and ask staff how frequent they clean it	
		Cleaning of utensils and food trolleys	2	SI/OB	Check the cleanliness and how frequent they clean it	
		Decontamination of heavily soiled linen	2	SI/OB		
		Cleaning of washing equipments	2	SI/OB		
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Proper cleaning of items used for preparation and cooking of food	2	SI/OB		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of routes for clean and dirty items in kitchen	2	OB		
		Facility layout ensures separation of routes for clean and dirty items in laundry	2	OB		
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Surface & fixtures are visibly clean with no dust or debris	2	OB		
		Staff is trained for spill management	2	SI/RR		
		Floors are clean	2	OB		
		No stray animals in the facility/ Patient Care areas	2	OB		
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of different category of waste as per guidelines	2	OB/SI		

		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2	OB		
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of post exposure prophylaxis	2	OB/SI	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disinfection of liquid waste before disposal	2	SI/OB		
		Daily disposal of food waste with general waste	2	SI/OB		
	Area of Concern - G Quality Management					
Standard G1	The facility has established organizational framework for quality improvement					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Auxillary	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G2	Facility has established system for patient and employee satisfaction					
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	Hospital has system to take feed back regarding quality of diet	2	RR		
		Hospital has system to take feed back regarding cleanliness of linen provided	2	RR		
Standard G3	Facility have established internal and external quality assurance programs wherever it is critical to quality.					
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Check for entries in Round Register	
ME G3.2	Facility has established external assurance programs at relevant departments	Kitchen is has system of regular external inspection by Municipal/ FDA(To be reworded) authorities	2	SI/RR		
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5					DELETED	
Standard G4	Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for Dietary and Laundry department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Standard operating procedure for Medical record Department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instruction/clinical protocols are displayed in Dietary and Laundry Department	2	OB		
		Work instruction/clinical protocols are displayed in Medical Record Department	2	OB		
		Work instructions are displayed for hospital cleaniness	2	OB		
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Record Department has documented procedure for indexing, receiving, compiling, maintaining, issuing and retention of the records	2	RR		
		Record department has documented procedure for pest and rodent control	2	RR		
		Diet department has documented procedure for diet schedule, calculation of diet required in wards, procurement of food items	2	RR		
		Diet department has documented procedure for preparation, distribution and disposal of remaining food	2	RR		
		Diet department has documented procedure to check the quality of food provided to the patient	2	RR		
		Diet department has documented procedure for cleaning of kitchen and utensils	2	RR		
		Diet department has documented procedure for checkups of kitchen workers at defined intervals	2	RR		
		Linen department has documented procedure for collection, sorting, cleaning, sluicing of the blood/bidy fluid stained linen and distribution of linen	2	RR		
		Linen department has documented procedure for physical verification of the linen for cleanliness or torn out and condemnation of linen	2	RR		
		Linen department has documented procedure corrective and preventive maintenance of laundry equipments	2	RR		
		Security department has documented procedure for duty hours, control of incoming and outgoing items	2	RR		
		Security department has documented procedure for visiting hours in patient care area	2	RR		
		Security department has documented procedure for fire safety in hospital	2	RR		
		Security department has documented procedure for electrical safety	2	RR		
		Security department has documented procedure for training and drills of security staff	2	RR		
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages					

ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1					DELETED	
					DELETED	
ME G7.2					DELETED	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	No of cases for which medical audit done	2	RR		
		No of cases for which death audit is done	2	RR		
		Linen Index	2	RR	No. of bed sheet washed in a month/Patient bed days in month	
		Diet Index	2	RR	No. of meals provided in the month/no. of times meal served in a day * bed days	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Proportion of maternal deaths audited	2	RR		
		Proportion of newborn deaths audited	2	RR		
		Cycle for laundry services	2	RR	Time elapsed between collection of used linen and receiving clean linen	
		Proportion of special diets	2	RR	No. of special diets (diabetic, hypertensive, semi solid or other diet) in the month*100/tital no. of diets provided in the month	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Medical Audit Score	2	RR		
		Death Audit Score	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Patient feedback on cleanliness of linen	2	RR		
		Patient feedback on quality of food	2	RR		

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Checklist for Mortuary	19

Assessment Summary

Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Mortuary Score Card

Area of Concern wise Score			Mortuary Score
A	Service Provision	100%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No.	ME Statement	Checkpoints	Compliance	Assessment method	Audit Support	Remark
	Area of Concern - A Service Provision					
Standard A1	**The facility provides Curative Services**					
ME A1.14	Services are available for the time period as mandated	Availability of services 24X7	2	SI/RR		
Standard A5	**The facility provides support services**					
ME A5.8	The facility provides mortuary services	Dead bodies are kept till the relatives take over the bodies	2	SI/RR		
		Dead bodies are brought to hospital for medico legal post mortem work	2	SI/RR		
		Unclaimed bodies are kept until disposal is arranged	2	SI/RR		
	Area of Concern - B Patient Rights					
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed	
		Restricted area signage are displayed	2	OB		
ME B1.6	Information is available in local language and easy to understand	Signage's are available in local language and pictorial	2	OB		
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Post mortem records of deceased are issued to police/next kin of deceased as per state guideline	2	OB		
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**					
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services	Religious and cultural preferences of deceased and relatives are taken in to consideration while handling over the body	2	OB/SI		
ME B2.3					DELETED	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	There are arrangements that Post mortem room is not in direct line of sight of general public/ visitors	2	OB	Provision of curtain, screen or buffer area or any other in post mortem room	
ME B3.2					DELETED	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous to deceased relative	2	PI/OB		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV and suicidal cases	2	RR/SI		
	Area of Concern - C Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**					
ME C1.1	Departments have adequate space as per patient or work load	Adequate space to accommodate dead bodies	2	OB		
ME C1.2	Patient amenities are provide as per patient load	Availability of adequate seating arrangement in waiting area	2	OB		
		Availability of Drinking water	2	OB		
		Availability of functional toilets	2			
ME C1.3	Departments have layout and demarcated areas as per functions	Mortuary has morgue freezer for preservation of bodies as per requirement	2	OB		
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors of Mortuary area are wide enough to allow passage of trolleys	2	OB	Not less than 8 ft	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of telephone and Intercom Services	2	OB		
ME C1.6	Service counters are available as per patient load	Availability of deep freezer for storage as per load	2	OB		
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Mortuary has functional linkage with hospital Emergency, OT and IPD etc.	2	OB		
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured	
ME C2.3	The facility ensures safety of electrical establishment	Mortuary building does not have temporary connections and loosely hanging wires	2	OB		
		Adequate electrical socket provided for safe and smooth operation of morgue freezer	2	OB		
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Mortuary are thick, durable and can be easily cleaned	2	OB		
		Window have wire meshwork and intact window panes	2	OB		

		Floors of the Mortuary are non slippery and even	2	OB		
Standard C3	The facility has established Programme for fire safety and other disaster					
ME C3.2	The facility has adequate fire fighting Equipment	Fire Extinguisher that is Class A , Class C type or ABC type are installed in mortuary	2	OB		
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR		
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR		
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load					
ME C4.1					DELETED	
ME C4.4					DELETED	
ME C4.5	The facility has adequate support / general staff	Availability of sweeper (substitute with Housekeeping staff)in Mortuary	2	SI/RR		
		Availability of security staff in mortuary	2	SI/RR		
Standard C5	The facility provides drugs and consumables required for assured services.					
ME C5.2	The departments have adequate consumables at point of use	Repairing Material	2	OB/RR	Thread, needle, cotton wool, wool waste, clothes, malleable wire, polythene bag, gloves, mask and apron	
		Plastic bins	2	OB/RR	for fixing specimens	
Standard C6	The facility has equipment & instruments required for assured list of services.					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	DELETED	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of Cutting Instruments trays	2	OB	DELETED	
ME C6.5	Availability of Equipment for Storage	Availability of Cabinets for storage of dead bodies	2	OB	Refrigerated body storage room, Instrument trolley	
ME C6.6					DELETED	
ME C6.7						
Standard C7	Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff					
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for preservation of dead bodies in the mortuary	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
		Staff is skilled for maintaining post mortem records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
	Area of Concern - D Support Services					
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.					
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.	
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the monitoring equipments are calibrated	2	OB/ RR		
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions for critical equipments are available	2	OB/SI		
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas					
ME D2.5					DELETED	
ME D2.7					DELETED	
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.					
ME D3.1					DELETED	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Hospital ensures unauthorised entry into mortuary is not permitted	2	OB/SI		
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in Mortuary	2	OB/RR	Fans/ Air conditioning/Heating/Exhaust/Ventilators as per environment condition and requirement	
ME D3.4	The facility has security system in place at patient care areas	Hospital has sound security system to manage overcrowding in Mortuary	2	OB		
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI		
Standard D4	The facility has established Programme for maintenance and upkeep of the facility					
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/whitewashed in uniform colour	2	OB		
		Interior of patient care areas are plastered & painted	2	OB		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs	
		Surface of furniture and fixtures are clean	2	OB		
		Toilets are clean with functional flush and running water	2	OB		
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB		
		Window panes , doors and other fixtures are intact	2	OB		
		Post-mortem table is intact and with out rust	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material stored in the mortuary	2	OB		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB		
Standard D5	The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms					
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Availability of water in sinks, washbasin and post mortem table should be fitted with water hose	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in mortuary	2	OB/SI		
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.					
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual	
		Staff is aware of their role and responsibilities	2	SI		
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)	
		There is designated in charge for department	2	SI		
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor and support staff adhere to their respective dress code	2	OB		
Standard D12	The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations					
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/Maintenance) provided are done by designated in-house staff	
	Area of Concern - E Clinical Services					
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage					
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Department has process for storage and retrieval of Medico-legal record	2	RR/SI	MLC case reports etc.	
Standard E11	The facility has defined and established procedures for Emergency Services and Disaster Management					
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR		
		Role and responsibilities of staff in disaster is defined	2	SI/RR		
Standard E16	The facility has defined and established procedures for the management of death & bodies of deceased patients					
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives	2	SI/RR		
ME E16.2	The facility has standard procedures for handling the death in the hospital	The body of deceased is handled with respect and dignity	2	SI/RR/OB		
		Socio-cultural beliefs of patient 's family are identified and respected	2	SI/RR/OB		
		Unclaimed bodies are handled/ handed over, buried or cremated as per applicable laws and regulation	2	SI/RR	All the unclaimed bodies are handled with respect and dignity	
ME E16.3					DELETED	
	Area of Concern - F Infection Control					
Standard F1	The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection					
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxic etc	
		Periodic medical checkups of the staff	2	SI/RR		
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
Standard F2	The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis					
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin and elbow operated tap near the point of use	
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular	
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration	
		Staff aware of when to hand wash	2	SI		
Standard F3	The facility ensures standard practices and materials for Personal protection					

ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Clean gloves are available at point of use	2	OB/SI		
		Availability of Masks	2	OB/SI		
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps and Aprons	
Standard F4	**The facility has standard procedures for processing of equipment and instruments**					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of mortuary table	2	SI/OB	Ask stff about how they decontaminate the mortuary table (Wiping with 0.5% Chlorine solution)	
		Decontamination of instrument after use	2	SI/OB	Ask staff how they decontaminate the instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Staff know how to make chlorine solution	2	SI/OB		
		Sterilization of mortuary equipment	2	SI/OB		
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	High level disinfection by boiling or chemical done as per protocol at mortuary	2	SI/OB		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic	2	OB		
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Gluteraldehye, carbolic acid	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR		
		Cleaning of patient care area with detergent solution	2	SI/RR		
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and solied waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids,dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vaccutainers with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	
		There is no mixing of infectious and general waste	2			
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.	
		Seggregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation.Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done	
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI/OB		
		Disinfection of liquid waste before disposal	2	SI/OB		
		Transportation of bio medical waste is done in close container/trolley	2			
		Staff is aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to lacate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF	
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Mortuary	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality	
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system daily round by Hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services	2	SI/RR	Check for entries in Round Register	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved	2	RR		
		Current version of SOP are available with process owner	2	OB/RR		
		Work instructions are displayed	2	OB	Work Instruction for Dead body storage, receiving and issue of dead body	
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for death in ward and emergency	2	RR		
		Department has documented procedure for receiving, storage and tagging of the body in mortuary	2	RR		
		Department has documented procedure for temperature maintenance and its corrective & preventive maintenance in cold store	2	RR		
		Department has documented procedure for maintenance of records	2	RR		
		Department has documented procedure sending the bodies for autopsy	2	RR		
		Department has documented procedure for hand over the body to deceased relatives	2	RR		
		Department has documented procedure for issuing the records to police and patient relatives	2	RR		
		Department has documented procedure for storage and send the viscera/tissue for further investigation	2	RR		
		Department has documented procedure for cleaning and upkeep of mortuary and post mortem room(Can be deleted)	2	RR		
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR		
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1	The facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2	The facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3	The facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	

ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1	The facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk asesement of all processes should be done using pre define critera at least once in three month.	
	Area of Concern - H Outcomes					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1	Facility measures productivity Indicators on monthly basis	Proportion of non MLC cases	2	RR		
		Occupancy rate of cold storage for dead bodies	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					
ME H2.1	Facility measures efficiency Indicators on monthly basis	Mean storage time for dead body in cold storage	2	RR		
		Down time Cold storage equipments	2	RR		
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Waiting time for carrying out post mortem	2	RR		
		Waiting time for getting post mortem report in MLC cases	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Haemodialysis Centre			20
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Hemodialys Centre Score Card

	Area of Concern Wise Score		Haomodialysis Score
A	SERVICE PROVISION	100%	100%
B	PATIENT RIGHTS	100%	
C	INPUTS	100%	
D	SUPPORT SERVICES	100%	
E	CLINICAL SERVICES	100%	
F	INFECTION CONTROL	100%	
G	QUALITY MANAGEMENT	100%	
H	OUTCOME	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunites for Improvement
1	
2	
3	
4	

5		
	Signature of Assessors	
	Date	

Standard	Measurable elements	Checkpoints	Compliances	Assessment	Mean of verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	**The facility Provides Curative Services**					
MEA1.14	Services are available for the time period as mandated	Dialysis services are available as per time mandate	2	RR/OB/SI	Check for timing of Dialysis centre as per MOU/As per State mandate(to be Reworded to "as per individual hospital protocol)	
ME A1.19	The facility provides Dialysis services	Availability of haemodialysis services	2	RR/OB/SI		
		Availability of services to manage complications during dialysis process	2	RR/OB/SI	1. Hypotension 2. Dialyzer reactions (both anaphylactic reaction and non-specific reaction) 3. Haemolysis 4. Air embolism 5. Seizures 6. Chest pain, MI 7. Arrhythmias 8. Sudden cardiac arrest 9. Nausea, Vomiting 10. Chills, Rigors, Fevers	
		Availability of Nutritional Counselling Services	2	RR/OB/SI	Counselling may be provided by dietician/nephrologist/MO	
Standard A3	**The facility Provides diagnostic Services**					
ME A3.1	The facility provides Radiology Services	Availability of Portable X ray Services	2	OB/SI	Within centre or linkage with the main hospital	
		Availability of USG services	2	OB/SI	Within centre or linkage with the main hospital	
ME A3.2	The facility Provides Laboratory Services	Availability of lab services	2	OB/SI	Within centre or linkage with the main hospital for: Heamogram, Iron study, LFT, KFT, Hb1Ac, Viral Marker, Vit D	
		Availability of Point of care diagnostic devices	2		Hb, Blood Sugar, Blood Group, HIV, HbsAg(HBV)	
ME A3.3	The facility provides other diagnostic services, as mandated	Functional ECG Services are available	2	OB/SI	Within centre and staff should be trained to operate ECG machine	
Standard A4			**2**			
ME A4.13	The facility provide services as per Pradhan Mantri National Dialysis Programme	Availability of Haemodialysis services free of cost for BPL & Economically Weaker Section(EWS) patients	2	RR/PI/SI	Economically weaker Section(EWS) certifcate issued by appropriate authority(District Magistrate/Revenue Ofificer not below the rank of Tahsildar/Sub Divisional Officer)	
	Area of Concern - B Patient Rights					
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental and directional signages	2	OB	Numbering, main department and internal sectional signages	

