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STATE HEALTH AGENCY KERALA

FASP





TRAINING ON QUALITY CERTIFICATE STANDARDS FOR AB PM-JAY-KASP





EXPECTATIONS!





TRAINING DELIVERABLES

Additional Support to create quality culture
 To Exchange Indicator based quality tool
 Patient safety and Increased care for Patient
 Improve National Recognition of EHCPs





INTRODUCTION

PM-JAY established a 3 level Hospital Quality certification







BENEFITS

- Incentivization (Silver & Gold)
- To provide Quality of services, Enhance patient satisfaction and improve Standard of care





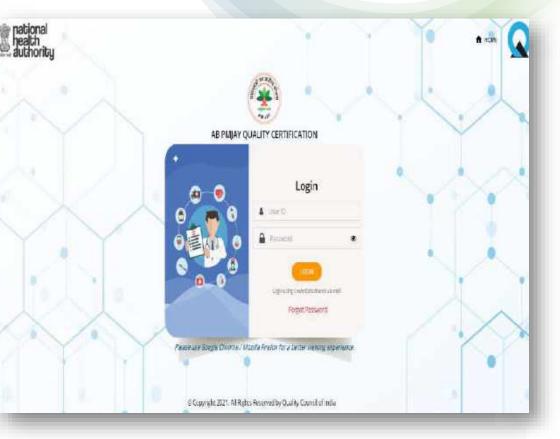
PROCESS TO OBTAIN BRONZE CERTIFICATION

Launched in August 2019 Bronze quality certificate is a pre-entry level certificate

Aims to bring both private and public AB PMJAY empanelled hospitals at par in terms of quality of service

Comprehensive, User Friendly, Evidence-Based, Digital Certification, Objectivity, Balanced

Approx. 75% small healthcare organisation (SHCO) will be able to start their journey to improve quality



https://pmjay.qcin.org/pages/login

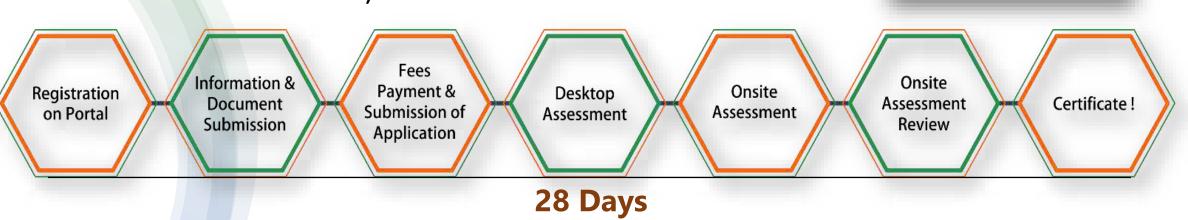




CERTIFICATION STANDARDS

BRONZE CERTIFICATION

- Hospitals that are empaneled with AB PM-JAY
- Do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate
- 53 standards & 182 means of verification (Inputs, Clinical and Support services, patient care and Health outcomes)



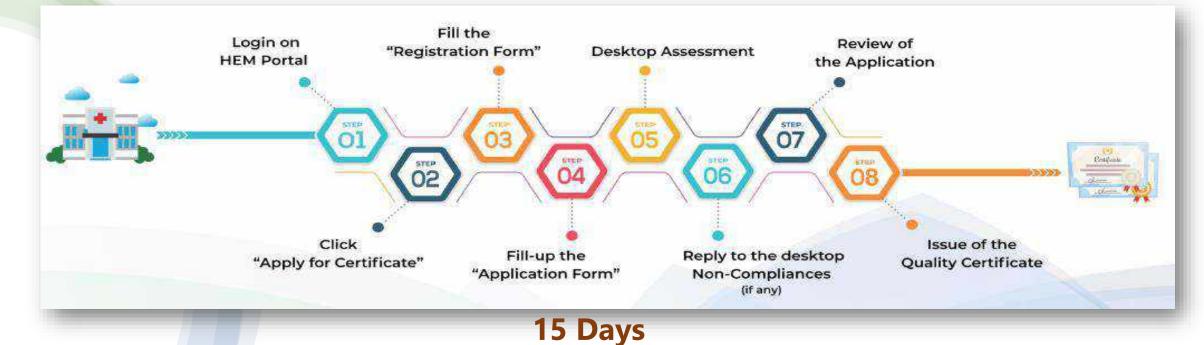




SILVER & GOLD QUALITY CERTIFICATE

Silver Quality Certificate is the second level of Ayushman Bharat Quality Certification which is revised terminology for Entry level NABH/NQAS Certification.

Gold Quality Certificate is the third & the highest level of Ayushman Bharat Quality Certification which is revised terminology for NABH full /JCI Certification.



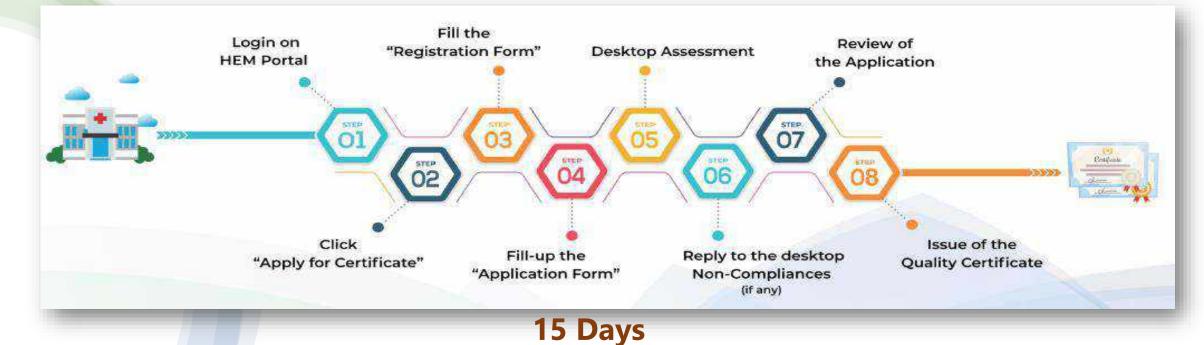




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HOW TO OBTAIN AB PM-JAY GOLD / SILVER / BRONZE QUALITY CERTIFICATE





GOLD QUALITY CERTIFICATE FOR AB PM-JAY

Gold Quality Certificate is the highest level of Ayushman Bharat Quality Certification which signifies that the certified hospital is complying with most of the healthcare protocols to ensure best quality of services and patient care. Gold Quality Certificate is revised terminology for already existing outcome -based incentivization structure i.e. NABH Full / JCI Accreditation to AB PM-JAY Gold Quality Certification. Silver Quality Certified hospital can directly apply for this certification. Gold Quality Certified hospitals will get additional and higher financial benefits over and above the 'Hospital benefit plans'.







GOLD QUALITY CERTIFICATE FOR AB PM-JAY







SILVER QUALITY CERTIFICATE FOR AB PM-JAY

Silver Quality Certificate is the second level of Ayushman Bharat Quality Certification which is revised terminology for already existing outcome -based incentivization structure i.e. Entry level NABH/NQAS Certification. It indicates that hospital has better quality of services and patient care but need to focus next on organization centered standards in terms of responsibility of management system among others. It is intended to motivate hospitals to keep increasing the level of quality in their services. Bronze Quality Certified hospital can directly apply for this certification. Silver Quality Certified hospital financial benefits over and above the 'Hospital benefit plans'.







SILVER QUALITY CERTIFICATE FOR AB PM-JAY







QUESTIONS FOR AB PM-JAY GOLD / SILVER QUALITY CERTIFICATION:-

Questions are divided in two parts-

1. AB PM-JAY Specific Questions (25)

2. Quality Audit Checklist Questions (20) -

PM-JAY
View Approved Application
👩 Certification 🐱
👩 Update Application 🗸
😭 Upgrade Application 🗸
😭 Quality Austit 🐱
Quality Audit CheckList
- View Quality Audit
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Enhancements Search

Note:- <u>After completion of Quality Audit Checklist please submit and take Screenshot and this</u> <u>Screenshot should be upload as an evidence of AB PM-JAY Specific Question number – 25.</u>





1. Are 'scope of services' registered under AB PM-JAY clearly defined and displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.)?







2. Are 'scope of services' registered under AB PMJAY displayed bilingually (Malayalam & English)?







3. Is the hospital staff aware of 'scope of services' registered under AB PMJAY?

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4. Is there a dedicated kiosk/ counter for AB PMJAY at prominent place in the hospital?











5. Is the kiosk/ counter manned by Pradhan Mantri Arogya Mitra (PMAM)/ trained staff during the operational hours (e.g. Arogya Mitra & its Duty list) ?

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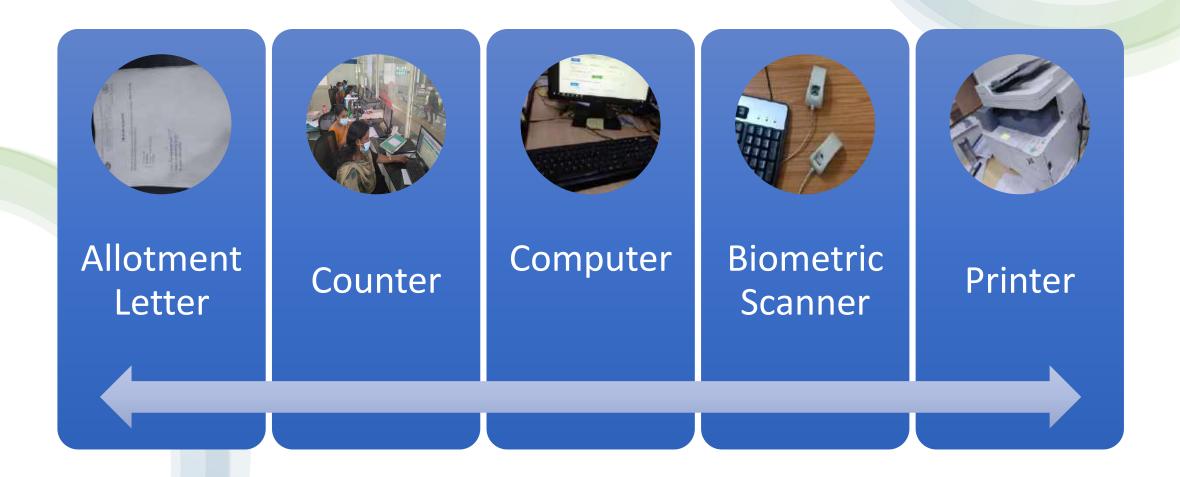


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6. Are required equipment's provided to Arogya Mitra for AB PM-JAY beneficiary identification?







8. Does the hospital have at least one Pradhan Mantri Arogya Mitra (PMAM)/ dedicated person per shift appointed for looking after the work of Ayushman **Bharat Scheme?**



Dute: = 31. et. 2.014.

Dr. Heena Prabhuram Thaidur Block No. 5, 5btsb Bunglows. Telephone Exchange Road, Near Karmahhoomi Society, Putun-384265 Moh. No.: 997400703979825761049

Sub-Appointment for the post of Medical Clinical Coordinator (Trainee)

With reference to your Campus interview held on 14,11,2016 at this institute for the post of Medical Clinical Coordinator (Trainee), we are pleased to appoint you as a Medical Clinical Coordinator (Trainee) at this institution purely on probation with the following terms and conditions.

- You will have to join the post within a week from the date of issue of this letter or within the time timit extended on your request by the Institute, failing which your appointment order will be treated as cancelled.
- Your appointment has been made for a period of aix menths from the date of joining. purely on probation. The probation pariod may be ascanded at the sole discretion of the Institute or your service may be dispensed with earlier either during the probation period or during the extended period of probation. You will continue to be on Probation without any increment till you are given confirmation letter by the institute.
- On completion of probation period satisfactorily, your appaintment will be on contractual basis for a period of TWO YEARS which includes the probation period.
- Your appointment will not be treated as confirmed employee, unless you are given confirmation letter by the institute and the period would automatically expire after the completion of the said period, and there will be severance of relationship between you and the institute.
- You have to undergo special training for 3 months at the institute and during noch training puriod, your pay will be Rs.25000/-[Rapces Twenty Five Thousand Only] per month. After completion of successful training satisfactory, your pay will be Rs.27500/-(Ruppes Twenty Seven Thousand Five Hundred Only) per month. No other allowances of any kind will be admissible. You will be ordinarily given 10% yearly increment.
- Group Health Insurance & other benefits would be given as per the rules of the Institute. EPF & Gratuity will be applicable as per the rules.
- During probation period your services shall be liable for termination without any notice. No notice of termination is necessary on expiry of probletion period or at the end of contractual neriod
- In view of the fact that you are working in Cardiac institute it would be mandatory for you to give "two months" notice for getting relieved from the services for the institute before leaving the job during the period of contractual appointment. Unless your resignation is accepted following proper formality, experience certificate and No Objection Certificate will not be insured. You will hand over the books, journal or any other property of the Institute to the surferned officer and produce no due certificate before you are relieved.



U. N. Mehta Institute of Cardiology & Research Centre (Affiliated to B. J. Medical College, Atmodeland) (Sell Hotelta) . Asswer, Ahmedaland - 380 US2 Gyderat Strike) Phone (1079) 23062395, 23684355, 33626200 Fax (0079) 22062092 small : unmicrosognalizers arebate : and anniet org

Job Description of Medical Clinical Coordinator (MA Yolana)

- > To check complete medical details of MA yejana patient.
- > To check MA yojana data and repister the patient.
- > Once fingerprint verify, then register the potient under MA yojana.
- After registration of patient, change category of patient in HMIS of the hospital.
- > Stan complete document of patient.
- * To update complete detail of treatment in software for indeer patient. Coordinate with Ceth, OT coordinator and unit coordinator for MA Vojana nationts.
- > Collecting all operation notes for operative patient.
- > Take daily approval of Indoor patients. (For each and every approval we have to upload respective preoperative reports of patient).
- > In case of Adhoc procedure of patient, taking approval from pre-auth department of MA Yojana on same day.
- > To coordinate with respective CVTS and Cardiologist for different diagnosis
- > At the time of discharge responsible for collecting operative or cath procedure documents, post-operative reports and discharge card of the patient and verify all received documents of patient before discharging.
- > At the time of discharge responsible for uploading of all post-operative report and discharge card in MA Yojewa site, responsible to take signature of patient or patient relative on the documents and give Rs.300/- as transportation allowance. Further responsible for photo capture of Rs.300/r and medicine with [on. relative patient nis/ner OF name in MA card) after verifying finger print.
- Responsible to generate invoice after discharge. Submit and claim in MA vojana software elter stemp and sign from Account Manager.
- > Generating the bill and to submit physical copies of entire bill with all supporting documents take PRP[Pre-outhorization form], discharge summary, satisfactory letter discharge card and undertaking at claim department of MA Yolmin.
- > Any other work assigned by the H.O.D/ C.E.O/ Director and Top management from time to time.

Signature of Employee Signature of Authoritys





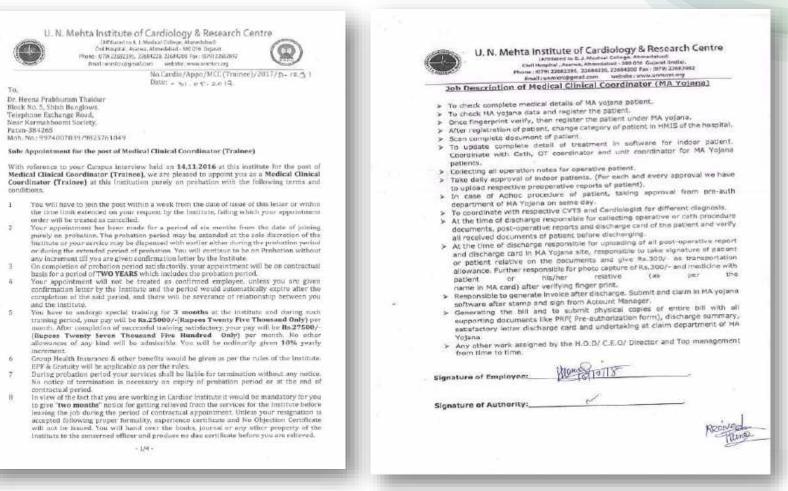
7. Does the hospital have a dedicated team for AB PMJAY?







8. Does the hospital have at least one Pradhan Mantri Arogya Mitra (PMAM)/ dedicated person per shift appointed for looking after the work of Ayushman Bharat Scheme?







9. Does the nominated AB PMJAY team have doctor(s) engaged?

U. N. Mehta Institute of Cardiology & Research Centre (Affigued to & L Medical College, Abstractional) Col Rispital, Analog, Almodalian - 186 016 Tripical Phone: 10791 (20092395), 724842230, 22684200 Fea: 10791 22662012 Analogination whitewww.unckr.og No.Eardio/Appo/MCE/Chrainee)/2017/fb- (2.5.1

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- 14 You will not be allowed any Madial private practice. You shall not enter into previoes or beengaged or he intersected in any other anguaration directly, indirectly or engage your selfis other professional vocational to occupational activities.
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- 10 You will have by once without any additional remainer also at any 404.47 allowances at any department for the work of the builtudies (stand of with the builture and you shall perform duties as may be assigned to you from tune to time.
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U. N. Mehta Institute of Cartfology & Research Centre. Addressing (and athles Northlat) ON BOILS Association 381776 Course

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- U. N. Mehta Institute of Cardiology & Research Centre (Attracted to 5.3 Medical College. Attractation) Chill Horphal, Asarwa, Attractation - 200 DTE Guisent India: Phone: 079122082385, 23484225, 22654200 Fax: 079123682992 Analisenticipgmal.com website:www.evente.org Job Description of Medical Clinical Coordinator (MA Yolana)
- To check complete medical details of MA vojana patient.
- > To check HA yotana data and register the patient. > Once fingerprint verify, then register the patient under MA yojana.
- > After registration of patient, change category of patient in HMIS of the hospital. > Scan complete document of patient.
- > To update complete detail of treatment in software for indoor patient. Coordinate with Ceth, QT coordinator and unit coordinator for MA Yojana
- patients.
- > Collecting all operation notes for operative patient. > Take daily approval of Indear patients. (For each and every approval we have to upload respective preoperative reports of patient).
- > In case of Achoc procedure of patient, taking approval from pre-auth
- department of MA Yojena on same day. > To coordinate with respective CVTS and Cardiologist for different diagnosis.
- > At the time of discharge responsible for callecting operative or cath procedure documents, post-operative reports and discharge card of the patient and verify
- all received documents of patient before discharging. > At the time of discharge responsible for uploading of all post-operative report and discharge card in MA Yojana site, responsible to take signature of patient or patient relative on the documents and give Ra.300/ as transportation allowance. Further responsible for photo capture of Rs.300/- and medicine with patient of hts/her relative (as per the
- name in MA card) after verifying finger print. Responsible to generate invoice after discharge. Submit and clarm in MA yojana
- software after stamp and sign from Account Manager. > Generating the bill and to submit physical copies of entire bill with all supporting documents like PRP(Pre-authorization form), discharge summary, satisfactory letter discharge card and undertaking at claim department of HA
- > Any other work assigned by the H.D.D/ C.E.O/ Director and Top menagement from time to time.

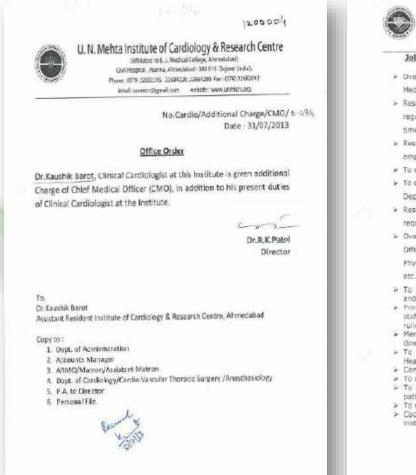
Signature of Employee:	Marghons	_

Signature of Authority:





10. Does the nominated AB PMJAY team have a member from administration department?





U. N. Mehta Institute of Cardiology & Research Centre Chilliamed to B. J. Medical College, Alertedated Collborgham Argeney Alternational - MIDIFIN Carpert Index. Huma: (279) 1268(1995, 22694225, 2269426) Fax: (279) 2258(1092)

Amail: semined-philipped website www.unmiercary

Job Description of Clinical Cardiologist Cum Incharge C.M.O.

- Overall in charge of the general administration in the discipline of the Medical Department.
- > Responsible for coordination of all the relevant acts, rules and regulations and Protocol, systems that may be in force from time to time,
- * Responsible for ensuring the smooth delivery of nealth care to the . employees of the Trust and their families.
- To conduct, surprise, inspection of the Department of the Institute.
- * To conduct penodical progress and review meetings of the Medical Department.
- > Responsible for making alternate postings/duty arrangements when required.
- > Overall supervision of the postings made in respect of Medical Officers, Nursing personnel, First Ald Service and Ambulance, Physiotherapists, Rediographers, Metico Social Workers, Attendants
- > To inspect various Inpatient and Outpatient sections of the Hospital and ensure cleanliness and sanitation, availability of Staff, etc.
- Provides assistance in the manoging of the affairs of the entire medical staff that are in accordance with the prevailing ethical standards and the ruling policies of the organization.
- Member of Quality assurance committee, Medical audit committee, Grievance represses committee, Infection control committee etc.
- > To participate in the in-service education programme inclusive of CPR
- Health, Fire Safety training. Consultation of patients in Cardiology OPD (new case & old case).
- > To make arrangement for reimbursement of patient bills.
- > To coordinate with cardiologist for estimation as well as admitsion of patients.
- To manage duty list of Medical Officers and Physiotherapists.
- > Coordination & Management of the Parametical Courses (17) run by the institute



U. N. Mehta Institute of Cardiology & Research Centre Chillianed to B. I. Medical College, Abriedabod Out human Aranes Atmetimat - 300 Fin Super Indu. Phone: (979) 1268(1975, 2269422); 22694265 Fax: (779) 2258(1092) Amail: unminedepail.com website www.unmionally

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- Consultation of patients in Cardiology OPD (new case & old case).
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- patients.
- > To manage duty list of Medical Officers and Physiotherapists. > Coordination & Management of the Parametical Courses (17) run by the
- institute.





11. Does the hospital have AB PMJAY specific IEC materials near hospital entry and at prominent areas?

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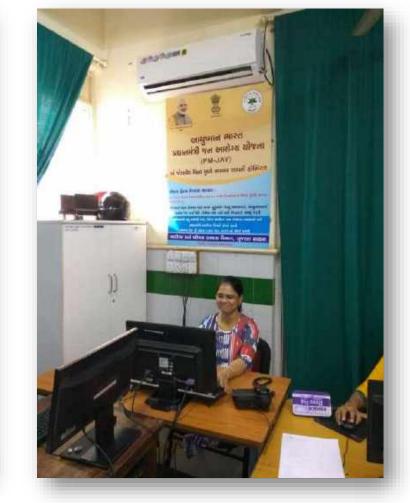






12. Does the AB PMJAY kiosk/ counter has IEC materials pertaining to AB PMJAY on or near it?











13. Has hospital conducted any promotional activity (like camping) for spreading awareness regarding the AB PM-JAY scheme?







14. Is hospital's scope of services mapped with hospital's Manpower/Human Resources?

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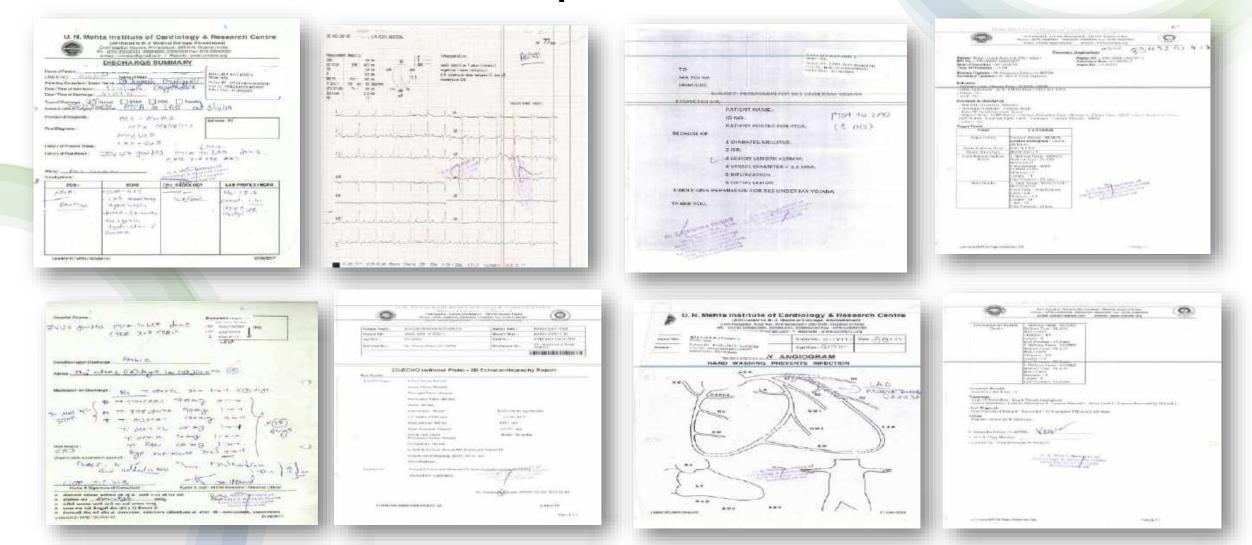
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1	Dr Ramsub Dabyeddai:Patul	MD (Dector of Medicies)	11674	26
2	De Agistas Chendral act Pujara	MD (Dector of Medicine)	34356	32
3	Dr Rireih Babul d. Shok	MD (Dector of Medicine)	11496	36
4	Be Hamang Kiritkamas Ganihi	MD (Bectar of Medicies)	12555	11
5	Dr Rajesb Matkhand Shid Thousai	MD (Dector of Medicine)	7566	n
ñ	De Meugesh Manifal Prajapari	MD (Dector of Medicine)	12956	5
7	Dr Divys hant Kondini Parsser	MD (Deccer of Medicine)	19025	5
8	De Siger Jackson fait Paul	MD (Dector of Medicine)	1 55 75	5
9	Dr Jiger Heshmulchisk at Panelial	MD (Dector of Medicier)	16278	9
10	Dr Bharat G Makwane	MD (Dector of Medistry)	14568	7
n	Dr Saywedshmed Y Vehra	MD (Dector of Medicine)	21676	
12	Dr Doopol Virikalitest Prajapati	MD (Dector of Medicine)	19975	
13	Dr Väharad C Triveli	MD (Doorse ef Medicine)	19137	
14	Dr Alpeik C Sarvaia	DM (Docurate of Medicae)	24845	5
15	Dr Hamistik N Patal	DNI (Doctorate of Mathemat)	2624	
14	De Sanilkasnar Narschleini Nisama	MD (Durnin al Madicine)	15:999	
17	Dr Inackla Vidyaethi Jain	MD (Decise of Medicine)	8585	2
18	De Niev Pacifik	MD (Dortor of Modicies)	12005	•
19	Dr Jiger Surti	MD (Dortor of Modicine)	13751	3





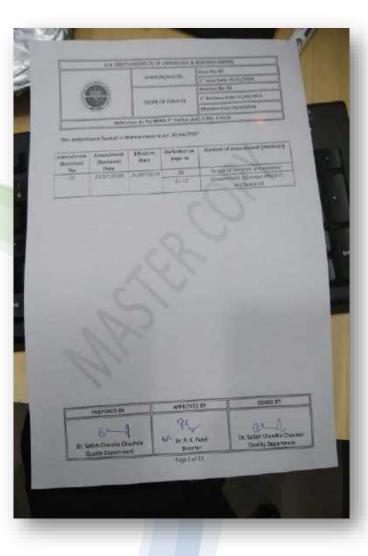
15. Do the hospitals maintain proper medical records maintained for AB PMJAY patients?







16. Is AB PMJAY claim process documented in the hospital's policies?



Name of Policy Policy No.	Policy for Registration & Admission	PATIENT FLOW IN THE HOSPITAL
	& Admission NCHS/AAC/02/A	Patient Enters in to Hospital
Purpose	& of and to the with the aims to:needs and expectations of customers.	Follow up Cases New Patient
	Customers satisfaction.	OPD Reg. & IP Reg. & Emergency
	a of patients.	Cash Counter Admission Desk Emergency
	Feedback continuous improvements.	OPD Wards ICU OT Diagnost Test
scope	All patients undergoing at NCHS.	24 Hr. Pharmacy
Responsibility	All members of front /Case window staff, nursing staff of NCHS.	Out IP Billing Discharge





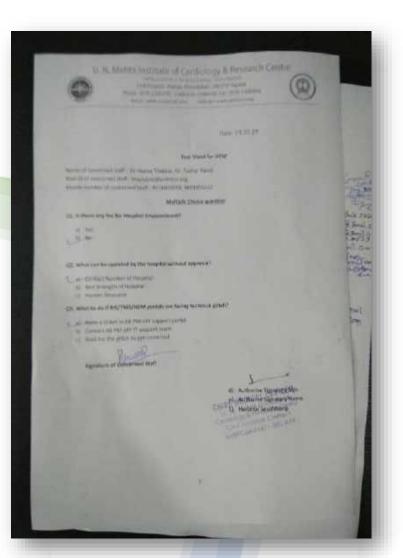
17. Does the hospital charge any extra money from AB PMJAY beneficiaries?

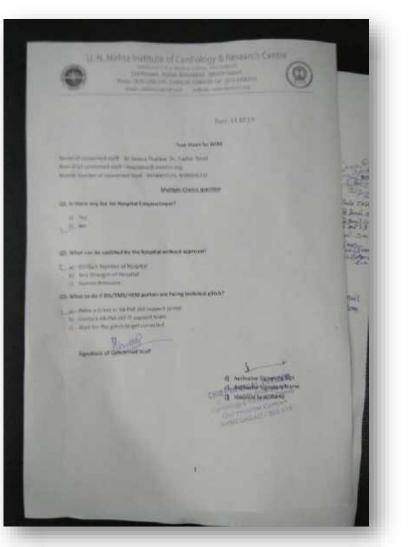


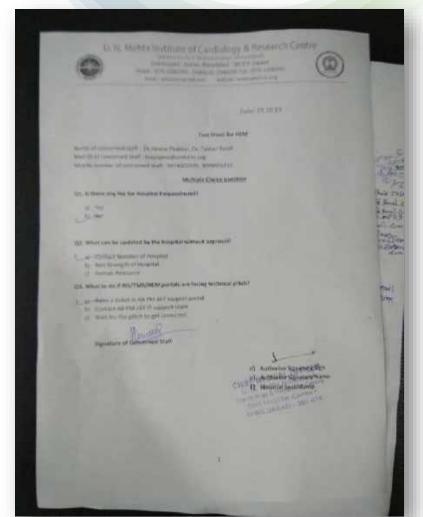




18. Are the deployed staff members trained for HEM portal?



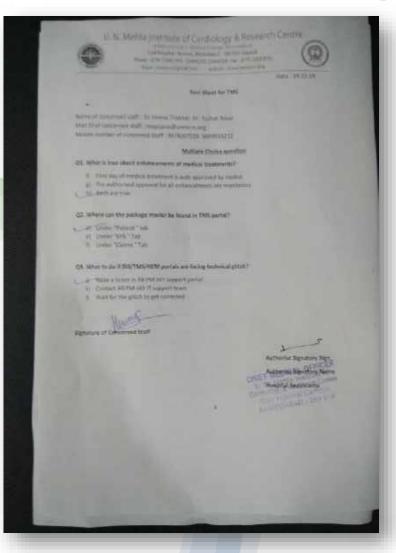


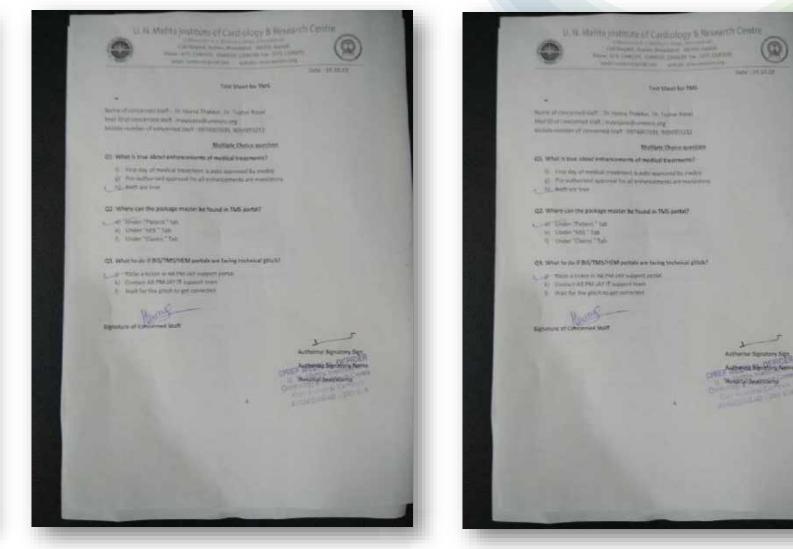






19. Are the deployed staff members trained for TMS portal?

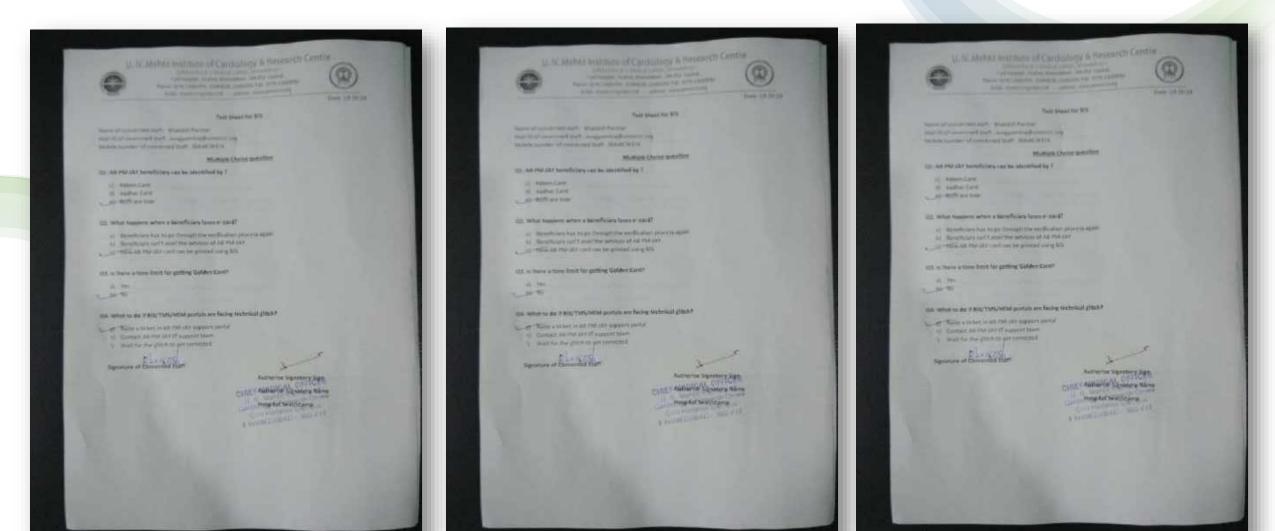








20. Are the deployed staff members trained for BIS portal?







21. Does the hospital maintain proper records for AB PMJAY referred beneficiaries?

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1	APRIL	IPD/2019/ 04/00090 19	UNM- 2019-04- 025045	01-04-19	01-04-19	NEW IPD	HIRALAL MANGILA L PRAJAPAT I	Male	49y	40Y - 60Y	ADULT		Cardiology Unit - 2	Married	Gujarati	WARD NO- 17	TARAKHE DI	Jaora		MADHYA PRADESH	OTHER STATE	MADHYA PRADESH	INDIA
2	APRIL	IPD/2019/ 04/00090 26	UNM- 2018-07- 058187	24-07-18	01-04-19	FOLLOW UP	VANITABE N BALKISHA N NORA	Female	40y 8m	40Y - 60Y	ADULT	24/07/197 8	Cardiology Unit - 1	Married	Gujarati	585/3691, G.H.B.,BA PUNAGAR	AHMEDAB AD	AHMEDAB AD	AHMEDAB AD	GUJARAT	GUJARAT	GUJARAT	INDIA
3	APRIL	IPD/2019/ 04/00090 28	UNM- 2019-03- 021286	18-03-19	01-04-19	FOLLOW UP	SHAKARIB EN BHULESH WARBHAI DARJI	Female	70y	>= 60Y	ADULT	18/03/194 9	Cardiology Unit - 2	Widow	Gujarati	NR. BAL MANDIR	kankanol	HIMATNA GAR	SABARKA NTHA	GUJARAT	GUJARAT	GUJARAT	INDIA
4	APRIL		UNM- 2019-04- 025122	01-04-19	01-04-19	NEW IPD	MANJULA BEN MAHESHB HAI JADAV	Female	52y	40Y - 60Y	ADULT	01/04/196 7	Cardiology Unit - 2	Married	Gujarati	B/H RAILWAY CROSSING , NEW CHAMUN DA SOC- 36, NR. NAVRANG HIGH SCHOOL, JAGATPUR ROAD, CHANDKH EDA	AHMEDAB AD	AHMEDAB AD	AHMEDAB AD	GUJARAT	GUJARAT	GUJARAT	INDIA
5	APRIL	IPD/2019/ 04/00090 63	UNM- 2019-03- 021083	16-03-19	01-04-19	FOLLOW UP	MANGILA L RAMLALJI DHANGAR	Male	56y	40Y - 60Y	ADULT	16/03/196 3	CVTS Unit - 1	Married	Hindi	-	SARSOD	Daloda		MADHYA PRADESH	OTHER STATE	MADHYA PRADESH	INDIA
6	APRIL	IPD/2019/ 04/00090 68	UNM- 2019-04- 025070	01-04-19	01-04-19	NEW IPD	GOPAL RODUJI SURYAVA NSHI	Male	36y 9m	18Y - 40Y	ADULT		Cardiology Unit - 2	Married	Gujarati	-	RAHIMGA RH	Sitamau		MADHYA PRADESH		MADHYA PRADESH	INDIA
7	APRIL	IPD/2019/ 04/00090 78	UNM- 2019-04- 025095	01-04-19	01-04-19	NEW IPD	PUSHPAB EN PRAKASH BHAI DHOBI	Female	42y 3m	40Y - 60Y	ADULT	01/01/197 7	CVTS Unit - 1	Married	Gujarati	BIHAND SANSAD BHAVAN	MANDSA UR	Mandsaur		MADHYA PRADESH		MADHYA PRADESH	INDIA
8	APRIL		UNM- 2019-03- 016731	01-03-19	01-04-19	FOLLOW UP	NATVARL AL MOHANL AL SOLANKI	Male	69y 8m	>= 60Y	ADULT	07/07/194 9	CVTS Unit - 2	Married	Gujarati	OD VAS,BUKD I ROAD	PATAN	PATAN	PATAN	GUJARAT	GUJARAT	GUJARAT	INDIA
9	APRIL	IPD/2019/ 04/00091 07	UNM- 2019-04- 025431	01-04-19	01-04-19	NEW IPD	RASIKBHA I MOHANB HAI MAKWAN A	Male	55y	40Y - 60Y	ADULT	01/04/196 4	Cardiology Unit - 2	Married	Gujarati	-	BAHADUR PUR	PALITANA	BHAVNAG AR	GUJARAT	GUJARAT	GUJARAT	INDIA





22. Number of AB PMJAY beneficiaries referred to AB PMJAY hospitals in last 6 month







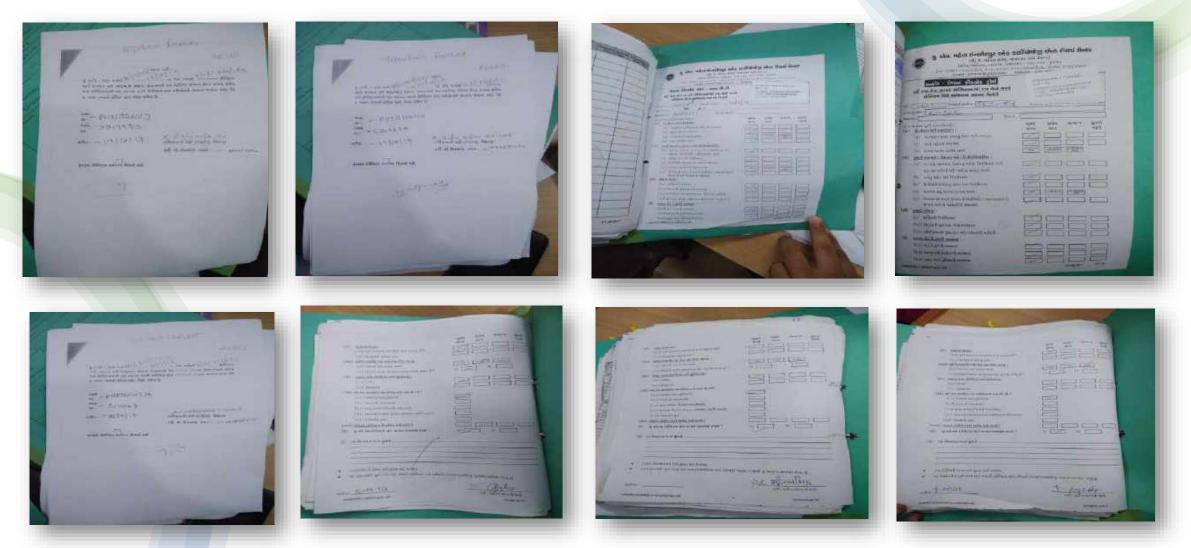
23. Number of AB PMJAY In-Patient Department (IPD) census for last 6 months







24. Does the hospital collect feedback during discharge from AB PMJAY beneficiaries?







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25. AB PM-JAY quality audit checklist filled regularly in HEM portal?

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Guidelines for Quality Audit Checklist Link:- https://hospitals.pmjay.gov.in

- > Quality Audit Checklist to be filled for all 20 parameters.
- Each parameter to be assessed based on compliance to required evidences.
- Method of Assessment includes Direct observation, Patient Interview, Staff Interview and Record Review required as per parameter.
- Scoring is 0 (Non Compliance), 5 (Partial Compliance) and 10 (Full Compliance) based on the evidences
- Empaneled hospitals have to perform an online self assessment every month and average score will be considered as yearly assessment score.





1. All the services being provided by AB – PMJAY Empanelled Hospitals, patient rights and responsibilities are clearly defined & display at prominent place in understandable language.



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1. All the services being provided by AB – PMJAY Empanelled Hospitals, patient rights and responsibilities are clearly defined & display at prominent place in understandable language.



PATIENT & FAMILY RIGHTS	RESPONSIBILITIES
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cð da sanda neve hi anni cancích afgd and.	પેટાએ દેવે વિવે શહુલે મહિદી, છામને આપ્ય કેમદી, પુન કેશ પર દોવ માટલ કેમદી. વિવેદેવીમિ પ્રકાર મહિદીસવતે સમયતે
શાસભાગ પ્રકાશ કારણે, ગયાસમાં કારણાં, દાગમાં, દાગણાં પ્રાપ્ત મારાક દાગસાં પ્ર	ાલાઝાત મારે ભરદાદાલાળા આવ્યું અને સાવસા મારુપાલના ભારત અને સાધભાગ ગાળા મેલ
DEATY.	આરાગાગામાં દાળા
શી અને તેન સ્વારે નવાર પ્રતે સ્વારા દાગમાં દાગમાં દાને વ્યવેત્વન, આવિ પ્રતે ત્રાંગુનિક	જોવના બિજન બાદે સાધેન સુધનો અને સેવલર વહુ છે. સ્વારંત કરવું અને સાધવાયું વર્તનું
મન્ડતાએનું સ્વતન વ્યવણ	પાસન કરવું
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શ્વા દિશામાં આપવે સાંદા થયું આવ્યું. ત્યાં અને તેના આપને વન્નીય ગોધવ અને વિવેશ અને ગણક નાળ્યું.	કારણ માં માં આવતા ગામમાં માં માં માન્યાના પ્રકાશ માં માં માનવાડમાં શકાય કરે. ભારતા માં માં આવ્યા પ્રકાશ માં આવ્યા છે. શીર્વાજીમાં કરવાડું સાવવાર વેચા માટે સ્વાર્થમાં આવ્ય તેઓ તેને પ્રત્ય કેનુ પ્રવાસ કરવું. તેમ આરક્તર તે આવે લાક્ષ્ય તે કોર્ટ્સ અને પ્રત્ય કે રહી.
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	Sr.	Patient & Family Rights	Responsibilities			
]	No					
	1	Information about their health in language and format	Give us as much information as you can			
		that they can understand.	about your present health, past illness, allergies and any other relevant details			
l	2	Respecting any special preferences, spiritual and	Follow the prescribed and agreed			
		culture needs & personal dignity.	treatment plan and comply with the instructions given			
	3	Respecting personal dignity and privacy during	To show consideration towards the			
		examination procedure and treatment	rights of other patients by following hospital rules			
	4	Protection from neglect and abuse	Stick to the appointments that you make			
			or else notify the hospital as early as possible, if you are unable to do so			
	5	Keep patient information confidential.	Do not ask us to provide incorrect			
			information or certificates			
	5	Refusal of treatment	Do not litter the hospital			
Ľ	7	Seek an additional opinion regarding clinical care	Keep toilets clean after each use			
	8	Informed consent before transfusion of blood and blood	Do not smoke or spit inside the hospital			
		products, anesthesia, surgery, initiation of any research	premises			
		protocol and any other invasive/high risk				
		procedure/treatment.				
!	9	Patient and family are made aware to lodge complaint	Wait patiently for your turn			
		and give feedback. The complaint is addressed to				
F		grievance redressal committee				
	10	Information on the expected cost of the treatment and	Maintain silence			
		about financial implications when there is a change in				
\vdash		the patient condition or treatment setting				





2. Hospital has displayed the IEC pertaining to Ayushman Bharat at prominent place

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) The banner or poster of AB- PMJAY is displayed at prominent		100% compliance of all three evidences.	10	
place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b) The banner or poster of AB-	Direct observation & Staff interview	non compliant.	5	AB PM-JAY Banner displayed at prominent place in hospital premsis.
PMJAY is visible to patient or visitors c) Staff aware about the AB- PMJAY		Non-compliance of all three evidences.	0	





2. Hospital have displayed the IEC pertaining to Ayushman Bharat at prominent place







3. The initial assessment by doctors for in-patients is documented within 24 hours or earlier and the Patient record file have care and treatment orders which is signed, named, timed and dated by the concerned doctor.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)	
See minimum 5 in-patients files of existing (admitted) patient record and check for: a) Availability of Initail assesment form		100% compliance of all four evidences.	10		
 b) Initial assemnent form filled by concerned personal c) Time of admission ,Time of initial 	Record review & Staff interview	if any of the four evidence is found to be non-compliant.	5	Doctor's initial assessment form and Nursing initial	
assessment, Initial assesment start and completion time. d) Treatment orders are signed, named, timed and dated by the concerned doctor		Non-compliance of all four evidences.	0	assessment form.	





3. The initial assessment by doctors for in-patients is documented within 24 hours or earlier and the Patient record file have care and treatment orders which is signed, named, timed and dated by the concerned doctor.

	L ASSESSMENT BY lled by Doctor on arriv	DODION	D-FF-05	Nutritional Advice: Type of Diet: √ □ FD,□ CFD,□ FFD, □ HPD, □ DD, □ LD,□ SRD. Rehabilitation: √ □ Physiotherapy □ Social □ Occupational Therapy □ Psychological □ Speech Therapy □ Vocational
lame of Patient:		UHID No.:		Prosthetics & Orthotics
(ard.:	Date://20_	Age: S	ex: Male 🛛 ,Female 🗆	Reference:
istory Informant: Po atient Arrival status; resenting complaints: yncope Vomiting In Hematemesis I,PR Blo ,retention of urine/ Ar	Time atient0, Other D Patien Ambulatory D Wheel Chair Fever D Cough Dyspnor digestion/ Heart burn D ab seding, D Anorexia D Weig wrig, Dovuria D, Jaundice D ums others	tt Brought by-self/ 108/ Poli □ Stretcher □ Other □, ea □Chest pain□ Haemop dominal pain □ Diarrhoea ht Loss □Weight Gain, □Pol 1,Headache □, Pain □ Gid	tysis D,Palpitation D D,Constipation, <u>vuria</u> DBurning <u>Micturition</u> diness D Backache	Reference to Reason for reference 1.
atient History: V		Family History: V F-Fath	er, M-Mother,B-Brother,	
ypertension	Asthma	S-Sister Hypertension	Asthma	
eart Disease	Stroke	Heart Disease	Stroke	4
abetes	Cancer	Diabetes	Cancer	Name of <u>Doctor</u> ; Sign:DateTime:
	Other Chronic	Dyslipidaemia	Other	Name of <u>Consultant</u> : Sign:DateTime:





4. The results of the diagnostic (Laboratory, Radiology, etc.) tests should be made available in defined time frame and intimated about the critical results to the concerned personnel immediately.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Time frame of diagonostic results		100% compliance of all three evidences.	10	Turn around Time,
are displayed in diagnostic department and followed.	I Direct observation, Record review,	if any of the three evidence is found to be non-compliant.	5	
) See minimum five cases of Critical value and check for:		Non-compliance of all three evidences.	0	Critical value Chart are displayed in Diagnostic area. Registry maintained for TAT and Critical value





4. The results of the diagnostic (Laboratory, Radiology, etc.) tests should be made available in defined time frame and intimated about the critical results to the concerned personnel immediately.



Date	Patient's Name	Age/ Sex	UHD	Critical Alert Result Report	Critical Alert Result Receiving Time	Critical Alert Result Response Time	Clinical Intervention	Remarks
				(1)	(2)	(3)	(4)	-5
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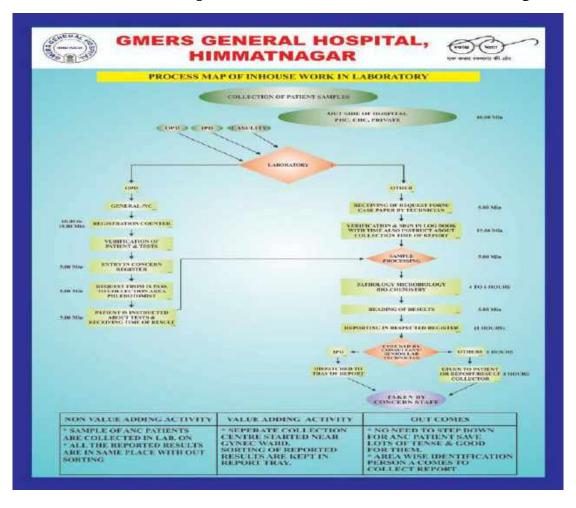
પા. આ. કેન્દ્ર સલુણમાં ઉપલબ્ધ લેબોરેટરી સેવાઓની વિગત

4	Sec dH	61	২০ সালায
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9	ટાચકોચડની તપાસ (S-WIDAL)/	61	<u>३०</u> भीनीर
9	બ્લક સુગર	€ I	૧૦ મીનીટ
c	યુરીન પ્રેગન્નસી ટેસ્ટ	61	10 Molla
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10	युरीन - सुगर, Alb.	5 1	<u>૧૦ મીનીટ</u>
44	Stool ली तपास (Routine stool)	ଗୋ	
92	વેટ માઉન્ટ (કંગસની તપાસ)	ના	
13	સીફલીસની તપાસ (VDRL)	61	ક ૦ મીનીટ
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4. The results of the diagnostic (Laboratory, Radiology, etc.) tests should be made available in defined time frame and intimated about the critical results to the concerned personnel immediately.







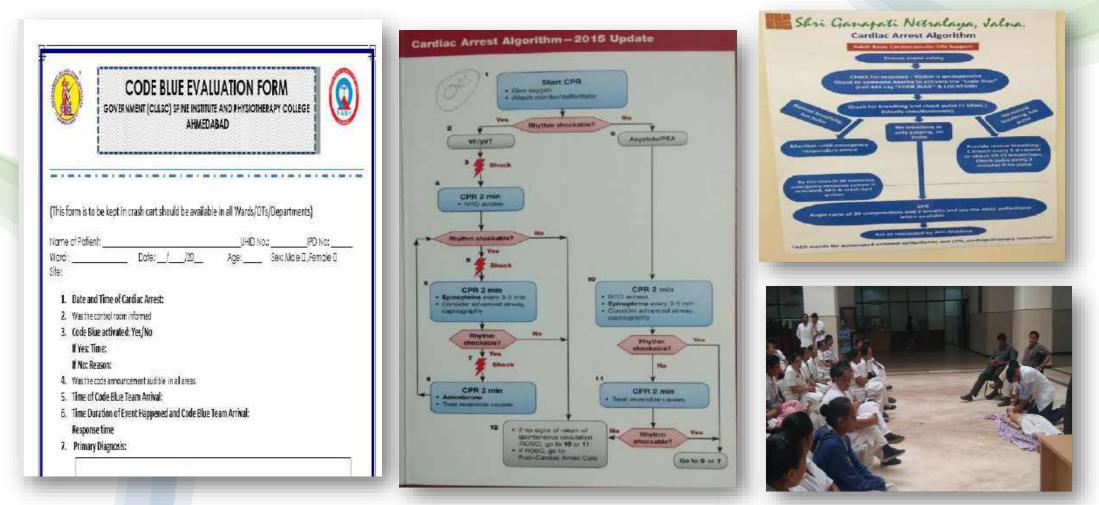
5. Events during cardio-pulmonary resuscitation are recorded and mock drills conducted at regular interval; sequence of CPR in pictorial manner should be displayed.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)	
a) Policy for cardio-pulmonary resuscitation b) CPR process flow chart		100% compliance of all four evidences.	10		
 displayed in patient care area c) Staff aware of steps in cardio- pulmonary resuscitation d) Documentation of Regular mock drill conducted, variations 	Direct observation, record review & Staff interview	if any of the four evidence is found to be non-compliant.	5	Documents of CPR mock drills conducted at regular intervals and CPR chart display in patient care area.	
observed in each drill and CAPA taken by respective personnel's.		Non-compliance of all four evidences.	0	patient care area.	





5. Events during cardio-pulmonary resuscitation are recorded and mock drills conducted at regular interval; sequence of CPR in pictorial manner should be displayed.







6. Informed consent about the information on risks involved, benefits, alternatives for the procedures, surgeon who will perform the requisite procedure in an understandable language

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
		100% compliance of all four evidences.	10	
 a) SOP developed for taking the informed consent from patient or patient relative. b) See minimum 5 in-patients files of previous month and check availability of: 		if any of the four evidence is found to be non-compliant.	5	
 i) Clearly defined information on risks involved, benefits, alternatives for the procedures by surgeon who will perform the requisite procedure in an understandable language. ii) Informed consent is duly signed by patient or patient relative and countersigned by concerned surgeon. iii) Post operative notes by concerned surgeon. 	Direct observation, Record review, Patient interview & Staff interview	Non-compliance of all four evidences.	0	Informed consent form and Post operative notes in patient files.





7. The regular and periodic monitoring of anaesthesia components like recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anaesthesia should be done.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 post-operative files of previous month and check for: a) Availability of completely filled Pre-		100% compliance of all three evidences.	10	a) Complete documentation:
 anaesthesia, during anaesthesia and post- anaesthesia form in each patient file. b) Pre-anaesthesia consent is duly signed by patient or patient relatives 	Record review & Staff interview	if any of the three evidence is found to be non-compliant.	5	Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway
 and countersigned by anaesthetists in each patient file c) Complete documentation (e.g. Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway security recorded) in each patient file. 		Non-compliance of all three evidences.	0	security b) Pre-anaesthesia consent duly signed by pt. or pt. relatives and countersigned by anaesthetists





7. The regular and periodic monitoring of anaesthesia components like recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anaesthesia should be done.