		Signage for restricted area and safety hazard are displayed	2		1.Restricted signages at the entry & restricted area within the dialysis centre 2. Safety Hazard and Caution signs, for e.g. hazards from electrical shock, inflammables etc. shall be displayed at appropriate places	
ME B1.2	The facility displays the services and entitlements available in its departments	Services available and not available in the dialysis centre are displayed	2	OB	e.g.. Display of Haemodialysis for HIV or Hepatitis B/C patients	
		Name of the Nephrologist/in charge with registration number are displayed	2	OB	Contact details & days of visits of Nephrologist/in charge, Quality Managers are displayed	
		Important numbers are displayed	2	OB	Blood Banks, Fire Department, Police, Ambulance Services, ICU and OT	
ME B1.4	User charges are displayed and communicated to patients effectively	User Charges for dialysis services are displayed	2	OB	User charges(if any) are displayed at prominent places including display of free dialysis services for BPL/EWS patients	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC materials are displayed in waiting area	2	OB	IEC to prevent infection for patient with catheters & patient with fistulas or grafts, dietary advice are displayed IEC for care givers to manage day to day management	
		Relevant IEC are displayed inside dialysis unit(can be combined witrh above row in same column)	2	OB	Check for IEC related to fluid intake, Know about dry weight, Patient guide for access care are displayed inside the unit	
ME B1.6	Information is available in local language and easy to understand	Signages and information are available in local language	2	OB	At least in two languages with one being local	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Dialysis card/Logbook is provided to all patient	2	RR/SI/OB	Check dialysis card/Logbook is provided to the patient and records are updated after each session	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**					
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female attendant/female staff, if a male staff examine, treat or manage a female patient	2	OB/SI	Ask the staff about the adopted procedure	
ME B2.3	Access to facility is provided without any physical barrier & friendly to specially able people	Availability of Wheel chair and stretcher for easy Access to the Dialysis unit	2	OB	Check availability of both wheel chair and stretcher for the dialysis patients	
		Availability of ramp with appropriate gradient	2		A gradient of 1:8	
		Availability of disabled friendly toilets	2	OB/SI	At least one disabled-friendly toilet readily accessible to the Dialysis unit	
ME B2.4	There is no discrimination on basis of social & economic status of patients.	There is no discrimination on the basis of social and economic status of the patients	2	OB/PI	Look for any discrepancies from the previous patient records receiving the services	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen/curtains	2	OB	Check for screen/curtains between the beds	

ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors	2	OB/SI	Confidentiality, security and integrity of records shall be ensured at all times	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV cases	2	OB/SI	HIV status of the patient is coded and not displayed publicly Internal policy to be checked(for maintenance of record)	
Standard B4	**The facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent are obtained from the patient/ next of kin/ legal guardian as and when required	2	RR/SI	The consent includes general condition of the patient, treatment options, adverse reactions, consequence of missing dialysis, risk and complications Frequency of consent: before every session /every procedure	
ME B4.2	Patient is informed about his/her rights and responsibilities.	Patients' rights and responsibilities are displayed	2	PI/OB	Patients are aware of their rights and responsibilities	
ME B4.3	Staff are aware of Patients' rights and responsibilities	Staff is aware of patients' rights and responsibilities	2	SI	Randomly choose any staff	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Dialysis Unit has a system in place to communicate with patient/ their family member regarding the nature and seriousness of the illness	2	PI/SI	Ask the family members whether they have been communicated and involved in the treatment plan and progress	
ME B4.4	The facility has defined and established grievance redressal system in place	Check availability of complaint box	2	OB/RR/SI	Check when it was last open, check for complaint received and action taken	
		Availability of display of process for grievance re addressal and whom to contact is displayed	2	OB/SI	Check for display regarding mechanism of grievance redressal	
Standard B5	**The facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	All Drugs and consumables as per MoU with the private partner/hospital EML are free for BPL/EWS and other notified patients	2	PI/RR	Notified patients are the other poor patients validated by the facility in charge of the hospital	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that BPL/EWS and other notified patient has not incurred expenditure on diagnostics from outside	2	PI/RR	For APL Patients cost of diagnostics is included in the package rate	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Dialysis services are free for BPL and other notified patients	2	PI/RR/SI		
		APL Patients are charged as per the MoU rates	2	PI/RR/SI	The rates are inclusive of drugs, consumables and diagnostics (Give full compliance if it is free for all, or not applicable for the centre)	
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme.	Dialysis sessions of BPL families registered under PMJAY/Equivalent schemes are funded by respective scheme up to its maximum coverage	2	RR/SI	Check for any duplication of payments received under Pradhan Mantri National Dialysis programme and PMJAY/equivalent schemes	
Standard B6	**The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					

ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.	Ethical norms for Medical officers, Staff nurses and technician are defined and staff are aware about it	2	SI/RR	Ask staff about the ethical norms	
ME B6.3	The facility has an established procedure for entertaining representatives of drug companies and suppliers	No medical representatives are allowed in the dialysis unit	2	OB/RR/SI	Check that no promotional posters/activities are encouraged for drugs and diagnostics. Ask staff about the current practice	
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization.	Check dialysis unit has defined protocols for data sharing	2	RR/SI	Check list of agencies with whom the data is to be routinely shared. For any other agency a formal permission is sought from competent authority before sharing the data including press	
ME B6.6	There is an established procedure for 'end-of-life' care	Patients relatives are informed clearly about the deterioration in health condition of Patients	2	SI/RR/PI		
		There is established procedure for transfer of patients to other facilities in end stage of life	2	SI/RR/PI	Check the records for transfer of the patients to Specialist Hospital/Tertiary Hospital /Palliative Care Centres	
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific treatment	Declaration is taken from the patient seeking early termination of dialysis and the consequences are explained	2	RR/SI	Check for filled declaration form	
ME B 6.9	There is an established procedure to issue of medical certificates and other certificates.	Check hospital has documented policy for issuing medical certificates	2	RR/SI	Check for policy defines List of certificates can be issued by the dialysis centre, Who can issue certificates, Formats shall used for different certificates, Record keeping of issued certificate, Procedures for issuing duplicate certificates	
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dillemas' in a time-bound manner through ethical committee	Check facility has defined its ethical issues management framework	2	SI/RR	(a) Check the adequacy of the framework. It address the ethical issues and decision making in clinical care (b) Check facility's ethical management framework address issues like admission, discharge, transfer, disclosure of information or any professional conflict which may not be in patient's best interest	

		Check facility has ethical committee or person designated to address the ethical issues confronted by medical professionals while delivering the services	2	SI/RR	Facility's supporting human subject research activities/ publishing the scientific papers/ supporting medical students in thesis writing/ running any course where patient data is collected and used for above mentioned actvities - an ethical committee is constitituted and approval are taken before publication. or Facility may collaborate with the institutions where there are ethical committee is present and appropriate approvals, guided by applicable laws and regulations is taken. or the facilties where they are not involved in research actvities, to address the ethical dielamma's a person or group is appointed to address the dilemmas effectively within legal parameter	
		Check the list of ethical issues is available and regularly updated	2	RR/SI	Check when the list was last updated. Engage with the available medical professionals to check what type of ethical dilemmas they are facing while performing their job & how they are dealing with dielmma's.	
		Check the facility has defined mechanism identification and reporting of the ethical issues/ dilemmas confronted during services delivery	2	SI/RR	Check staff is aware of reporting mechanism	
		Check regular review of identified and reported ethical issue is done by appointed personnel /group/ committee	2	RR/SI	Check the timely resolution of the identified and reported ethical issues is done	
		Check all the decisions related to ethical dilemma's are communicated to all concerned	2	SI	Check information regarding ethical dilemma's & its handling is also given to new joinee's	
	Area of Concern C: Inputs					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.**					
ME C1.1	Departments have adequate space as per patient or work load.	Availability of adequate space for Dialysis room/area/Machine area	2	OB	At least 120 square feet per machine	
		Availability of dedicated Consultation room	2	OB		
		Availability of dedicated Water treatment area	2	OB/RR	The area have booster pumps, particle filters, water softener, carbon filter and RO system	
		Water treatment area have sufficient space for soft curving of tubings to prevent right angle bends	2	OB		
		Availability of Dual water treatment system	2	OB	Each water treatment system includes reverse osmosis membrane	

		Availability of administrative area	2	OB	This area includes registration, medical records and billing / insurance	
		Availability of dedicated Dialyzer Reprocessing room/area	2	OB	Check the followings: 1. A work bench with sink having side board & drainage. 2.The work bench is supplied with treated as well as untreated water which are separately marked. 3.Two sinks for the work bench 4.Sufficient space for at least two persons working simultaneously.	
		Availability of dedicated Storage area (both dry & wet)	2	OB	1.Check the dry storage area is capable of storing 3months supply of dialyzers, tubings, hemodialysis concentrate solutions, IV fluids. It should also have space for stationery, linen etc. 2.Reprocessed dialyzers & tubings are being stored in the wet storage	
ME C1.2	Patient amenities are provided as per patient load.	Availability of seating arrangement in Waiting area and Drinking water	2	OB	The centre shall have waiting area with sufficient seating arrangement for patients and visitors	
		Availability of functional Toilets separate for male & female	2	OB		
ME C1.3	Departments have layout and demarcated areas as per functions.	Demarcated stretcher & trolley bay	2	OB	Check the corridor is wide enough for easy movement of stretcher/trolley	
		Dedicated nursing station	2	OB	Location of nursing station should be such that the patients are under direct and easy observation	
		Demarcated changing area for staffs with adequate privacy	2	OB	Separate male & female changing room	
		Demarcated area for Infectious patients (HBV,HCV,HIV etc)	2	OB		
		Demarcated dirty utility room/area	2	OB	For cleaning and storage of housekeeping consumables	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law.	Corridors at Dialysis unit are broad enough for easy moment of stretcher and trolley	2	OB	Corridors are around 3 meter wide	
ME C1.5	The facility has infrastructure for intramural and extramural communication.	Availability of functional telephone/ Intercom Services /CUG	2	OB/RR	Please ask the staff about the availability of intra/extramural communication	
ME C1.6	Service counters are available as per patient load.	Availability of adequate no. of machines	2	OB/RR	Waiting time for scheduling session is not more than 24hrs. At least one machine is dedicated for infectious patients	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital).	Unidirectional flow of services.	2	OB	Check the directional flow as follows: 1. entry 2. reception & registration 3. Admission, and Discharge 4. Procedure 5. Ancillary area (water treatment, dialyzer reprocessing, toilets and stores)	

		Functional linkage and access to critical departments	2	OB	Dialysis has functional linkage with ICU , laboratories, Blood Bank, Emergency dept, OT	
Standard C2	**The facility ensures the physical safety of the infrastructure.**					
ME C2.2	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/board	Measures are being taken for safety of lifts	2	OB/RR	If the dialysis centre is at ground floor or accessible through ramp, give full compliance	
ME C2.3	The facility ensures safety of electrical establishment.	Dialysis room does not have temporary connections and loosely hanging wires	2	OB	Check there is no multi plug system mechanism for periodical check/test of all electrical installation by competent electrical Engineer	
		Each dialysis machine has in-built UPS or supplied with a UPS	2	OB/RR		
ME C2.4	Physical condition of buildings are safe for providing patient care.	Floors of the Dialysis room are non slippery and even	2	OB	Easily cleanable and acid, alkaline proof	
		Windows have grills and wire meshwork	2	OB		
Standard C3	**The facility has established Programme for fire safety and other disaster.**					
ME C3.1	The facility has plan for prevention of fire.	Dialysis Centre has sufficient fire exit to permit safe escape to its occupant at time of fire	2	OB	Check the fire exits are clearly visible and routes to reach exit are clearly marked	
ME C3.2	The facility has adequate fire fighting equipment	Fire Extinguisher ABC type are installed	2	OB	Expiry date and due date for next refilling is clearly mentioned	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation.	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	OB/SI	Randomly ask one of the staff to operate fire extinguisher	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.**					
ME C4.1	The facility has adequate specialist doctors as per service provision.	Availability of Nephrologist or equivalent	2	OB/RR	Qualified Nephrologist / MD Medicine with one year dialysis training from recognized centre performing one visit every fortnight and clinical review for all patients	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load.	Availability of duty medical officer	2	OB/RR	Medical Officers (on duty) – One doctor (MBBS) per shift	
ME C4.3	The facility has adequate nursing staff as per service provision and work load.	Availability of Nursing staff / dialysis technician	2	OB/RR/SI	1. One dedicated staff nurse/technician for 3 patients 2. One dedicated staff nurse/technician for each infectious patient 3. One of the staff nurse/technician trained in CPR is available in each shift	
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of Dialysis Unit Manager/in-charge for day to day management	2	OB/RR	With management/medicine/quality background	
ME C4.5	The facility has adequate support/general staff.	Availability of housekeeping staff and other support staff	2	OB/SI/RR	At least one housekeeping staff and one hospital attendant per shift	
		Availability of dedicated security guard	2	OB/RR	At least one security guard per shift	
Standard C5	**The facility provides drugs and consumables required for assured services.**					
ME C5.1	The departments have availability of adequate drugs at point of use.	All the drugs and consumables are available at point of use	2	OB/RR	As per MoU with the private partner/hospital EML	

		Availability of adequate quantity of dialysate as per requirement	2	OB/RR/SI	Dialysate prepared either commercially or on-site on daily basis meeting standards or regulatory requirements (ISO 23500:2014, ISO 13958:2014, ISO 11663:2014)	
		Availability of medical gases	2	OB/RR	Oxygen cylinders and suction machine or through piped supply	
ME C5.2	The departments have adequate consumables at point of use.	Availability of consumables, connectors, Tubing	2	OB/RR	Adequate quantity of disposable consumables like Blood tubing set, Fistula needle(16 G), Sodium Bicarbonate powder, IV sets, Dialyser starting kit, , Double lumen catheter set 12F(curved), etc. are available	
		Availability of adequate quantity of functional dialyser as per requirement	2	OB/RR/SI	Every patient is provided with either a new dialyser or a reprocessed dialyser of the same patient. All reprocessed dialysers must meet the standard norms for test of performance	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed.	Emergency Drug Tray/Crash Cart is maintained at dialysis unit	2	OB/RR	Inj. Adrenaline, Atropine, Hydrocortisone, Dexamethasone, Warfarin, Erythropoietin, ET Tube, Ambu Bag with Mask, Laryngoscope, etc.	
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients.	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP Apparatus, Stethoscope, Weighing Scale, Thermometer, Torch, X-ray view box, Multipara monitor	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility.	Availability of instruments for dialysis procedure	2	OB	Dialysis starting kit, Equipment for dressing/bandaging/suturing, Stand-by heamodialysis machine, Equipment for water treatment and dialyser reprocessing, etc.	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility.	Availability of Point of care diagnostic devices	2	OB	Glucometer, ECG and HIV rapid diagnostic kit, Blood group testing,HbsAg(HBV)	
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients.	Availability of functional Instruments for Resuscitation.	2	OB	1.Laryngoscope 2.Endotracheal tubes 3.Suction equipment 4.Xylocaine spray 5.Oropharyngeal and Nasopharyngeal airways 6.Ambu Bag- Adult & Paediatric	
ME C6.5	Availability of Equipment for Storage.	Availability of equipment for storage for drugs	2	OB	Refrigerator, Crash cart/Emergency Drug tray, instrument trolley/tray, dressing trolley/tray	
ME C6.6	Availability of functional equipment and instruments for support services.	Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste bins, cleaning brushes	
		Availability of equipment for sterilization and disinfection	2	OB	Autoclave	

ME C6.7	Departments have patient furniture and fixtures as per load and service provision.	Availability of patient bed with accessories	2	OB	1. Hospital graded Mattress 2. IV stand 3. Bed rails 4. Stool 5. Footstep, 6. Bedside locker	
Standard C7	**The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Criteria for Competence assessment are defined for doctor, nurse, technician.	2	SI/RR	Criteria may include skill, proficiency, knowledge and competencies required to carry out day to day procedures and manage complications. Competence assessment is done at least once in a year.	
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year	Performance based appraisal is done once in a year for all staff	2	SI/RR	Appraisal is done on the basis of objective assessments and linked with renumeration	
ME C7.9	The Staff is provided training as per defined core competencies and training plan.	All staff are trained in skills required for general management of the dialysis unit	2	SI/RR	Risk Management, Infection Control Practices, Bio-medical Waste Management, Patient and Fire Safety, Quality Management Comprehensive training programme for all staffs including PPP service providers	
		Doctors are trained in skills required for clinical management of dialysis unit	2	SI/RR	Evaluation, Initiation, Monitoring and Termination of Dialysis session including prevention and management of complication	
		Doctors, Nurses/Technicians are trained in general counselling of patients	2	SI/RR	Self-care, do's and don'ts, diet and psychological counselling	
		All staff are trained for life-saving skills	2	SI/RR	Basic life support (BLS)/ Advance life support (ALS) Doctors, nurses/technicians are trained for life saving skills	
		Periodic refresher training are provided for all staff	2	SI/RR	As mentioned in above checkpoints for different categories of staff	
	Area of Concern D: Support Services					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**					
ME D1.1	The facility has established system for maintenance of critical Equipment.	All equipment are covered under AMC including preventive maintenance.	2	SI/RR	Haemodialysis (HD) machine & all the assessories including alarms	
		AMC/CMC of Water treatment system with reverse osmosis	2	SI/RR		
		There is system of timely corrective break down maintenance of the equipment	2	SI/RR	1. Maintenance for all the major equipmemts including process of periodic inspection 2. Cleaning and maintenance 3.The unit may have AMC/CMC for individuals machines or collectively enrolled under BMEMP	
		Staff of dialysis unit is skilled for routine trouble shooting of minor equipment failure	2	SI/RR		