		 1 N O P Q R S T U V W A (To be filled in by Anesthesiologist)	G31- IPD-FF- 20	Notes on Pre-Anesthetic Check-Up Des 3/4/15. Ter - 8:104 Perret prover - 2002000- 1/42	Randor LLLA
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CVP 🔹	170 160 150			Signand Australia Hilling	NS with a bin





8. The documented procedure is defined and adhered to, for the prevention of adverse events like wrong site, wrong patient and wrong surgery.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 post-operative files of previous month and check : a) Availability of WHO safety		100% compliance of all two evidences.	10	
checklist. b) WHO safety checklist is filled and signed by anaesthetist(before induction of anaesthesia),	Record review & Staff interview	if any of the two evidence is found to be non-compliant.	5	WHO safety checklist signed by OT Incharge, anaesthetist and
surgeon(before skin incision) and OT incharge(before patient leaves OT)		Non-compliance of all two evidences.	0	surgeon





8. The documented procedure is defined and adhered to, for the prevention of adverse events like wrong site, wrong patient and wrong surgery.

lama	of the patient : of the doctor :	Date :	
Sr. No.	Have you checked ?	Ward NA	Recovery Room
1	Patient NBM gines		
2	Any known allergy/DM/HTN/Asthma		
3	Surgery Side marked		
4	Surgery Side : OD OS OU		
5	Surgery Consent		
8	Guarded visual prognosis consent (if required)	NA	
7	NIV consent		
8	Anaesthesia consent		
9	Anapsthosia fitness dona		
10	Physician/Paediatrician fitness done		
11	Amniotic membrane graft ordered/Not protered		
12	Consent for dispose of clinical histopathology samples		
13	Any pre-medication/ Inj. Manifol given		
14	вр		
15	Lab isvestigations		
16	AsSian		
17	Final IOL power decided by surgeon	NA	
18	IOL BRAND	NA	
19	Eyn Ditated		
	d over staff ve and Time		

TON/WRD/08

SURGICAL SAFETY CHECKLIST (To be filled by Operating Surgeon & Anesthetist)					
Pallent Name Unit/Word Date	Age U				
Before induction of Anesthesia (with at least nurse and anesthetist)	Before skin incision (with nurse, anesthetist and surgeon)	Before Patient leaves operating (with nurse, anesthetist and surgeon)			
Has the patient confirmed his/her identity, site, procedure and consent? Yes Is the site marked?	Confirm all team members have introduced themselves by name and role. Confirm the patient's name, procedure and where the incision will be made.	Nurse verbally confirms: The name of the procedure Completion of instrument, sponge ar			
Yes Not applicable Is the anesthesia machine and medication check complete?	Has antibiotic prophylaxis been given within the last 60 minutes? Yes Not applicable	needle counts Specimen labeling (read specimen labels aloud, including patient name) Whether there are any equipment problems to be addressed			
Yes Is the pulse eximeter on the patient and functioning? Yes	Anticipated Critical Events To Surgeon: What are the critical or non-routine steps? How long will the case take?	To Surgeon, Anesthetist and Nurse: What are the key concerns for recow and management of this patient?			
Does the patient have a; Known allergy? No Yes Difficult airway or aspiration risk? No Yes, and equipment/assistance available Risk of > 500ml blood loss (7ml/kg in children)?	What is the anticipated blood loss? To Anesthetist: Are there any patient-specific concerns? To Nursing Team: Has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?	Name of Surgeon Sign Name Of Anesthesiologist Sign Name of Scrub Nurse Sign			
No Yes, and two IVs/central access and fluids	Is essential imaging displayed? Yes				





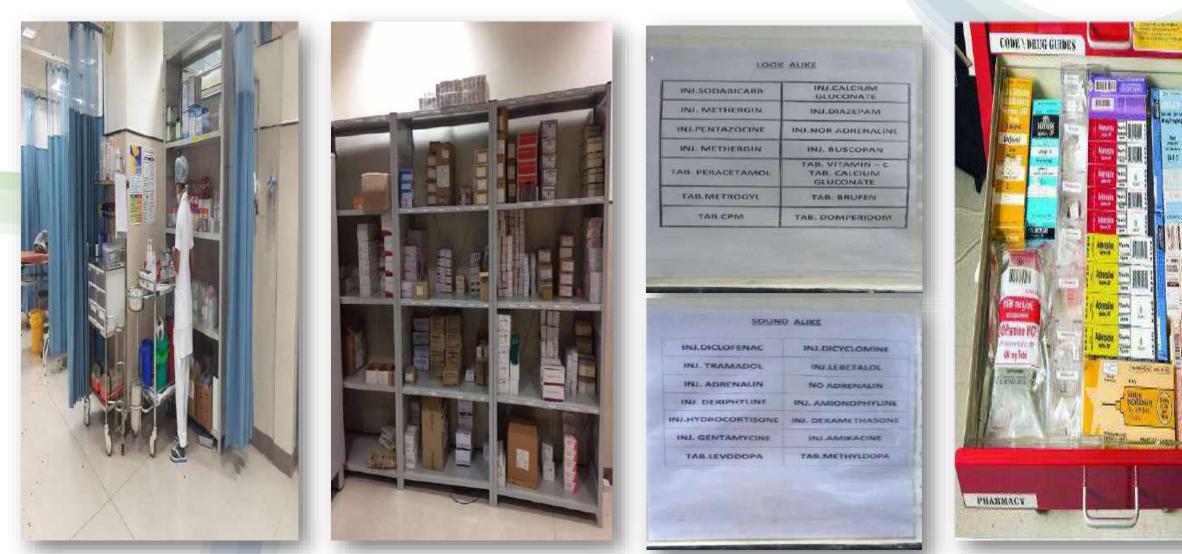
9. Documented procedure for management of medication are defined and implemented e.g. Sound alike and look alike medications are stored separately.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
 a) Defined list of sound alike and look alike medications b) Display of the sound alike and 		100% compliance of all three evidences.	10	a) List of sound alike and look alike defined and displayed in all
look alike medications list in all patient-care area c) Sound alike and look alike medications are stored separately	Direct observation, Record review & Staff interview	if any of the three evidence is found to be non-compliant.	5	b) Sound alike and look alike medications are
in pharmacy and all patient-care area		Non-compliance of all three evidences.	0	stored separately in pharmacy and all patient-care area





9. Documented procedure for management of medication are defined and implemented e.g. Sound alike and look alike medications are stored separately.



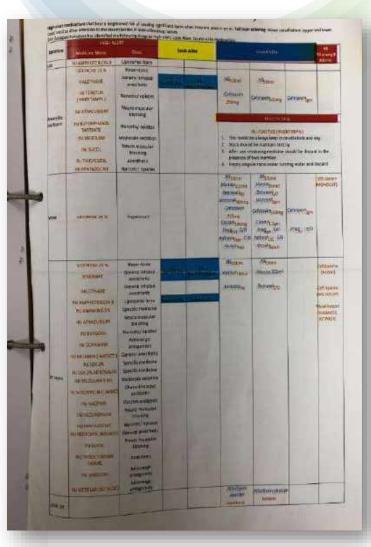




9. Documented procedure for management of medication are defined and implemented e.g. Sound alike and look alike medications are stored separately.

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	Evenistryc	Enemist an c/O		Celutarine (TAD)
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10. Listing and storage of High risk medications to be done & orders should be verified before their dispensing.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) The list of High risk medications are available b) Updated legal licence		100% compliance of all four evidences.	10	a) List of High risk medication b) High Risk
available if narcotics are stored and used.c) The high risk medications are stored separately in secure enviorment (double	Direct observation, Record review & Staff interview	if any of the four evidence is found to be non-compliant.	5	Medications are kept under lock and key in separate drawer c) Legal liscence for
lock). d) Check patient file for documentation verification.		Non-compliance of all four evidences.	0	narcotics if narcotics are stored and used.





10. Listing and storage of High risk medications to be done & orders should be verified before their dispensing.

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10. Listing and storage of High risk medications to be done & orders should be verified before their dispensing.

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11. Verification of dosage, route, timing and expiry date before administering the medication should be done.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)		
a) Defined SOP for process of administration of		100% compliance of all three evidences.	10			
medication b) Check minimum 5 in-	i	if any of the three evidence is found to be non-compliant.	5	a) Policy of		
patients files of previous month and look for implemented process as defined in SOPs (dosage, route, timing and expiry date before administering the medication) c) Medication orders are clear, legible, dated, named and signed by the concerned doctor.	Direct observation, Record review & Staff interview	Non-compliance of all three evidences.	0	Management of Medications b) Patient files with Medication orders that are clear, legible, dated, named and signed by the concerned doctor.		





11. Verification of dosage, route, timing and expiry date before administering the medication should be done.

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Sr. NO.	STEPS	RESPONSIBILITY		
1	Writing of medication orders	Consultant/ Resident Doctor		
2	In case of verbal order, signature shall be taken within 24 hours of order. Refer document verbal orders for medications	Attending Consultant		
3	Inform the patient about the prescription	Staff Nurse		
4	Medicine is provided as per doctor's orders. Medications from Hospital/ brought from outside Provided by staff nurse/ Self administration	Staff Nurse		
S.	Checking of UHID number, Name of Patient, expiry date, dosage (mg, gm), frequency of medicines while receiving.	Staff Nurse		
6	Keep these Seven 'R' in mind before giving medicine. 1) Right Patient 6)Right frequency 2) Right dose 7)Right documentation & Right Disposal 3) Right Route 4) 4) Right time 5) 5) Right drugs	Staff Nurse		









12. Adverse drug events are collected, analysed by the treating doctor and practices are modified (if necessary) to reduce the same.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Clearly defined policy for the adverse drug events.		100% compliance of all three evidences.	10	
 b) Adverse drug events are reported to concerned authority and record is available b) Corrective and preventive 	Record review & Staff interview	if any of the three evidence is found to be non-compliant.	5	Records of adverse drug events kept with CAPA.
action taken for Adverse drug events.		Non-compliance of all three evidences.	0	





12. Adverse drug events are collected, analysed by the treating doctor and practices are modified (if necessary) to reduce the same.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Clearly defined policy for the adverse drug events.		100% compliance of all three evidences.	10	
 b) Adverse drug events are reported to concerned authority and record is available b) Corrective and preventive 	Record review & Staff interview	if any of the three evidence is found to be non-compliant.	5	Records of adverse drug events kept with CAPA.
action taken for Adverse drug events.		Non-compliance of all three evidences.	0	



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12. Adverse drug events are collected, analysed by the treating doctor and practices are modified (if necessary) to reduce the same.

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13. The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing appropriate infection rates.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Availability of infection control committee formation letter with list of members's.		100% compliance of all five evidences.	10	a) SOPs are defined
 b) List of identified high risk areas. c) Defined SOP for tracking and analysing infection rates. 	Record review & Staff interview	if any of the five evidence is found to be non-compliant.	5	for Infection control b) Minutes of the meeting of infection control
 d) Minutes of the meeting of infection control committee. e) Corrective and preventive action taken to prevent infection. 		Non-compliance of all five evidences.	0	committee with corrective and preventive action





13. The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing appropriate infection rates.

COMPOSITION OF COMMITTEE										
Sr. No.	Designation Organization	Designation Committee								
1	Director	Chairman								
2	Microbiologist	Infection Control Officer & Member Secretary								
3	Assistant Professor (Ortho)	Member								
4	Assistant Professor (Anaesthesia)	Member								
5	Resident Medical Officer – (RMO)– Accreditation Coordinator	Member								
6	PIU Engineer- Civil	Member								
7	PIU Engineer - Electrical	Member								
8	Assistant Nursing Superintendent	Member								
9	Infection Control Nurse	Member								
10	Linen keeper	Member								
1	Sanitary Inspector	Member								
12	CSSD Technician	Member								

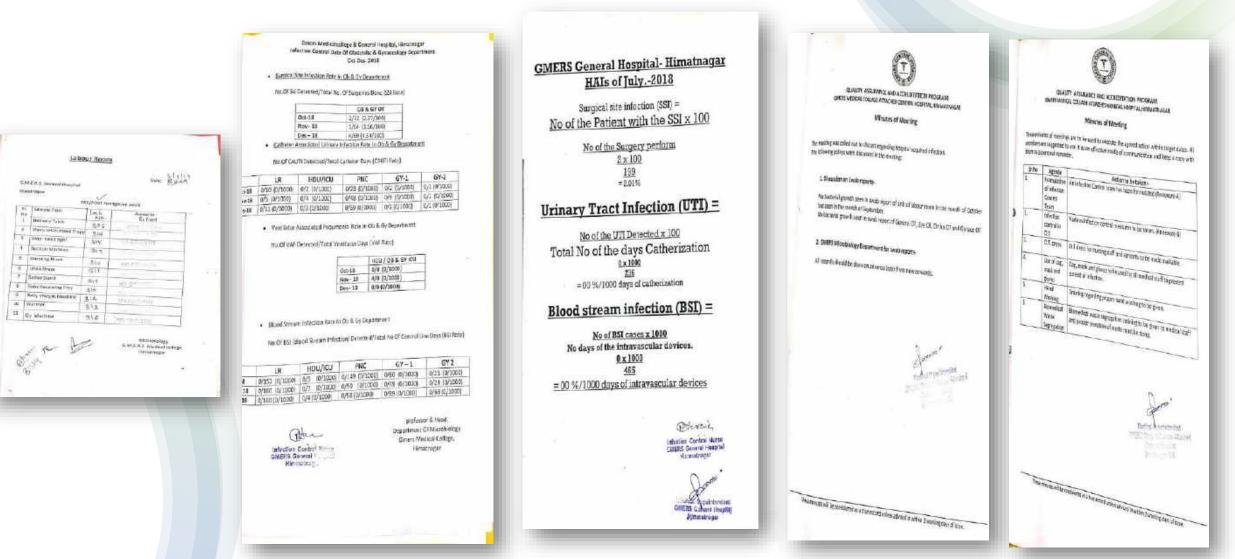
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Н	EALTH CARE ASSOCIAT	ED INFECTION SUI	RVEILLANCE FORM						
Patient UHID :		Gender : F / M	Age:						
Patient Name :		11							
Date Of Admission	Tra.In Date:	Ward/Unit :							
Birth Weight (grams	s) : (if applic	able)							
Admission Diagnosi	12	Final Diagnosis :							
Surgery performed: If Yes Type of opera		Date & Duration of Surgery :							
Elective/Emergency		Major/Minor:							
OT:		Anaesthesia Typ	e: General/Spinal/Local						
Shifted from other	Hospital : Yes / No	Date Of Dischar	ge:						
	IND	WELLING DEVICES							
DATE	URINARY CATHETER PUT ON		CENTRAL LINE PUT ON						

	HEALTH CARE ASSOCIATED INFECTION MONITORING																		
			CR	BSI	SSI					LAB REPORTS									
DATE	Fever/ Hypother mia	Burning urine	Urgency/ Frequency	pain at renal angle or suprap ubic	Turbid Urine	Tachy- cardia	Hypo- tension	BT: Yes/ No	ICU Stay (Post op day)	Wound Type:- clean/ contaminated /Dirty	Wound Dressing Pus/ Discharge (Post Operative Day): Yes/No	Type of SSI: Superficial SSI/Deep/ Organ/Space Involvement	Other Symptoms	Urine CS	Blood CS	Swab/ Pus CS	Radiology Reports	Anti- biotics taken	Remarks





13. The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing appropriate infection rates.







14. All the healthcare providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facilities.







Back of fingers





Fingernails



Wests



Rinse and Wipe dry





14. All the healthcare providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facilities.







14. All the healthcare providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facilities.

S. No.	Quality indicator	Jan-2019	Feb - 2019	Mar - 201
1	Hand hygiene for Doctors - Ward & OPD	95.85 %	81.25	90.48 9
2	Hand hygiene for Nurses Ward & OPD	90.38 %	92.50 %	91.67 %
3	Hand hygiene for Lab staff	88.88%	66.66 %	100 %
4	Hand hygiene for Optometrists- OPD	97.43%	80 %	97.43 %
5	Hand Washing for Canteen staff SN	91.66	50 %	•
6	Hand hygiene for House keeping staff Vlard, OPD	83.33 %	81.66 %	68.42 %
1	Hand Hygiene for DNB & PG Fellows doctors	94.44%	86 11%	

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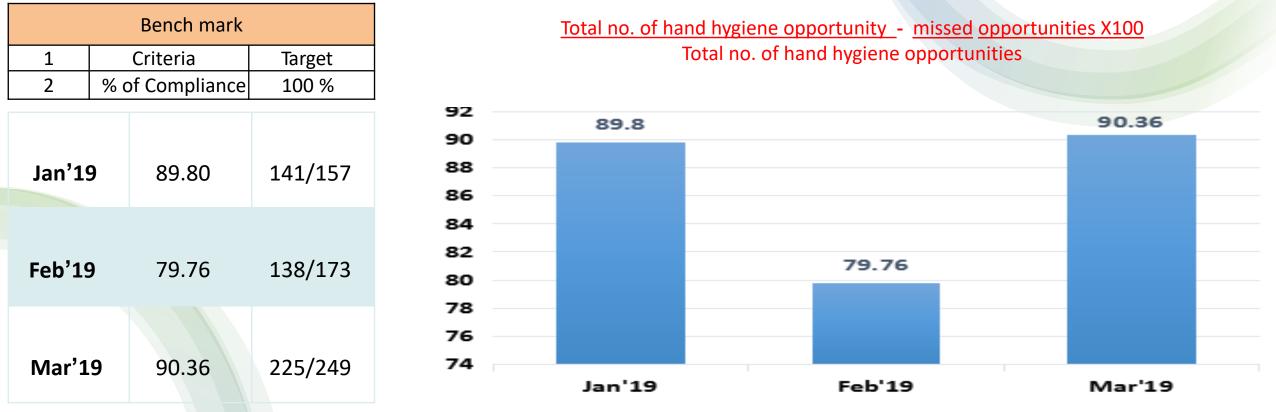
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90,48%





14. All the healthcare providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facilities.



- RCA Deviation from 100 % Compliance was observed due to –
- 1.Heavy workload
- 2. Emergency situation
- 3. Hand hygiene done but steps not followed properly.
- CAPA –
- 1. Regular training & education.





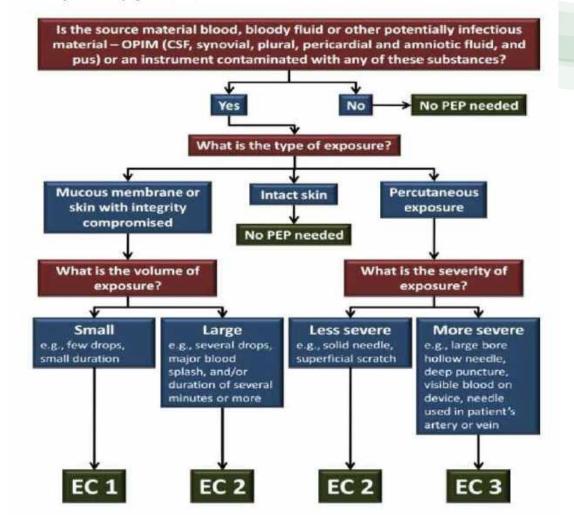
Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) The Vaccination (Inj. TT, Hepatitis – B, Typhoid)and medical checkup record available of all concerned staff members		100% compliance of all four evidences.	10	a) Staff vaccination record.
 b) Hospital provided Personal protective equipment to concerned staff. c) Staff uses Personal protective equipment while conducting any 	Direct observation, Record review & Staff interview	if any of the four evidence is found to be non-compliant.	5	 b) PPE Equipments used by staff while conducting any procedure/activity.
equipment while conducting any procedure/activity. d) Display of Post exposure prophylaxis chart in all patient care areas		Non-compliance of all four evidences.	0	 c) Post exposure prophylaxis chart in patient care area.





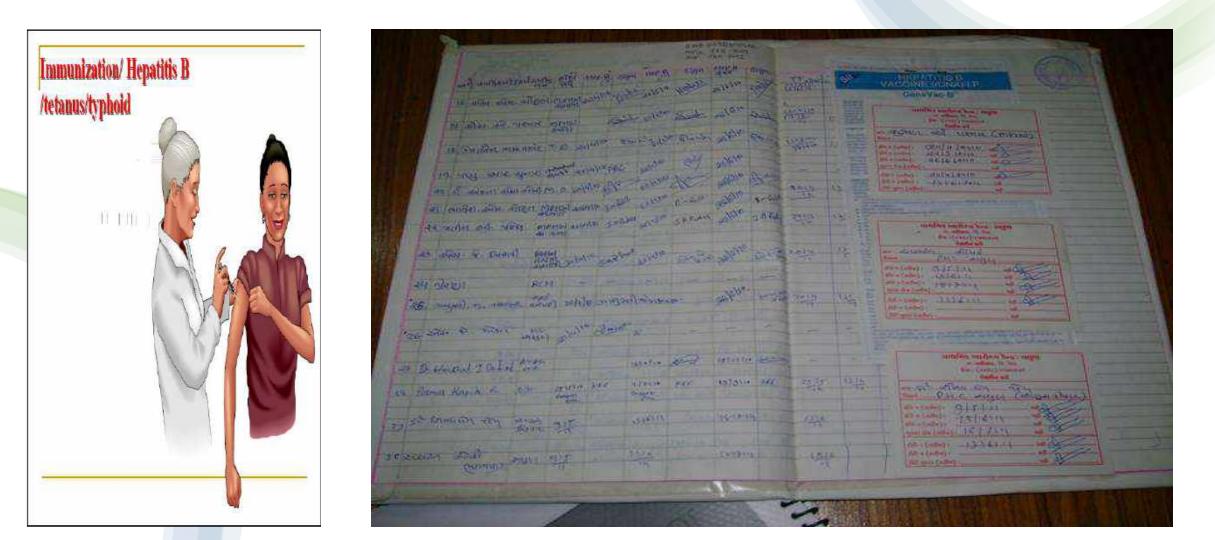


Post Exposure Prophylaxis (PEP) - NACO Guidelines









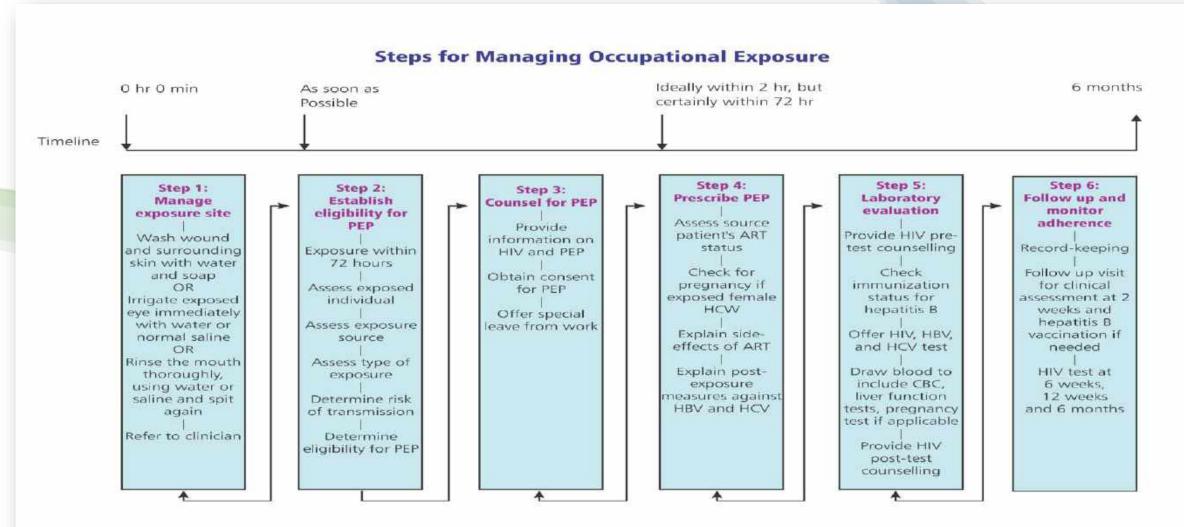




ŀ	S.N.	mame or staff	Dene		Vaccinat	ion Record		
	1	Dr Sandeep Ambaskar	Deparmer	nt	1st dose	the second		
	2	Madan Kawale	Residence Doc		15/11/2017	2nd dose	3rd dose	Duration
	3	Chaya Londhe	Opthalmic Nurs		15/11/2017	15/12/2017	15/05/2018	Due this month
Γ	4	Pragati Dubey	Nursing staff	F	18/11/2017	15/12/2017	15/05/2018	complited
	5	Usharani Hatagale	Nursing staff		20/12/17	20/12/2017	15/05/2018	complited
	6		Nursing staff		20/11/17	20/01/2018	20/06/2018	complited
\vdash	-	Chaya Lalzare	Nursing staff		A CONTRACTOR OF	20/12/2017	and the second second second	complited
	-	Rohit Pakhare	Nursing staff		18/11/2017	18/12/2017	20/05/2018	complited
-	-	Pratima Kamble	Nursing staff		20/11/17	20/12/2017	18/05/2018	complited
-	9	Valbhav Dhilpe	Nursing staff	-12	18/11/17	23/12/2017	20/05/2018	complited
10	IO F	Ribika Ghumare			15/06/2018	15/07/2018	23/05/2018	complited
1	1 R	Rohit Nirmal	Nursing staff	1	8/11/2017	20/12/2017	Not working	Not working
1		aishree Bhosle	Nursing staff	1.	5/06/2018		20/05/2018	complited
13		omal Kamble	Nursing staff	15	5/05/2018	15/07/2018	15/12/2018	
14		ariya Dodke	Nursing staff	15	/05/2018	15/06/2018	15/11/2018	complited
15			Nursing staff		/05/2018	15/06/2018	15/11/2018	complited
16		iyanka Shelke weta Chauthmal	Nursing staff		/05/2018	24/06/2018	24/11/2018	complited
17	The second second second	and the second se	Nursing staff	-		15/06/2018	15/11/2018	complited
18		hpa Jogdand	Nursing staff	18/	1-Jan-2019 12/2018	1-Feb-2019		complited
1071.0		ubai Khandebharad	Nursing staff	10,		18/01/2019	- 3011-2019	Jul-19
9	1	l Gaikwad	Nurssing Staff	1	1-Jan-2019	1-Feb-2019	18-May-2019	May-19
2	Varsl	ha Jadhav		-	09/2018	15/10/2018	2 3411-2019	Jul-19
	Anjali	i Bhaltilak	Nurssing Staff	15/0	19/2010	15/10/2010	15/03/2019	complited
			Nursing staff	OUT		SIDE	15/03/2019	complited
						and c	COMPLETED	complited











16. The proper implementation and regular monitoring of Bio-Medical waste segregation and collection in all the patient care areas of the hospital and staff should be trained in handling the Bio-Medical waste and provided with all personal protective measure.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Updated license available for Bio- Medical Waste Management practice as		100% compliance of all six evidences.	10	
per BMW Rule 2016		if any of the six evidence is		
b) SOP defined for the process of BMW		found to be non-	5	
as per Pollution control guidelines.		compliant.		a) Updated license of
 c) Staff follows the SOP. d) Waste management bins available and BMW guideline chart is displayed in all patient care area e) Personal protective measures (e.g. gloves, mask, apron, gum boots, heavy duty rubber gloves, etc.) are used by all categories of staff handling Bio-Medical Waste. f) Infection control committee visits common biomedical treatment facility. 	Direct observation, Record review & Staff interview	Non-compliance of all six evidences.	0	BMW. b) Available biomedical waste bins and displayed chart in patient care area. c) Biomedical waste storage area





16. The proper implementation and regular monitoring of Bio-Medical waste segregation and collection in all the patient care areas of the hospital and staff should be trained in handling the Bio-Medical waste and provided with all personal protective measure.











16. The proper implementation and regular monitoring of Bio-Medical waste segregation and collection in all the patient care areas of the hospital and staff should be trained in handling the Bio-Medical waste and provided with all personal protective measure.









17. A defined mechanism to be there for regular updating of the licences / registration certifications.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See the relevant		All aplicable legal liscence are upto date	10	List of applicable legal licences and MOU/Aggrement
statutory documents.	Record review	If any applicable legal liscence is expired or not available	5	with date of issue and validity is maintained.
		Non availability of legal liscence	0	





17. A defined mechanism to be there for regular updating of the licences / registration certifications.

r No	Name of License	Number & ID	Date of Issue	Valid Upto	Remarks	art and any pick the second se	Last Take Davised Ba	EHON-B Day and rule OLIVED on NUL CENTIFICATE OF EXCISTINATION of the sound T. d (start)
1	Bio-Medical Waste Authorization	PCB ID-40245, BMW Id:387557	15-06-2016	14-06-2021		Tarita Autor (13/00/01/01/01	angerended pås til	El Tancio dels more contrasteristica (M.) dels re- disputato al resentación d'Alexa, del Vol. 2011 (2010). Districtiva de actividades deres que transportativa de la casa de activida y la casa de la casa de la casa de Casa de actividades de la casa de la casa de la casa de Casa de actividades de la casa de la casa de la casa de Casa de la casa de Casa de la casa de Casa de la casa de Casa de la casa de Casa de la casa del la casa de Casa de la casa de Casa de la casa de Casa de la casa de Casa de la casa de la ca
2	Drug and Cosmetic License	ADC- 84507	13-10-2014	12-10-2019		International and an analysis of the State o	AND A DAS 200 A 2010 C Sancta AND A A Sancta da para stransmini agricolo (Crant Daple Henory) at 28 Jul	Processes ¹¹ Process Dynamic Terr ²¹ is a factor of the ex- perimentary of 200520 The supervisor is granted surface to the density of the minimum factors of granted and a secondary or prediction empty of the are result of Terr 2005. A functional Advance of the GALESA Disperse.
3	Narcotic Drug License	04/2014-2015	09/04/2018	31/03/2019		Type of Newfollow Back Laws Rationer M. Han Newfollow Mar Schwart System 6.00	rego nettiin, kaispaljai Wady Mongamon Ioma	Generating Provide Calify Generating Provide Calify Generating Provide Calify Calify Relation provide Calify
4	Spirit ,Denatured Sprit	44/10-13	01-04-2016	31-03-2021		Basist The D200 C CEO CO. In FMSTAPPERTURE. IN FERTILA, MARKWOTTEN, and E. ANKOY TO they associate to be been ready association property in support of the Association of Dataset ready. See Section 2010. In Proceedings on Section 2010, ISSN 2010, Control of Control (Control of Control of Control International Control of Control (Control of Control of Control of Control International Control of Control (Control of Control of Control of Control of Control of Control International Control of Control (Control of Control of C	annad XAA JAAN DOSING 2000 - 000 - 000	Institut antibility a. Samel Applicate in applicate - GMLES ille C. Annual Institute Applicate in Control In
5	X-Ray Installation C-Arm-1	ALLENGER HF -49R G-XR-22917 14-RLXE-21287	19-12-2017	19-12-2022		Bits Tophere and Linearize an impossible bit I. Record, or a plane with the damage execution of the I. Second and the second of t	andagus PALANA Samoni shishalara i Magadaa ada tofas	Created Review Review Deriver Theorem Deriver
6	X-Ray Installation C-Arm-2	ProRAD Premium /G-XR- 61335 17-LOP-181040	21-04-2017	21-04-2022		 Density requires eith two cillumities and terrari. Wet To figurate e constructivity and a DUDCNU (PEDV 100 PENV) of the ensurement from encoded automativity and even experiment. (I) C. We are in the Automativity and even experiment. 	n Tanatan Jana	Common Auffer Monomia A
7	X-RAY Mobile Machine	M.n.Allenger-60 G-XR-23830 17-LOEE -194387	22-06-2017	22-06-2022		Coll, DONNE DIRIVA IN MARKATERIMINA RESOURCE. INVESTIGATION, DATABATI REPORTS AND	pat Kandonje, J. (1794) Malda ad India (100 ad 100 al	Margaret and States an
8	X-RAY Mobile Machine	M.n.Diagnox-100R G-XR-67128 17-LOEE-194392	22-06-2017	22-06-2022		Image: Name of a physical structure of a difference of a dif		A MARTIN (A MARTIN (MARTIN PC ST) (A AMA MARTIN (A MARTIN (MARTIN PC ST)))
9	Radiography (Fixed)	DIAGNOX-300 G-XR-22885	19-12-2017	19-12-2022				

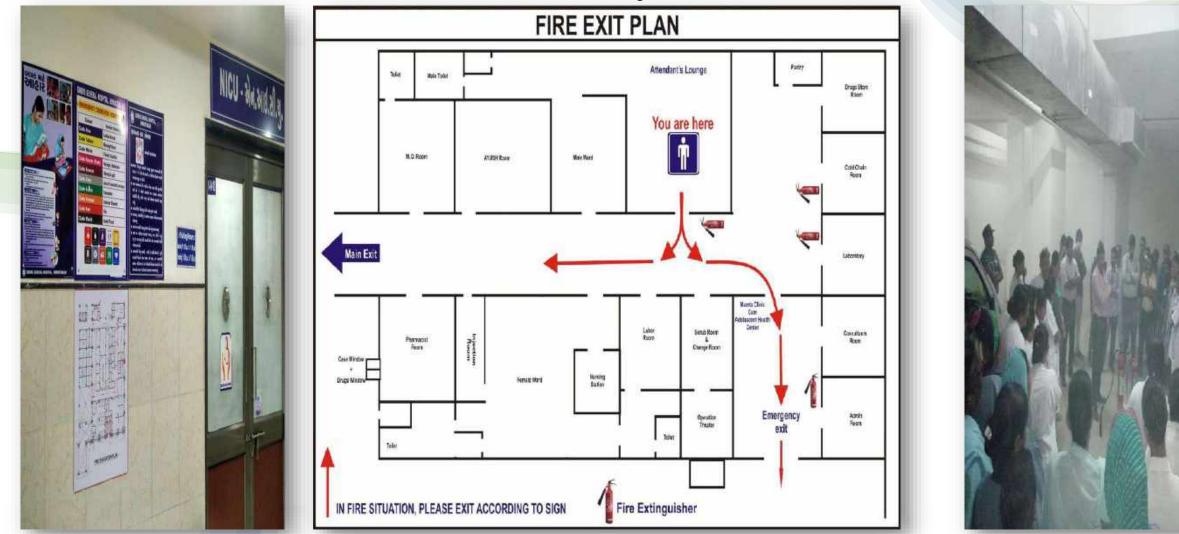




Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) SOP defined and implemented for safe exit plan in case of fire and non-fire		100% compliance of all four evidences.	10	a) All the signages are
emergencies. b) Sinages displayed of do's and don't's in case of fire c) Display of fire exit plan in all	Direct observation, Record review & Staff interview.	if any of the four evidence is found to be non-compliant.	5	displayed with fire exit plan. b) Document of mock drills conducted at
patient care areas. c) Record of Mockdrill's conducted and CAPA done		Non-compliance of all four evidences.	0	regular intervals



















FIRE MOCK DRILL /INCIDENT CHECKLIST **GOVERNMENT (CL&SC) SPINE INSTITUTE** AND PHYSIOTHERAPY COLLEGE, AHMEDABAD Fire Drill and/or Incident Report Date: Time: Location: 1st Response to fire Section 1 Describe fire drill scenario, fire incident or fire alarm occurrence: Drill or Actual incident Yes No Yes No Was the fire alarm activated Was the control room informed At what time Was the code red activated At what time Was the code announcement audible in all areas At what time Rapid response team arrived Higher authorities informed Was the fire department called? Were people in immediate danger evacuated? Zone of origin evacuated? See for stop, drop, cover and rolls technique Was immediate first aid provided if needed Were doors closed and latched to confine the fire and reduce smoke spread? Was an attempt made to extinguish the fire? Was attempt appropriate? Did sufficient staff respond and evacuate endangered occupants in an organized and timely manner? Was scene being supervised? Were instructions clear? Was evacuation conducted?







19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 personal files of staffs (e.g. Consultant RMO & Nurses, etc.) and check for their qualification, training and privelaging a) Medical professionals are granted previlages to		100% compliance of all five evidences.	10	
admit and care of patients in consonance with their qualification, training, experience and registration. b) Medical professionals admit and care care for	Record review &	if any of the five evidence is found to be non-compliant.	5	All files are maintained by HR Dept. with
 patients as per their privelaging. c) Nursing staff is granted previlages in consonance with their qualification, training, experience and registration. d) Nursing professional care for patients as per their privelaging. e) System developed for updating the personal files of staff. 	Staff interview &	Non-compliance of all five evidences.	0	all the the required details





19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

Grading

42 Excellent

Name of the Traince	Points Obtained	Grading
Dr Kaitvi Modi	5	Excel
8) Dr Vibinuti Podel	q	
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19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

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Privilarga	Requested	Approved (ves/ No
PATIENT IDENTIFICATION	TY Yes No	Yen
COLLECTING MEDICAL HISTORY	TOT YES NO	10
ADMISSION OF PATIENTS	Not ves No	4.20
MONITORING THE VITAL SIGNS	for yes No	401
INITIAL ASSESSMENT OF PATIENTS	VES NO	N.60
PRE OPERATIVE EVE CARE	FOC YOS NO	ND
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MONITORING STERILITY OF INVASIVE ITEMS	Crites 140	NEN
POST OPERATIVE LYE CARE	Ves No	NO
REASSESSMENT OF PATIENT	Ves 1 No	420
COMPORT, NUTRITIONAL AND HYGICNIC MELL		427
POSITIONING PATIENTS	NO YES NO	420
4595TING DOCTORS OURING ROUNDS	ICT Yes I No	400
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HOT AND COLD APPLICATIONS	TA Yest 1 tas	400
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SHUTTING AND MOVING PATIENTS	V Yes I' No	70
PREFARATION OF PUECTION	Yes No	400
ADMINISTERING OF MEDICATIONS	and the second se	YEA
DOCUMENTATION		700-
EDUCATING PATIENTS & ATTENDANTS		400
BO MEDICAL WASTE MANAGEMENT	1.8	40.
DECHARGE OF PATIENT	Ves No	401
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HANCHING OF MLC PATIENTS	Not Yes No	+er-
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	Shi Ganaf Nurses Clin	ati Netralaya nical Privileges	
36	HICC TRAINING OF CARE GIVERS	Yes No	yes
37.	ADMINISTRATION OF HEP & VACCINATION	Ves No	400
5.R.	NEEDLE STICK INJURY ANALYSIS AND FOLLOW UP	Yes No	Yes
19.	SSUANALAYSIS AND FOLLOW UP	Yes No	yes
40.	MAINTAINING OF MICROBIOLOGICAL REPORTS AT THE UNIT	V Yes No	400
11	EXTERNAL VISIT TO BMW TREATMENT PLANT AND OUTSOURCED LAUNDRY	Types C No	Yes
42.	CONDUCTING TEAM AUDITS IN COORDINATION WITH OTHER DEPARTMENT	Wes No	40
a 3	BLOOD SAMPLE COLLECTION	Tes D No	4:00
44	ECG procedure	VYES NO	400
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PARE	PING THE UNITS	and the state of t	
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	KEEPING THE NURSES COUNTERS EQUIPPED	VYES TI NO	460
	INDENTING MEDICATIONS	VYES EL NO	420
	INDENTING STATIONARY ITEMS	Ves No	420
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3	INFECTION CONTROL ACTIVITES	Ves No	Yen
	ADMINISTRATIVE ACTIVITIES	V Yes No	7.00
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19. The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.

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	as both & or incoversing more-some physicages through mean the specific threefeeld orthoride as outlined. Non-this physicages close parameter and a sangery	issue privileges: Secondal completion of a postgraduate transing program in pertainers and stratiumus with	
Miteman Qualification : M.B.A.S., DO, OND. Expansions: after degree/ Distorma : <u>2/13/19066</u>	Nac-sere privilegest bevolgesteller and an angest	egesience in the above surgical arcsectures	And the second sec
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20. Up to date and chronological details of the patient care should be available in the medical record including discharge summary

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) SOP defined for the process of keeping		100% compliance of all five evidences.	10	a) All the files in MRD
medical record file of discharge patient, MLC and Death case b) Staff is aware and follows the process defined in SOP c) See minimum 5 files from medical record		if any of the five evidence is found to be non-compliant.	5	section are arranged in cronological order. LAMA Death and MLC files are kept
 (e.g. Surgery, Medicine, MLC, Death, LAMA, etc.) and check the chronological account of patient care. i) Availability of checklist for maintainaing records in chronological order d) Medical record audit with corrective and preventive action. 	Record review & Staff interview	Non-compliance of all five evidences.	0	seperately. b) Checklist for maintaining records in cronological order in patient file. c) Summary of medical record audit.





20. Up to date and chronological details of the patient care should be available in the medical record including discharge summary

		MRD CHECK	(LIST	GSI -IPD- FF-32	
U of IF	D Book o	nd its booklet no,			
SR No	Form NO	Indoor Booklet	Mark (Yes-Y or No) If yes Complete-C / Incomplete-IC	Mark No- N- if forms not present	Page No
1	1	Information Form			
2	2	Registration Form			
3	за	General Consent Form (English)			
4	38	General Consent Form(Gujarati)			
5	4	Initial assessment by Nurse			
6	5	Initial assessment by Doctor			
7	6	Initial assessment by physiotherapist & occupation therapist			
8	7	Initial assessment by p&o			
9	8	Initial assessment by dietician			
10	9	MSW assessment form			
11	10	Initial assessment by clinical psychologiat			
12	11	Initial assessment by vocational			
13	12	Continuous sheet Reassessment by nurse			
14	13	Reassessment by Doctor			
15	14	Reassessment by Physiotherapist & occupational therapist			
16	15	physiotherapy Treatment sheet			
17	16	Occupational therapy Treatment Sheet	a		
18	17	Pre anaesthesia assessment moderate sedation form			
19	18A	Anaesthesia consent form (English)			
20	188	Anaesthesia consent form (Gujarati)			
21	19	Pre induction Assessment by surgeon & anaesthesia			
22	20	Monitoring of patients during Anaesthesia			
23	21	Anaesthesia notes			
24	22	Recovery criteria			
25	23	Anaesthesia note for			

CARGO C		epidural Injection	
26	24A	Consent for surgical, invasive, diagnostic, medical, intervention procedure	
27	248	Consent for surgical, Invasive, diagnostic, medical, intervention procedure	
28	25	Surgleal check list	
29	26	operation note by surgeon	
30	27	Appliance Prescription P & O	
31	28	Input out put chart	
32	29	Nursing Medication Chart	
33	30	discharge card	
34	31A	Blood and blood products administration/ High risk medication monitoring form	
35	318	Blood and blood products administration Consent form	
36	32	MRD checklist	
	arks of ature: e:	MRD:	Date: Time:
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20. Up to date and chronological details of the patient care should be available in the medical record including discharge summary

3. MEDICAL AUDIT COMMITTEE

Chairperson : Medical Superintendent , GMERS General Hospital, Himmatnagar

- Momber Secretary (AHA, GMERS General Hospital, Himmatnagar
- Members:

Sr No.	Designation
1	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J Vyas)
6	AO
7	MO (Rajesh .K Varma)
8	Matron
9	Senior Head Nurse

Background

- Addit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may wish to do in the future.
- Medical audit involves the study of some part of the structure, process and outcome of
 core clinical activities carried out by those personally engaged in the activity. It
 measures whether set objectives have been attained or not. It thus assesses the quality
 of rare delivered.

Involves

- A systematic examination of performance parameters
- · Comparison of results against set criteria
- · Assessment of quality of care with a view to improvement

Why audit

- Educational value for participants
- · Improve effectiveness and efficiency of care.

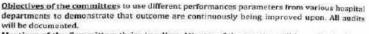
Reassure Consumers.

How to audit

 Define standards you should realistically reach for the area which you intend to audit Standards should be

GLEERS Gonores Hos

- Realistic
- · Owned/Ownable
- · Parallel to existing standards
- 2. Set the criteria by which you will measure those standards
- 3. Compare your results against your defined standard is change needed
- 4. Review the results of any changes made



Meetings of the Committee: thrice in a Year, Minutos of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.



MEDICAL RECORDS	Mc+ .
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GUIDELINE FOR HOW TO ACHIEVE BRONZE QUALITY CERTIFICATE IN AB PM-JAY EMPANELED HOSPITALS





ELIGIBILITY

Hospitals that are empanelled with AB PM-JAY scheme and which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.





STEPS FOR CERTIFICATION PROCESS

Hospitals that are empanelled with AB PM-JAY scheme and which do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH & JCI) can apply for this certificate.





STEPS FOR CERTIFICATION PROCESS

- 1. Login on HEM Portal
- 2. Click "Apply for certificate"
- 3. Fill the "Registration Form"
- 4. Fill-up the "Application Form"
- 5. Submit and pay the nominal Application Fee

7. Reply to the desktop Non-Compliances (if any)

- 8. On-site Assessment
- 9. Reply to on-site Non-Compliances (if any)
- 10. Review of the application

11. Issue of the Digital Quality Certificate

6. Desktop Assessment







BENEFITS OF THE BRONZE QUALITY CERTIFICATION

Additional Support to Create Quality Culture: Bronze Quality Certification will help hospitals to acquire recognized quality standards. The AB PM-JAY Bronze Quality Certification are inclusive and captures all the aspects of patient care and safety. The standards are also universally applicable as they remain same for all kinds of hospitals irrespective of their ownership and the scope of services provided.

Nationwide Recognized: The list of certified hospitals will be published online in a public domain that would help hospitals obtain a recognition among its peers.

Increased Credibility of Healthcare Provider: This certificate will establish trust amongst the beneficiaries for quality treatment in certified hospital.

Patient Safety and Increased Care for Patient: The certification focuses on quality protocols and patient safety which will help hospital in increasing their service quality with time.





THE SUMMARY OF THE CHAPTER OF BRONZE QUALITY STANDARDS ARE AS FOLLOWS

Chapters	No. of Standards	No. of Means of Verification
Chapter 1 : Key Inputs	10	40
Chapter 2 : Clinical Services	11	41
Chapter 3 : Support Services	10	40
Chapter 4 : Patient Care	11	41
Chapter 5 : Health Outcome	11	20
Total	53	182





CHAPTER 1: KEY INPUTS (OVERVIEW)

It is essential that a hospital should have a framework to support ongoing quality improvements and patient wellbeing. This section of key inputs broadly covers the structural part of the hospital. The certification criteria given in this chapter take into consideration the facility infrastructure, human resources requirements and training, appropriate space in hospital for patient movement, proper lighting facility in the hospital, medical instruments and equipment requirements and maintenance, fire-fighting equipment and basic amenities like drinking water, waiting area, canteen, suitable toilets for men and women etc. However, the focus of the standards has been in ensuring compliance to minimum level of inputs, which are required for ensuring delivery of committed level of the services.



Chapter 1: Key Inputs



KI 1	Physical facility of the building and hospital environment shall be developed and maintained for the safety of Patients, visitors, and staff		
KI 2	Hospital should have adequate space for ambulance and patient movement		
KI 3	Access to the hospital should be provided without any physical barrier and friendly to people with disabilities		
KI 4	The indoor and outdoor areas of the facility should be well-lit		
KI 5	Basic amenities should be provided for all patients, hospital staff and visitors		
KI 6	The hospital should ensure that all medical staff is adequately credentialed as per the statutory norms		
KI 7	The facility has functional equipment & instruments as per scope of services		
KI 8	Hospital should have fire detection and fire-fighting equipment installed as per fire safety norms along with staff training		
KI 9	Staff involved in direct patient care shall be trained in Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) along with a display of the same in all critical care areas		
KI 10	Annual Training Plan should be prepared for all staff covering all training needs.		





KI 1 - PHYSICAL FACILITY OF THE BUILDING AND HOSPITAL ENVIRONMENT SHALL BE DEVELOPED AND MAINTAINED FOR THE SAFETY OF PATIENTS, VISITORS, AND STAFF

Interpretation – The standard guide the provision of safe and secure environment for patients, visitors and staff. To ensure this, the hospital premises must have basic essentialities of infrastructure and shall have annual maintenance plan for infrastructure development. This includes appearance of the facility, cleaning processes, infrastructure maintenance and control of stray animals at the facility.





KI 1 - PHYSICAL FACILITY OF THE BUILDING AND HOSPITAL ENVIRONMENT SHALL BE DEVELOPED AND MAINTAINED FOR THE SAFETY OF PATIENTS, VISITORS, AND STAFF (Means of verification)

- 1. There should be no cattle or stray animals within the premises
- 2. The facility should have a guard available 24*7
- 3. The hospital boundary should be intact and not broken
- 4. Hospital (Building(s)) should be well maintained i.e. walls are well plastered (no cracks or seepage) and painted
- 5. Windows and doors are intact and have grill/ wire meshwork
- 6. The facility should have an annual maintenance plan for its infrastructure
- 7. Non-structural components such as cupboards, cabinets and other heavy equipment or hanging objects should be properly fastened and secured
- 8. Hospital building should not have wire hanging loosely
- 9. There should be no stains, grease, cobwebs and bird nest on walls and roofs of the hospital

10.There should be a closed drainage system with no direct contact with the environment





THERE SHOULD BE NO CATTLE OR STRAY ANIMALS WITHIN THE PREMISES



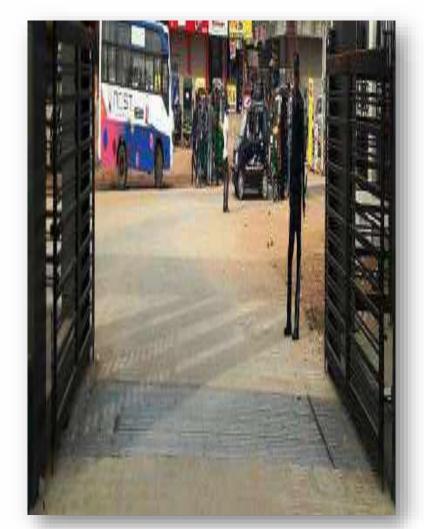






THE FACILITY SHOULD HAVE A GUARD AVAILABLE 24*7











THE HOSPITAL BOUNDARY SHOULD BE INTACT AND NOT BROKEN









HOSPITAL (BUILDING(S)) SHOULD BE WELL MAINTAINED I.E. WALLS ARE WELL PLASTERED (NO CRACKS OR SEEPAGE) AND PAINTED









WINDOWS AND DOORS ARE INTACT AND HAVE GRILL/ WIRE MESHWORK



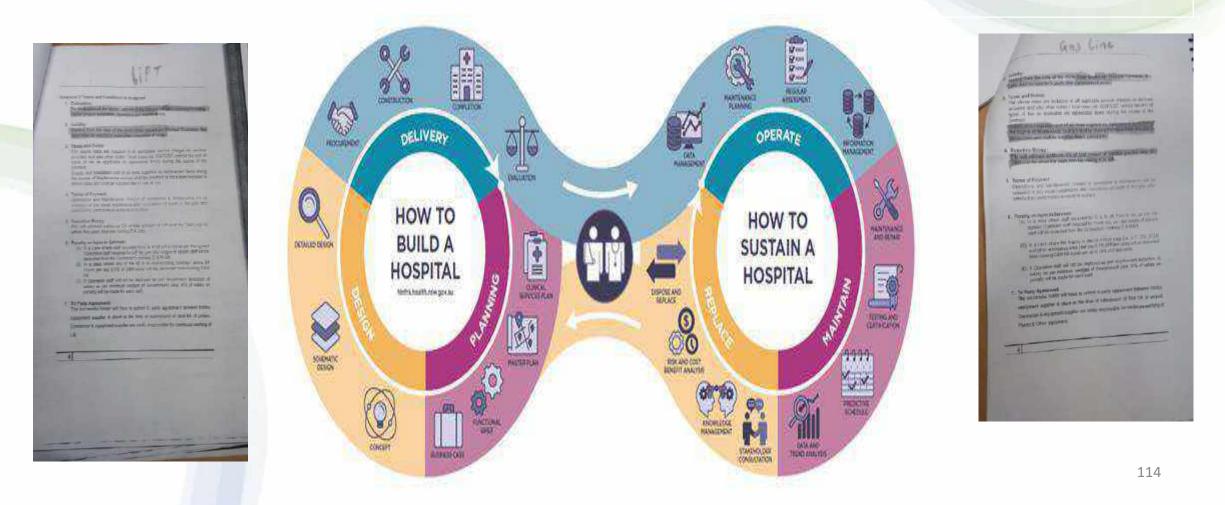








THE FACILITY SHOULD HAVE AN ANNUAL MAINTENANCE PLAN FOR ITS INFRASTRUCTURE







NON-STRUCTURAL COMPONENTS SUCH AS CUPBOARDS, CABINETS AND OTHER HEAVY EQUIPMENT OR HANGING OBJECTS SHOULD BE PROPERLY FASTENED AND SECURED









HOSPITAL BUILDING SHOULD NOT HAVE WIRE HANGING LOOSELY







THERE SHOULD BE NO STAINS, GREASE, COBWEBS AND BIRD NEST ON WALLS AND ROOFS OF THE HOSPITAL











THERE SHOULD BE A CLOSED DRAINAGE SYSTEM WITH NO DIRECT CONTACT WITH THE ENVIRONMENT







KI 2 - HOSPITAL SHOULD HAVE ADEQUATE SPACE FOR AMBULANCE AND PATIENT MOVEMENT

Interpretation – This standard requires that facility should ensure adequate space for ambulance movement and parking. The access to the emergency/ receiving area should be smooth and spacious for the ease of patient movement and safe handling.

Means of verification:

- 1. Ambulance should have direct access to the emergency/ receiving/ triage area and access road to emergency should be wide enough to streamline the movement of the patient till the emergency/ receiving area
- 2. No vehicle should be parked on the way or in front of the emergency entrance
- 3. Dedicated parking area for the ambulance





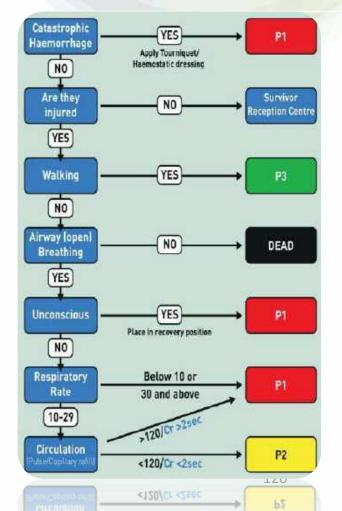
AMBULANCE SHOULD HAVE DIRECT ACCESS TO THE EMERGENCY/ RECEIVING/ TRIAGE AREA AND ACCESS ROAD TO EMERGENCY SHOULD BE WIDE ENOUGH TO STREAMLINE THE MOVEMENT OF THE PATIENT TILL THE EMERGENCY/ RECEIVING AREA





Triage category	Priority	Color	Conditions
Immediate	1	RED	Chest wounds, shock, open fractures, 2-3 burns
Delayed	2	YELLOW	Stable abdominal wound, eye and CNS injuries
Minimal	3	GREEN	Minor burns, minor fractures, minor bleeding
Expectant	4	BLACK	Unresponsive, high spinal cord injury
			cord injury

nign spinal







NO VEHICLE SHOULD BE PARKED ON THE WAY OR IN FRONT OF THE EMERGENCY ENTRANCE







DEDICATED PARKING AREA FOR THE AMBULANCE









KI 3 - ACCESS TO THE HOSPITAL SHOULD BE PROVIDED WITHOUT ANY PHYSICAL BARRIER AND FRIENDLY TO PEOPLE WITH DISABILITIES

Interpretation –Provisions should be available for physically challenged/ vulnerable person to make the entrance accessible with ramps and grab bars. The facility should have facility of wheelchair, stretcher and trolleys with safety belts for immediate support of the patient.

Means of verification:

- 1. Availability of wheelchair, stretcher for emergency with straps to protect the patient from falling
- 2. The wheelchair, stretcher and trolleys should be clean, operational and their wheels should be properly aligned.
- 3. Availability of ramps with railings at the entrance of the facility





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AVAILABILITY OF WHEELCHAIR, STRETCHER FOR EMERGENCY WITH STRAPS TO PROTECT THE PATIENT FROM FALLING







THE WHEELCHAIR, STRETCHER AND TROLLEYS SHOULD BE CLEAN, OPERATIONAL AND THEIR WHEELS SHOULD BE PROPERLY ALIGNED







AVAILABILITY OF RAMPS WITH RAILINGS AT THE ENTRANCE OF THE FACILITY











KI 4 - THE INDOOR AND OUTDOOR AREAS OF THE FACILITY SHOULD BE WELL-LIT

Interpretation – In order to provide safe, secure and comfortable environment to patients and staff the hospital should have provision of comfortable environment in terms of illumination either through electric bulbs and tubes at all the places, accompanied by natural source of light. Also, the front, entry and exit areas should also be well lit.

Means of verification:

- 1. There should be proper lighting in the indoor areas through natural light and by using sufficient electric bulbs
- 2. The facility's front, entry gate and access road are well illuminated





THERE SHOULD BE PROPER LIGHTING IN THE INDOOR AREAS THROUGH NATURAL LIGHT AND BY USING SUFFICIENT



ELECTRIC BULBS









THE FACILITY'S FRONT, ENTRY GATE AND ACCESS ROAD ARE WELL ILLUMINATED







KI 5 - BASIC AMENITIES SHOULD BE PROVIDED FOR ALL PATIENTS, HOSPITAL STAFF AND VISITORS

Interpretation – The hospital must have an appropriate waiting area with seating arrangement, drinking water, clean toilets sensitive to gender and physically challenged visitors and staff personnel should be present within the premises.