		Maintenance of different components of water treatment system are recorded	2	OB/SI	The log book is adequately maintained	
ME D1.2	The facility has established procedure for internal and external calibration of measuring equipment.	All the measuring equipment/ instruments are calibrated	2	OB/RR	Dialysis machine (Blood pump, Heparin pump, Pressure monitor, Conductivity meter), Weighing scale, Thermometer, BP Apparatus	
ME D1.3	Operating and maintenance instructions are available with the users of equipment.	Operating instructions for critical equipment are available	2	OB/SI	Operating Dialysis Machine, Water Treatment System, Dialyzer Reprocessing, Preparation of Dialysate	
		Lay-out and flow diagram of the water treatment system is displayed in the water treatment room	2	OB	The flow-diagram is self-explanatory and easy to comprehend	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.**					
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables.	There is established system of timely indenting of consumables and drugs	2	SI/RR	Forecasting or demand generation manually/IT	
ME D2.2	The facility has established procedure for procurement of drugs.	There is an established procedure for placing requisition	2	SI/RR	Requisition are timely placed	
ME D2.4	The facility ensures management of expiry and near expiry drugs.	Expiry and near expiry dates are maintained at emergency drug tray	2	OB/SI	Please check for records for expiry and near expiry drugs are maintained for drug stored in the department	
		No expired drugs or consumables found	2	OB/SI	Check expiry date of dialysate packaging	
ME D2.5	The facility has established procedure for inventory management techniques.	Department maintained stock and expenditure register of drugs and consumables including buffer stock	2	SI/RR	There is practice of calculating and maintaining buffer stock	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas.	There is no stock out of drugs & consumables	2	SI/RR		
ME D2.7	There is a process for storage of vaccines and other drugs, requiring controlled temperature.	Temperature of refrigerators are kept as per storage requirement and records are maintained	2	OB/SI/RR	Check for temperature charts are maintained and updated periodically (Erythropoietin)	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors**					
ME D3.1	The facility provides adequate illumination at patient care areas.	There is adequate illumination at the procedure area	2	OB	Provision of at least 300 lux.	
		There is adequate illumination at the water treatment area	2	OB	Provision of at least 300 lux.	
ME D3.2	The facility has provision of restriction of visitors in patient areas.	Entry of visitors into the dialysis unit are restricted	2	OB/SI	Visiting hours are defined, displayed & adhered with	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers.	The Dialysis unit shall be provided with effective and suitable ventilation to maintain comfortable room temperature.	2	OB/SI	Fans/ Air conditionings are available as per environment condition and requirement	
		Water treatment area should have measures for noise attenuation	2	OB		
		There is adequate ventilation to prevent over-heating	2	OB	In dialysis unit and water treatment area	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility.**					

ME D4.1	Exterior and interior of the facility building is maintained properly	Hospital infrastructure is adequately maintained along with interior of patient care areas are plastered & painted	2	OB/RR		
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, sinks patient care and circulation areas are clean	2	OB		
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/junk material in the dialysis centre	2	OB/SI/RR		
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/birds	2	OB/SI/RR		
Standard D5	**The facility ensures 24 × 7 water and power backup as per requirement of service delivery, and support services norms.**					
ME D5.1	The facility has adequate arrangement for storage and supply of potable water in all functional areas.	The unit shall have 24 hour provision of potable water for RO system	2	OB	Check the availability of functional water points for RO system	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load.	Availability of genset	2	OB	To meet the requirements of all machine	
		Availability of UPS	2	OB	Check the backup of UPS is at least up to 15 minutes in case of power failure/all dialysis machines are connected to a central servo controlled stabiliser of adequate capacity	
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply.	Availability of Centralized /local piped oxygen and vacuum supply	2	OB/RR	if oxygen cylinder/oxygen concentrator is available, then full compliance will be given	
ME D5.4	The facility has adequate arrangement for uninterrupted supply of RO water for dialysis unit	The dialysis unit have sufficient supply of RO water	2	OB	480 Litres of water needed per machine (Note: This does not include the water requirement of other activities of the unit such as hand washing)/ Water is available on 24*7 basis at all points of usages	
		The dialysis unit has adequate arrangements for preventing back flow of water	2	OB	1. Back-flow preventer 2. Temperature blending valve 3. Booster pump and raw water tank 4. ±acid feed pump etc.	
		The RO plant has adequate arrangements for pre-treatment of water	2	OB/RR	Pre-treatment should consist of: 1. Filtration for suspended particles. 2.Activated carbon filtration 3.Softener or deionizers	
		The RO plant has standardized pipes and valves for water distribution	2	OB/RR	Check for: 1.All pipelines after reverse osmosis system are of stainless steel (grade 316) or medical grade PVC. 2.All valves joints & connectors are of the same material. 3. Bends & blind loops must be avoided	
		The RO plant has adequate arrangements for post-treatment of water	2	OB/RR	Microbial and UV filters or/and deionization	

		There is adequate arrangements for safe storage of water	2	OB/RR	Please check for: 1. Storage tank is made up of stainless steel or medical grade PVC with an air tight lid 2.The tank has de-aeration valve & drain facility at the bottom	
		The facility has adequate arrangements for management of drainage System	2	SI/RR	The drains are provided with adequate gradients and adequate no. of floor traps are available to drain excess water	
Standard D6	**Dietary services are available as per service provision and nutritional requirement of the patients**					
ME D6.1	The facility has provision of nutritional assessment of the patients.	Availability of nutritional assessment and counselling facility	2	OB/PI	Ideally by a dietician else by the doctor(Arrangements could be made for videography lecture)	
Standard D7	**The facility ensures clean linen to the patients.**					
ME D7.2	The facility has established procedures for changing of linen in patient care areas	A fresh set of linen is provided to each patient and is changed in case of any major spill	2	OB/SI/RR/PI	On a daily basis	
ME D7.3	The facility has standard procedures for handling, collection, transportation and washing of linen.	There is an established procedures for handling dirty, soiled and clean linens	2	OB/SI/RR	Dirty, soiled and clean linens are collected, transported and stored separately	
Standard D9	**Hospital has defined and established procedures for Financial Management.**					
ME D9.1	The facility ensures proper utilization of the fund provided to it.	There is no delay in payments to the service provider	2	SI/RR	Payments to the providers are made as per the MoU. If not applicable, give full compliance	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1	The facility has established job description as per govt guidelines.	Staff is aware of their role and responsibilities	2	OB/SI/RR	Job descriptions/TOR are available with the facility	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments.	There is procedure to ensure that staff is available on duty as per duty roster and there is designated in charge for the department	2	OB/SI/RR		
ME D11.3	The facility ensures adherence to dress code as mandated by the administration.	Doctor, nursing staff and support staff adhere to their respective dress code	2	OB	All the categories of staffs are in proper dress code as assigned by the hospital management/administration	
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1	There is established system of contract management for the out sourced services.	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	RR/SI	There is a valid MoU with outsourcing agencies (If not applicable, give full compliance)	
ME D12.2	There is a system of periodic review of quality of out-sourced services.	Regular monitoring of quality of services	2	SI/RR	The quality of services are monitored periodically using objective criteria, process of black listing and provision of penalties for non-conformance(check MoU)	
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.1	The facility has established procedure for registration of patients	Every patient is provided with individual dialysis card/booklet with Unique identification number during registration	2	RR	The same card/booklet may be used for multiple sessions	

		There is provision of prior appointment for new & old patients	2	RR/PI	Check the process for appointment & also advanced communication is given to the patient in case of any cancellation/ delay	
		Patient details are recorded in Dialysis Card/Booklet	2	RR	Check for that patient details like Name, age, Gender, Blood group, Nephrologist details, Dialysis start date, HBV/HCV status, etc.	
ME E1.3	There is established procedure for admission of patients	There is an established criteria for initiation of dialysis session	2	SI/RR	Criteria based on Nephrologist's recommendations, Dry weight/weight gain, Vital sign, KFT results and Physical finding	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**					
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all patients on dialysis is done as per standard protocols	2	RR/SI	Initial Assessment will include weight, seated blood pressure, pulse rate, temperature, respiratory rate	
		Dialysis history is taken and recorded	2	RR	Check whether the patient has come for first session or a follow-up session	
		Physical Examination is done and recorded	2	RR	Look for signs of Mobility, Pain, Skin changes, Oedema, Signs of bruising & bleeding, Signs & symptoms of infection	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of stable and non-infective patients	2	RR/OB	Every hour and look for safety checks as Air detector/Line clamp, Dialysate Flow Rate, Dialysate temp, Conductivity, Status of heparin pump, "A" and "B" concentrate, Concentrate Na+, Alarm limit is set, if any	
		There is fixed schedule for reassessment of unstable and infective patients	2	RR/OB	Every half hour and look for safety checks as Air detector/Line clamp, Dialysate Flow Rate, Dialysate temp, Conductivity, Status of heparin pump, "A" and "B" concentrate, Concentrate Na+, Alarm limit is set, if any	
		There is system in place to identify and manage the changes in Patient's health status	2	RR/SI	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating	
		Check the treatment or care plan is modified as per re assessment results	2	RR/SI	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented	
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process	2	RR/SI	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors	

		Check treatment/care plan is prepared as per patient's need	2	RR/SI	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.	
		Check treatment / care plan is documented	2	RR/SI	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc	
		Check care is delivered by competent multidisciplinary team	2	RR/SI	Check care plan is prepared and delivered as per direction of qualified physician	
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer and referrals	There is an established procedure for patient transferred from dialysis unit to ICU /OT/ Emergency and vice versa	2	SI/RR	Check how hand over is given when patient is transferred from dialysis unit to ICU /OT/ Emergency and vice versa	
		There is an established procedure for referral of patients to higher facility	2	RR/SI	All patients are provided with referral card with details of patient, details of the facility where referred, treatment given, reasons for referral, etc.	
		Necessary support is provided for referral	2	RR/SI	Advance communication is done with higher centre, Referral vehicle is arranged	
ME E3.3	A person is identified for care during all steps of care	Doctor and nurse/technician is designated for each patient	2	RR/SI	At least one doctor is available for each shift and one nurse/technician for each patient	
		Detailed hand over is given between change of the shifts	2	RR/SI	Patient condition is reviewed during hand over between resident doctors as well as nurses/technicians	
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification of the patient before each dialysis session	2	OB/SI	Patient id band/ verbal confirmation/Bed no. etc. Any two identifiers may be used	
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Dialysis chart is maintained	2	RR	Check for Patient name, Age, Sex, Id no, Date, Dialysis no, Weight (Pre/Post), BP (Pre/Post), Starting and closing time of dialysis session, Any symptoms or medication given, etc.	
ME E4.4	Nursing records are maintained	General records of haemodialysis are adequately maintained	2	RR/SI	Look for Id on dialyzer, Dialyzer type, Dialyzer reuse no, Machine no, Bed no, Dialysis duration, start and termination time, Dialysis no	

		Pre-dialysis records are adequately maintained	2	RR/SI	Look for Machine rinse with RO water, Dialyzer sterilant active, pre dialysis weight, dry weight of the patient, interdialytic wt. gain, UF target, pulse, BP, Temp, Anticoagulation bolus and maintenance dose with signature of nurse/technician commencing Haemodialysis session	
		Post-dialysis records are adequately maintained	2	RR/SI	Look for UF reading, post dialysis weight, weight loss/gain, achieved Kt/V, BP, Temp, Pulse, Inj. EPO/Iron/Carnitine, if any	
		Records of the safety checks are adequately maintained	2	RR/SI	All general, pre-dialysis and post-dialysis records are duly signed by nurse/technician	
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority	2	OB/SI	Hepatitis B/C, HIV positive patients, Grossly dearranged KFT, Immuno-compromised patients and patients with pre-existing illnesses e.g. Heart Failure, IHD, LVF, HTM, COPD, etc.	
Standard E7	**Facility has defined procedures for safe drug administration**					
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs and chemicals available in department are identified	2	SI/OB	Dialysate A & B, Electrolytes like Potassium chloride, Anti thrombolytic agent, insulin, warfarin, Heparin, etc.	
		Maximum dose of high alert drugs are defined and communicated	2	SI/RR	Value for maximum doses are available with the technician and doctor in the dialysis unit	
		There is process to ensure that right doses of high alert drugs are only given	2	SI/RR	A system of independent double check before administration, Error prone medical abbreviations are not used	
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date, time and signature in comprehendible hand-writing	2	RR	Check for Date, Time, name of the doctor, reg no, no of medicines, dosage form, strength, time-duration, dosage route, signature of doctor, instructions for patient, etc.	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs and chemicals are checked for expiry and other inconsistency before administration	2	OB/SI		
		Check single dose vial are not used for more than one dose	2	OB	Check for any open single dose vial with left over content indented to be used later on	
		Any adverse drug reaction is recorded and reported	2	RR/SI		
ME E7.4	There is a system to ensure right medicine is given to right patient	Administration of medicines done after ensuring right patient, right drug, right dose, right time, right route, right reason and right documentation	2	SI/OB		
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Dialysis process is recorded as per defined assessment schedule	2	RR	Pre, Post and Intra Dialysis processes and investigations are recorded	

ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Each Dialysis session is planned and documented on dialysis card	2	RR	Before initiation of dialysis session	
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available	2	RR/OB	Check for the availability of Dialysis card, Dialysis chart, Dialysis record, Referral slip, Consent form, Lab requisition form, etc.	
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines	2	RR		
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records	2	OB		
Standard E9	**The facility has defined and established procedures for discharge of patient.**					
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Dialysis card is updated at the end of each dialysis session	2	RR/PI	Look for date of next session	
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge	2	PI/SI	Patient is counselled for do's and don'ts, care of access site, diet, water intake, dry weight, etc.	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.2	Emergency protocols are defined and implemented	Protocols of dialysis for emergency cases are defined and implemented	2	SI/RR	Acute renal failure/septicaemia in IPD/ICU patients	
Standard E12	**The facility has defined and established procedures of diagnostic services**					
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection	2	OB		
ME E12.2	There are established procedures for testing Activities	Facility for point of care diagnostic tests are available	2	OB/SI	Blood Sugar, Blood group, HbsAg(HBV) etc.	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**					
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion	2	RR		
		Patient's identification is verified before transfusion	2	SI/OB		
		Blood is kept on optimum temperature before transfusion	2	RR		
		Blood transfusion is monitored and regulated by qualified person	2	SI/RR		
		Blood transfusion note is written in patient records	2	RR		
ME E13.10	There is an established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person	2	RR		
Standard E24	**The facility has defined and established procedure for Haemodialysis Services**					
ME 24.1	The facility has defined and established procedure for Pre Haemodialysis assessment	Patient washes hand and relevant limb (with AVF/GF) with soap and water before entering the dialysis unit	2	OB/RR/SI	Encourage the patients to wash their hands themselves	
		All the patients are weighed before entering the dialysis unit	2	OB/RR/SI	Encourage the patients to weigh themselves	
		Pre-dialysis observations are performed and pre-recorded	2	OB/RR/SI	Seated blood pressure, pulse, temp, respiratory rate are recorded	
		Complete assessment of the patient is done before commencement of the dialysis	2	OB/RR/SI	Look for any changes since last session in mobility, pain, skin state, oedema, bruising/bleeding or any sign or symptom of infection	

		Information of the previous dialysis session is reviewed	2	OB/RR/SI	Note pre and post dialysis observation of the previous dialysis session and any dialysis variances	
		Baseline information is reviewed	2	OB/RR/SI	Weight gain (ideally less than 5%), urine output, blood glucose level	
		Dialysis plan is documented based on observation and patient assessments	2	OB/RR/SI	Plan should have details of Ultra filtration goal (amount of fluid to be removed), Ultra-filtration rate, dialysis duration, any expected complications	
		Review and prepare for pre-dialysis testing	2	OB/RR/SI	HbSAg, HCV, HBV, HIV, MRSA	
		Blood sample is taken for pre-dialysis testing	2	OB/RR/SI	Hb, KFT, LFT	
ME 24.2	The facility has defined and established procedure for care during Haemodialysis	Prepare the access sites	2	OB/RR/SI	Cleaning and disinfection with antiseptic solution	
		Safety checks for Blood tubing are ensured	2	OB/RR/SI	Check that Inserted canula is secured, check for air bubble via Air detector/Line clamps, and patency of the circuit	
		Safety checks for Dialysis machine are ensured	2	OB/RR/SI	Check that Dialysis machine is disinfected and rinsed with RO water. Conductivity is maintained. Alarm limit and dialysate flow rate is set	
		Safety checks for dialyzer and dialysate are ensured	2	OB/RR/SI	Check that Dialyzer reuse no is written, Check for Dialysate temp and A and B concentrate	
		Periodic and regular monitoring of the patient is done	2	OB/RR/SI	All the observations are recorded including BP, Pulse, Respiratory Rate, Machine parameters	
		Patient with any comorbidity are monitored and parameters are recorded periodically	2	OB/RR/SI	Blood sugar monitoring of diabetic patient and INR of patients on Warfarin	
		Routine medications are administered to patients as scheduled	2	SI/RR		
		Intervention/Medication during the session are monitored and recorded	2	OB/RR/SI	Change in machine settings Iron/Erythropoietin	
		Strict monitoring of the dialysis related errors is done	2	OB/RR/SI	Needle dislodgement and clotted circuit	
ME 24.3	The facility has defined and established procedure for care after completion of Haemodialysis	Keep equipment ready to terminate the session and disconnect the patient from the machine	2	OB/SI	Swab, Tape, Bandage	
		Take post-dialysis sample	2	OB/RR/SI	For KFT or any other investigations	
		Disconnect the access as per the protocols	2	OB/RR/SI	Sequence and timing of removing the cannulas and tubing's	