Means of verification:

- 1. Availability of seating arrangement in the waiting area(s) within the hospital premises for attendants
- 2. Availability of potable drinking water on each floor (functional RO/filters)
- 3. There should be a provision of canteen facility for visitors & staff inside the premises
- 4. Every floor should have at least one toilet for hospital staff and visitors
- 5. Availability of clean and functional toilets with no foul smell in and around the toilet along with functional water taps
- 6. The toilets floor should be dry and no drain should be overflowing
- 7. Availability of disabled friendly toilet with bars or railings and is accessible through a ramp
- 8. Availability of 24*7 working telephone help line in hospital for effective communication





AVAILABILITY OF SEATING ARRANGEMENT IN THE WAITING AREA(S) WITHIN THE HOSPITAL PREMISES FOR ATTENDANTS







AVAILABILITY OF POTABLE DRINKING WATER ON EACH FLOOR (FUNCTIONAL RO/FILTERS)









THERE SHOULD BE A PROVISION OF CANTEEN FACILITY FOR VISITORS & STAFF INSIDE THE PREMISES











EVERY FLOOR SHOULD HAVE AT LEAST ONE TOILET FOR HOSPITAL STAFF AND VISITORS



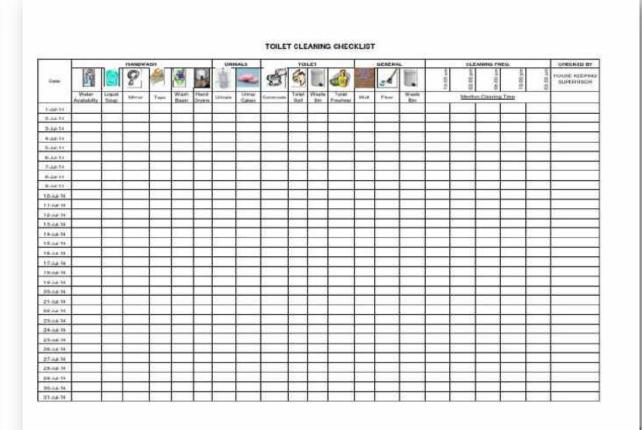






AVAILABILITY OF CLEAN AND FUNCTIONAL TOILETS WITH NO FOUL SMELL IN AND AROUND THE TOILET ALONG WITH FUNCTIONAL WATER TAPS









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THE TOILETS FLOOR SHOULD BE DRY AND NO DRAIN SHOULD BE OVERFLOWING







ET WITH BARS OR RAILINGS AND IS ACCESSIBLE THROUGH A RAMP







AVAILABILITY OF 24*7 WORKING TELEPHONE HELP LINE IN HOSPITAL FOR EFFECTIVE COMMUNICATION









KI 6 - THE HOSPITAL SHOULD ENSURE THAT ALL MEDICAL STAFF IS ADEQUATELY CREDENTIALED AS PER THE STATUTORY NORMS

Interpretation – The organization shall ensure that the medical professionals who have required qualification, training, experience and consonance with the law are permitted to provide the services and such information should be appropriately verified. Also, the facility should maintain an adequate number and mix of staff to meet the care, treatment and services needs of patients.

Means of verification:

- 1. Doctor/ Nurse/ Paramedic Staff/ Admin & Support Staff along with the current designation, educational qualification, registration council of name and the associated registration number along with the date of joining and area/working department
- 2. Organization should plan human resource with adequate number and with mix and credentials of staff as per the statutory norms
- 3. Hospital has dedicated staff (3 members) for AB PM-JAY





DOCTOR/ NURSE/ PARAMEDIC STAFF/ ADMIN & SUPPORT STAFF ALONG WITH THE CURRENT DESIGNATION, EDUCATIONAL QUALIFICATION, REGISTRATION COUNCIL OF NAME AND THE ASSOCIATED REGISTRATION NUMBER ALONG WITH THE DATE OF JOINING AND AREA/WORKING DEPARTMENT

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	(3) Intra Muscular Injection Administration	_				
	(d) Intra Venous Injection	_				
	(5)Blood Transfusion Monitoring	_				
	(6) Assisting Operation Procedure (7) Oxygen Administration					
		-				
	(8)Administration of High Risk Medicine (9)Urinary Catheterization	-				
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	Defibrillator	-				
	Vac Machine	-				
	- VOL WIGGINIE					
	(13) Multi Para Monitoring					





HOSPITAL HAS DEDICATED STAFF FOR AB PM-JAY











KI 7 - THE FACILITY HAS FUNCTIONAL EQUIPMENT AND INSTRUMENTS AS PER SCOPE OF SERVICES

Interpretation – The hospital must have all the equipment and instruments according to the scope of services they are offering. Basic functional diagnostic equipment should also be ready available.

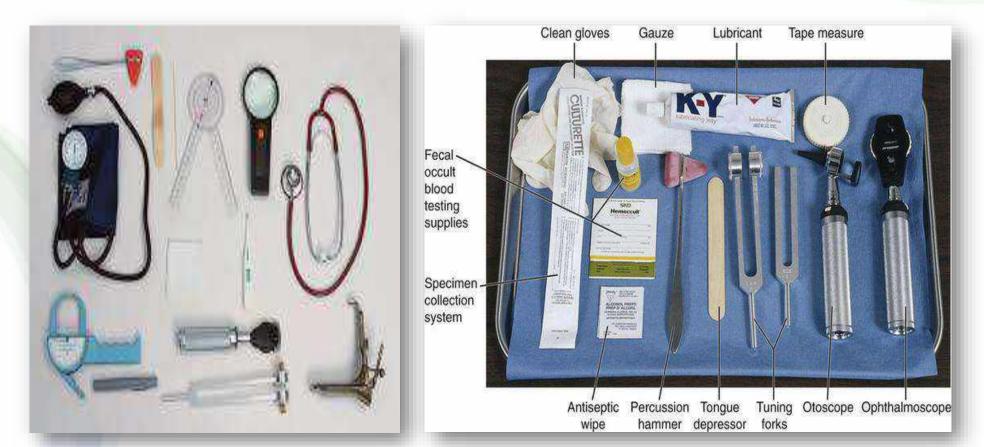
Means of verification:

 Availability for examination and monitoring of patients - BP apparatus, Multipara meter Torch, hammer, an instrument to measure height, weight and Blood Pressure (BP) to conduct a general examination





AVAILABILITY FOR EXAMINATION AND MONITORING OF PATIENTS - BP APPARATUS, MULTIPARA METER TORCH, HAMMER, AN INSTRUMENT TO MEASURE HEIGHT, WEIGHT AND BLOOD PRESSURE (BP) TO CONDUCT A GENERAL EXAMINATION







KI 8 - HOSPITAL SHOULD HAVE FIRE DETECTION AND FIRE-FIGHTING EQUIPMENT INSTALLED AS PER FIRE SAFETY NORMS ALONG WITH STAFF TRAINING

Interpretation – The facility should have plan and provisions for early detection, abatement and containment of fire emergencies such as documented safe fire exit plan and trained staff. The periodic training shall include information, demonstration to use fire extinguisher and mock drills.

Means of verification:

- 1. Check if fire extinguisher, fire/smoke detectors are installed in patient care areas with firepanel
- 2. Check for date of expiry on fire extinguisher which should be the beyond current date
- 3. The organization has a documented safe exit plan in case of fire and non-fire emergencies
- 4. Periodic training with mock drill is provided for using fire extinguishers





CHECK IF FIRE EXTINGUISHER, FIRE/SMOKE DETECTORS ARE INSTALLED IN PATIENT CARE AREAS WITH FIRE-PANEL







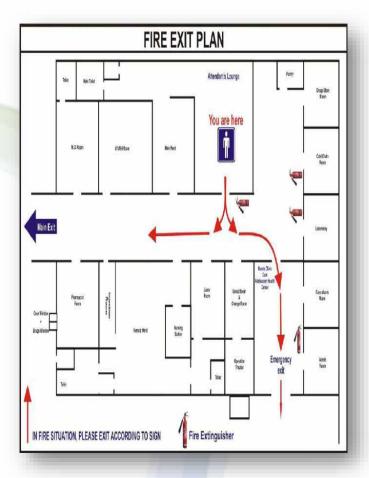
CHECK FOR DATE OF EXPIRY ON FIRE EXTINGUISHER WHICH SHOULD BE THE BEYOND CURRENT DATE







THE ORGANIZATION HAS A DOCUMENTED SAFE EXIT PLAN IN CASE OF FIRE AND NON-FIRE EMERGENCIES



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PERIODIC TRAINING WITH MOCK DRILL IS PROVIDED FOR USING FIRE EXTINGUISHERS











KI 9 - STAFF INVOLVED IN DIRECT PATIENT CARE SHALL BE TRAINED IN CARDIO PULMONARY RESUSCITATION (CPR) AND BASIC LIFE SUPPORT (BLS) ALONG WITH A DISPLAY OF THE SAME IN ALL CRITICAL CARE AREAS

Interpretation – The organization shall provide regular training to the staff providing direct patient care. If the facility has a CPR team (e.g. code blue team) it shall ensure that it is trained in advanced cardiopulmonary resuscitation (adult, pediatric and neonatal) and is present in all shifts. All doctors and nurses working in ICU/ HDU should undergo appropriate training and display the CPR algorithm at all the critical areas.

Means of verification:

- 1. Training Records for Basic Life Support (BLS)
- 2. There should be a code blue protocol in the organization
- 3. Check the display of CPR algorithm in or near ICU, Clinical area and Emergency areas.
- 4. Check the records for CPR events & CPR Mock drill along with the corrective & Preventive measures taken





TRAINING RECORDS FOR BASIC LIFE SUPPORT (BLS)

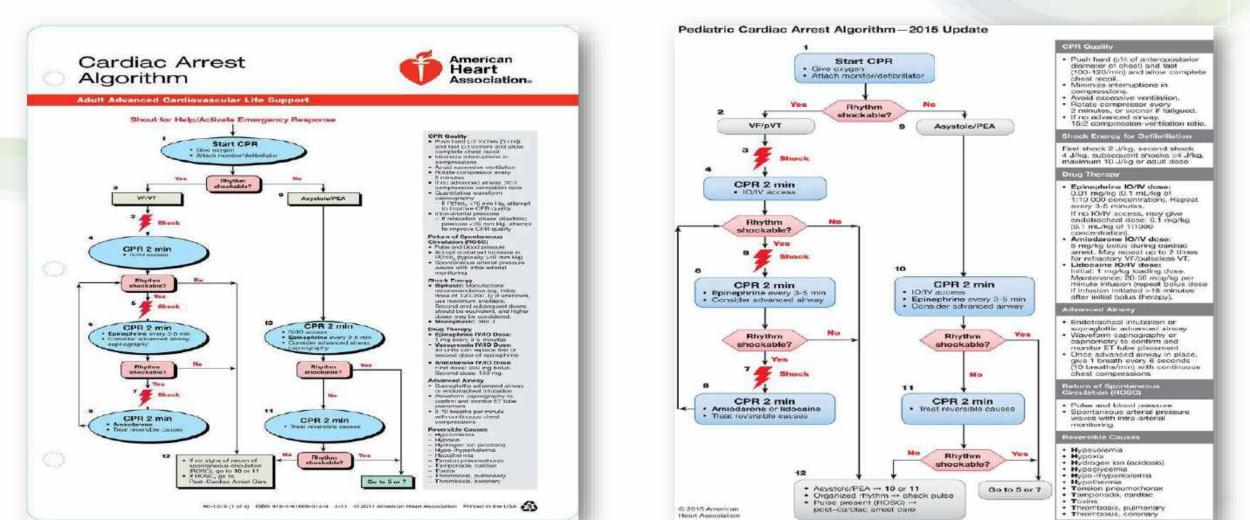








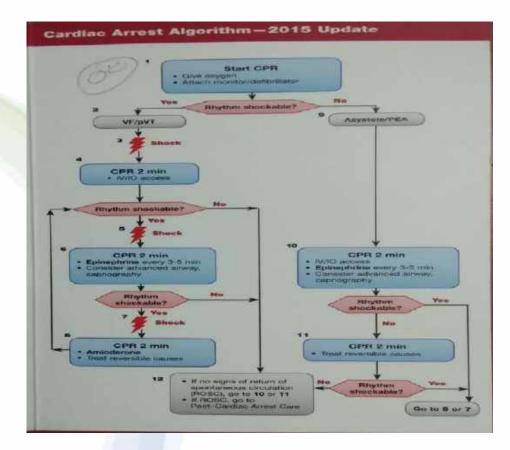
THERE SHOULD BE A CODE BLUE PROTOCOL IN THE ORGANIZATION

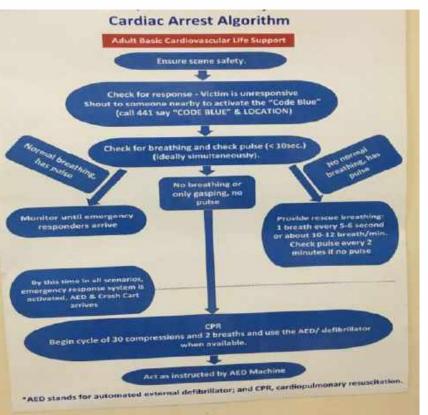






CHECK THE DISPLAY OF CPR ALGORITHM IN OR NEAR ICU, CLINICAL AREA AND EMERGENCY AREAS









CHECK THE RECORDS FOR CPR EVENTS & CPR MOCK DRILL ALONG WITH THE CORRECTIVE & PREVENTIVE MEASURES TAKE

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1. Date and Time of Cardia	ic Arrest:		
2. Was the control room info	rmed		
3. Code Blue activated: Ye	s/No		
If Yes: Time:			
If No: Reason:			
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KI 10 - ANNUAL TRAINING PLAN SHOULD BE PREPARED FOR ALL STAFF COVERING ALL TRAINING NEEDS

Interpretation – The hospital should document plan and prepare a training calendar to ensure staff is able to identify the patient's rights and responsibilities, potential hazards, maintain required quality and take appropriate actions during any disaster.

Means of verification:

- Facility prepares training calendar as per training need assessment, training feedback records - Training on Disaster Management, Patient safety and rights, facility level Quality Assurance.
- 2. AB PM-JAY specific training (e.g. BIS, TMS, HEM & Support Portal, etc) to all concerned staff.





FACILITY PREPARES TRAINING CALENDAR AS PER TRAINING NEED ASSESSMENT, TRAINING FEEDBACK RECORDS - TRAINING ON DISASTER MANAGEMENT, PATIENT SAFETY AND RIGHTS, FACILITY LEVEL QUALITY ASSURANCE

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AB PM-JAY SPECIFIC TRAINING (E.G. BIS, TMS, HEM & SUPPORT PORTAL, ETC) TO ALL CONCERNED STAFF







CHAPTER 2: CLINICAL SERVICES (OVERVIEW)

The definitive motive of a hospital is to provide clinical care. Therefore, clinical services are the most basic and significant in hospitals. These are the processes that determine the outcome of services and quality of care. These standards include processes such as consultation, clinical assessment, continuity of care, nursing care, identification of high risk and vulnerable patients, prescription practices, safe drug administration, blood bank requirement, antibiotic policy, maintenance of clinical records etc. These standards are based on the technical guidelines published by the Government of India (GoI) on individual programs and processes. It may be difficult to assess clinical processes; as direct observation of clinical procedure may not always be possible at the time of certification assessment. Therefore, assessment of these standards would largely depend upon a review of the clinical records and documents as well.





CHAPTER 2: CLINICAL SERVICES

CS 1	Patients privacy should be maintained in Out Patient Department (OPD) and In-Patient Department (IPD)
CS 2	The lab diagnostic services, whether in house or outsourced, should be as per the scope of services
CS 3	Blood bank services if available shall be as per the statutory/regulatory norms.
CS 4	The hospital should adhere to the radiation safety precautions as per the regulatory requirements
CS 5	Intensive Care unit (ICU) services should be available as per the scope of services along with the required infrastructure and manpower
CS 6	OT complex should be available as per the regulatory requirements
CS 7	Look-alike and sound-alike medicines need to be identified and stored separately to avoid any dispensing and administration errors.
CS 8	Policies and procedures for identification, safe dispensing and administration of all high-risk medicines should be documented and implemented
CS 9	The facility has defined and established antibiotic policy
CS 10	Pre-operative, Intra-operative and post-operative assessment should be done and documented by appropriately qualified staff in standardized format.
CS 11	Pre-Anesthesia assessments, type of Anesthesia and Post Anesthesia status should be documented.





CS 1 - PATIENTS PRIVACY SHOULD BE MAINTAINED IN OUT PATIENT DEPARTMENT (OPD) AND IN-PATIENT DEPARTMENT (IPD)

Interpretation – During all the stages of patient care, be it examination or carrying out a procedure, hospital staff shall ensure that the patient's privacy and dignity is maintained. There should be a provision of screens and curtains to ensure precautions are taken while providing care to patients.

Means of verification:

1. Check availability for privacy screens or curtains in OPD and wards for maintaining visual privacy for the patients





CHECK AVAILABILITY FOR PRIVACY SCREENS OR CURTAINS IN OPD AND WARDS FOR MAINTAINING VISUAL PRIVACY FOR THE PATIENTS







CS 2 - THE LAB DIAGNOSTIC SERVICES, WHETHER IN HOUSE OR OUTSOURCED, SHOULD BE AS PER THE SCOPE OF SERVICES

Interpretation – The facility should have MoU/ Agreement for the out-sourced laboratory services, which incorporates quality assurance and requirements of this standard. Also, a list of services provided by the hospital or outsourced should be available. If the services are outsourced, then the hospital should ensure safe and timely transportation of specimens.

Means of verification:

- 1. List the number of in-house lab services
- 2. List the number of outsourced lab services with their scope of work.
- 3. In the case of outsourced services, is there a sample collection room and a procedure to monitor the quality and adequacy of these services.
- 4. There should be a system in place for the daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge of monitoring diagnostic services 162





LIST THE NUMBER OF IN-HOUSE LAB SERVICES

Laboratory Services

Laboratory Procedures

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LIST THE NUMBER OF OUTSOURCED LAB SERVICES WITH THEIR SCOPE OF WORK

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IN THE CASE OF OUTSOURCED SERVICES, IS THERE A SAMPLE COLLECTION ROOM AND A PROCEDURE TO MONITOR THE QUALITY AND ADEQUACY OF THESE SERVICES





SAMPLE EQAS MONTHLY REPORT

Do-Rad Laboratorie Clinical Chemistry (Monthly) Sample Number: 7 Laboratory Number, 000 Sample Date: 23/01/03 12: Glucose Your Result: 64.0 mg/100 ml No. And Advantages Name sectabled 525 644 1.08 -0.02 82.4 3.15 -430 You Gray 100 Comparatur Mean THE MIDNE 642 226 Mathead - Mill , 745 M , Intra-Section Resetts Magnite 511-545/56 7 Analyti Levery-Jeanings Chart - Discour Statistic ر از از او او ای بخر ان او ان او ان از او او CON Neutri OUF Ses IIII TATONA 80-IIII to both the local LADIMENT Manual Ext 42.94 H125 67.41 (0.43 > 71.4 fample Cipe A Tarti and To Lit family Last 12 Sample Dates Lovey Janaings Comparator





THERE SHOULD BE A SYSTEM IN PLACE FOR THE DAILY ROUND BY MATRON/HOSPITAL MANAGER/ HOSPITAL SUPERINTENDENT/ HOSPITAL MANAGER/ MATRON IN CHARGE OF MONITORING DIAGNOSTIC SERVICES

Annual Building Inspection Checklist

Facility Exterior	YES	NO	N/A
is the building address or identification clearly visible?			
Are exterior lights in working order?			
Are the exits onto public streets free from visibility obstructions?			
Are all building sides accessible to emergency equipment?			1
Does the building appear to be in good repair?			
Are exterior walls free from cracks or other damages?			
Are windows free from cracks or broken pages?			
Are paved surfaces inspected and repaired (i.e., lifts, crincks, etc.)?			
Are stars, landings and handraits in good repair and fastened securely? (inspect the bottom of each step)			
Are facilities periodically inspected and documented?			
Are all sever clean our caps in place?			
Are al impation covers in place?			
Do entrance doors dose slowly to avoid hazards to fingers?			
Facility Interior	VES	NO	N/A
Electrical Systems			
Are all electrical panels secured?			Ľ.
Have all electrical directs been identified?			
Are all electrical avritches and receptactes in good repart?			
Have Ground Fault Interrupter's been provided on clicuits in proximity to water?			
Is there a "lock-out" procedure in place?			

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CS 3 - BLOOD BANK SERVICES IF AVAILABLE SHALL BE AS PER **THE STATUTORY/REGULATORY NORMS**

Interpretation – The blood bank should be functioning and adhere to standards procedures for blood collection and testing. In case the hospital doesn't have the blood bank, it shall have a MoU with the blood bank or the organization having a blood bank which has a valid license. IEC material for blood donation should also be displayed at all strategic locations.

Means of verification:

- 1. Blood bank services are available in house or outsourced. If outsourced then adequate supply/storage shall be ensured from a nearby authorized blood bank
- Blood bank has a valid license under Rule 122(G) Drug and cosmetic act 2.
- Blood bank has a facility of blood collection and storage along with emergency stock of blood 3.
- IEC material is displayed in blood bank and nearby area to provide information and promote blood donation 4.
- Check for availability of adequate functional equipment for blood products Blood bags refrigerator with 5. thermograph and alarm device, Insulated carrier boxes with ice packs, Blood bag weighing machine and deep freezer 167





BLOOD BANK SERVICES ARE AVAILABLE IN HOUSE OR OUTSOURCED. IF OUTSOURCED THEN ADEQUATE SUPPLY/STORAGE SHALL BE ENSURED FROM A NEARBY AUTHORIZED BLOOD BANK



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BLOOD BANK HAS A VALID LICENSE UNDER RULE 122(G) DRUG AND COSMETIC ACT

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GOVERNMENT OF KERALA DRUGS CONTROL DEPARTMENT

ML2.6850/2014/DC Dated: 23/05/2014 Office of the Drugs Controller Thiruvananthspursus-695-035

VALIDITY CERTIFICATE

This is to certify that

Vadimain, Alappuzha Dist., is holding Blood Bank Licence in Form 28C bearing No. 181/28C/RER/DC-CLAA/2009 dated 25/04/2009, issued by this department to operate a Blood Bank, for processing Whole Human Blood LP & its components as per the provision of Drugs & Cosmetics Act, 1940 and Roles there under.

It is further certified that the renewal application of the license of the institution is received in this office for the period 25/04/2014 to 24/04/2019 and the file is under process.

As per the provisions of Drugs and Cosmetics Act. 1940 and Rules there under the licence shall continue to be in force, until orders are passed on the application and as such the institution is entitled to collect, storage and process Whole Human Bluod 1.P.&. Blood Components under the above license.

The licence is currently valid under rule 122G and 122F of the Drugs and Cosmeric Rules 1945.

This contificate is issued on the request of the institution, for submitting before the Medical Council of India and is valid up to 22/05/2015

P. HARI-FRASAD Drugs Controller and Licensing Authority Kerala State

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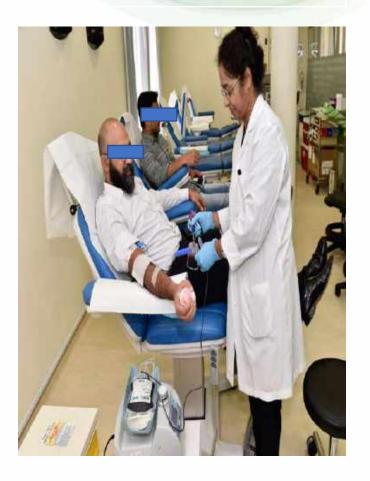




BLOOD BANK HAS A FACILITY OF BLOOD COLLECTION AND STORAGE ALONG WITH EMERGENCY STOCK OF BLOOD





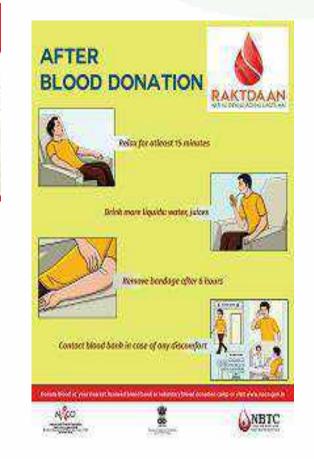






IEC MATERIAL IS DISPLAYED IN BLOOD BANK AND NEARBY AREA TO PROVIDE INFORMATION AND PROMOTE BLOOD DONATION





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CHECK FOR AVAILABILITY OF ADEQUATE FUNCTIONAL EQUIPMENT FOR BLOOD PRODUCTS - BLOOD BAGS REFRIGERATOR WITH THERMOGRAPH AND ALARM DEVICE, INSULATED CARRIER BOXES WITH ICE PACKS, BLOOD BAG WEIGHING MACHINE AND DEEP FREEZER

Blood Bag Tube Sealer	Blood Collection Monitor	Bicod Roller Mixer	Plasma Extractor
Freezer	Refrigerator	Cryobath	Plasma Thawing Bath
Centrifuge	Counter Balance	Syringe & Needle Destroyer	Clevofuge
Blood Donor Chair	Blood Denor Couch	Blood Warmer	Platelet Incubator









CS 4 - THE HOSPITAL SHOULD ADHERE TO THE RADIATION SAFETY PRECAUTIONS AS PER THE REGULATORY REQUIREMENTS

Interpretation – Shielding of body parts of staff and patients, attendants should be adhered to by using protective devices and equipment, along with precautions as per law for radiation safety. The facility should also ensure standard practices, usage and supply of Personal Protective Equipment (PPE).

Means of verification:

- 1. Clean gloves, aprons and masks are available at the point of use
- 2. TLD badges should be provided to each staff member in the radiation room
- 3. Lead aprons, thyroid shields and other radiation protection devices should be provided for the staff in the radiation field. These should be tested once in 2 years as per AERB norms
- 4. Availability of ECG services





CLEAN GLOVES, APRONS AND MASKS ARE AVAILABLE AT THE POINT OF USE





Bouffant Caps



Disposable Apron







Shoe Cover





Surgcial Gloves

Face Mask



PP Nose Mask



Surgeon Caps





TLD BADGES SHOULD BE PROVIDED TO EACH STAFF MEMBER IN THE RADIATION ROOM







LEAD APRONS, THYROID SHIELDS AND OTHER RADIATION PROTECTION **DEVICES SHOULD BE PROVIDED FOR THE STAFF IN THE RADIATION** FIELD. THESE SHOULD BE TESTED ONCE IN 2 YEARS AS PER AERB **NORMS**

























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AVAILABILITY OF ECG SERVICES







CS 5 - INTENSIVE CARE UNIT (ICU) SERVICES SHOULD BE AVAILABLE AS PER THE SCOPE OF SERVICES ALONG WITH THE REQUIRED INFRASTRUCTURE AND MANPOWER

Interpretation – The ICU should be equipped with necessary monitoring equipment along with the suitably manned by trained staff. The hospital should provide proper and safe environment to the infected patients and necessary procedures should be followed for the same.

Means of verification:

- 1. Flooring of the ICU should be non-slippery and smooth
- 2. Windows/ air vents if any should be intact and sealed
- 3. Comfortable temperature & humidity should be maintained
- 4. Availability of general duty doctor, nursing staff, paramedic and security staff as per requirements
- 5. Critical care equipment is available and maintained- Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley, Ventilator, Infusion pump, C-PAP, tray, monitors, Electrical panel with a bed, bedhead panel with an outlet for Oxygen and vacuum, X-ray view box, defibrillator
- 6. Availability of isolated area for infectious patient
- 7. Isolation and barrier nursing procedures are followed for septic cases





FLOORING OF THE ICU SHOULD BE NON-SLIPPERY AND SMOOTH









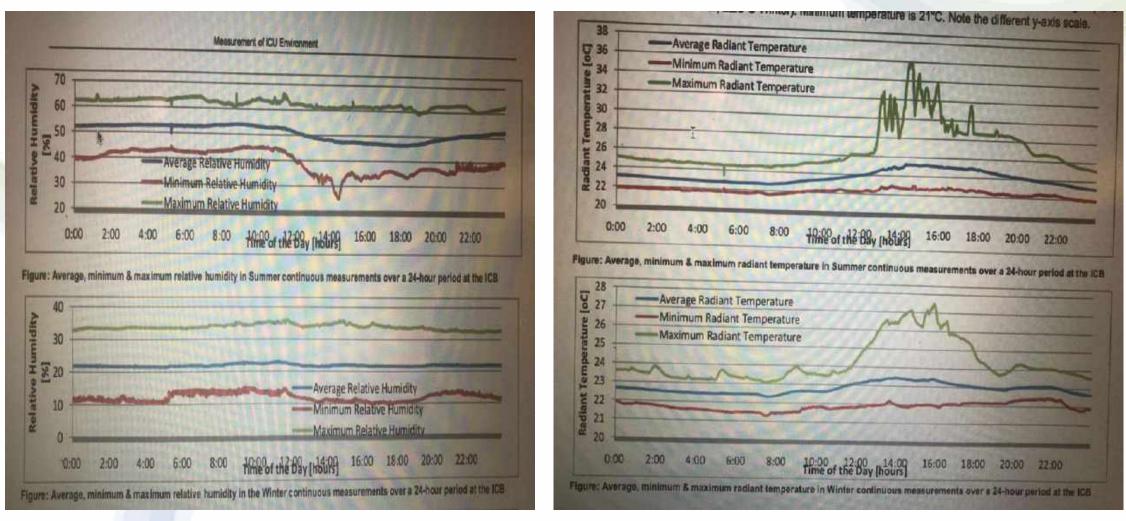
WINDOWS/ AIR VENTS IF ANY SHOULD BE INTACT AND SEALED







COMFORTABLE TEMPERATURE & HUMIDITY SHOULD BE MAINTAINED







AVAILABILITY OF GENERAL DUTY DOCTOR, NURSING STAFF, PARAMEDIC AND SECURITY STAFF AS PER REQUIREMENTS

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CRITICAL CARE EQUIPMENT IS AVAILABLE AND MAINTAINED- REFRIGERATOR, CRASH CART/DRUG TROLLEY, INSTRUMENT TROLLEY, DRESSING TROLLEY, VENTILATOR, INFUSION PUMP, C-PAP, TRAY, MONITORS, ELECTRICAL PANEL WITH A BED, BEDHEAD PANEL WITH AN OUTLET FOR OXYGEN AND VACUUM, X-RAY VIEW BOX, DEFIBRILLATOR

Equipment I tem	Location in Health Centre	Asset # or Serial #	Frequency of Service	Loan required for Backfill?	Last Serviced	Sent	Returned	Next Due	Comment
Air nebuliser			Annual	Yes		1		2	
Baby scales			Annual	Yes			h Ki		
Centrifuge			Annual	Yes					May be able to arrange a loan through Westerns
Defibrillator - ZOLL monitor			6 mthly	Yes				4	
Defibrillator - 20LL battery charger			Annual	No					
Defibrillator - HEARTSTART			6 mthly	Yes					
ECG machine			Annual	Yes					
Examination light 1 (Welch Allyn)			As required						
Examination light 2 (Weldt Allyn)			As required						
Foetal Doppler 1			Annual						
Foetal Doppler 2			Annual						
Haemoglobinometer Hemocue 1			Annual			r			
Haemoglobinometer Hemocue 2			Annual						
Haemoglobinometer Hemocue 3			Annual						
i-STAT analyzer			Six Monthly software upgrade	No					Coordinate with the PPN (CA) ph 5951 5945
IVAC infusion pump			Annual						
Oto/Opthalmoscope set 1			As Required						
Oto/Opthalmoscope set 2			As Required						
Oto/Opthalmoscope set 3			As Required	-		-			
Oxy flow meter 1			Annual						
Oxy flow meter 2			Annual				88		
Oxy flow meter 3			Annual		-		B S	3 8	
Oxy flow meter 4			Annual						
Oxy flow meter 5			Annual						
Oxy regulator 1			Annual	-					
Oxy regulator 2			Annual						





AVAILABILITY OF ISOLATED AREA FOR INFECTIOUS PATIENT







ISOLATION AND BARRIER NURSING PROCEDURES ARE FOLLOWED FOR SEPTIC

CASES

A Nurse's Guide To Isolation Precautions

- Contact Isolation Precautions
- Droplet Isolation Precautions
- Airborne Isolation Precautions
- Neutropenic and Radiation Precautions





Follow CONTACT ISOLATION

- Used to prevent transmission of microorganisms spread by direct/indirect contact with the source
- examples:
- -MRSA
- -VRE

-C. diff

- contagious skin infections... Lice & Scabies



Five major routes of transmission

What germs are on our hands ??

1. Contact:

- Direct (person-person) Indirect (through an object)
- 2. Droplet
- 3. Airborne
- 4. Common vehicle
- 5. Vector borne

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CS 6 - OT COMPLEX SHOULD BE AVAILABLE AS PER THE REGULATORY REQUIREMENTS

Interpretation – The organization shall ensure that the operation theater has facilities for demarcated areas, separate changing rooms for males and females along with proper illumination and temperature.

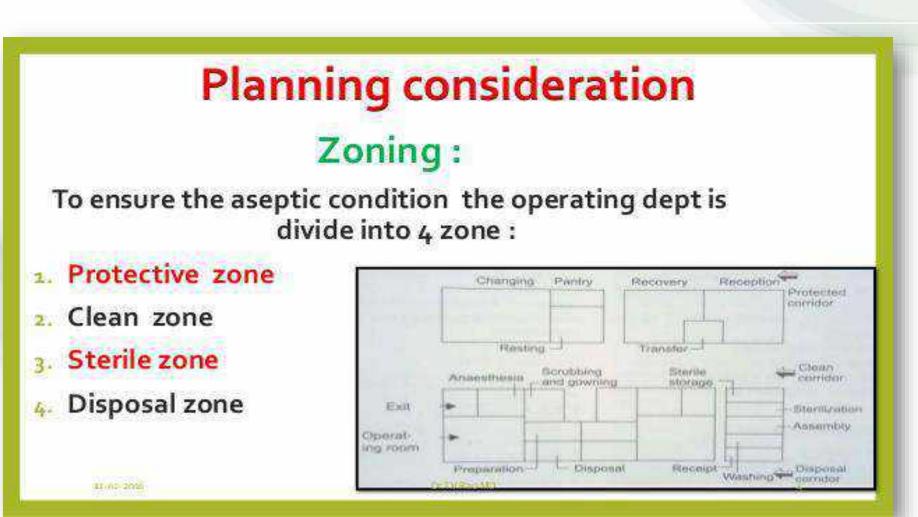
Means of verification:

- 1. Proper demarcation of the following areas: protective zone, clean zone, sterile zone and disposal zone
- 2. Availability of signage stating that the entry to OT is restricted
- 3. Pre-operative and post-operative area should be well-lit
- 4. Change rooms are available for male and female staff; entry in OT should be allowed only after change in attire
- 5. Temperature and humidity are maintained and record of same is kept





PROPER DEMARCATION OF THE FOLLOWING AREAS: PROTECTIVE ZONE, CLEAN ZONE, STERILE ZONE AND DISPOSAL ZONE



187





188

AVAILABILITY OF SIGNAGE STATING THAT THE ENTRY TO OT IS RESTRICTED







PRE-OPERATIVE AND POST-OPERATIVE AREA SHOULD BE WELL-LIT







CHANGE ROOMS ARE AVAILABLE FOR MALE AND FEMALE STAFF; ENTRY IN OT SHOULD BE ALLOWED ONLY AFTER CHANGE IN ATTIRE











TEMPERATURE AND HUMIDITY ARE MAINTAINED AND RECORD OF SAME IS KEPT

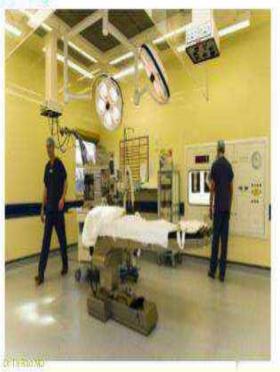
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Maintaining the Operation theaters is a priority

Stress must be laid on

- Temperature
- Humidity
- Ventilation
- Temperature : 24-270 C
- Relative Humidity : 450 600 C for adult
- 550 650 C for infants

11-02-202







CS 7 - LOOK-ALIKE AND SOUND-ALIKE MEDICINES NEED TO BE IDENTIFIED AND STORED SEPARATELY TO AVOID ANY DISPENSING AND ADMINISTRATION ERRORS.

Interpretation – The drug store should arrange the stock in alphabetic/ uniform/ standardised order and storage requirement of the drugs should be adhered to. The overall cleanliness and temperature of the storage area should be maintained. One look alike should be stored apart from its other look alike.

Means of verification:

- 1. Product of similar name and different strength (look alike and sound alike drugs) should be stored separately.
- 2. Medicine storage shall be in a clean, well lit, and in a safe environment in accordance with the applicable laws and regulations.
- 3. Stock is arranged neatly in alphabetic order with the name facing the front and labels must have drug name, strength and frequency
- 4. Drug store has inventory management software





PRODUCT OF SIMILAR NAME AND DIFFERENT STRENGTH (LOOK ALIKE AND SOUND ALIKE DRUGS) SHOULD BE STORED SEPARATELY

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INJ. METHERGIN	INJ. BUSCOPAN
TAB. PERACETAMOL	TAB. VITAMIN - C TAB. CALCIUM GLUCONATE
TAB.METROGYL	TAB. BRUFEN
TAB.CPM	TAB, DOMIPERIDOM



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	INI. ADRENALIN	NO ADRENALIN
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	NI. HYDROCORTISONE	INJ. DEXAMETHASONE
INJ. GENTAMYCINE INJ.AMIKACINE	INJ. GENTAMYCINE	INJ.AMIKACINE
TAB.LEVODOPA TAB.METHYLDOPA	TAB.LEVODOPA	TAB.METHYLDOPA







MEDICINE STORAGE SHALL BE IN A CLEAN, WELL LIT, AND IN A SAFE ENVIRONMENT IN ACCORDANCE WITH THE APPLICABLE LAWS AND REGULATIONS















STOCK IS ARRANGED NEATLY IN ALPHABETIC ORDER WITH THE NAME FACING THE FRONT AND LABELS MUST HAVE DRUG NAME, STRENGTH AND FREQUENCY









DRUG STORE HAS INVENTORY MANAGEMENT SOFTWARE

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(A) Stock Control Card

Essential Drug Stor	ck Control Card
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(B) Report and Requisition Form

BARRY LEWISCHURG

REPORT AND REQUISITION FOR ESSENTIAL DRUGS

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* #Maste

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CS 8 - POLICIES AND PROCEDURES FOR IDENTIFICATION, SAFE DISPENSING AND ADMINISTRATION OF ALL HIGH-RISK MEDICINES SHOULD BE DOCUMENTED AND IMPLEMENTED

Interpretation – Clear policies to be laid down for dispensing of high-risk medicines and the list of such medicines should be available at the drug store. The narcotics drugs should be stored in secure manner.

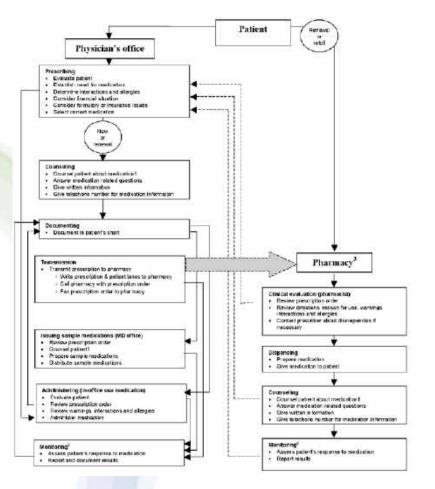
Means of verification:

- 1. Documented procedure incorporating storage, prescription and dispensing of medications
- 2. Narcotic medicines are kept in double lock
- 3. Pharmacy has a list of high-risk drugs available with it



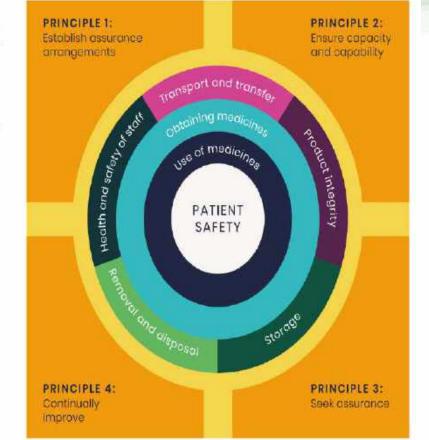


DOCUMENTED PROCEDURE INCORPORATING STORAGE, PRESCRIPTION AND DISPENSING OF MEDICATIONS



Framework for the safe and secure handling of medicines

FIGURE 3:







NARCOTIC MEDICINES ARE KEPT IN DOUBLE LOCK











PHARMACY HAS A LIST OF HIGH-RISK DRUGS AVAILABLE WITH IT

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CS 9 - THE FACILITY HAS DEFINED AND ESTABLISHED ANTIBIOTIC POLICY

Interpretation – The Hospital must have an established antibiotic policy ensuring rational use of antibiotic/drug.

Means of verification:

1. Facility should ensure the rational usage of antibiotics/ drugs and policy for the same is in place and implemented.





FACILITY SHOULD ENSURE THE RATIONAL USAGE OF ANTIBIOTICS/ DRUGS AND POLICY FOR THE SAME IS IN PLACE AND IMPLEMENTED



Antimicrobial resistance happens when bacteria and other microorganisms change after being exposed to antimicrobial drugs. Antibiotics are among the most common antimicrobial drugs used in humans and animals. The overuse and misuse of antibiotics is speeding up the development of resistance and putting us all at risk.

Antibiotic resistance can affect anyone, of any age, in any country. It is a threat to human health, food security and sustainable development.

WHAT YOU CAN DO

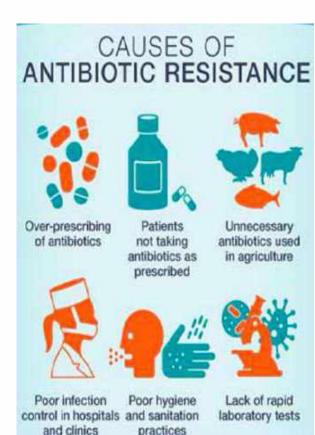


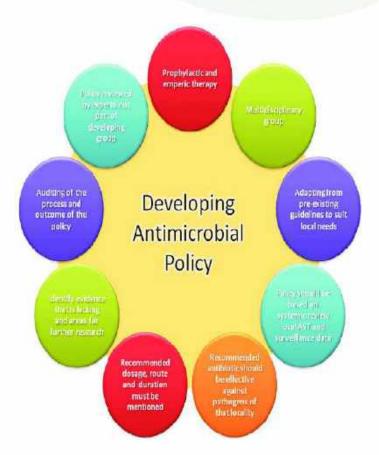
www.antibioticawarenessweek.org

> Keeping vaccinations up to date



World Health Organization Western Pacific Region









CS 10 - PRE-OPERATIVE, INTRA-OPERATIVE AND POST-OPERATIVE ASSESSMENT SHOULD BE DONE AND DOCUMENTED BY APPROPRIATELY QUALIFIED STAFF IN STANDARDIZED FORMAT

Interpretation – All the patients undergoing surgery should be assessed pre-operative, intraoperative and post-operative by the trained staff, which should be documented in a standardized format. Also, a documented procedure should be available for preventing adverse like wrong site, wrong patient and wrong surgery.

Means of verification:

- 1. There is a procedure for pre-operative and intra-operative assessment Physical examination, result of lab investigation, diagnosis and proposed surgery (3 samples)
- 2. Patient reports with post-operative notes that should contain vital signs, pain control, urine and gastrointestinal fluid output, other medications and Laboratory investigations (3 samples)
- 3. Documented procedure to address the prevention of adverse events like wrong site, wrong patient and wrong surgery.





THERE IS A PROCEDURE FOR PRE-OPERATIVE AND INTRA-OPERATIVE ASSESSMENT - PHYSICAL EXAMINATION, RESULT OF LAB INVESTIGATION, DIAGNOSIS AND PROPOSED SURGERY

	CHECKLIST BEFORE S	IRCERY	
	of the patient :	MRD Number	÷.
	of the doctor :	Datet	
		Ward	Recovery
Sr. No.	Have you checked ?	NA	Room
1	Patient NBM since		
2	Any known allergy/DM/HTN/Asthma		
3	Surgery Side marked		
4	Surgery Side : OD OS OU		
5	Surgery Consent		
6	Guarded visual prognosis consent (if required)	NA	
7	HIV consent		
8	Anaesthesis concent		
9	Anaesthesia fitness done		
10	Physician/Paediatrician fitness done		
11	Amniotic membrane graft ordered/Not ordered		
12	Concent for disposal of clinical histopathology samples		
13	Any pre-medication/ Inj. Manitel given		
14	BP		
15	Lab investigations		
18	A-Scan		
17	Final IOL power decided by surgeon	NA	
18	IOL BRAND	NA	
19	Eve Dilated		

REMARK : CASH PAID / TPA / ECHS / CGHS / FREE / WEAKER / BEFORE DISCHARGE / AMOUNT TO BE PAID TOMORROW MORNING

Identify high-risk surgical patient

Shoemaker/Boyd criteria, P-POSSUM Establish functional capacity

Ensure optimum management of chronic disease and acute physiology

Refer to ACC/AHA guidelines

SURGERY

Institute flow monitoring and goal-directed fluid therapy pre-operatively and intra-operatively if possible

Admit to intensive care unit post-operatively

Institute flow monitoring Ensure adequate oxygenation and haematocrit

Target oxygen delivery/tissue perfusion goals

i.e. DO₂i ≥ 600ml/min/m² and CI ≥ 4.5l/min/m² using fluids initially until no longer preload responsive Add inodilators e.g. dopexamine up to 1 microgram/kilogram/minute if goals not achieved

Maintain monitoring and goals

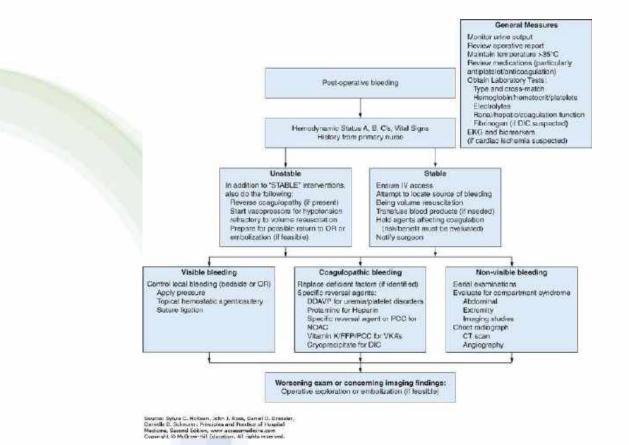
For up to 8 hours

Adapted from Lees et al (2009) Clinical review: Goal-directed therapy in high risk surgical patients *Critical Care*, **13**:231 CI = cardiac index, DO_2i = oxygen delivery index





PATIENT REPORTS WITH POST-OPERATIVE NOTES THAT SHOULD **CONTAIN VITAL SIGNS, PAIN CONTROL, URINE AND GASTROINTESTINAL** FLUID OUTPUT, OTHER MEDICATIONS AND LABORATORY **INVESTIGATIONS**



World Health

Postoperative care

Post-operative nots and orders

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Aftercare: Prevention of complications

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- restation about father insregerent including drigs presented.
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DOCUMENTED PROCEDURE TO ADDRESS THE PREVENTION OF ADVERSE EVENTS LIKE WRONG SITE, WRONG PATIENT AND WRONG SURGERY

Before entering OR	Before inducing anesthesia	Final pause before incision	Before leaving OR	Postoperative destination
Patient check-in	Upon entry Stretcher/table locked for transfer	All staff review critical events before incision	Nurse verbally reviews with the team	Upon arrival
Patient states name and 0.0.5. Patient confirms ID band/consent Patient states procedure, site, side Patient names his/her surgeon Patient asked when they last ate Determine need for interpreter Allergies reviewed/recorded Verify with or board Site marked if applicable and confirmed* H & P updated and in chart	Strotcharrtable locked for transfor Safety beit in place Team members introduced Patient identity confirmed Confirm record labeling Allergies verbalized Confirm procedure(s) being performed Patient positioning confirmed Emergency equipment available Special equipment available	Attending surgeon reviews critical/additional steps and anticipated blood loss Anesthesia provider reviews patient specific concerns/issues Circulator reviews sterility and equipment issues Tissue and implants checked and verified Neutral zone established	Final count pause Instrument, sponge, needle counts performed per policy Specimens reconciled by RN Final diagnosis confirmed and recorded Name of procedures(s) Wound classification verified with surgeon	Team members introduced Vital signs and temperature Or nurse/surgeon review concerns for recovery Orders by surgeon Anesthesia report Allergies verbalized Patient history Last or vital signs Drugs administered
Consents up-to-date/signed Anesthesia preop/consent done ASA status verified/documented Antibiotic ordered if applicable VTE prophylaxis if applicable Precautions identified Preop RN/circulator briefling Preop RN/circulator briefling Determine potential need for unit bed Confirm B blocker usage and document if applicable Steroid protocol if applicable	Imaging displayed and reviewed Review prior to induction Pulse eximeter on/functioning Risk of difficult airway/aspiration Surgeon reviews duration, Irrigation fluids and risk of retained foreign body Blood available if applicable All drugs/solutions labeled Compression boots if applicable Antibiotics doee/redoeing B-blocker/glucose control Temperature control measures Fibid menagement stretery	Final pause Stop all activity Attending surgeon present Prep dried Surgeon site marking visible and confirmed alter prep and drape and prior to incision when applicable Remark site and redo timeout if initials not visible Incision time confirmed and recorded For additional surgeons OR timeout	Attending surgeon Date:Time: RN: Date:Time: Date:Time: Commode/sysys) Review critical events Aneethesia provider, nurse and surgeon review the key concerns for recovery and management of the patient Discussion of post	Unine output/blood loss Fluids/blood products Prior to final sign out Procedure note in chart Anesthesia drug/discharge orders Need for consults/x-rays/labs Post anesthesia progress note Timing of antibiotics if applicable Final disposition RN: Date:Time:
Hand off Preop RN: Circulator: Date: Time: (mmvdd/vyyy)	Fluid management strategy Perform or timeout Patient, procedure, site, side, level, implants, structure, position and consents reviewed and verified Stop all activity Attending surgeon Attending anesthesiologist: Circulator: Time:	Patient, procedure, site, side, level, implants, structures, position and consents reviewed and verified Attending surgeon Attending anesthesiologist Circulator: N/A	Discussion of positive analyseia/block Procedure note by surgeon Determine if there were any equipment issues Steps to exit initiated Call postop destination with any precautions and equipment	(mm/dd/yyyy)

Source: Gerard M. Doherty: Current Diagnosis & Treatment: Surgery, 14th Edition www.accessmedicine.com Copyright © McGraw-Hill Education, All rights reserved.







Interpretation – The pre-anesthesia, post anesthesia and type of anesthesia should be monitored and documented in a standardized format. Also the patient records must contain regular and periodic monitoring records of patients who are under observation Post Operative/Anesthesia for the purpose of taking corrective and preventive actions.

Means of verification:

- 1. Department has documented procedure for pre-operative anesthesia checkup
- 2. Anesthesia plan is documented before entering into OT
- 3. Post anesthesia status is monitored and recorded
- 4. Post-Operative/Anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency



on mark MG



DEPARTMENT HAS DOCUMENTED PROCEDURE FOR PRE-OPERATIVE ANESTHESIA CHECKUP

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1. 2 ID bands applied (different extremities)					
 3 Blood bands applied # Astelegous/donor directed blood avail galiferant extremities) 					
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5. Advance directives signed and on chart		<u> </u>	-		1 Wearing two I D Bands that are legible
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Source: Butterworth JF, Mackey OC, Wasnick JD: Morgan & Mikhaif's Clinical Anesthesiology. EU. Cliffort toron and an and intervention

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ANESTHESIA PLAN IS DOCUMENTED BEFORE ENTERING INTO OT

Anesthesia Care Plan Development:

DOS

- ✓ Review current lab data
- \checkmark Review medical & surgical history with the patient
- ✓ Perform physical assessment for anesthesia
- \checkmark Discuss plan with supervisor
- ✓ Revise the plan as needed

✓ Discuss plan with patient and obtain consent

The anesthetic care plan is based on:

- · A review of the medical record available
- Medical history
- Prior anesthetic experiences
- Drug therapies
- Medical examination and assessment of any physical conditions that might affect the decision about the preoperative risk management
- A review of medical test and consultations that might reflect on the anesthesia administration
- An appropriate preoperative medications needed for the conduct of anesthesia
- Providing appropriate preoperative instructions and other preparations as needed

3 Stages of Plan Development

Prior to Day of Surgery (DOS):

- Patient / nursing completes a health assessment including pre-anesthesia
- Old medical records, including anesthesia, may be reviewed Develop a care plan based on this information

DOS:

Conduct patient interview Perform anesthesia physical assessment Review current lab data Revise the preliminary plan if needed

Intraoperative:

Provide vigilant care Continually assess the plan and prepare to revise as needs arise



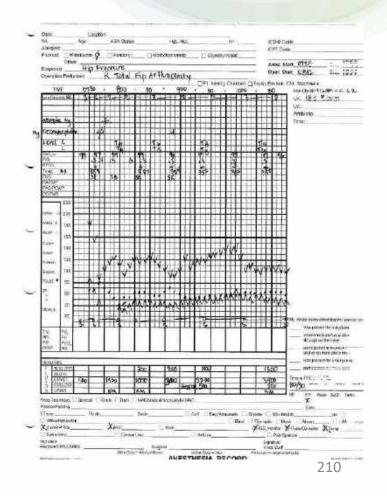




POST ANESTHESIA STATUS IS MONITORED AND RECORDED

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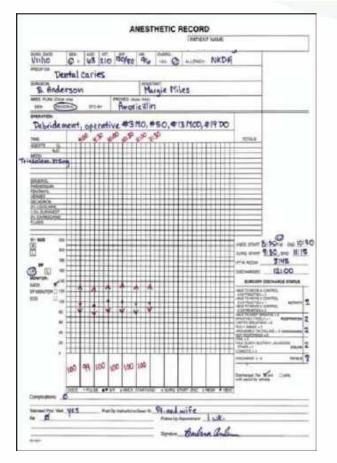






POST-OPERATIVE/ANESTHESIA MONITORING INCLUDES REGULAR AND PERIODIC RECORDING OF HEART RATE, CARDIAC RHYTHM, RESPIRATORY RATE, BLOOD PRESSURE, OXYGEN SATURATION, AIRWAY SECURITY AND PATENCY

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CHAPTER 3: SUPPORT SERVICES (OVERVIEW)

Support services are fundamental foundation of every healthcare facility and helps other departments things run smoothly. And when things are running well, patients receive better care, so the expected clinical outcome cannot be visualized in the absence of support services. This chapter includes parameters to evaluate cleanliness, sterilization, infection control practices, security and facility management, water and power supply, dietary services and laundry. These standards also cover some of the administrative processes like legal and statutory compliances, contract management, Bio-Medical waste disposal etc. If these services and facilities are in place and are managed efficiently, supported and maintained, mainline healthcare delivery will be effective.



CHAPTER 3: SUPPORT SERVICES



SS 1	Hospital should be clean and have well managed flooring
SS 2	Temperature control and ventilation should be maintained in patient care and nursing area
SS 3	The hospital should have arrangement of water storage and should be tested periodically as per requirement
SS 4	The hospital should have 24 hours supply of electricity, either through direct supply or from other sources
SS 5	Medical gases and vacuum shall be made available all the time and stored safely. Compressed air should be made available as per the scope of services.
SS 6	The facility should adhere to the practices specified under statutory compliances as per the scope of services - Licenses with Certificate number, date of issue and date of expiry
SS 7	The hospital should ensure that appropriate infection control practices are being followed along with hand hygiene practices
SS 8	Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules, 2018)
SS 9	Hospital should ensure that services i.e. (Laundry, Housekeeping, Dietary, security, Ambulance, Mortuary, Central Sterile Supply Department (CSSD) etc. are available (in-house or outsourced).
SS 10	Sexual harassment and grievance handling procedure should be available.





SS 1 - HOSPITAL SHOULD BE CLEAN AND HAVE WELL MANAGED FLOORING

Interpretation – The flooring of the hospital should be well managed and have adequate cleaning processes like mopping, scrubbing etc. conducive for the infection control.

Means of verification:

- 1. The floor should be non-slippery and dry
- 2. The floor surface should be smooth enough for effective cleaning and walking
- 3. The facility should be cleaned at least twice in the day with a wet mop and are also rigorously cleaned with scrubbing at least once in a month. Check cleaning records for regular and frequency of cleaning





THE FLOOR SHOULD BE NON-SLIPPERY AND DRY









THE FLOOR SURFACE SHOULD BE SMOOTH ENOUGH FOR EFFECTIVE CLEANING AND WALKING













THE FACILITY SHOULD BE CLEANED AT LEAST TWICE IN THE DAY WITH A WET MOP AND ARE ALSO RIGOROUSLY CLEANED WITH SCRUBBING AT LEAST ONCE IN A MONTH. CHECK CLEANING RECORDS FOR REGULAR AND FREQUENCY OF CLEANING







SS 2 - TEMPERATURE CONTROL AND VENTILATION SHOULD BE MAINTAINED IN PATIENT CARE AND NURSING AREA

Interpretation – Arrangement for comfortable work environment in terms of temperature control should be available in patient care areas and work stations.

Means of verification:

1. Availability of fans/ air conditioning/ heating/ exhaust/ air vents as per the requirement and weather condition.





AVAILABILITY OF FANS/ AIR CONDITIONING/ HEATING/ EXHAUST/ AIR VENTS AS PER THE REQUIREMENT AND WEATHER CONDITION







SS 3 - THE HOSPITAL SHOULD HAVE ARRANGEMENT OF WATER STORAGE AND SHOULD BE TESTED PERIODICALLY AS PER REQUIREMENT

Interpretation – The hospital shall ensure that there is sufficient water supply to meet the requirements at all point of use round the clock. Alternate source of water should be available as backup for any failure or shortage and same should be tested on regular basis. The results of the tests should be documented.