		Post-dialysis observations are recorded	2	OB/RR/SI	BP, Pulse, Temp, Respiratory Rate, Blood Sugar, UF reading, weight, Inj. Iron/Erythropoietin	
		Patient is counselled for self-care	2	OB/RR/SI	Water intake, Protein intake, Care of the access site, do's and don't, alarming signs and when & whom to contact in case of emergencies	
	Area of Concern - F: Infection Control					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection.**					
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas.	Dedicated person is in-charge for infection control in the dialysis unit	2	SI/RR	Doctor/Nurse/Technician may be designated Person responsible for quality can also handle	
		Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces at least once in month like machine, machine control panel, dialyzer(in case of reuse), bed railing, working bench,machine,dialysate, RO,connectors used /supply to machine etc.	
		Water samples are taken for microbial culture and microelements in RO water	2	SI/RR	Analysis of water used for haemodialysis for bacteria required to be done at least monthly and analysis for chemicals required to be done at least every six months	
ME F1.3	The facility measures hospital associated infection rates.	There is procedure to report cases of infection with blood borne infections	2	SI/RR	The facility should develop methods to monitor, review and evaluate all blood borne infections	
ME F1.4	There is provision of Periodic Medical Check-up and immunization of staff.	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B and Tetanus Toxoid etc.	
		Periodic medical check-ups of the staff	2	SI/RR	At least once in a year including housekeeping and support staff	
ME F1.5	The facility has established procedures for regular monitoring of infection control practices.	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals	
Standard F2	**The facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use.	Availability of hand washing facility as per norms	2	OB	One hand wash basin to be provided for every 2-3 dialysis stations in the main dialysis area	
		Availability of running water	2	OB/SI	Ask Staff if water supply is regular	
		Availability of antiseptic liquid soap with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted	
		Availability of Alcohol based Hand rub	2	OB/SI	One alcohol hand rub for every dialysis machine. Ask staff for regular supply.	
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language	
		Availability of elbow operated taps	2	OB		
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB		

ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask for demonstration	
		Staff aware of when to wash hand	2	SI	Ask 5 moments for hand washing	
ME F2.3	The facility ensures standard practices and materials for antisepsis.	Availability of Antiseptic Solutions	2	OB	Providine iodine, Isopropyl alcohol, etc.	
		Proper cleaning of vascular access site with antiseptics	2	OB/SI	Before preparing the access for cannulation/blood tubing, before giving IM/IV injection and drawing blood (If not applicable, give full compliance)	
Standard F3	**The facility ensures standard practices and materials for Personal protection.**					
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements.	Clean gloves are available at point of use	2	OB/SI		
		Availability of Mask	2	OB/SI		
		Availability of gown/ Apron	2	OB/SI	Staff and visitors	
		Availability of shoe cover	2	OB/SI	Staff and visitors	
		Availability of Caps	2	OB/SI	Staff and visitors	
		Personal protective kit for infectious patients	2	OB/SI		
ME F3.2	The facility staff adheres to standard personal protection practices.	No reuse of disposable gloves, Masks, caps and aprons.	2	OB/SI		
		Compliance to correct method of wearing and removing the gloves	2	SI		
Standard F4	**The facility has standard procedures for processing of equipment and instruments.**					
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and equipments	Cleaning & Decontamination of dialysis machine and patient care area	2	SI/OB	Surfaces like dialysis bed or chair, countertops, external surfaces of dialysis machine & control panel etc. by wiping with .5% hypochlorite solution followed by removing chlorine residues from metallic surfaces with water	
		Proper Decontamination of instruments after use	2	SI/OB	Ask staff how they decontaminate the instruments like scissors, haemostats, clamps (Soaking in 0.5% Chlorine Solution), blood pressure cuffs, stethoscopes, etc. (Wiping with 0.5% Chlorine Solution or 70% Alcohol)	
		Contact time for decontamination is adequate	2	SI/OB	10 minutes	
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination	
		Proper handling of Soiled and infected linen	2	SI/OB	Sorting, Rinsing or sluicing of soiled/infected linen is done outside the dialysis unit/ Patient care area	
		Staff know how to make chlorine solution	2	SI/OB	Prepared chlorine solution has 500-600ppm free chlorine (e.g., 1:100 dilution of a 5.25-6.15% sodium hypochlorite provides 525-615 ppm available chlorine)	

ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Dialysis machines are disinfected after each session taking in to account level of biofilm and endotoxin removal	2	OB/SI	Using Citric acid in the hydraulic circuit of haemodialysis machines	
		Bottles containing unused dialysate are disinfected after session	2	OB/SI		
		Opened bottles containing unused fluid should be discarded after 24 hours	2	OB/SI		
		Unfinished bottles used for infected patients must be discarded immediately	2	OB/SI		
		Cleaning and disinfection of Hemodialysers is done as per protocols	2	OB/SI/RR	Blood compartment is rinsed with water till the effluent is clear while hydrogen peroxide should be instilled in dialysate compartment followed by rinsed out of cleaning agents from dialysate compartment with water	
		Backwashing or Reverse Ultrafiltration is done as per protocols	2	OB/SI/RR	Backwashing is carried out for at least 15 minutes with periodic 1-2 minute rinsing of the blood compartment. The direction of flow should be reversed at 5 minute intervals.	
		Only dialysers clearing the 'Test of performance' are reused	2	OB/SI/RR	The 'Test of Performance' includes testing for total cell volume (TCV should be more than <80%), membrane integrity (should pass leak test) and perform residual disinfection (shall be checked using 'Potency Test Strip'). Dialyser failing 'Test of Performance' are discarded	
		Labelling and storage of Dialyzer is done appropriately	2	OB/SI/RR	Dialyzer should be kept in a sealed polythene bag/leakproof box with the patients name, TCV, reuse number and date marked with indelible ink over it. If stored for more than 7 days prior to the subsequent use, it should be refilled with disinfectant before use	
		Cleaning/Disinfection of the pipes of water management system	2	OB/SI/RR	Distribution loop of water treatment system should be cleaned preferably, once in 6 months	
		Autoclaved dressing material is used	2	OB/SI	Ensure the traceability of sterilized packs is maintained during storage	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.1	Functional area of the department are arranged to ensure infection control practices	Facility layout ensures separation of general patient from infectious patients	2	OB	Separate bed/area for HBV, HCV and HIV cases	
		Facility layout ensures separation of routes for clean and dirty items	2	OB		
		Floors and wall surfaces are easily cleanable	2	OB	Look for non-slippery floor (or epoxy grout in tiles), surfaces should be smooth & washable, seamless and impervious with sealed or welded joints	

ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Sodium Hypochlorite solution, Citric acid, Glutaraldehyde	
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution	
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR	Blood spill management	
		Cleaning of patient care area with detergent solution	2	SI/RR	chair, armrests, bedside table top/counter, and drawer/ cupboard handles) and high touch surfaces (the exterior surfaces of the HD machine, computer screens, and keyboards	
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR		
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out	
		Cleaning equipment like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided	
		Use of three bucket system for mopping	2	OB/SI		
		External foot wares are restricted	2	OB		
ME F5.4	The facility ensures segregation infectious patients.	Isolation and barrier nursing procedure are followed for septic cases	2	OB/SI		
		Separate staff for infected patients	2	OB/PI	Staff caring for HBV, HCV, HIV patients	
ME F5.5	The facility ensures air quality of high risk area.	Negative pressure is maintained in Isolation	2	OB/SI		
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste carried out as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.	
		Availability of colour coded non chlorinated plastic bags	2	OB		
		Segregation of Anatomical and soiled waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Dialysers after treatment, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.	
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, dialysers filters, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers with their needles cut) and gloves	
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language	

		There is no mixing of infectious and general waste	2	OB		
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional hub cutters	2	OB	See if it has been used or just lying idle.	
		Segregation of sharps waste including Metals in white (translucent) puncture proof, leak proof, tamper proof containers	2	OB	See availability near the point of generation. Needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.	
		Staff knows what to do in condition of needle stick injury	2	SI	Look for facilities for post-exposure prophylaxis	
		Contaminated and broken glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass	
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled	2	SI/OB		
		Disinfection of liquid waste before disposal	2	SI/OB	Dialysate A and B, Discarded disinfectant	
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB		
	Area of Concern - G : Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement.**					
ME G1.1	The facility has a quality team in place.	A Quality Circle is formed and functional with a designated nodal officer for quality.	2	RR/SI	Quality circle may have nephrologist/equivalent, Technician, nurses and housekeeping staff.	
ME G1.2	The facility reviews quality of its services at periodic intervals.	Quality Circle meets once in a month and review quality of services.	2	RR/SI	Quality circle meets at least once in a month and minutes are recorded.	
Standard G2	**The facility has established system for patient and employee satisfaction.**					
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals.	Patient satisfaction survey done on monthly basis	2	RR/SI		
ME G2.2	The facility analyses the patient feedback, and root-cause analysis.	Analysis of low performing attributes of patient feedback is done	2	RR/SI		
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients.	Action plan is prepared to address the areas of low satisfaction	2	RR/SI		
		Action plan is implemented to improve the patient satisfaction	2	RR/SI		
Standard G3	**The facility has established internal and external quality assurance Programmes wherever it is critical to quality.**					
ME G3.1	The facility has established internal quality assurance programme in key departments.	There is system of daily round by Dialysis Unit in charge for monitoring of services	2	SI/RR	Unit In charge should visit on daily basis and the findings/instructions during the visits are recorded	
ME G3.3	The facility has established system for use of check lists in different departments and services.	Internal assessment is done at periodic interval	2	RR/SI	NQAS assessment toolkit is used to conduct internal assessment	
		Departmental checklist is used for monitoring and quality improvement	2	SI/RR	Staff is designated for filling and monitoring of these checklists	

		Non-compliances are enumerated and recorded	2		Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	SI/RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvemnet Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1	Departmental standard operating procedures are available.	Standard operating procedure for department has been prepared and available	2	RR		
		Current version of SOP are available with process owner	2	RR	Check current version of SOP is available with the staff of Dialysis Unit.	
ME G4.2	Standard Operating Procedures adequately describes process and procedures.	Department has documented procedure for ensuring patients rights including consent, privacy, confidentiality & entitlement	2	RR	Processes pertaining to ensuring privacy, confidentiality, respectful maternity care and consent	
		Department has documented procedure for safety & risk management	2	RR	Processes related to physical safety, patient safety and risk assessment	
		Department has documented procedure for support services & facility management.	2	RR	Process description of support services such as equipment maintenance , calibration, housekeeping, security, storage and inventory management	
		Department has documented procedure for general patient care processes	2	RR	Processes of triage, assessment, admission, identification of high risk patients, Referral , Medication management and maintenance of clinical records	
		Department has documented procedure of pre-dialysis care.	2	RR	Processes of physical assessment, information related to previous dialysis session and dialysis plan	
		Department has documented procedure of care during dialysis session.	2	RR	Monitoring of the patient, frequency of observation as per their clinical status, safety measures e.g. needle dislodgement, clotted circuit, adverse drug reaction, etc.	
		Department has documented procedure of post-dialysis care.	2	RR	Protocols for post-dialysis investigations, disconnecting access, dressing, post-dialysis advice and counselling	
		Department has documented procedure for infection control & bio medical waste management	2	RR	Process of Hand Hygiene, personal protection, environmental cleaning, instrument sterilization, asepsis, Bio Medical Waste management , surveillance and monitoring of infection control practices.	

		Department has documented procedure for quality management & improvement	2	RR	Process of internal quality assessment & gap analysis, Root cause analysis, Change ideas to address the gap, implementing & monitoring the change ideas (PDCA)	
		Department has documented procedure for data collection, analysis & using the information for improvement	2	RR	Process related to collection of data & quality indicators , their analysis and use for quality improvement	
ME G4.3	Staff is trained and aware of the procedures written in SOPs.	Check Staff is aware of relevant part of SOPs	2	SI/RR	Interview dialysis Unit staff for their awareness about content of SOPs	
ME G4.4	The facility ensures the documented policies and procedures are appropriately approved and controlled	Standard operating procedure for department is duly approved by the competent authority	2	RR		
		Work instructions are duly approved	2	OB		
		Work instructions are displayed	2	OB	How to calculate dry weight, information on maintaining fluid balance before, during and after dialysis session, bio-medical waste management, hand wash instructions (when and how), diet counselling, etc.	
		SOP is controlled by providing unique identification number	2	RR		
		Standard operating procedure for department is reviewed periodically by quality circle	2	RR	At least once in a year	
		Revision history of the SOP is documented	2	RR	Date of revision, revision no, changes suggested by, changes made, reason of change, etc.	
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1	The facility maps its critical processes.	Process mapping of critical processes done	2	SI/RR	Critical processes are the ones where there are some problem-delays, errors, cost, time, etc. and improvement will make our process effective and efficient.	
ME G5.2	The facility identifies non value adding activities/waste/redundant activities.	Non value adding activities are identified	2	SI/RR	Non value adding activities are wastes. In these steps resources are expanded, delays occur, and no value is added to the service.	
ME G5.3	The facility takes corrective action to improve the processes.	Processes are improved & implemented	2	SI/RR	Look for the improvements made in the critical process in measurable terms.	
Standard G6	**The facility has defined Mission, Values, Quality policy and Objectives, and prepares a strategic plan to achieve them.**					
ME G6.1	Facility has defined mission statement	Check if mission statement has been defined adequately	2	RR/SI	Mission statement should be defined by the implementing agency (In-house/PPP) with purpose, target users and long term goal of dialysis unit. Mission should be aligned with the stated mission of Pradhan Mantri National Dialysis Program	
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	RR/SI	Check quality policy has been defined in consultation with dialysis unit staff and duly approved by appropriate authority.	

ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	RR/SI	Check if the Quality objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check if staff is aware of Mission , Values, Quality Policy and objectives	2	RR/SI	Interview with staff for their awareness. Check if Mission Statement and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	RR/SI	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with staff.	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	RR/SI	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S	
		Advance quality improvement method	2	SI/OB	Six sigma, lean.	
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used	
Standard G8	**Facility has defined, approved and communicated Risk Management framework for existing and potential risks.**					
ME G8.1	Risk Management framework has been defined including context, scope, objectives and criteria	There is a well defined and documented Risk Management Framework	2	SI/RR	The risk management framework should include incident reporting related to 1. Patient: Identification, Assessment, Diagnosis, Patient fall 2. Device related: Dialyzer identification, Efficacy of dialyzer, Alarm failure, Clotted circuit, Short-circuit 3. Process related: Haematoma, Air, Embolism, Fluid Imbalance, Dialysis plan, Monitoring errors, Infection control and prevention, Needle dislodgement and Safety checks and mitigation measures	
ME G8.3	Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders	Check if process of reporting risks and hazards have been defined and implemented	2	SI/RR	Responsibility of identifying the existing and potential risks is defined amongst staff and all the staff are aware of how to identify the risks, how to report them and mitigate them	
ME G8.5	Modality for staff training on risk management is defined	Check training on risk management has been provided to all staff members	2	SI/RR	Verify with the training records . Training on risk management at least should be provided to person/staff responsible in haemodialysis unit for indemnifying and managing risks	

ME G8.6	Risk Management Framework is reviewed periodically	Check risk management framework is reviewed at least once in a year	2	SI/RR	Check with the records that quality circle reviews the framework at least once in a year	
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
G9.3	Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders	Check if risk assessment checklist is available with stakeholders	2	SI/RR	Check if facility has prepared assessment checklist for identifying risk on routine basis. This checklist has been disseminate to the staff members responsible for identifying and reporting risks	
G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria	Check if periodic assessment of Physical, Fire and electrical safety risk is done using the risk assessment checklist	2	SI/RR	Verify with the assessment records. Comprehensive of physical, Fire and electrical safety should be done at least once in three month	
G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	Check if Periodic assessment of violence risks is done	2	SI/RR	Verify with records. At least once in year and whenever a major incident has occurred.	
G9.8	Risks identified are analysed, evaluated and rated for severity	Check if various risks identified during the risk assessment proceeds are evaluated	2	SI/RR	Risk identified should be listed and evaluated for their severity, frequency for occurrence and consequences.	
G9.9	Identified risks are treated based on severity and resources available	Risks are prioritized and action plan is made to eliminate/mitigate the risks	2	SI/RR	Verify with the records that a risk priority number (RPN) is given to each identified risk. Risks are prioritized based on their RPN and action plan is prepared and implemented to eliminate/mitigate the occurrence of risks	
Standard G10	**The facility has established clinical governance framework to improve the quality and safety of clinical care processes**					
ME G10.3	Clinical care effectiveness criteria has been defined and communicated	Criteria for effectiveness of dialysis sessions are defined and communicated	2	SI/RR	For e.g. URR (Urea Reduction Ratio), and Kt/V (amount of fluid that is cleared of urea during each dialysis session/volume of water a person's body contains), Symptomatic improvement	
		The facility has established process to review the clinical care	2	RR/SI	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.	
		Check regular ward rounds are taken to review case progress	2	RR/SI	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-	
		Check the patient /family participate in the care evaluation	2	RR/SI	Feedback is taken from patient/family on health status of individual under treatment	
		Check the care planning and co-ordination is reviewed	2	RR/SI	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress	

ME G10.4	Facility conducts the periodic clinical audits including prescription, medical	Periodic dialysis unit audits are conducted.	2	SI/RR	Look for records. Should be conducted at least quarterly.	
		There is procedure to conduct medical audits	2	RR/SI	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission	
		There is procedure to conduct death audits	2	RR/SI	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)	
		There is procedure to conduct prescription audits	2	RR/SI	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings	
		All non compliance are enumerated recorded for medical audits	2	RR/SI	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for death audits	2	RR/SI	Check the non compliances are presented & discussed during clinical Governance meetings	
		All non compliance are enumerated recorded for prescription audits	2	RR/SI	Check the non compliances are presented & discussed during clinical Governance meetings	

ME G10.5	Clinical care audit data is analysed, and actions are taken to close the gaps identified during the audit process	Non Compliance are enumerated and recorded, Action plan prepared, Corrective and preventive action taken	2	SI/RR	Look for completeness of audit report with non-compliances identified, action plan with designated responsibilities, corrective and preventive plan is implemented with measurable improvements	
		Check action plans are prepared and implemented as per medical audit record findings	2	RR/OB	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per death audit record's findings	2	RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check action plans are prepared and implemented as per prescription audit record findings	2	RR	Randomly check the actual compliance with the actions taken reports of last 3 months	
		Check the data of audit findings are collated	2	RR	Check collected data is analysed & areas for improvement is identified & prioritised	
		Check PDCA or revalent quality method is used to address critical problems	2	RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement	
ME G10.6	Governing body/top management of healthcare facilities ensures accountability for clinical care provided	Top management review the audit reports and PSS periodically	2	SI/RR	Members of the top management meet at least quarterly, audits and PSS analysis reports are reviewed, minutes of the meeting are recorded, the minutes show that data relating to audit reports and grievances are discussed, decisions to improve quality are made and progress is followed.	
ME G10.7	Facility ensures easy access and use of standard treatment guidelines and implementation tools at point of care	Standard norms, guidelines and other implementation tools are accessible to Dialysis unit's staff	2	SI/RR	Ask staff how they adhere with norms, guidelines and implementation tools during the provision of care at Haemodialysis Unit	
		Check standard treatment guidelines / protocols are available at point of use	2	SI/RR	Staff is aware of Standard treatment protocols/ guidelines	
		Check treatment plan is prepared as per Standard treatment guidelines	2	SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan	
		Check the drugs are prescribed as per Standards treatment guidelines	2	RR	Check the drugs are as per EML or formulary	
	Area of Concern - H: Outcomes					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National Benchmarks.**					
ME H1.1	The facility measures productivity Indicators on monthly basis	Average dialysis session conducted per day	2	RR	Total no of dialysis sessions done in a month/ total no of days in a month	
		Percentage of dialysis session conducted free of cost for entitled patients	2	RR	No of dialysis session done free*100/ total no of dialysis sessions conducted	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark.**					
ME H2.1	The facility measures efficiency Indicators on monthly basis	Average dialysis sessions performed per machine	2	RR	Total no of dialysis sessions performed/ total no of functioning dialysis machine	
		Downtime critical equipments/unit	2	RR		

		Percentage of patients shortening their dialysis sessions	2	RR	No of patients leaving dialysis session before completion of dialysis session*100/ total no of dialysis sessions conducted	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	The facility measures Clinical Care & Safety Indicators on monthly basis	Dialysis complication rate (Percentage of incidence of complication occurring while dialysis session)	2	RR	Total no of complications occurring during dialysis session e.g. Haematoma, Needle dislodgement, Dialyzer mismatch, Air embolism, Clotted circuit/ Total no of dialysis sessions	
		No of adverse events per thousand patients	2	RR		
		Average Urea Reduction Ratio	2	RR	Average of (pre dialysis urea-post dialysis urea) of all the patients underwent dialysis session	
		Average Kt/V	2	RR	Average of Kt/V (1.2)(amount of fluid that is cleared of urea during each dialysis session/volume of water a person's body contains) of all the patients underwent dialysis session	
		Dialyser reuse rate	2	RR	Total no of dialysis sessions performed/ Total no of dialyzer used	Single Dialyzer not to be used for more than 8 times (in reprocessing machine) or bundle volume is >70% which is earlier.
		Culture Surveillance sterility rate	2	RR	% of environmental swab culture reported positive	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	The facility measures Service Quality Indicators on monthly basis	Average days in availing follow up sessions	2	RR		Avg.Waiting time for follow up session
		Patient Satisfaction Score	2	RR		

National Quality Assurance Standards for District Hospitals			Version: DH/NQAS-2020/00
Checklist for Administration			21
Assessment Summary			
Name of the Hospital		Date of Assessment	
Names of Assessors		Names of Assessees	
Type of Assessment (Internal/External)		Action plan Submission Date	

Administration Score Card

	Area of Concern wise Score		Administration Score
A	Service Provision	97%	100%
B	Patient Rights	100%	
C	Inputs	100%	
D	Support Services	100%	
E	Clinical Services	100%	
F	Infection Control	100%	
G	Quality Management	100%	
H	Outcome	100%	

	Major Gaps Observed
1	
2	
3	
4	
5	
	Strengths / Good Practices
1	
2	
3	
4	
5	
	Recommendations/ Opportunities for Improvement
1	
2	
3	
4	
5	
	Signature of Assessors
	Date

Reference No.	ME Statement	Checkpoint	Compliance	Assessment Method	Means of Verification	Remarks
	Area of Concern - A Service Provision					
Standard A1	Facility Provides Curative Services					
ME A1.16.	The facility provides Accident & Emergency Services	Availability of functional A& E department	0	SI/OB		
		Availability of functional disaster management unit	2	SI/OB		
ME A1.17.	The facility provides Intensive care Services	Availability of functional Intensive care unit	2	SI/OB		
ME A1.18.	The facility provides Blood bank & transfusion services	Availability of functional Blood Bank	2	SI/OB		
Standard A2	Facility provides RMNCHA Services					
ME A 2.1.	The facility provides Reproductive health Services	Availability of Post Partum unit at the facility	2	SI/OB		
ME A2.3.	The facility provides Newborn health Services	Availability of functional SNCU	2	SI/OB		
ME A2.4.	The facility provides Child health Services	Availability of dedicated paediatric ward	2	SI/OB		
Standard A3	Facility Provides diagnostic Services					
ME A3.1.	The facility provides Radiology Services	Availability of X-Ray Unit	2	SI/OB	Availability of in-house services. Partial Compliance if it is outsourced	
.		Availability of Ultrasound services	2	SI/OB	Availability of in-house services. Partial Compliance if it is outsourced	
.		Availability of CT scan	2	SI/OB		
ME A3.2	The facility Provides Laboratory Services	Availability of In-house/ outsourced lab	2	SI/OB		
ME A 3.3	The facility provides other diagnostic services, as mandated	Availability of ECG Services	2	SI/OB		
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme					
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Formation of District Apex Group	2	SI/RR	Headed by Dermatologist/ Physician along with specialists of Orthopaedics/ General Surgery, Ophthalmology, assisted by Physiotherapist and laboratory Technician	
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Availability Functional ICTC is available	2	SI/OB		
ME A4.7.	The facility provides services under National Programme for the health care of the elderly as per guidelines	Availability of Geriatric ward/Clinic	2	SI/OB		

ME A4.8.	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability of CCU	2	SI/OB		
ME A4.9	The facility Provides services under Integrated Disease Surveillance Programme as per Guidelines	Hospital has System for immediate reporting of any disease out break authorities	2	SI/RR		
		A Nodal person is designated for collecting and reporting data to IDSP cell	2	SI/RR		
		Hospital disseminate the list of conditions to be reported to all clinical department	2	SI/RR		
Standard A5	**Facility provides support services**					
ME A5.1.	The facility provides dietary services	Availability of dietary service	2	SI/OB		
ME A5.2.	The facility provides laundry services	Availability of laundry services	2	SI/OB		
ME A5.3.	The facility provides security services	Availability of security services	2	SI/OB		
ME A5.4.	The facility provides housekeeping services	Availability of Housekeeping services	2	SI/OB		
ME A5.5.	The facility ensures maintenance services	Availability of maintenance services	2	SI/OB		
ME A5.6.	The facility provides pharmacy services	Availability of drug storage and dispensing services	2	SI/OB		
ME A5.7.	The facility has services of medical record department	Availability of Medical record services	2	SI/OB		
ME A5.8	The facility provides mortuary services	Availability of mortuary services	2	SI/OB		
Standard A6	**Health services provided at the facility are appropriate to community needs.**					
ME A 6.1.	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of 300 indoor functional beds per ten lakh population (as per IP population/NMC norms)	2	SI/RR		
ME A 6.2.	There is process for consulting community/ or their representatives when planning or revising scope of services of the facility	Community representative are consulted while revising or expanding the scope of service	2	SI/RR		
		User charges if any are decided in consultation with user groups /RKS	2	SI/RR		
	Area of Concern - B Patient Rights					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**					
ME B1.1.	The facility has uniform and user-friendly signage system	Name of the facility prominently displayed at front of hospital building	2	OB		
.		Hospital lay out with location and name of the departments are displayed at the entrance.	2	OB		
.		Hospital has established directional signage	2	OB		
.		List of departments are displayed	2	OB		
		All signages are in uniform colour scheme	2	OB		
		Signages are user friendly and pictorial	2	OB		
ME B1.2	The facility displays the services and entitlements available in its departments	Services not available are displayed	2	OB		
		Availability of administrative services like handicap certificate, death certificate services are displayed.	2	OB		
		Mandatory information under RTI is displayed	2	OB		
ME B1.3.	The facility has established citizen charter, which is followed at all levels	Citizen charter is established in the facility	2	OB		
		Citizen Charter includes Mission statement and Quality Policy of the facility	2			
.		Citizen charter includes the services available at the facility	2	OB		
		Citizen Charter includes the days and timings of different services available	2	OB		
		Citizen Charter Includes Rights of Patient	2	OB		
		Citizen Charter includes Responsibilities of Patients and Visitors	2	OB		
		Citizen Charters includes Beds available	2	OB	Check for display of number for General beds, critical care beds	
		Citizen Charters Includes Complaints and Grievances Mechanism	2	OB		
		Citizen Charter mention about paid services, if applicable	2	OB		
		Citizen Charter includes Grievance Redressal's Help Desk	2	OB	Check for Toll free number, name, contact number and email id of designated officer for assistance	
		Citizen Charter include details of visitor policy	2		Check for visiting time (Morning & Evening), details of visiting pass system	
ME B1.4					DELETED	
ME B1.6.	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB		
ME B1.7.	The facility provides information to patients and visitor through an exclusive set-up.	A dedicated facilitation counter/Rogi sahayata Kendra available	2	OB	Important contact no. are available at the counter/Rogi sahayata kendra	
.		Information regarding services available at the counter	2	OB		
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Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**					
ME B2.1	Services are provided in manner that are sensitive to gender	Hospital has defined policy for non discrimination according to gender	2	SI/PI		
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services	Environment of the health facility should be inclusive of all religious faiths	2	OB		
		Staff is respectful to patients religious and cultural beliefs	2	PI/SI		
		Hospital has defined policy to ensure the religious and cultural preferences of the patient	2	RR/SI		
ME B2.3.	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Approach road to hospital is accessible without congestion or encroachment	2	OB		
		Internal Pathways and corridors of the facility are without any obstruction / Protruding Object	2	OB		
		There are no open manholes/Potholes at access road and internal pathways	2	OB		
		Hospital has defined policy to provide barrier free services to patient	2	OB		
		Ramps are conducive for use	2	OB	At least 120 cm width, gradient not steeper than 1:12, ramp has slip resistance surface	
		Warning blocks have been provide at beginning and end of the ramp and Stairs	2	OB	To aid people with visual impairment	
		Hand rails are provided with stairs	2	OB		
		Facility conducts periodic Access Audits	2	OB		
		Parking area is earmarked for People with disabilities	2	OB		
		Symbol of Access is displayed at the facilities available for people with disabilities	2	OB	Ramps, Wheel Chair Bay, Lifts, Toilets	
ME B2.4	There is no discrimination on basis of social and economic status of the patients	There is no discrimination on basis of social and economic status of the patients	2	PI/SI		
ME B2.5	There is affirmative actions to ensure that vulnerable sections can access services	There are arrangement and Linkages for care of terminally ill patients	2	RR/SI	Linkage for Palliative Care , Hospice	
		There are Linkages for care , Counselling and Protection of Victims of Violence including domestic violence	2	RR/SI	Linkages with NGOS, Police Mediation Cell	

		There are arrangements for adequate care and post discharge support of Orphan patients including homeless children	2	RR/SI	Linkages with NGOS , Orphan , old age home, Children home	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**					
ME B3.1	Adequate visual privacy is provided at every point of care	Hospital has defined policy for maintenance of privacy of patients	2	RR/SI		
ME B3.2	Confidentiality of patients records and clinical information is maintained	Hospital has defined policy for maintenance of patient records and clinical information	2	RR/SI		
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Hospital defines and communicate policy regarding decent communication and courteous behaviour towards the patient and visitors	2	RR/SI		
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Hospital defines the policy for privacy and confidentiality of the patient and condition related with social stigma and vulnerable groups	2	RR/SI		
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**					
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Hospital define policy for taking consent.	2	RR/SI		
ME B4.2	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.	2	OB		
ME B4.3	Staff are aware of Patients rights responsibilities	Staff is aware of patients rights responsibilities	2	SI		
		Staff is regularly sensitize about rights and responsibilities of the patient	2	SI/RR		
ME B4.5.	The facility has defined and established grievance redressal system in place	Availability of complaint box at administrative office and display of process for grievance re Redressal and whom to contact is displayed	2	OB		
		Hospital defines policy for grievance redressal mechanism	2	RR/SI		
		There is defined frequency of collecting complaints from complaint box	2	RR/SI		
		Records of patient complaints suggestion are maintained	2	RR		
.		There is system of periodic review of patient complaints	2	RR/SI	Check for: 1. There is evidence of action taken on complaints 2. Action taken are informed to the complainant	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**					
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Hospital establish policy for providing free services for GoI and state scheme	2	RR/SI		
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Hospital has established policy for providing all drugs in the EDL free of cost	2	RR/SI		
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Hospital has established policy for providing all diagnostics free of cost	2	RR/SI		
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Methods for verification of documents of patient is user friendly	2	PI/SI		
		Hospital has established policy to provide free of cost treatment to BPL patients	2	RR/SI		
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Hospital has establish policy for timely Reimbursement and payment to beneficiaries	2	RR/SI		
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme	Availability of dedicated PMJAY help desk	2	OB	Availability of a help desk/ kiosk/Arogya Mitra Sahayta Kendra near the reception area run by Pradhan Mantri Aarogya Mitra (PMAM)	IF APPLIACABLE
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**					
ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.	Check that hospital administration has defined code of conduct for various cadre of staff	2	RR/SI	Check for any circular, policy, notice, government order issued that explains the code of conduct for staff such as doctor and nurses.	
ME B6.2	The Facility staff is aware of code of conduct established	Check if staff is aware of code of conduct	2	RR/SI	Interview doctors and nursing / paramedical staff on sample basis.	
ME B6.3	The Facility has an established procedure for entertaining representatives of drug companies and suppliers	Check hospital has implemented a policy of not entertaining representative of pharma companies within hospital premises	2	RR/SI	Ask medical superintendent / manager regarding any such circular / instructions issued to the doctors. Check on sample basis if doctors are aware of this policy and do not entertain medical representatives in hospital premises	
ME B6.4	The Facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions	Check hospital administration has aware of protocols for examination and treatment t of individuals brought police	2	RR/SI	As per state law and supreme court direction	
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization	Check hospital administration has defined protocols for data sharing	2	RR/SI	Check list of agencies with which data shared has routinely shred has been prepared . For any other agency a formal permission is sought from competent authorities before sharing the data including international agencies, press and NGOs.	
ME B6.6	There is an established procedure for 'end-of-life' care	Facility has established has established policy of end of life care	2	SI/RR		
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research	Check hospital ensures that informed consent is taken from patient participating in any clinical or public Health research	2	SI/RR	Check for policy or practice	
ME B6.9	There is an established procedure to issue of medical certificates and other certificates	Check hospital has documented policy for issuing medical certificates	2	SI/RR	Check for policy defines List of certificates can be issued by hospital Who can issue certificates Formats shall used for different certificates Record keeping of issued certificate procedures for issuing duplicate certificates	
ME B6.10	There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services	Hospital has laid strategy to resume the basic emergency and patient care services during strikes	2	SI/RR	Check hospital administration has made Buffer stock and alternate source pf supplies for consumables Strategy and coordination with local disruption to maintain hospital functions	
ME B6.11	An updated copy of code of ethics under Indian Medical council act is available with the facility	Check code of conduct copies are available at the hospital	2	SI/RR	Check for availability of printed copies of code of conduct distributed to staff	
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dilemmas' in a time-bound manner through ethical committee	Check facility has defined its ethical issues management framework	2	RR/SI	(a) Check the adequacy of the framework. It address the ethical issues and decision making in clinical care (b) Check facility's ethical management framework address issues like admission, discharge, transfer, disclosure of information or any professional conflict which may not be in patient's best interest	