Means of verification:

- 1. At least 200 liters of water per bed per day is available on a daily 24x7 basis. Adequate backup for continuous water supply should be available (check alternate sources also)
- 2. Water is available at all points of use for hand washing, OT, Labor room, wards, Patients toilet & bathroom.
- 3. All water tanks are kept tightly closed to ensure safety
- 4. Check the records for periodic tests of the quality of water from the source (municipal supply, borewell, etc.) for bacterial and chemical content as per the guidelines





AT LEAST 200 LITERS OF WATER PER BED PER DAY IS AVAILABLE ON A DAILY **24X7 BASIS. ADEQUATE BACKUP FOR CONTINUOUS WATER SUPPLY SHOULD BE AVAILABLE (CHECK ALTERNATE SOURCES ALSO)**

According to WHO guidelines, the **minimum water** requirement of **a hospital** is about 50 litres per person per day. Normally, the water requirement is 115 litres per person per day. A district hospital with about 100 patients and 200 personnel, or a total of 300 people, will need at least 34,500 litres of water per day. **Examples of alternative water sources**



Hospital has a unctional rain water harvesting system

include:

- Harvested rainwater from roofs
- Harvested storm water
- Reclaimed wastewater
- •Gray water
- Captured condensate
- Additional alternative water sources
 - **Atmospheric water generation**
 - **Discharged water from water** purification processes
 - Foundation water
 - **Blowdown water**
 - **Desalinated water.**





WATER IS AVAILABLE AT ALL POINTS OF USE FOR HAND WASHING, OT, LABOR ROOM, WARDS, PATIENTS TOILET & BATHROOM







ALL WATER TANKS ARE KEPT TIGHTLY CLOSED TO ENSURE SAFETY







CHECK THE RECORDS FOR PERIODIC TESTS OF THE QUALITY OF WATER FROM THE SOURCE (MUNICIPAL SUPPLY, BOREWELL, ETC.) FOR BACTERIAL AND CHEMICAL CONTENT AS PER THE GUIDELINES



Parameter	Drinking water quality as per			
	EQS standard	WHO standard	EC standard	
pН	6.0-8.5	6.5-8.5	6.5-8.5	
TDS (mg/l)	1,000	1,000	1,000	
Iron (mg/l)	0.3-1.0	0.3	0.20	
Sodium (mg/l)	200	200	175	
Chloride (mg/l)	150-600	250	250	
Sulphate (mg/l)	400	400	25	
Fluoride (mg/l)	1.0	1.5	1.5	
Arsenic (mg/l)	0.05	0.05	0.05	
Ammonium (mg/l)	0.5	1.5	0.5	
Nitrate (mg/I)	10	10	10	
Phosphate (mg/l)	6.0	-	5.0	
Potassium (mg/l)	12.0		10	
Endrin (mg/l)	0	0.2	0.2	
Heptachlor (µg/l)	0	0.1	0.1	
DDT (ug/l)	0	1.0	0.1	

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Source [10]





SS 4 - THE HOSPITAL SHOULD HAVE 24 HOURS SUPPLY OF ELECTRICITY, EITHER THROUGH DIRECT SUPPLY OR FROM OTHER SOURCES

Interpretation – Hospital should have availability of power back up in the form of emergency lights, DG sets, solar energy, UPS, noiseless generators or any other suitable source. The staff involved in maintenance of electricity must have rubber mats, gloves and boots for safe working and prevention from any mis happening.

Means of verification:

- 1. Check the availability of power back up, availability of UPS, emergency lights or noiseless generators
- 2. Rubber mats are available in the electrical room below the panels and rubber gloves, boots and safety gears are provided to the electrical staff





CHECK THE AVAILABILITY OF POWER BACK UP, AVAILABILITY OF UPS, EMERGENCY LIGHTS OR NOISELESS GENERATORS





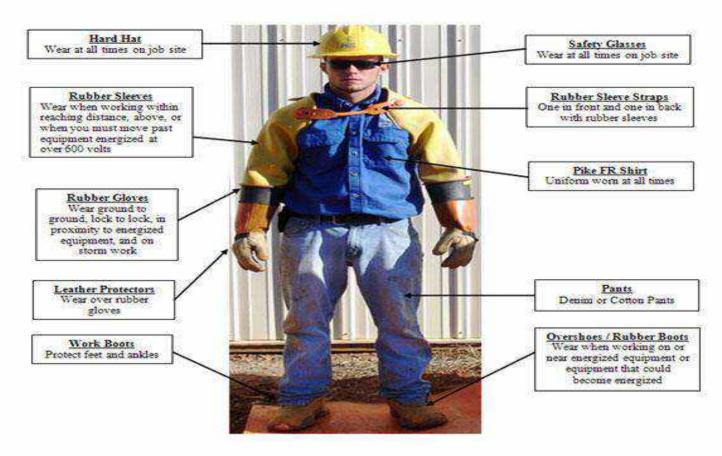






RUBBER MATS ARE AVAILABLE IN THE ELECTRICAL ROOM BELOW THE PANELS AND RUBBER GLOVES, BOOTS AND SAFETY GEARS ARE PROVIDED TO THE ELECTRICAL STAFF









SS 5 - MEDICAL GASES AND VACUUM SHALL BE MADE AVAILABLE ALL THE TIME AND STORED SAFELY. COMPRESSED AIR SHOULD BE MADE AVAILABLE AS PER THE SCOPE OF SERVICES.

Interpretation – Manifold room should be accessible and have adequate back up of oxygen cylinders. Availability of central oxygen and vacuum supply should especially be assessed in critical area like OT and ICU with standardized colour coding of cylinders and pipelines. A prompt replacement procedure and alarm system should be available to indicate any abnormal pressure change in the room. The instructions for operating different equipment's in manifold room should be displayed clearly.

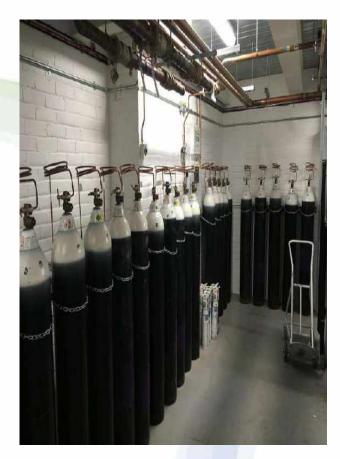
Means of verification:

- 1. The manifold room should be located on the ground floor and entry to the room is prohibited for the unauthorized people.
- 2. The manifold room should have at least 3 days of oxygen and other medical gases stock, that is chained appropriately
- 3. Colour of the gas pipeline (if applicable) and the gas cylinder has to be as per the standards
- 4. The alarm system should be operational to indicate any abnormal pressure change
- 5. Adequate back-up of B-type cylinders in critical areas like ICU, OT and for patient transfer purpose
- 6. The procedure being followed for prompt replacement of empty cylinders with filled cylinders
- 7. Instruction for operating different equipment in the manifold room should be clearly displayed





THE MANIFOLD ROOM SHOULD BE LOCATED ON THE GROUND FLOOR AND ENTRY TO THE ROOM IS PROHIBITED FOR THE UNAUTHORIZED PEOPLE



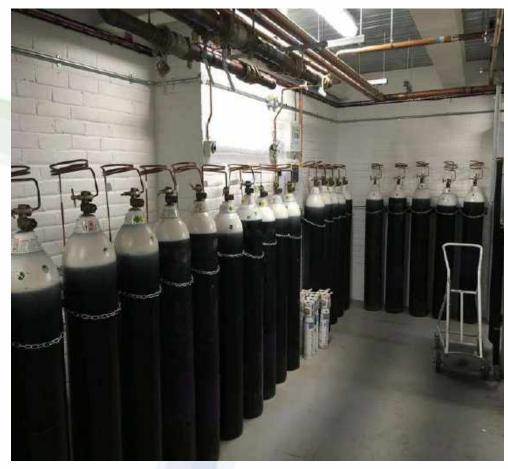








THE MANIFOLD ROOM SHOULD HAVE AT LEAST 3 DAYS OF OXYGEN AND OTHER MEDICAL GASES STOCK, THAT IS CHAINED APPROPRIATELY

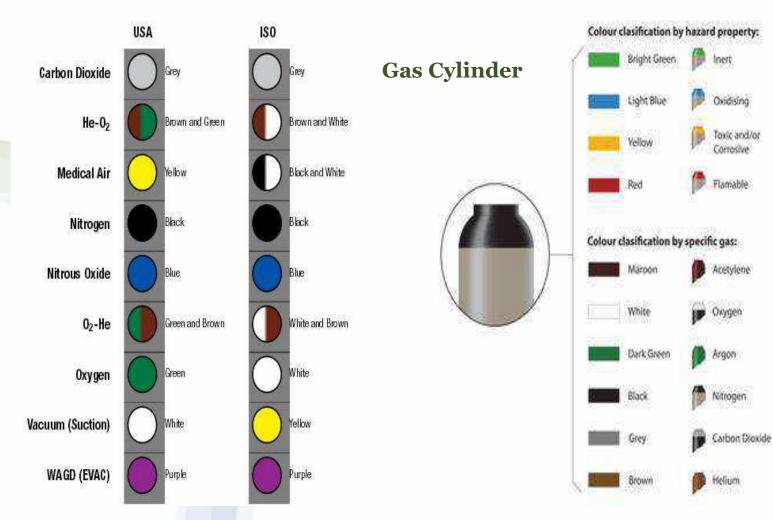








COLOUR OF THE GAS PIPELINE (IF APPLICABLE) AND THE GAS CYLINDER HAS TO BE AS PER THE STANDARDS Gas pipeline



Material Property	Letter Color on Field Color	Example
Single Gases		2
Oxygen USP [†]	White on Green	⇒ OX YGEN 50-55 PSI ⇒
Carbon Dioxide [†]	White on Gray	⇒ CARBON DIOXIDE →
Nitrous Oxide [†]	White on Blue	♦ NITROUS OXIDE ♦
Cyclopropane [‡]	Black on Orange	
Helium USPt	White on Brown	🔿 HELIUM 50-55 PSI ♦
Nitrogen NF ⁺	White on Black	→NITROCEN 160-200 PSI→
Medical Air USP [†]	Black on Yellow	♦ MEDICAL AIR ♦
Instrument Air†	White on Red	⇒INSTRUMENT AIR →
Waste Anesthetic Gas Disposal [†]	White on Purple	➡ WASTE ANESTHETIC ➡
Laboratory Air [†]	Black on White/Yellow Checkerboard	→ LABORATORY AIR →
Laboratory Vaccum [†]	Black on Black/White Checkerboard ²	LABORATORY VACUUM
Medical-Surgical Vaccum [†]	Black on White	MEDICAL VACUUM





THE ALARM SYSTEM SHOULD BE OPERATIONAL TO INDICATE ANY ABNORMAL PRESSURE CHANGE



232

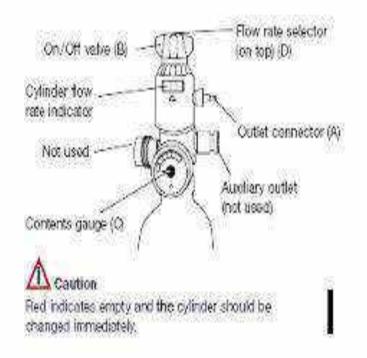




ADEQUATE BACK-UP OF B-TYPE CYLINDERS IN CRITICAL AREAS LIKE ICU, OT AND FOR PATIENT TRANSFER PURPOSE



Cylinder valve (some B10 cylinders)









THE PROCEDURE BEING FOLLOWED FOR PROMPT REPLACEMENT OF EMPTY CYLINDERS WITH FILLED CYLINDERS

Cylinder Safety

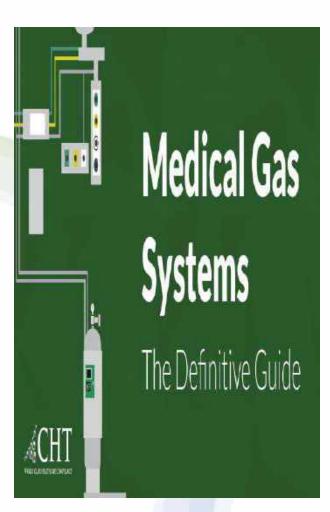
Below is a summary of the **DO's/DON'Ts** when working with gas cylinders

			<u> </u>
Storage and Handling of Gas C	ylinders Guidelines Contents	DO	DON'T
Background	Sogragata Incompatible	Ensure a regulator is fitted before use	Repaint a cylinder
Scope	Segregate Incompatible Gases and Dangerous Goods	Ensure cylinder is firmly secured	Change the markings on a cylinder
Definitions	Heat and Ignition Sources	Ensure connections are tight and suitable	Use oil or lubricants on cylinder valve
Types of Gases Types of Gas Cylinders	Safe Handling Practices Using Gas Cylinders	Ensure cylinders are stored and used away from ignition sources	Tamper with the gas cylinder test tag
Classes of Gases dentification and Labelling	Manifest of Hazardous Chemicals	Store full and empty cylinders separately	Tamper with or remove the barcode from a gas cylinder
Cylinder Valves and Regulators Cylinder Valves	Transporting Gas Cylinders Transport within Buildings	Ensure valve guards or caps are fitted when cylinders are not in use	Roll cylinders along the ground
Regulators Risks and Hazards from Gas	Transport with Vehicles Troubleshooting	Use mechanical assistance when handling cylinders	Attempt to fight a fire involving a gas cylinder
Cylinders Hazard Management	Cylinders in a Fire Leaks	Ensure adequate ventilation is available for the gas in question	Transport gas cylinders in the passenger compartment of a vehicle
Storing Cylinders Bulk Cylinder Storage	Cylinder Safety Related Documents and	Ensure exposure limits are not exceeded	Use a cylinder that shows evidence of damage or corrosion
Laboratory Specific Storage	References	Read the SDS	Fill cylinders with any material at all
Requirements – Cylinders in	Version Control Table	Follow appropriate SWP	
Use		Have gas detection devices installed if required	





INSTRUCTION FOR OPERATING DIFFERENT EQUIPMENT IN THE MANIFOLD ROOM SHOULD BE CLEARLY DISPLAYED



4. GAS MANIFOLD

Gas manifolds are designed to supply the pipeline system with sufficient quantity of gas by cylinders and/or tanks.

The typical manifold for medical gases usually consists of a two-sided cylinder supply with automatic changeover between the empty and full side, and an additional third source for emergency supply.

MANIFOLD ROOM

- Consists of a cylinder manifold and a control panel
- Manifold can be of 2 banks of 2 cylinders each or 2 banks of 20 cylinders each.
- Control panel: primary and secondary pressure regulations: warning lamp.











SS 6 - THE FACILITY SHOULD ADHERE TO THE PRACTICES SPECIFIED UNDER STATUTORY COMPLIANCES AS PER THE SCOPE OF SERVICES - LICENSES WITH CERTIFICATE NUMBER, DATE OF ISSUE AND DATE OF EXPIRY

Interpretation – Hospital should adhere to the statutory norms/ compliances laid down by government as per the scope of services and must provide certificates/ licenses for the same. **Means of verification:**

- 1. Fire Department Clearance Certificate
- 2. NOC from Pollution Control Board for air and water pollution
- 3. Lift License (if applicable)
- 4. Hospital Registration Certificate
- 5. Bio-Medical Waste Management
- 6. PCPNDT Act Registration
- 7. AERB
- 8. Pharmacy License & Narcotics Drugs License (if applicable)
- 9. Ambulance Registration Certificate, insurance Policy, pollution control and Driver License (if in house or outsourced) 236





FIRE DEPARTMENT CLEARANCE CERTIFICATE

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विषय - प्रतिष्ठान में स्थापित प्रनयर एक्सटिप्युसर्ग को कार्वशीलवा / रिकसिंग / हाईद्रोलिक टेस्टिंग के प्रमाणीसरण के सम्बन्ध में-

संदर्श- आपने प्रार्थमा पत्र संख्या-निन विनोक-25.12.2018

उपरांक्त सरभित विश्वक आपके प्रार्थना पत्र को कम में आपके संस्थान में उपलब्ध-20 अपट फायर एक्साटिंग्यलरों की टेरिटेंग हेत सासनावेश लंख्या -११२०(१) / आठ, विनाक- २७ १२ १९४२ में दिये गये सिर्वजी के अनुसार निर्धारित आशा समया-200 / -भारतीय श्टेल वेक शाखा वेक रोज. ालगात-गोरकार, में पालान सहया- LE46366 जिनाम 27.12.2018 दारा जमा कपाया मया। प्रापित रसीह पास होने के उपरास 20 जबह कायर एक्सरियरास का वरीक्षम किया गया. जिसका विवरण निम्नवग है-

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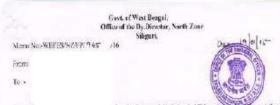
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· (1)	फायर एक्सटिम्यूशन का प्रकार	ALANILI.	नाख्या	कार्यशील/अकार्यशील
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आगर्क संस्थान में उपलब्ध फायर एक्सटिप्प्रश्चों की कार्यशीलता / रिप्राटिंग / हाईडोलिक

देरितन अपसंकलनुसार प्रमाणित जी जाती है। National building code and UP Building Byelaws ye Uttar pradesh fire prevention and fire safety Act/Rules-2005 if निर्धारित मानकों के अनुसार शेष सुरक्षा व्यवस्थाव वाछनीय होगी। मारतीय मानक जुरो के निर्धारित मानकों वे जनुसार प्रतिवर्ष कार्यणीलना / दिपालिग / डाइड्रोलिक टेस्टिंग प्रमाणित जराये जाते का उत्तरदायित्व भवन प्रस्तभाक/ भवन स्थामी का होगा





Sales-Fire Safety Recommendations for the Propused G+2 Shorted Educational handing at the place an captioned aboved Plot no. 247,248, Khuo 732, Jino 74, Mouze Kushmundi P.S. Kushmundi, Dist-Dalehin Dinkipur.

Ref. > 1) Application no-

Sit

With reference to the letter noted above regarding the Provisional NOU for the G+I Storied Educational building, you have submitted different documents inter alls the Building Plan. After sentimizing the same from fire and fife selety points of slow, the fire safely recommendation 3 here by issued as per the direction of the authority subject to the compliance of the same within three month from the date of issue of this recommendation.

Recommendations-

As Construction Part-I] The whole summation of the proposed building shall be carried out as par represent plan & conforming all the relevant building rules of local authority.

(i) The floor area exceeds 500 separities shall be satisfied compartmented by separation walls up to celling. level having at least two lost fire resisting conscity. iii) The interior finish decombos of the building shall be made of low flagre spread materials conforming 18

Seconcation.

b) All construction materials should be of four lars. Fire resisting type-

with Door and windows should be of at least 2 law first rea sting type.

vi) All opening of service dutts, word, gap, and joints should be scaled with for check mercelab.

v) Parking area should not used for any storage. B) Electrical Installation: 1946:1982:-

itAl) electrical mataliation should be done in accordings with National Electrical code & part VIII-Building Service "section -2 "Electrical Installation" good practice[4(10)].

If All earlie should be of FRLS type and all wiring should be done by the support wire along with appropriate gauge such as 1.2 squam for light, bulls, far etc.2.5 squam for freeze, TV& 4 squam for gryser, washing machine ev-

in) Electrical institution shall be used periodically by the licensed electrician where as 85% of firm originated from electrical source of energy.

C) Alternate power supply :-Arrangement shall be made to sumb power with the bein of a Generator to operate at least the free pump, pump for data tube-well. Fire alarm spaces, "Illumination of states, considers, means of example, exc. In case of numual power failure.

D) Fire Fighting Water:

)The building should be provided with \$2000 liters capacity of underground stand water with rescarsionage analgement of 1000 liters of which per miniates mcRaubly fives two different sources. The beight of the exerviti should not be exceeding 30 an from the ground lovel. Fire water reservoir shall have overflow and connected with the domestic water reservoir as well as to owild sugnancy of water. The water reservoir shall by kept full at all times.

iothe location of the underground water reservoir should be such so that fine service vehicles easy got access to the sale of the reservoir with a view to draw the water from the said reservoir.

F) Internal hydrant system IS 3844-1989;-





NOC FROM POLLUTION CONTROL BOARD FOR AIR AND WATER POLLUTION

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Constructions of Construction

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HARVANA STATE POLLUTION CONTROL BOARD C-11, SC/TOR-6, PARCHULA Pt. 25***770**** Swall: hearthfulgeneilisen Office Onler

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LIFT LICENSE (IF APPLICABLE)



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GOVERNENT OF CUJARAT GOVERNENT OF CUJARAT LICENSE TO	Licence No.: 5089000006351 Form C GOVT. OF N.C.T OF DELHI LABOUR DEPARTMENT (ELECTRICAL SECTION) DISTRICT: SOUTH . DELHE LICENCE FOR WORKING A LIFT	Regi No.0E . 02 . 25 . 002654 AA/ 230 / 04 / 2024 महाराष्ट्र ज्ञासन [दिवा अभिरतस्त] उद्योग, उत्पां व कामगार विमाग ाुख्य विद्युत निरिद्यक 3री मजाला प्रशासकर्यीय इमारल रामकृष्ण प्रेश्तकर मार्ग वेषुर (पूर्व) मुंबई 200 084
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Authorized by Govt. Notification, E & P Deptt., No. GU/2013/37/ELA/11-2012/2401/K, dated the 22ad APRIL 2013 M/s.1 is hereby authorized to carry out Electrical Installation Works in the Gujarat State, subject to the conditions mentioned in the Regulations issued the Government of Gujarat under Government Notification, Energy Petrochemical Department, No. GU/ 2013/ 37/ ELA/ 11/ 2012/2401/K, Dated 22nd April 2013. Energy & Petrochemicals Dept. Gujarat State, Gandhinagar. Issue Date:02/03/1998 President Usensing board Gandhinagar Sectoriary	In 1997 is tare hereby authorised to work the lift no. 1 installed in the premises owned by Sh/Smt/M/s GARRY LAKHANPAL and situated at E-16, GEETANJALI ENCLAYE, NEW DELHI - 110017 subject to the terms & conditions mentioned below as per the Delhi Lifts Rules, 1942. Terms & conditions - Evely owner(s) of the place, where the lift is initiated, shall be responsible to make increases by transportents to as to maintain the lift as per the requirements set forth in the First Schedule to the Demi-Lifts Rules, 1942. Reference EP No.: 50880000007865 Dated: 22/04/2019	उद्याहम वालविष्याची अनुहार्थी । १९२२ २०२० २०२० घररायर स्वाप्त स्वाप्त २६.जे. प्रेस्टर - भ, द्यारघर, स्वी मुंबई - वरणान्मारक बाना पूर्वइ उदवहन विषम, १९२५ व्य निवन ५ (२) व्या बहाुवीनुतार खातीक अतीव्या लोग राहुन नमूट कंडले ल्ट्याहन वालविष्णार्था अनुहार्त्र वाहण् मजुन सन्यथल के आहं छत्यहम अश्वतंत्र्या जमीभा चना व स्वाम उद्दहारन क. र द पोल्ठ केंदर, प्लीट व. ५, रीस्टर - केंन २, ताखे, नवी मुंबई - उद्याहनगाया तपशील DETAILS OF THE LIFT (!) Make of hit - शिवलस (६) श्वत्व्व विष्ठलस् (२) कि. त. (३) श्वत्व्य विष्ठलस् (२) कि. (३) श्वत्व्य विष्ठलस् (२) कि. (३) श्वत्व विष्ठलस् (२) कि. (३) श्वत्व्य विष्वलस्य (२) कि. (३) श्वत्व्य विष्वलस् (२) कि. (३) श्वत्व्य विष्वलस् (२) कि. (३) व्य त्व्य विष्वल
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HOSPITAL REGISTRATION CERTIFICATE

Pittvisional registration No.3564000123 Coversment of this **GOVERNMENT OF ANDAMAN & NICOBAR ISLANDS (UT)** District Registering Authority SOUTH ANDAMAN CERTIFICATE OF PROVISIONAL REGISTRATION No. 59 CR1 (Regolitation and Regulation) Act, 2010. The Clinical Establishment is registered for providing medical services us a Hoigital Polyolise, Haenatology,Biochemetry, Xray Center, HCG Contro, Ulrealound Center under Allophathy System of Medicine. This Certificate is valid for a period of one year from the date of issue Nursing Home) DRA: South Andaman Designation of the lesuing Authority nursing home. Place South Anduman Office Port BA Date of Issue 27/11/2015 1. The holder of this Certificate of Registration shall comply with all the provisions of Clinical Establishment Act (Registration and Regulation) 2010 and the Rules made there under. 2. The Certificate of Registration is not transferable. The Certificate of Registration shall be displayed in a prominent place in a part of the promotes open to the public. 3. Any change of ownership or change of category or change of management or on reasing to function as a clinical establishment, the coefficients of implatiation and he surrendoed to the authority and application for Mesh registration sobmitted.

"Additional forms and conditions are as elemented by the appropriate registering automati-

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AHMEDNAGAR ZILLA PARISHAD AHMEDNAGAR.

FORM 'C'

(See Rule 5)

Certificate of Registration under section 5 of the Bombay Nursing Homes

Registration Act. 1949

This is to certify that Sphismt Dister Julima Disoura Administrator has been registred under the Bombay Nursing Homes Registration Act. situated at AlP -1949, in respect of -Sheugaan Bl Sheugaan (Hear insert the name of the 989. A. Nagar Nitra Seva right end has been authorised to carry on the said Registration No. Ab/59 Date of Registration. 31/8/07 Piace: A.Nagar Date of issue of Certificate: 13/9/07 This Certificate of registration shall be valid upto 31st March,200 2010 Signature of the registering authority The Perished, A'nagar







BIO-MEDICAL WASTE MANAGEMENT

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PCPNDT ACT REGISTRATION



Government of Karnataka





State PC and PNDTCell Directorate of Health & Family Welfare Services, Anand Rao Circle, Bangalore-560009

Certificate of Registration

This is to Certify that

"34/1347-

A. Florican Road, Malaparamoe, Calcut-673009 Karala is registered with Stata Appropriate Authority constituted under socian 17 of Pre Conception and Pre Natal Diagnostic Techniques Act 1994 to soll, buy back or repair Ultresonography / Imaging Machines in Kamataka as per rule 3A of PC & PNDT Rules-1996

Registration No. : PCPNDTMMKAR 0004 Date of Registration: 26-09-2016

> Authorized signatory For State Appropriate Authority, PC & PNDT Dept. of Health & Family Welfare Services





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ATOMIC REGULATORY ENERGY BOARD (AERB)



LICENCE FOR HANDLING AND OPERATION OF INDUSTRIAL RADIOGRAPHY EXPOSURE DEVICES

1. In exercise of powers conferred under Section 16 of the Atomic Energy Act, 1962 read in conjunction with Rule 3 of the Atomic Energy (Radiation Protection) Rules (AER/R). 2004, the Atomic Energy Regulatory Board (AERB) hereby issues the amendment to the Liennes in respect of Industrial Radiography Exposure Device(s), IREDs), in favour of the Preprinter, Mrs National Radiographic Inspection Co., Chennal to present and use the following IREDs containing radioactive material and X-ray muchines for industrial radiography at authorised site(i):

No	Model of IREDs	Que ntity	Sr. No. of IREDs	Source /X-ruy	Mas. Capacity (TBq / Ci)/ Mas. kV, mA
1	SPEC 2T	03	1202,1318, 1251	100 lt	7.4 TBq (200 Ci)
2	Roli-3	02	09073, 09048	192 jr	0.74 TBg (20 Ci)
3	Delta-880	01	136202	142]k	5.55 TBq (150 Ci)
4	Roli-I	03	09625,091010,03475	190 jr	1.3 TBq (35 Ci)
5	Gammanad-TI	02	666,1439	192 hr	1.48 TBg (40 Ci)
6	Dang Dong XXQ2502	01	9367	X-ray	250kVp_5mA
7	Dang Dong XXH2505	01	9120	X-ray	250kVp.5mA

2. The Proprietor, M/s National Radiographic Inspection Co., Chennai shall ensure that the functional performance of their IRFDs containing radioactive material / X-ray source are satisfactory during useful life of the IREDs.

3. The Proprietor, M/s National Radiographic Inspection Co., Chennal shall comply with the provisions of the AE(RP)R,2004, applicable surveillance procedures and Codes (AERB Sefety Code on Industrial Radiography AERB/SC/IR-1 and on Transport of Radioactive Motorial AERB/SC/TR-1) issued by AERB from time to time. Any unusual incident involving loss / theft / damage to the IREED / source or overexposure to indiation workers shall be immediately reported to AERB.