		Check facility has ethical committee or person designated to address the ethical issues confronted by medical professionals while delivering the services	2	RR/SI	Facility's supporting human subject research activities/ publishing the scientific papers/ supporting medical students in thesis writing/ running any course where patient data is collected and used for above mentioned activities - an ethical committee is constituted and approval are taken before publication. or Facility may collaborate with the institutions where there are ethical committee is present and appropriate approvals, guided by applicable laws and regulations is taken. or the facilities where they are not involved in research activities, to address the ethical dilemma's a person or group is appointed to address the dilemmas effectively within legal parameter	
	Area of Concern - C Inputs					
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms					
ME C1.1.	Departments have adequate space as per patient or work load	Residential quarters for clinical and support staff	2	OB/RR		
		Hospital has adequate space as per bed strength	2	OB/RR	80 to 85 sqm per bed .	
ME C1.2.	Patient amenities are provide as per patient load	Availability of public toilet for visitors	2	OB		
.		Availability of dharmshala/stay facility for attendants	2	OB		
		Adequate number of Staff toilets available in proximity to duty area	2	OB/SI		
		Adequate number of Staff change room available in proximity to duty area	2	OB/SI		
		Separate cafeteria for patient and their relatives	2	OB		
		Cafeteria/ Recreation room for staff	2	OB/SI		
		Availability of Staff amenities at nursing station and duty room	2	OB/SI		
ME C1.3.	Departments have layout and demarcated areas as per functions	Hospital has independent entry for emergency, OPD and support services/staff	2	OB		
.		Corridors shall be at Wide to accommodate the daily traffic.	2	OB		
.		The general traffic should not pass through the indoor/ critical patient care area	2	OB		
.		Ambulatory services are located in outermost zone	2	OB	OPD, Emergency and Administrative offices are situated in near the entry/ exit of the hospital with direct access from approach road	
.		Clinical support Services are located in proximity to outer zone	2	OB	Lab , Radiology and Pharmacy	
		Procedure and Intensive Care areas are located in Middle zone of the Hospital	2	OB	Operation Theatre, ICU, SNCU, Labour Room	
		Indoor area are located in Inner zone of the Hospital	2	OB	Wards and Nursing Units are located in inner most area	
ME C1.4.	The facility has adequate circulation area and open spaces according to need and local law	Corridors shall be at Wide to accommodate the daily traffic.	2	OB		
		Facility maintains open area as per floor area ratio mandated by authorities	2	OB		
ME C1.5.	The facility has infrastructure for intramural and extramural communication	Hospital has 24X7 functional telephone connection	2	OB		
.		There is designated person to answer the telephone enquiries	2	OB/SI/RR		
.		Hospital has broadband internet connectivity	2	OB		
		There is establish system for managing postal communication	2	OB/RR	Records are maintained for received and dispatched communication	
		There is established system for internal movement of documents and communication	2	OB/RR	System for communicating circulars, notices and orders etc.	
		There is assigned person for managing internal and external movement of documents and communications	2	OB/RR		
		General notices and information are displayed at notice boards at relevant points	2	OB/RR		
		There is system of removal of old notices and updating the notice board	2	OB/RR		
ME C1.6	Service counters are available as per patient load	Availability of admission counter as per load	2	OB/RR		
ME C1.7.	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	There is no crises cross between General and Patient Traffic	2	OB		
Standard C2	The facility ensures the physical safety of the infrastructure.					
ME C2.1.	The facility ensures the safety of the building infrastructure	Facility has been surveyed by Structural engineer for vulnerability	2	OB/RR	Ask for records of survey	
ME C2.2.	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/ board	Lifts are installed with Automatic Rescue device.	2	OB/RR		
.		Every lift has Emergency Alarm System	2	OB/RR		
.		Periodic Maintenance of lift	2	OB/RR		
.		Licence for lift operation	2	OB/RR		
ME C2.3.	The facility ensures safety of electrical establishment	Facility has mechanism for periodical check / test of all electrical installation by competent electrical Engineer	2	OB/RR		
.		Facility has system for power audit of unit at defined intervals	2	OB/RR		
		Danger sign is displayed at High voltage electrical installation	2	OB		
		All electrical panels are covered and has restricted access	2	OB		
		Personal protective equipment are available with electrician	2	OB/SI		
ME C2.4.	Physical condition of buildings are safe for providing patient care	Windows have grills and wire meshwork	2	OB		
.		Terrace, roof, balconies and stair case have protective railing	2	OB		
.		Hospital premises has intact boundary wall	2	OB		
.		Hospital has functional gate with provision of cattle trap	2	OB		
.		There is system of periodic inspection of patient care areas of safety related issues	2	OB		
		Hospital building including walls, roofs, floor, windows , balconies and terraces are maintained	2	OB		
		Access to roof and terraces are restricted	2	OB		
Standard C3	The facility has established Programme for fire safety and other disaster					

ME C3.1.	The facility has plan for prevention of fire	Check the fire exits provide egress to exterior of the building or to exterior open space	2	OB		
.		Check the fire exits are free from obstruction	2	OB		
.		Facility has conducted fire safety audit by competent authority	2	OB/RR		
.		Evacuation plan is displayed at critical areas	2	OB		
		Facility has defined and implemented evacuation plan in case of fire	2	OB/RR		
		No smoking sign displayed inside and outside the working area	2	OB/RR		
ME C3.2.	The facility has adequate fire fighting Equipment	Facility has fire safety alarm	2	OB		
		There is system to track the expiry dates and periodic refilling of the extinguishers	2	OB/RR		
ME C3.3.	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Periodic Training is provided for using fire extinguishers	2	OB/RR		
		Periodic mock drills are conducted	2	OB/RR		
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**					
ME C4.1.	The facility has adequate specialist doctors as per service provision	Availability of General Surgeon	2	OB/RR/SI	As per patient load	
.		Availability of Obstetric & Gynae Specialist	2	OB/RR/SI	As per patient load	
		Availability of General Medicine specialist	2	OB/RR/SI		
.		Availability of Paediatrician	2	OB/RR/SI	As per patient load	
.		Availability of Anaesthetics	2	OB/RR/SI	As per patient load	
.		Availability of Ophthalmologist	2	OB/RR/SI	As per patient load	
.		Availability of Orthopaedic Surgeon	2	OB/RR/SI	As per patient load	
.		Availability of Radiologist	2	OB/RR/SI	As per patient load	
.		Availability of Pathologist	2	OB/RR/SI	As per patient load	
.		Availability of ENT specialist	2	OB/RR/SI	As per patient load	
.		Availability of Dentist	2	OB/RR/SI	As per patient load	
.		Availability of Dermatologist	2	OB/RR/SI	As per patient load	
.		Availability of Psychiatrist	2	OB/RR/SI	As per patient load	
.		Availability of Microbiologist	2	OB/RR/SI	As per patient load	
.		Availability of AYUSH Doctors	2	OB/RR/SI	As per patient load	
ME C4.2.	The facility has adequate general duty doctors as per service provision and work load	Availability of general duty doctors	2	OB/RR/SI	As per patient load	
ME C4.3.	The facility has adequate nursing staff as per service provision and work load	Availability of nursing staff	2	OB/RR/SI	As per patient load	
ME C4.4.	The facility has adequate technicians/paramedics as per requirement	Availability Lab Tech	2	OB/RR/SI	As per patient load	
.		Availability Pharmacist	2	SI/RR	As per patient load	
.		Availability Radiographer	2	SI/RR	As per patient load	
.		Availability ECG Tech/Eco	2	SI/RR	As per patient load	
.		Availability Audiometrician	2	SI/RR	As per patient load	
.		Availability Optha. Technician/Referactionist	2	SI/RR	As per patient load	
.		Availability Dietician	2	SI/RR	As per patient load	
.		Availability Physiotherapist	2	SI/RR	As per patient load	
.		Availability O.T. technician	2	SI/RR	As per patient load	
.		Counsellor	2	SI/RR	As per patient load	
.		Dental Technician	2	SI/RR	As per patient load	
.		Rehabilitation Therapist	2	SI/RR	As per patient load	
.		Biomedical Engineer	2	SI/RR	As per patient load	
ME C4.5.	The facility has adequate support / general staff	Availability of storekeeper	2	SI/RR		
.		Availability of Housekeeping supervisor/In charge	2	SI/RR		
.		Availability of security In charge	2	SI/RR		
Standard C5	**Facility provides drugs and consumables required for assured list of services.**					
ME C5.1	The departments have availability of adequate drugs at point of use	Hospital has policy to ensure drugs at all point of use as per DG-ESIC RC List	2	SI/RR		
Standard C6	**The facility has equipment & instruments required for assured list of services.**					
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for Facility management	2	OB	Equipment's for horticulture, electrical repair, plumbing material etc	
		Availability of equipment for processing of Bio medical waste	2	OB	Autoclave and mutilator	
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of fixture for administrative office	2	OB		
		Availability of furniture for administrative office	2	OB		
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**					
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.	
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done	
ME C7.3	Criteria for performance evaluation clinical and Para clinical staff are defined	Check performance criteria for clinical staff has been defined	2	RR	Check if performance appraisal critical clinical staff has been defines as per state service rules/ NHM Guidelines and job description of staff	
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year	Check if annual performance appraisal for clinical staff is practiced	2	RR	Verify with records that performance appraisal has been done at least once in a year for all Doctor, Nurses and paramedic staff .I. Check that predefined criteria has been used for the appraisal only.	
ME C7.5	Criteria for performance evaluation of support and administrative staff are defined	Check performance criteria for support staff has been defined	2	RR	Check if performance appraisal critical for both support/ administrative staff has been defines as per state service rules/ NHM Guidelines and job description of staff	
ME C7.6	Performance evaluation of support and administration staff is done on predefined criteria at least once in a year	Check if annual performance appraisal for support & administration staff is practiced	2	RR	Verify with records that performance appraisal has been done at least once in a year for all administrative and support staff either appointed at hospital . Check that predefined criteria has been used for the appraisal only.	
ME C7.7	Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff	Check staff if competence assessment and performance appraisal program includes staff is inclusive contractual staff.	2	RR	Verify with records that staff on contract under NHM or any other program, staff working through outsource agencies such as housekeeping and security are also go through the competence assessment along with regular staff. Also their performance appraisal is done at least once in year by their respective employer.	
ME C7.8	Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan	Check if hospital administration has a system for identifying the training needs and plan to address them	2	RR	Check that hospital administration has listed the gaps found during competence assessment and performance appraisal exercise . These gaps in performance and competence are factored in while developing training plan for staff. This includes both clinical as well as non clinical staff.	
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Facility conduct training need assessment periodically for all cadre of staff	2	SI/RR		
		Facility has program for continuous medical education for doctors and nursing staff	2	SI/RR		
		Facility prepares training calendar as per training need assessment	2	SI/RR		
		Training feed back is taking and records are maintained for training		SI/RR		
		Details and Records of training provided are available with unit	2	SI/RR		
		Training on Disaster Management	2	SI/RR		
		Training on Cardio Pulmonary resuscitation	2	SI/RR		

		Training on staff Safety	2	SI/RR		
		Training on Measuring Hospital Performance Indicators	2	SI/RR		
		Training on facility level Quality Assurance	2	SI/RR		
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Hospital has policy for regular competence testing as per job description.	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps	
ME C7.11	Feedback is provided to the staff on their competence assessment and performance evaluation	Check if feedback is given after each round of competence assessment and performance appraisal	2	RR	Verify with records of performance appraisal for feedback has been written on appraisal form and shared with staff. Interview staff for verification for feedback has been shared	
	Area of Concern - D Support Services					
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.					
ME D1.1.	The facility has established system for maintenance of critical Equipment	Facility has contract agency for maintenance for equipment	2	SI/RR		
		Contact details of the agencies responsible for maintenance are communicated to the staff	2	SI/RR		
		Asset list of all equipment are maintained	2	SI/RR		
		There is system to maintain records of down time of equipment	2	SI/RR		
		Indexing of all equipment is done	2	SI/RR		
		All equipment are covered under AMC including preventive maintenance for computers and other IT equipment	2	SI/RR		
		There has system to label Defective/Out of order equipment and stored appropriately until it has been repaired	2	OB/RR		
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR		
		There is system of timely corrective break down maintenance of the for computers and other IT equipment	2	SI/RR		
ME D1.2.	The facility has established procedure for internal and external calibration of measuring Equipment	Facility has contracted agency for calibration of equipment.	2	SI/RR		
		Records of the calibrated equipment are maintained	2	RR		
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas					
ME D2.4	The facility ensures management of expiry and near expiry drugs	Hospital has system to ensure that short expiry drugs are not procured	2	SI/RR	Check record of stock receipt from warehouse and Local purchase purchase receipt	
		Hospital has process for proper disposal and prevention of unintended use of expired drugs	2	SI/RR	Check policy for disposal of expired drugs and consumables	
ME D2.5	The facility has established procedure for inventory management techniques	Hospital implements scientific inventory management system according to their needs	2	OB/RR/SI	Previous consumption pattern, disease burden, local disease prevalence, seasonality, ABC, VED, FSN	
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	Hospital has policy that there is no stock out of the drugs and consumables at patient care area	2	RR/SI	Check policy for no stock out situation, stock replenishment	
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Hospital has a policy for ensuring proper management and restriction of unintended use of narcotic substance and psychotropic drugs as per prevalent law	2	RR/SI		
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.					
ME D3.1.	The facility provides adequate illumination level at patient care areas	Adequate illumination in open area at night	2	OB		
		Adequate illumination in circulation area	2	OB	Stairs, corridor and waiting area	
		Adequate illumination in toilets	2	OB		
		Hospital periodically measure illumination at different area of the hospitals	2	OB		
		Adequate illumination at approach roads to hospital	2	OB		
ME D3.2.	The facility has provision of restriction of visitors in patient areas	There is restriction on entry of vendors and hawkers inside the premise of the hospital	2	OB		
.		Hospital has visitor policy in place	2	OB/RR		
.		Hospital has policy for restriction of media person in side the hospital	2	OB/RR		
		Hospital implement visitor pass area for indoor areas	2	OB/RR		
ME D3.4.	The facility has security system in place at patient care areas	Hospital has in-house/outsourced security system in place	2	RR/SI		
.		Duty roaster is available for security staff	2	RR/SI		
.		Training and Drills of security staff is done	2	RR/SI		
.		Security staff is aware of patient right, visitor policy and disaster Management	2	RR/SI		
.		There is system for supervision of security staff	2	RR/SI		
.		Facility has a security plan for deputation of guard at different location	2	RR/SI		
.		Responsibility and timing of opening and closing different department is fixed and documented	2	RR/SI		
.		There is established procedure for safe custody of keys	2	RR/SI/OB		
.		There is procedure for handing over the keys at the time of shift change	2	RR/SI		
.		Hospital has system to manage violence /mass situation	2	RR/SI		
ME D3.5.	The facility has established measure for safety and security of female staff	No female staff is posted alone at night	2	SI		
.		Where ever there are male employees/patients female staff are posted in pairs	2	SI/RR		
.		Timing of the shift is arranged keeping in mind the safety of female staff	2	SI/RR		
.		Committee against sexual harassment is constituted at the facility	2	RR/SI		
		Staff has been provided awareness training on Gender issues	2	RR/SI		
Standard D4	The facility has established Programme for maintenance and upkeep of the facility					
ME D4.1.	Exterior of the facility building is maintained appropriately	Boundary Walls of building is plastered and whitewashed.	2	OB		
.		No unwanted/outdated posters on hospital boundary and building walls	2	OB		
.		Hospital Buildings are in uniform colour scheme	2	OB		
.		Hospital has system to whitewash the building periodically	2	OB/RR		
ME D4.2.	Patient care areas are clean and hygienic	General waste from hospital is removed daily by municipal/outsourced agency	2	OB/RR		
		Every department has Schedule of cleaning	2	SI/RR	Every department has schedule for inspection of cleaning work	
ME D4.3.	Hospital infrastructure is adequately maintained	Hospital has system for periodic maintenance of infrastructure at defined interval	2	OB/RR		
.		There is no clogged/over flowing drain in facility	2	OB		
.		Hospital sewage is linked with municipal drainage system	2	OB/SI/RR		
.		Facility has a closed drainage system	2	OB		
.		Intramural roads are in good condition without potholes/ditches	2	OB		
.		Facility has a annual maintenance plan for its infrastructure	2	RR/SI		

ME D4.4.	Hospital maintains the open area and landscaping of them	Availability of parking space as per requirement	2	OB		
.		Dedicated parking space for ambulances	2	OB		
.		No water logging in side the premises of the hospital	2	OB		
.		There is no abandoned /dilapidated building in the premises	2	OB		
.		Proper landscaping and maintenance of trees, garden	2	OB		
.		There shall be no encroachment in and around the hospital	2	OB		
.		Hospital has rain water harvesting facility	2	OB		
.		Hospital has Herbal garden	2	OB		
ME D4.5.	The facility has policy of removal of condemned junk material	Hospital has condemnation policy in place	2	RR/SI		
.		Periodic removal of junk material done	2	OB/RR		
.		Hospital has designated covered place to keep junk/condemned material	2	OB		
.		No junk/condemned articles in open spaces	2	OB		
ME D4.6.	The facility has established procedures for pest, rodent and animal control	Pest control measures are evident at facility	2	RR/SI		
.		Anti Termite treatment of the wooden furniture	2	RR/SI		
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**					
ME D5.1.	The facility has adequate arrangement storage and supply for portable water in all functional areas	Hospital has adequate water storage facility as per requirements	2	OB/RR/SI	450-500 Litres per bed per day	
.		Hospital has adequate water supply from municipal /under ground source	2	OB/SI		
.		All water tanks are kept tightly closed	2	OB		
.		Periodic cleaning of water tanks carried out	2	OB/RR	Records of cleaning is maintained	
		Hospitals periodically tests the quality of water from the source (municipal supply, bore well etc) for bacterial and chemical content	2	RR		
		Chlorination of water is done as per requirement	2	RR		
		RO/ Filters are available for potable drinking water	2	OB		
		Hospital ensures that the distribution pipelines are not running in close vicinity of the sewage system.	2	RR/SI		
ME D5.2.	The facility ensures adequate power backup in all patient care areas as per load	Availability of noiseless generators for power back up	2	OB/SI		
		Estimation of power consumption of different department of hospitals is done	2	RR/SI		
		Generator has adequate capacity to provide 24x7 power back at least critical areas	2	RR/SI		
.		Hospital has dedicated sub station for electrical supply	2	OB/RR/SI		
		Hospital has adequate power supply connection	2	RR/SI	3Kw to 5Kw per bed	
		Use of energy efficient bulbs/solar panel for light	2	SI		
ME D5.3.	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Manifold room is located on ground floor	2	OB		
		Manifold room has adequate stock of Oxygen and Nitrogen Cylinders	2	OB/SI	At least for three days	
		Cylinders banks are in duplicate	2	OB/RR/SI	Check for there two dedicated banks - Running and reserve fitted with automatic changeover device	
		Colour of gas pipeline and Gas Cylinder are as per standards	2	OB/RR		
		Alarm system has been provided to indicate any abnormal pressure change	2	RR/SI		
		LMO storage tank has a Petroleum and Explosive Safety Organisation (PESO) license	2	RR/SI	Also check for availability of Medical Gas Pipeline System (MGPS) network in the hospital	
		LMO tank is located away from the indoor environment or not located near drain or pits	2	OB		
		Availability of vacant space within a radius of 5 meters around the tank	2		Check that 1. flammables and combustibles are not stored in near vicinity 2. Postage of 'No Smoking" and 'No Open Flames' signages	
		There is procedure for prompt replacement of empty cylinders with filled cylinders	2	SI/RR/OB		
		There is a procedure for periodic checking of all terminal units for malfunctioning	2	SI/RR		
		Entry to Manifold room/LMO plant is prohibited	2	OB/SI		
		Instruction for operating different equipment clearly displayed	2	OB		
Standard D7	**The facility ensures clean linen to the patients**					
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Hospital has policy to change linen	2	RR/SI		
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**					
ME D8.1.	The facility has established procedures for management of activities of Rogi Kalyan Samitis	Hospital Management Society/RKS is registered under societies registration act	2	RR		
.		Availability of Income tax exemption certificate for donations	2	RR		
.		RKS meeting are held at prescribed interval	2	RR		
.		Minutes of meeting are recorded	2	RR		
.		Participation of community representatives/NGO is ensured	2	RR		
.		RKS reviews the patient complaint/ feedback and action taken	2	RR		
.		RKS generates its own resources from donation/leasing of space	2	RR/SI		
ME D8.2.	The facility has established procedures for community based monitoring of its services	Community based monitoring/social audits are done at periodic intervals	2	RR/SI		
		Facility communicate updated information on Quality of services	2	RR/SI		
		Facility participates in Jan Sunawais and Jan Samvads at regular intervals	2	RR/SI		
Standard D9	**Hospital has defined and established procedures for Financial Management**					
ME D9.1.	The facility ensures the proper utilization of fund provided to it	There is system to track and ensure that funds are received on time	2	RR/SI		
		Funds/Grants provided are utilized in specific time limit	2	RR		
.		There is no backlog in payment to beneficiaries as per their entitlement under different schemes	2	RR/PI	E.g.; Payment for JSY ,Family planning & ASHA	
.		Salaries and compensation are provided to contractual staff on time	2	RR/SI		
.		Facility provides utilization certificate for funds on time	2	RR		
ME D9.2.	The facility ensures proper planning and requisition of resources based on its need	Facility prioritize the resource available	2	RR/SI		
.		Requirement for funds are sent to state on time	2	RR/SI		
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**					

ME D10.1.	The facility has requisite licences and certificates for operation of hospital and different activities	Availability of valid No objection Certificate from fire safety authority	2	RR		
.		Availability of Biomedical Waste Management Authorisation for generating BMW as per prevalent norms/regulations	2	RR		
.		Availability of certificate of inspection of electrical installation	2	RR		
		Availability of licence for operating lift	2	RR		
ME D10.2.	Updated copies of relevant laws, regulations and government orders are available at the facility	Availability of copy of Bio medical waste management rules 2016 and it's subsequent amendments	2	RR		
		Drug and cosmetic Act 2005	2	RR		
		Safety code for Medical diagnostic X ray equipment and installation	2	RR	AERB safety code no. AERB/SC/MED-2(Rev 1)	
		Narcotics and Psychotropic substances act 1985	2	RR		
		Code of Medical ethics 2002	2	RR		
		Nursing Council Act	2	RR		
		Medical Termination of Pregnancy 1971 & amendments	2	RR		
		Person with disability Act 1995	2	RR		
		Pre conception pre natal diagnostic test 1996	2	RR		
		Right to information act 2005	2	RR		
		Indian Tobacco control Act 2003	2	RR		
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**					
ME D11.1.	The facility has established job description as per govt guidelines	Job description of Specialist Doctor is defined and communicated	2	RR	Regular + contractual	
		Job description of General duty Doctor is defined and communicated	2	RR	Regular + contractual	
.		Job description of nursing staff is defined and communicated	2	RR	Regular + contractual	
.		Job description of paramedic staff is defined and communicated	2	RR	Regular + contractual. Lab technician, X ray technician, OT technician, MRD technician etc.	
		Job description of counsellor is defined and communicated	2	RR	Regular + contractual	
		Job description of ward boy is defined and communicated	2	RR	Regular + contractual	
		Job description of security staff is defined and communicated	2	RR	Regular + contractual	
		Job description of cleaning staff is defined and communicated	2	RR	Regular + contractual	
		Job description of Administrative staff is defined and communicated	2	RR	Regular + Contractual MS, Hospital Manager, supervisor, Matron, Ward Master. Pharmacist etc.	
ME D11.2.	The facility has a established procedure for duty roster and deputation to different departments	Duty roster of doctors is prepared, updated and communicated	2	RR/SI		
		Duty roster of Nurses is prepared, updated and communicated	2	RR/SI		
		Duty roster of Paramedics is prepared, updated and communicated	2	RR/SI		
		Duty roster of Cleaning staff is prepared, updated and communicated	2	RR/SI		
		Duty roster of security staff is prepared, updated and communicated	2	RR/SI		
		There is provision of Rotatory posting of staff	2	RR/SI		
		Facility has established line of reporting for clinical and administrative staff	2	RR/SI		
ME D11.3.	The facility ensures the adherence to dress code as mandated by its administration / the health department	Facility has policy for dress code for different cadre of hospital.	2	RR/SI		
.		I Cards have been provided to staff	2	OB		
.		Name plate have been provided to staff	2	OB		
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**					
ME D12.1.	There is established system for contract management for out sourced services	Valid contract for disposal for Bio Medical waste with common treatment facility	2	RR		
.		Selection of outsourced agencies done through competitive tendering system	2	RR		
		Eligibility criteria is explicitly defined as per term of reference	2	RR		
.		There is system to make payment as per adequacy and quality of services provided by the vendor	2	RR	Check for that Contract document has provision for dedication of payment if quality of services is not good	
.		Payment to the outsourced services are made on time	2	RR		
ME D12.2.	There is a system of periodic review of quality of out sourced services	Facility as defined criteria for assessment of quality of outsourced services	2	RR		
		Regular monitoring and evaluation of staff is done according against defined criteria	2	RR		
		Actions are taken against non compliance / deviation from contractual obligations	2	RR/SI		
		Records of blacklisted vendors are available with facility	2	RR		
	Area of Concern - E Clinical Services					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**					
ME E1.3	There is established procedure for admission of patients	Facility ensures that there is process for admission of patients after routine working hours	2	RR/SI		
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Facility updates daily availability of vacant patient beds in different in door units	2	RR/SI/PI		
		Facility has established plan for accommodating high patient load due to situation like disaster/ mass casualty or disease outbreak	2	RR/SI		
		Facility has policy for internal adjustment of the patient within cold wards for accommodating patient as extra temporary measure	2	RR/SI		
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**					
ME E3.1.	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established policy for co ordination and handover during interdepartmental transfer	2	RR/SI		
.		There is a policy for consultation of the patient to other specialist with in the hospital	2	RR/SI		
ME E3.2.	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	There is policy for referral of patient for which services can not be provided at the facility	2	RR/SI		
.		Facility maintain list of higher centres where patient can be managed.	2	RR/SI		
.		Facility ensures the referral patient to public healthcare facilities	2	RR/SI		
.		Facility defines and communicate referral criteria for different departments	2	RR/SI		
		There is system to check that patient are not unduly referred for the services those can be available at the facility	2	RR/OB		

ME E3.4	Facility is connected to medical colleges through telemedicine services	There is functional telemedicine centre	2	OB		
		Telemedicine services are utilized for continual medical education	2	RR/SI		
Standard E4	**The facility has defined and established procedures for nursing care**					
ME E4.1	Procedure for identification of patients is established at the facility	There is policy for identification of patient before any clinical procedure	2	RR/SI		
ME E4.2.	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	There is a policy for ensuring accuracy of verbal/telephonic orders	2	RR/SI		
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Hospital has policy for patient hand over during shift change	2	RR/SI		
ME E4.4	Nursing records are maintained	Hospital has policy for maintaining nursing records	2	RR/SI		
ME E4.5	There is procedure for periodic monitoring of patients	There is policy for periodic monitoring of patient	2	RR/SI		
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**					
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Hospital identify and communicate the category of patient considered as vulnerable	2	OB/SI		
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	Hospital identify and communicate the category of patient considered as high risk	2	OB/SI		
Standard E6	**Facility follows standard treatment guidelines defined by state/Central government for prescribing the generic drugs & their rational use.**					
ME E6.1.	Facility ensured that drugs are prescribed in generic name only	Facility has policy and enabling order for prescribing drugs in generic drug only	2	RR		
ME E6.2	There is procedure of rational use of drugs	Facility provides adequate copies of STG to respective department	2	SI/RR		
		Facility maintains a list of updated version of STG	2	RR		
		Facility provides training on use of STG	2	SI/RR		
Standard E7	**Facility has defined procedures for safe drug administration**					
ME E7.3	There is a procedure to check drug before administration/ dispensing	Facility has policy for reporting of adverse drug reaction	2	RR/SI	Adverse drug event trigger tool is used to report the events	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**					
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Hospital has policy for retention period for different kinds of records	2	RR		
		Hospital has policy for safe disposal of records	2	RR		
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**					
ME E11.3.	The facility has disaster management plan in place	Hospital has prepared disaster plan	2	RR		
.		Disaster management committee has been constituted	2	RR		
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**					
ME E16.1.	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives	2	SI/RR		
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**					
ME E20.1	The facility provides immunization services as per guidelines	Facility has established produce for reporting and follow up of AEFI	2	SI/RR		
		Staff is trained for detecting , managing and reporting of AEFIs	2	SI/RR		
	Area of Concern - F Infection Control					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**					
ME F1.1.	Facility has functional infection control committee	Infection control committee constitute at the facility	2	SI/RR		
		ICC is approved by appropriate authority	2	SI/RR		
.		Roles and responsibilities are defined and communicated to its members	2	SI/RR		
		ICC meet at periodic time interval	2	SI/RR		
		Records of Infection control activities are maintained	2	SI/RR		
ME F1.2.	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Facility has in-house/ linkage with microbiology lab for culture surveillance	2	SI/RR		
		There is defined format for requisition and reporting of culture surveillance	2	SI/RR		
		Reports of culture surveillance are collated and analysed	2	SI/RR		
		Feedback is given to the respective departments	2	SI/RR		
ME F1.3	Facility measures hospital associated infection rates	Sample are taken for culture to detect HAI in suspected cases.	2	SI/RR		
		There is defined criteria and format for reporting HAI based on clinical observation	2	SI/RR		
		Reports from different department are collated and analysed	2	SI/RR		
		Feedback is given to the respective departments	2	SI/RR		
ME F1.4.	There is Provision of Periodic Medical Check-ups and immunization of staff	Records of immunization available	2	SI/RR		
.		Records of Medical Check-ups are available	2	SI/RR		
ME F1.5.	Facility has established procedures for regular monitoring of infection control practices	There is designated person for Co coordinating infection control activities	2	SI/RR	Infection control nurse	
.		There is defined format/checklist for monitoring of hand washing and infection control practices	2	SI/RR		
ME F1.6.	Facility has defined and established antibiotic policy	Facility has antibiotic policy in place	2	SI/RR		
		There is system for reporting Anti Microbial Resistance with in the facility	2	SI/RR		
		Antibiotic policy includes plan for identifying, transferring , discharging and readmitting patients with specific antimicrobial resistant pathogen	2	SI/RR		
		Policy Includes Rational Use of Antibiotics	2	SI/RR		
		Standard treatment guidelines are followed while developing Antibiotic Policy	2	SI/RR		
		There is procedure for periodic Laboratory Surveillance for Antibiotic Resistance	2	SI/RR		
		Facility Measures the Antibiotic Consumption Rates	2	SI/RR		
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**					
ME F2.1	Hand washing facilities are provided at point of use	Facility ensures uninterrupted and adequate supply of antiseptic soap and alcohol hand rub in all departments	2	SI/RR		
ME F2.2	Staff is trained and adhere to standard hand washing practices	Check for the records that training have been provided	2	SI/RR		
ME F2.3	Facility ensures standard practices and materials for antisepsis	Facility ensures uninterrupted and adequate supply of antiseptics	2	SI/RR		
Standard F3	**Facility ensures standard practices and materials for Personal protection**					
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Availability of Heavy duty gloves for cleaning staff	2	OB/SI		
		Availability of gum boats for cleaning staff	2	OB/SI		
		Availability of mask for cleaning staff	2	OB/SI		
		Availability of apron for cleaning staff	2	OB/SI		
		Facility ensure adequate and regular supply of personal protective equipment	2	SI/RR		

ME F3.2	Staff is adhere to standard personal protection practices	There is policy for judicious use of personal protective equipment specially sterile gloves	2	SI/RR		
Standard F4	**Facility has standard Procedures for processing of equipment and instruments**					
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Facility ensure adequate supply of disinfectant at the point of use	2	SI/RR	Disinfectant like hypochlorite, bleaching powder etc.	
		Staff is trained for preparation of disinfectant solution	2	SI/RR		
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**					
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Facility ensure the availability of good quality disinfectant and cleaning material	2	SI/RR		
ME F5.4	Facility ensures segregation infectious patients	Hospital has policy for identification and segregation of infectious patient	2	SI/RR		
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**					
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Facility ensures adequate and regular supply of non chlorinated colour coded liners	2	SI/RR		
		Separate bins for Recyclable and biodegradable waste is available	2		Check adequacy in patient care and administrative areas. Also check there is no mixing of waste	
		There is established procedure for daily monitoring of proper segregation of Bio medical waste by a designated person	2	SI/RR		
		Bar code system for the bags or containers containing BMW	2			
ME F6.2	Facility ensures management of sharps as per guidelines	Facility ensures supply of puncture proof containers and needle cutters	2	SI/RR	Containers are puncture proof, leak proof and temper proof	
		Facility ensures availability of post exposure prophylaxis drugs	2	SI/RR		
		There is system for reporting of needle stick injuries	2	SI/RR		
ME F6.3.	Facility ensures transportation and disposal of waste as per guidelines	Facility has secured designated place for storage of Bio Medical waste before disposal	2	SI/OB		
		BMW is stored in lock and key	2	SI/OB	Check there is no scope for unauthorized entry	
		Log book /Record of waste generated is maintained on day to day basis	2	RR	Check records are being displayed monthly on its web site	
		No signs of burning within the premises.	2	OB		
		Check infectious liquid waste is not directly drained in to municipal sewerage system	2	OB		
		Display of Bio Hazard sign at the point of use	2	OB		
		Infectious Waste is not stored for more than 48 hours	2	RR		
		Disposal of anatomical waste as per BMW rule	2	OB/SI/RR	Preferably by CTWF/in-house deep burial pits/ In house incinerator with prior approval	
		Disposal of solid waste as per BMW rule	2	OB/SI/RR	Preferably by CTWF/ Deep burial/ in absence of above autoclaving or micro waving/ hydroclaving followed by shredding or mutilation or combination of sterlization and shredding.	
		Disposal of sharp waste as per BMW rule	2	OB/SI/RR	Preferably by CTWF/autoclaving or dry heat sterlization followed by shredding or mutilation or encapsulation in metal contained or cement concrete	
		Disposal of contaminated waste (recyclable) as per BMW rule	2	OB/SI/RR	Preferably by CTWF/Autoclaving or microwaving/ hydroclaving followed by shredding or mutilation or combination of sterlization and shredding	
		Disposal of Glass ware and metallic body implants (Blue)	2		Preferably By CTWF/ disinfection (by soaking the washed glass waste after cleaning with detergent and Sodium Hypochlorite treatment) or through autoclaving or microwaving or hydroclaving	
		Annual report to the pollution control board is submitted	2	RR		
		Biomedical waste transported in authorized vehicle	2	OB/SI/RR		
	Area of Concern - G Quality Management					
Standard G1	**The facility has established organizational framework for quality improvement**					
ME G1.1	The facility has a quality team in place	District Quality Team for district hospitals are Constituted	2	SI/RR	Check for Office order by designated authority	
.		There is designated person for co coordinating with the quality circles and overall quality assurance program at the facility	2	SI/RR	Hospital Manager	
		There is designated head of the quality team	2	SI/RR	MS	
		Team members are aware for of there respective responsibilities	2	SI/RR		
ME G1.2.	The facility reviews quality of its services at periodic intervals	Quality team meets monthly and review the quality activities	2	SI/RR		
		Minutes of meeting are recorded	2	RR		
		Results for internal /External assessment are discussed in the meeting	2	SI/RR	Check the meeting records	
		Hospital performance and indicators are reviewed in meeting	2	SI/RR	Check the meeting records	
		Progress on time bound action plan is reviewed	2	SI/RR	Check the meeting records	
		Follow up actions from previous meetings are reviewed	2	SI/RR	Check the meeting records	
		Resource requirement and support from higher level are discussed	2	SI/RR	Check the meeting records	
	TRY TO SHORTEN THESE IN ONE OR TWO ACTION POINTS	Quality team review that all the services mentioned in RMNCHA are delivered as per guideline	2	SI/RR		
		Quality team review that all the services mentioned in National Health Program are delivered as per guideline	2	SI/RR		
		Resolution of the meeting are effectively communicated to hospital staff	2	SI/RR	Check how resolution are communicated to staff	
		Quality team report regularly to DQAC about Key Performance Indicators	2	SI/RR		
		Quality Team DQAC about internal assessment results and action taken	2	SI/RR		
Standard G2	**Facility has established system for patient and employee satisfaction**					
ME G2.1.	Patient Satisfaction surveys are conducted at periodic intervals	There is person designated to co ordinate satisfaction survey	2	SI/RR		
.		Patient feedback form are available in local language	2	RR		
		Adequate sample size is taken to conduct patient satisfaction	2	RR		
		There is procedure to conduct employee satisfaction survey at periodic intervals	2	RR		
ME G2.2.	Facility analyses the patient feed back and do root cause analysis	There is procedure for compilation of patient feedback forms	2	RR		
		Patient feedback is analysed on monthly basis	2	RR	Overall department wise/attribute wise score are calculated	
		Root cause analysis is done for low performing attributes	2	RR		
	MAKE SHORT	Results of Patient satisfaction survey are recorded and disseminated to concerned staff	2	RR/SI		
		There is procedure for analysis of Employee satisfaction survey	2	RR		
		There is procedure for root cause analysis of Employee satisfaction survey	2	RR		
ME G2.3.	Facility prepares the action plans for the areas of low satisfaction	There is procedure for preparing Action plan for improving patient satisfaction	2	RR/SI		
	CAN HAVE ONLY ONE POINT	There is procedure to take corrective and preventive action	2	RR/SI		

		There is procedure for preparing action plan for improving employee satisfaction	2	RR/SI		
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**					
ME G3.1.	Facility has established internal quality assurance program at relevant departments	Daily round schedule is defined and practiced	2	SI/RR	Check for entries in Round Register	
ME G3.2.	Facility has established external assurance programs at relevant departments	External Quality assurance is done on(at) defined interval by DQAC(can be deleted)	2	SI/RR		
		External Quality assurance is done on(at) defined interval by SQAC(can be deleted)	2	SI/RR		
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment	
		Departmental checklist are used for monitoring and quality assurance	2	SI/RR	Staff is designated for filling and monitoring of these checklists	
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings	
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism	
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report	
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**					
ME G4.1.	Departmental standard operating procedures are available	Hospital has documented Quality system manual	2	RR		
		Hospital has Records of distribution of Standard operating procedure	2	RR		
		Hospital has system for periodic review of the standard procedures as and when required	2	RR		
ME G4.2.	Standard Operating Procedures adequately describes process and procedures	Hospital has documented system for Internal audits at defined intervals	2	RR		
		Hospital has documented procedure for control of documents and records	2	RR		
		Hospital has documented procedure for defining Quality objectives	2	RR		
		Hospital has documented procedure for action planning	2	RR		
		Hospital has documented procedure for training and CMEs of hospital staff at defined intervals	2	RR		
		Hospital has documented procedure for monthly review meeting	2	RR		
ME G4.3.	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is trained for relevant part of SOPs	2	SI/RR	Check for the training records	
ME G4.4	The facility ensures documented policies and procedures are appropriately approved and controlled	Hospital has established procedure for drafting, reviewing, approving the Quality Management systems documents	2	RR	(a) Check availability of requisition forms & formats for developing the required documents. A system in place to draft, review the QMS documents and approval to use the documents is given by appropriate authority. (b) Check the detailed procedure is mentioned in Quality Improvement manual and followed	
		Hospital has established procedure for controlling & updating the QMS documents	2	RR	(a) Check all the QMS documents and records (both internal & external origin) are controlled. (b) Check the documents are updated as and when required	
		Hospitals has established system to provide identification number to the QMS documents and records	2	RR	(a) Check system in place to retention and retrieval the all QMS documents (b) Check all documents have title, effective date, reference number etc and signed by competent authority (C) Check the system is meticulously followed in all departments	
		Master list of the documents and records is available	2	RR	(a) Check master list of documents and records is maintained. (b) Check the list is updated.	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**					
ME G5.1.	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR		
ME G5.2.	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR		
ME G5.3.	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR		
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**					
ME G6.1	Facility has defined mission statement	Check if mission statement has been defined adequately	2	SI/RR	Mission state meant should define the purpose , target users and long term goal of facility. Mission should be defined in consultation with stakeholders and duly approved by head of facility. Mission should be in coherence with the stated mission of state health department and National Health Mission	
ME G6.2	Facility has defined core values of the organization	Check if core values of the facilities have been defined	2	SI/RR	Check if core values of organization such as non discrimination, transparency, ethical clinical practices, competence etc have been defined	
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department	
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.	
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points	
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management	
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet	
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**					
ME G7.1.	Facility uses method for quality improvement in services	PDCA	2	SI/RR		
		5S	2	SI/OB		
		Mistake proofing	2	SI/OB		
		Six Sigma	2	SI/RR		
ME G7.2.	Facility uses tools for quality improvement in services	Basic tools of Quality	2	SI/RR		
		Prateo/Priorization	2	SI/RR		
		Gantt Chart/Project Management	2	SI/RR		
Standard G8	**Facility has de defined, approved and communicated Risk Management framework for existing and potential risks.**					

ME G8.1	Risk Management framework has been defined including context, scope, objectives and criteria	Check for adequacy of Risk Management Framework	2	SI/RR	Review the risk management framework document. Check scope and objectives of the framework is contextual to the facility and criterion for identifying risk has been explicitly laid out.	
ME G8.2	Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions	Check if responsibilities for identifying and managing risk has been defined and communicated	2	SI/RR	Review risk management framework delineation of responsibilities amongst staff for identifying the risk in their work area and their management. Verify with the staff members if they are aware of their responsibilities	
ME G8.3	Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders	Check if process of reporting risks and hazards have been defined	2	SI/RR	Review risk management framework for process of reporting incidents including near miss and potential risks	
ME G8.4	A compressive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared	Check if list of existing and potential risk have been prepared	2	SI/RR	Review risk management framework includes list of identified current and potential risks. These may included safety, strategic, financial, statutory, operational and environmental risks.	
ME G8.5	Modality for staff training on risk management is defined	Check training on risk management has been provided to key staff members	2	SI/RR	Verify with the training records . Training on risk management at least should be provided to person responsible for indemnifying and managing risks	
ME G8.6	Risk Management Framework is reviewed periodically	Check risk management framework is reviewed at least once in a year	2	SI/RR	Check with the records that quality team/ risk management committee reviews the framework at least once in a year	
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**					
ME G9.1	Risk management plan has been prepared and approved by the designated authority and there is a system of its updating at least once in a year	Check if a valid risk management plan is available at the facility	2	SI/RR	Review the risk management plan document. Check it has been updated at lest once in a month and duly approved by the head of facility.	
ME G9.2	Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders	Check if risk management plan has been communicated to all stake holders	2	SI/RR	ask staff if they are aware of key actionable points of risk management plan of their concerned areas. Check what measures hospital administration has taken for effective dissemination of risk management plan amongst staff members, outsource agencies and as well as concerned officials in district and state health administration	
ME G9.3	Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders	Check if risk assessment checklist is available with stakeholders	2	SI/RR	Check if facility has prepared assessment checklist for identifying risk on routine basis. This checklist has been disseminate to the staff members responsible for identifying and reporting risks	
ME G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria	Check if periodic assessment of Physical and electrical safety risk is done using the risk assessment checklist	2	SI/RR	Verify with the assessment records. Comprehensive of physical and electrical safety should be done at least once in three month	
ME G9.5	Periodic assessment for potential disasters including re is done as per de defined criteria	Check periodic assessment pf potential disaster is done periodically	2	SI/RR	Check comprehensive assessment of both manmade and natural potential disaster is done at least once in year	
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define d criteria at least once in three month.	
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	Check if Periodic assessment of violence risks is done	2	SI/RR	Verify with records. At least once in year and whenever a major incident has occurred.	
ME G9.8	Risks identified are analysed evaluated and rated for severity	Check if various risks identified during the risk assessment proceeds are formally evaluated	2	SI/RR	Risk identified should be listed and evaluated for their security and frequency for occurrence. A risk severity score / grade should be give to each risk identified and according gaps should be rated. Verify with the records	
ME G9.9	Identified risks are treated based on severity and resources available	Check if risk have high severe are prioritised.	2	SI/RR	Check risks are prioritized base on their severity rating. Verify with the records	
ME G9.10	A risk register is maintained and updated regularly to risk records identify ed risks, there severity and action to be taken	Check if a risk register is maintained	2	SI/RR	Check hospital administration/ responsible committee maintains a risk register which risk identified, their severity, action to be taken to mitigate risk and follow up action. Check if risk register share been updated timely.	
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**					
ME G10.1	The facility has defined clinical governance framework	Facility has defined framework for clinical Governance	2	RR/SI	(a) Framework reflects facility's commitment & accountability for Continuous quality improvement in their Clinical services . (b) Framework define the responsibilities of clinical Governance board (c) Framework defines the approaches used to implement clinical Governance in healthcare facility i.e. audits, risk management, clinical effectiveness, patient & public involvement, education and training, information management etc	
		Facility has clinical Governance Board at place	2	RR/SI	(a) Check Clinical Governance Board/Apex Committee has representation from all the clinical departments. (b) Department Heads/ Inchages/Representatives are identified or appointed (c) Members of Apex Committee is aware about their roles & responsibilities	
		Clinical Governance Board/Apex committee prepared & approve the facility's plan for improving clinical quality and safety of patients	2	RR/SI	All the Clinical committee viz Infection control committee, medical, death and prescription audit committee etc. are functioning under guidance of Clinical Governance board	
	NEEDS REDUCTION	Clinical Governance Board/ Apex committee regularly receive reports on the quality and patient safety activities	2	RR/SI	Board review the reports & monitor the compliance to action taken reports. Also, provide support for the compliance .	
		Clinical Governance board meet at regular intervals	2	RR/SI	At least once in month	
		Check clinical care outcomes & indicators are reviewed	2	RR/SI	Aggregate patient data is collected and reviewed: (a) Clinical Outcomes (b) Clinical indicators (c) Adverse/sentile events that occurred	
		Decision taken in clinical Governance meeting are communicated to all concerned staff	2	RR/SI	Check the system in place to communicate the decisions of clinical governance meetings to all medical professionals	
		There is system in place to conduct grand rounds regularly	2	RR/SI	(1) To promote collegiality, communication, collaboration, and learning among healthcare professionals (2) Check how frequently the grand rounds are conducted	
ME G10.2	Clinical Governance framework has been effectively communicated to all staff	Check staff is aware of Clinical Governance framework	2	SI	Staff is aware of role of clinical Governance in improving quality of care	
ME G10.6	Governing body of healthcare facilities ensures accountability for clinical care provided	Hospitals has defined accountability & responsibility for day to day operations	2	RR	Check hospital has defined & documented organogram	
	Area of Concern - H Outcome					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**					
ME H1.1.	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate	2	RR		
.		No. of total admissions per thousand population	2	RR		
.		IPD per thousand population	2	RR		
.		OPD consultation per Thousand Population	2	RR		
.		Number of beds per 10 thousand	2	RR		
.		Maternal mortality per 1000 deliveries	2	RR		
.		Neonatal mortality per 1000 live births	2	RR		
.		Nurse to bed ratio	2	RR		
.		No. of meeting held under RKS	2	RR		
		Proportion of BPL patient in hospital	2	RR		
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**					

ME H2.1	Facility measures efficiency Indicators on monthly basis	Overall Referral Rate	2	RR		
		Overall discharge rate	2	RR		
		Proportion of obstetric cases out of total IPD	2	RR		
		Proportion of fund/ grant utilized	2	RR		
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**					
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average Length of Stay	2	RR		
		Crude mortality rate	2	RR		
		Maternal mortality per 1000 deliveries	2	RR		
		Neonatal mortality per 1000 live births	2	RR		
		Hospital acquired infection rate	2	RR	Surgical Site, Device related hospital acquired infection rate	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**					
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Overall LAMA Rate	2	RR		
		Patient satisfaction Score IPD	2	RR		
		Staff Satisfaction Score	2	RR		
		Turn over rate of contractual staff	2	RR		