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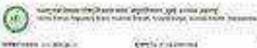
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PHARMACY LICENSE & NARCOTICS DRUGS LICENSE (IF APPLICABLE)

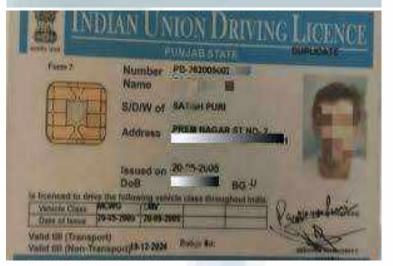
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Licence to Operate a	REGISTRATION OF DRUGS CERTIFICATE		
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This is to certify that the business trading under the name of	I Trade name under which marketed Z Approved name		
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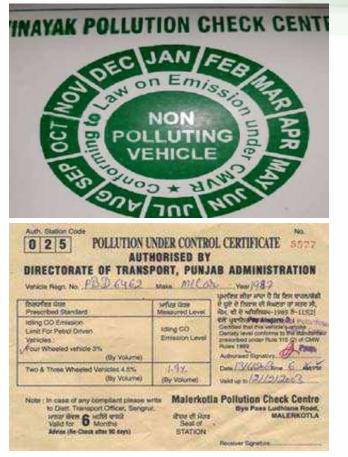


AMBULANCE REGISTRATION CERTIFICATE, INSURANCE POLICY, POLLUTION CONTROL AND DRIVER LICENSE (IF IN HOUSE OR OUTSOURCED)

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SS 7 - THE HOSPITAL SHOULD ENSURE THAT APPROPRIATE INFECTION CONTROL PRACTICES ARE BEING FOLLOWED ALONG WITH HAND HYGIENE PRACTICES

Interpretation – The hospital infection control and prevention process should be documented which aims at preventing and reducing risk of healthcare associated infection. The organsiation shall also adhere to hand hygiene, cleaning, disinfection and sterilization guidelines.

Means of verification:

- 1. Availability of wash basin near the point of use along with antiseptic soap with soap dish/ liquid antiseptic with dispenser
- 2. Availability of alcohol-based hand rub
- 3. Availability of disinfectant/cleaning agent as per requirement
- 4. Check if infection control manual showing periodic update and surveillance activities available/ monitoring takes place
- 5. The facility should follow standard practices and materials for disinfection and sterilization of instruments/ equipment
- 6. Staff should be trained for all infection control practices, hand hygiene guideline, occupational risk and its prevention.





AVAILABILITY OF WASH BASIN NEAR THE POINT OF USE ALONG WITH ANTISEPTIC SOAP WITH SOAP DISH/ LIQUID ANTISEPTIC WITH DISPENSER







Alcohol-Based Hand Sanitizer

and water as soon as you can.

- Before and after visiting a friend or a loved one in a hospital or nursing nome, unless

the person is sick with Clostridium difficile

(if so, use soop and water to wash hands).

alcohol-based hand sanifizer that contains

at least 60% alcohol, and wash with soap

Do NOT use hand confider if your hands are visibly

dirty or greasy: for example, after gardening,

playing outdoors, or after fishing or camping

judiess a handwashing station is not available). Wash your hands with scap and water instead,

If soap and water are not available, use an

AVAILABILITY OF ALCOHOL-BASED HAND RUB



When should I use?

Soap and Water

- Before, durino, and after preparing food
- · Before eating food . Before and after paring for someone
- who is sick
- · Before and after treating a cut or wound
- After using the bathroom, changing diapers, or cleaning up a child who has used the bathroom.
- After blowing your nose, coughing. or sneezing
- After touching an animal, animal food or treats, animal cages, or animal waste
- After touching garbage
- · If your hands are visibly dirty or greasy



C DC

How should I use?

Soap and Water

- Wet your hands with clean running water (warm or cold) and apply soap.
- Lather your hands by rubbing them. together with the scap.
- Scrub all surfaces of your hends, including the palms, backs, fingers, between your fingers, and under your neits. Keep scrubbing for 20 seconds. Need a timer? Hum the "Happy Birthday" song twice.
- · Rinse your hands under clean, running water.
- Dry your hands using a clean towel or air dry them.

Alcohol-Based Hand Sanitizer

Use an alcohol-based hand sanitizer that contains at least 60% alcohol. Supervise young children when they use hand sanitizer to prevent swallowing alcohol, especially in schools and ohlidsare facilities.

- · Apply. Put enough product on hands to cover all surfaces.
- . Rub hands together, until hands feel dry. This should take around 20 seconds.

Note: Do not rinse or wipe off the hand sanitizer before it's dry, it may not work as well against germs.





AVAILABILITY OF DISINFECTANT/CLEANING AGENT AS PER REQUIREMENT

Cleaning and Disinfectant Agents

- Hospital Grade Disinfectants
- · Alcohols (60-90% ethyl or isopropyl)
- Chlorine sodium (bleach) and calcium hypochlorite
- Phenolics
- Quaternary Ammonium Compounds (Quats)
- lodophors
- · Accelerated Hydrogen Peroxide (AHP)







Infection Prevention and Control

An Inglementation Handbook for Public Health Replicies in



CHECK IF INFECTION CONTROL MANUAL SHOWING PERIODIC UPDATE AND SURVEILLANCE ACTIVITIES AVAILABLE/ MONITORING TAKES PLACE

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THE FACILITY SHOULD FOLLOW STANDARD PRACTICES AND MATERIALS FOR DISINFECTION AND STERILIZATION OF INSTRUMENTS/ EQUIPMENT

The organisation provides adequate space and appropriate zoning for sterilization activities.

Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.

Reprocessing of instruments and equipment are covered.

Regular validation tests for sterilization are carried out and documented.

There is an established recall procedure when breakdown in the sterilization system is identified.

GENERAL HOSPITAL

OBJECTIVE:

To reassemble the instrument sets in a standard way, received from OT and other consume departments and units, make care that the astruments and aneithry equipment are in good condition.

INDICATION:

This step applies to any instruction poing back into a set. Instrument sets should be neasestabled as soon inspeciable after drying the automotors, to avoid recontamination by the AE, is the CSSD picelaging area, by CSSD Technician.

EQUIPMENT

- · Lagework surface.
- Working tables
- Good lighting.
- Magnifying glass
- Silcon tiblog
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- Satis is asserting a process, each up to -date
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- bpare, extra intranente
 Wire biskets
- Instruments box, containers, and any iterilization genr with specific iterus, and likey equipment, enternal likeling, or other orthopodic equipment.

TECHNIQUE:

- Wash hamla
- + Make sure that the instruments are dry
- Check the instanton one by one using magnifying gloss if necessary and make size they see all in good condition and is working order.
- If they are not functioning properly, lubineate them with about tree labreaut oil or spraysreplace them if that does not correct the problem.
- Replace any instruments marked earlier with a string "damaged instruments".
 Business Med the analysis the following the two and which a lists are for both a business.
- Rationamblective and, strictly following the pro-established lots: refer to the hinder hidding the sheets with reference name and in some cases, images of instruments, equipment.
- Amonge the instruments in a wise baslert in surgical order, aligned in the same direction, or in their proper place in special mays, bases. Put the humanitations mitigate in the battom of the basicat.
- Cover the ends of sharpinsymmetric with a near 1 pixe of silicon tabing to prevent them from
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- · Close keiling foreeps of the first notels.
- Plose bools, lidney mays upside down to prevent from collecting condensed water in the weiliter.
- · The instrument sole are now ready for packaging.

IMPORTANT REMARKS

· Check all insurances was by 12 CSSD Technicians, suprepared by and set checked by

GENERAL HOSPITAL

COLLECTING INSTRUMENTS FROM OPREATION THEATRE

OBJECTIVE

To collect well-distinguish for inspects of XS-0 cleaning, decontamination area, while exacting start safety and microsofty, the fact of speciality genus in the contraction

INDICATION

Any unwarged network (RDD) is an operation therite, whether each or encoder on the code to the each procedure, \Rightarrow (pickly as provide, by the sender once directing mass or OTT technician in operation busits.

EQUIPMENTS

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TECHNIQUE:

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- · Colocitle astractions
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- The procedure, in the time performance based on tasking that, in the plastic fact,
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- Take if glowes and watchbards with doin tection solution and water
- Dec of physics and washingth with down octure volumes and

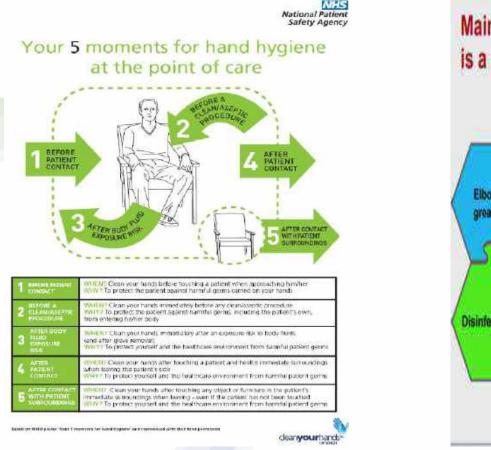
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- · Take care no to contaminate the stasile of tab with wild given

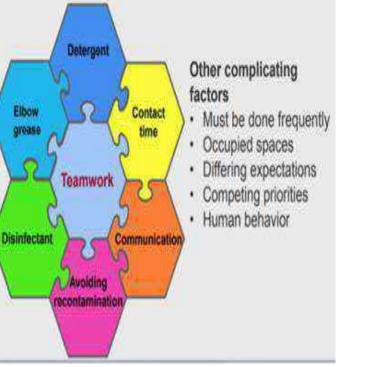




STAFF SHOULD BE TRAINED FOR ALL INFECTION CONTROL PRACTICES, HAND HYGIENE GUIDELINE, OCCUPATIONAL RISK AND ITS PREVENTION



Maintaining a clean and safe environment is a very complex process.



How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUS Duration of the entire procedure: 46-63 seconds





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SS 8 - Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules, 2018)

Interpretation – The organization shall be authorized by the appropriate authority for management of bio-medical waste. The waste should be segregated and collected in different color coded bags and containers as per statutory norms and same should be available at all the point of waste generation. Management of biomedical waste including its segregation, transportation, management and disposal of waste should be done by an authorized agency with a designated place for waste collection and segregation near the premises.

Means of verification:

- 1. Availability of color-coded bins at the point of waste generation along with the display of work instructions for segregation and handling of Biomedical waste
- 2. The waste should be handed over to an authorized agency and not discharged in any drain. If outsourced, check the contract document of outsourced services. Register with the weight of waste collected from different colored bags should be maintained
- 3. Facility has secured designated place for segregation and storage of Bio-Medical waste before disposal at the waste collection site
- 4. Transportation of bio-medical waste should be done in a closed container/trolley





AVAILABILITY OF COLOR-CODED BINS AT THE POINT OF WASTE GENERATION ALONG WITH THE DISPLAY OF WORK INSTRUCTIONS FOR SEGREGATION AND HANDLING OF BIOMEDICAL WASTE











THE WASTE SHOULD BE HANDED OVER TO AN AUTHORIZED AGENCY AND NOT DISCHARGED IN ANY DRAIN. IF OUTSOURCED, CHECK THE CONTRACT DOCUMENT OF OUTSOURCED SERVICES. REGISTER WITH THE WEIGHT OF WASTE COLLECTED FROM DIFFERENT COLORED BAGS SHOULD BE





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Common Biomedical Waste Treatment Facility –Process of Treatment







FACILITY HAS SECURED DESIGNATED PLACE FOR SEGREGATION AND STORAGE OF BIO-MEDICAL WASTE BEFORE DISPOSAL AT THE WASTE COLLECTION SITE









TRANSPORTATION OF BIO-MEDICAL WASTE SHOULD BE DONE IN A CLOSED CONTAINER/TROLLEY













SS 9 - HOSPITAL SHOULD ENSURE THAT SERVICES I.E. (LAUNDRY, HOUSEKEEPING, DIETARY, SECURITY, AMBULANCE, MORTUARY, CENTRAL STERILE SUPPLY DEPARTMENT (CSSD) ETC. ARE AVAILABLE (IN-HOUSE OR OUTSOURCED).

Interpretation – The services like laundry, housekeeping, dietary, security, mortuary, ambulance CSSD etc. should be available in-house or out-sourced. The hospital shall ensure that they establish adequate controls by having a policy to monitor/ audit these services. If these services are outsourced, then they should have MoU/ agreement for the same. **Means of verification:**

- 1. Checklist for Desktop Assessment Availability Yes/No & If outsourced, MoU should be available for the same.
- 2. Internal audits of the services to be conducted on regular intervals





CHECKLIST FOR DESKTOP ASSESSMENT - AVAILABILITY YES/NO & IF OUTSOURCED, MOU SHOULD BE AVAILABLE FOR THE SAME

AREAS TO BE CLEANED

S.NO.	AREA/ ITEM	DISINFECTION METHOD	FREQUENCY
1.	Floor	Cleanser	3 in each shift/ week
2.	Walls	Pesticide Spray 2% Glutaridehyde + Formaldehyde	Once daily/ Once in two weeks
3.	Fans	Wet Mopping	One in two weeks
4.	AC	Vacuum Cleaning	Once in two weeks/ once a week
5.	Refrigerator	2% Gluterdehide Defrost cleaning with soap	Once in two weeks
6.	Sinks	Clean so	Daily Once
7.	Buckets	Soap Water	Daily
8.	Windo pans	Mopping	Daily
9.	Doors/ pale mates	Mopping	Daily
10.	Toilets Mirror, Basin Pots	Cleaning with detergent	Three times daily
11.	Machine Cleaning	Scrubbing	Once Week

Broom	Air Freshener	Old Rags
Dustpan	All Purpose Cleaner	Old Toothbrash
Vacuum Cleaner	Antibacterial Cleaner	Garhage Bags
Sponge/Cotton Mop	🔲 Baking Soda 🛛 🚺	Paper Towels
Extendable Duster	Bleach	
Bucket	Distrivashing Liquid	
Supply Caddy	Disinfecting Wipes	
Toilet Brush	Fabric Cleaner/Spray]
Scrub Brush	Fabric Softener Sheets	
Hand Duster	Floor Cleaner	
Microfiber Cloths	Furniture Polish	
Sponges	Glass Cleaner]
Scour Pads	Laundry Detergent	
Rubber Gloves	Mild Abrasive Cleaner	
Spray Bottle	Oven Cleaner	
Squeegee	White Vinegar	

Cleaning Supplies Checklist

	Out Soursed Services			
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INTERNAL AUDITS OF THE SERVICES TO BE CONDUCTED ON REGULAR INTERVALS

	Protocol Selection (confirmed by Director of HPC, or QA team leader)		Items No	t in C	Com	plian	ice a	and	Aud	lit Fr	equ				TREAL		
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Internal Austi: Agencia - Best Bet Laborauries	Opening meeting		SPC CHARTS and INSPECTION DOCUMENTATION 55 REDURENETS, NEAT AND CLEAN AREAS PART LEBURENIG AND CLEANLINESS	M	T	WI	F	5	M	W		+ 5	M	T.		F	5
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SS 10 - SEXUAL HARASSMENT AND GRIEVANCE HANDLING PROCEDURE SHOULD BE AVAILABLE

Interpretation – There should be disciplinary and grievance handling procedures in place with a dedicated committee/team established to handle cases against sexual harassment and various other grievances.

Means of verification:

- 1. Committee against sexual harassment is constituted at the facility
- 2. Documented disciplinary and grievance handling procedure





COMMITTEE AGAINST SEXUAL HARASSMENT IS CONSTITUTED AT THE FACILITY



MEMBERS OF THE COMMITTEE FOR PREVENTION OF SEXUAL HARASSMENT

Please reach out to any of the Members of the Committee for Prevention of Sexual Harassment whose names are placed below in case you have any concerns or complaints.

Name	Committee Designation	E-mail 10	Contact Number
	Chairperson		
	Member		
	Member		
	Member Secretary		
Martine Line Line Line	Member		





DOCUMENTED DISCIPLINARY AND GRIEVANCE HANDLING PROCEDURE

DISCIPLINE AND GRIEVANCES: Discipline and Grievances are each one side of the same 'complaints coin's.

DISCIPLINE AND GRIEVANCES: Discipline is a 'Management's Complaints' against an employee. • Grievance is an 'Employee's complaint' against management.

WHY DISCIPLINING EMPLOYEES: Employees experience conflict at work and sometimes break the rules. • It then becomes your job to minimize the conflict and get things going back on track. • Disciplinary policies and actions play the prime role in prohibiting unwanted employee behaviors.

DISCIPLINARY POLICY GROUND RULES: Employees should know what they can and can't do. • You should clearly communicate the discipline that will take place if employees break your rules. • For this reason, company need to have a good disciplinary policy in place and well communicated to everyone.

DISCIPLINARY POLICY: The policy must be communicated to employees by periodically providing a copy, posting it, or including it in an employee handbook. • Employees should be required to sign an acknowledgment that they have received and read the policy. • The policy also should be covered in new employee orientation.

CORRECTIVE DISCIPLINE: The purpose of discipline is to assist employees in changing their unwanted behavior. • Absenteeism • Poor Performance or • Inappropriate Behavior • Employees should have adequate information about their current performance versus the desired performance. • This will also decrease your legal risk!

DISCIPLINARY SYSTEMS: There are many systems available for disciplining employees. • One system, called progressive discipline, is very popular. • It requires the employer to progress through each step before proceeding to the next.





DOCUMENTED DISCIPLINARY AND GRIEVANCE HANDLING PROCEDURE

TYPES OF DISCIPLINARY ACTIONS: 1. Verbal counselling 2. Written warning 3. Suspension 4. Termination

 Verbal counselling: This is generally the first step. However, for a serious problem, skip this step. Verbal warnings should always be done privately. Verbal counselling sessions should be documented by a formal memo or informal note in the employee's personnel file.
 Written Warning: Should include, at a minimum, the following elements: • The date of the warning • The employee's name • The name of the supervisor administering the warning • A description of the misconduct or inadequate performance • The date of the misconduct or poor performance • A signature line for the supervisor • A signature line for the employee, indicating his receiving only! • A signature line for the witness. • An action plan to fix the behavior in a given time frame!

Suspension: This may range from one day to two weeks or more, depending upon the circumstances, and is almost always unpaid.
 Next step may be suspension of increasing length or directly go to termination.
 Whatever it is, should be stated in the suspension letter!
 Termination: Before termination, the personnel file and all relevant documents must be reviewed to ensure that the termination is appropriate and defensible in a subsequent lawsuit
 Some behavior warrants automatic dismissal, like:
 Violent behavior or threats of violence;
 Drug and alcohol use on duty;
 Carrying a weapon on company property;
 Theft, destruction of company property - Insubordination;

Other forms of discipline: Demotion, • Transfer and • Reduced raises or bonuses. • Many employees can be very satisfactorily managed by economic concerns, such as bonuses and raises.

DISCIPLINE: THE UNION CONTEXT: If a union represent your employees, your disciplinary system is most likely governed by your collective bargaining agreement or CBA. • All of your managers and supervisors are well trained on how to follow the disciplinary procedure in the CBA. • The CBA will most likely have progressive discipline steps and provide that the employee can grieve any disciplinary action. • Disputes that are not resolved through the grievance process end up in the hands of an arbitrator!

FACTORS TO CONSIDER: Mitigating factors • long service with the company • history of satisfactory appraisals • prior commendations or awards • Aggravating factors • short length of service • history of unsatisfactory performance • prior instances of performance/conduct/attendance problems • Once you have made the choice, stick with it and remember to document all of your steps!





DOCUMENTED DISCIPLINARY AND GRIEVANCE HANDLING PROCEDURE

EMPLOYEE GRIEVANCES: A method for employees to use to resolve conflicts when they feel they have been treated unfairly by management.

EMPLOYEE GRIEVANCES Typical procedure: • Discuss problem with manager • Discuss problem with manager's superior • Superior may refer problem to grievance committee or CEO • Union employee grievances are handled differently...

UNION EMPLOYEE GRIEVANCES: Union grievances are often resolved through: • Arbitration - A hearing before someone empowered to resolve the dispute. • Mediation - Negotiation between two parties, using a neutral intermediary to assist in settling a dispute.

GRIEVANCE IDENTIFICATION TECHNIQUES: Observations, Grip Boxes, Exit Interview & Open Door Policy

1. OBSERVATION: Knowledge of human behavior is requisite quality of good manager. From the changed behavior of any employee, he should snuff the causes of grievances, without its knowledge to the employee.

2. GRIP BOXES: The suggestion boxes, for instance are placed at easily accessible spots to most employees in the organization. The employees can file anonymous complaints about their dissatisfaction in these boxes.

3. OPEN DOOR POLICY: Most of the organizations still don't practice this but open door policy demands that the employees, even at the lowest rank, should have easy access to the Chief Executive to get his grievances redressed.

4. EXIT INTERVIEW: These interviews are conducted to know the reasons for leaving the job. Properly conducted exit interviews can provide significant information about the strengths and weaknesses of the organization and can pave way for further improvements.

BENEFITS: Enables the management to know the pulse of its employees. grievances. Provides clues about the behavior and attitude of the managers and supervisors towards their subordinates. Gives an assurance to the employees about the existence of a mechanism for the prompt redressal of their grievance. Keep up the morale of the employees.

CONCLUSION: Managers must use judgment, empathy, consistency, and fairness when administering employee discipline. • All disciplinary actions should be documented in a factual, nonjudgmental way. • Employees can use the grievance procedure to resolve conflicts with management.





CHAPTER 4: PATIENT CARE (OVERVIEW)

The sheer availability of healthcare services does not serve the purpose until the services are accessible to the users, and are provided with dignity and confidentiality. Access to healthcare services includes physical access as well as financial access. The government has launched AB PM-JAY schemes for ensuring that the service packages are available cashless to different targeted groups. Giving quality patient care have a positive effect on patient outcomes and recovery experience. Patients' rights are also an integral part of patient care. The important patient rights include informed consent, confidentiality of medical records, legible prescription etc. This chapter includes standards such as uniform user-friendly signage, IEC for educating patients, patient-friendly admission and referral process, consent policies, retaining of medical record and education of patients.



CHAPTER 4: PATIENT CARE



PC 1	Hospital should have uniform and user friendly signage system in English and in the local language understood by Patient / family and community.
PC 2	All signage those are required by law should be displayed at all strategic location
PC 3	Contact information of key medical staff and specialist should be readily available in the emergency department
PC 4	Service counters for the enquiry are available as per the patient load and are duly managed by hospital staff for the registration of patients
PC 5	Hospital should have established procedure for admission of patients
PC 6	The patient should be referred to another facility along with the documented clinical information, in case of non-availability of services and/or beds.
PC 7	General Consent and Informed Consent should be taken during the admission and before any procedures /surgery and anesthesia/ sedation.
PC 8	User charges are displayed and communicated to patients effectively at the time of registration, admission to the ward and in case of a change in medical and surgical plan.
PC 9	Patient should be properly educated on additional care as deem required and all the vital information should be recorded for continuity of care.
PC 10	Hospitals should ensure that all medications and associated instructions are written in the prescription.
PC 11	Medical records should be retained as per the policies of Hospital based on national and local law.





PC 1 - HOSPITAL SHOULD HAVE UNIFORM AND USER-FRIENDLY SIGNAGE SYSTEM IN ENGLISH AND IN THE LOCAL LANGUAGE UNDERSTOOD BY PATIENT / FAMILY AND COMMUNITY.

Interpretation – Adequate signage should be displayed at all strategic locations which are permanent in nature. The services, departmental and directional signage, and list of departments should be prominently displayed at all strategic locations in a uniform color scheme. Also the essential information like list of emergency contact numbers, list of doctors, patient rights and responsibilities etc. should be displayed within the hospital premises. It is preferable that the signage is displayed in bilingual language for the ease and understanding of patients.

Means of verification:

- 1. Name of the hospital and entry-exit should be clearly displayed outside the hospital. Entry to the emergency department should also be defined and displayed strategically
- 2. Hospital has directional signage with a uniform color scheme.
- 3. List of departments (as per scope of services) should be displayed in bilingual language
- 4. The scope of services should be displayed in the waiting area/ OPD/ Emergency/ Reception in bilingual language
- 5. All the services registered under AB PM-JAY are clearly defined & displayed in prominent places in understandable language.
- 6. Display of floor layout at each floor
- 7. Display of patients' rights and responsibility & other related IEC material (outdated and torn posters/wallpapers etc. should not be put on display)
- 8. Hospital has IEC specific to AB PM-JAY.
- 9. List of doctors (as per scope of services) with their departments and availability
- 10. No smoking signage to be present within the hospital premises
- 11. Display of hand washing instruction at the point of use (5 moments and 7 steps of hand hygiene)
- 12. Display of emergency numbers including ambulance, blood bank, police and referral centers





NAME OF THE HOSPITAL AND ENTRY-EXIT SHOULD BE CLEARLY DISPLAYED OUTSIDE THE HOSPITAL. ENTRY TO THE EMERGENCY DEPARTMENT SHOULD ALSO BE DEFINED AND DISPLAYED STRATEGICALLY







HOSPITAL HAS DIRECTIONAL SIGNAGE WITH A UNIFORM COLOR SCHEME







LIST OF DEPARTMENTS (AS PER SCOPE OF SERVICES) SHOULD BE DISPLAYED IN BILINGUAL LANGUAGE

Scope of Servic	es उपलब्ध सेवाएं				
Clinical Services नैदानिक सेवाएं	Laboratory Services लेबोरेटी सेवाएं	- # 			
1. Urology & Lithotripsy पुरोलाजी एवं लियोट्रिपसी 2. Laproscopy लेप्रोसकोपी 3. General Surgery () जनरल सर्जरी Diagnostic Services हायग्नांस्टक सेवाएं	1. Clinical Pathology क्लीनिकल पंथोलॉजी 2. Clinical Biochemistry क्लीनिकल बायोकॅपिस्ट्री 3. Hematology हेमाटोलॉजी 4. Serology सेरॉलॉजी	Trings are mission of the bogolar alfreen frace wal First a life may frace wal First a transmission task data protocomender are refer that have a set station of the weak of table of a set of the set	ECTAT SUBSET :- • Effective viewices stream • Effective viewices stream • Effective viewices stream • Effective viewices stream • Effective viewices at • Effective viewices at • Effective viewices • Effective vie		ECA STRUCTURE SALES - CAR Strad over ande sold med have disson what distantion - Bar, with which dee proves the sale over the med annext suppose - Balviese data traditional structures the Barters of the distantion over structures the Barters of the distantion over structures the - Balviese data distantion over structures the - Balviese structures over some shared - Balviese structures over some some some some some - Balviese structures over some some some some - Balviese structures over some - Balviese some
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2. Ultrasound	Professions Allied to Medicine व्यवसायी चिकित्सा के लिए अन्य सेवाएं	Masser, "Frend Selfmer de salver gale Technique sondiq, possibil eriche "salvers af for affekte" inscheringer auf derent insuremeinstechten." und finst. spens ywei fin og solge solge sone.	KOCK ADMANT KOSKATKANGOTOLICOLUTENKE KOSTANGER CAKA ROVE KOSTANGER CAKA ROVE	માંદ લેવલ ૧૮ન ચત્ર સ્ટ્ટાના બનાવના માંઘટા હડીલોલ ગ્રામ પશાધલ ખાતે થતી કોરો પ્રત્ય અને મરાટના પ્રત્ય ભપત્ર ઠડીલોલ ગ્રામ પંચાયત ખાતેથી પ્રેશની લેવાના દેશે.	 Recently to the self Houtes sume for events. The self-self houtes with houtes summarized and the self-self-self-self-self-self-self-self-
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THE SCOPE OF SERVICES SHOULD BE DISPLAYED IN THE WAITING AREA/ OPD/ EMERGENCY/ RECEPTION IN BILINGUAL LANGUAGE

Scope of Servic	es उपलब्ध सेवाएं
Clinical Services नैदानिक सेवाएं	Laboratory Services लेबोरेट्री सेवाएँ
1. Urology & Lithotripsy युरोलॉजी एवं लियोट्रिपसी 2. Laproscopy लेप्रोसकोपी 3. General Surgery ()) जनरल सजी	1. Clinical Pathology क्लीनिकल पंथोलॉजी 2. Clinical Biochemistry क्लीनिकल बायोकीयस्ट्री 3. Hematology हेमाटोलॉजी
Diagnostic Services हायग्नोस्टिक सेवाएं	4. Serology संरोताजी
1. X-Ray (Fixed) एक्स-रे (फिक्सड)	5. Histopathology हिस्तोपैधोलाजी
2. Ultrasound अल्टासाउंड	Professions Allied to Medicine व्यवमायी चिकित्मा के लिए अन्य मेवाएँ
3. Urôflowmetry gitvelitý	1. Dietetics डायटेटिक्स
Gynaecologist Services Available on Call	Note : We do not serve any other modical emergencies

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	അണിപ്പോകോട് നിക്കുകളിൽ ഉൾശ്യൊത്ത ചികിന്തകൾ റേണ്ട്. സന്താൻ അതിനുള്ള അനുമതി പോട്ടേൺ വഴി ഇർക്കുറൽസ് ഹസ്തീയിൽ നിന്നും തോക
	സാരേഷിക കൊറു കാരണം രാധികളെ മടക്കി അതംബുത്. ഇക്കാര്യം ബന്ധങ്ങെ ഇൻകുറൻസ് കമ്പൺയെ അദിമിച്ച മാരുവയായി ഡ്രാസന് അതേണമാണ്.
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	ട്ടെസ്റ്റാകളും നാരാന്യമാലി ചടിക്കോണ്. ഡിസ്പ്പാടത് നടത്തത് 5 ദിവസംതാക്കുള്ള കുന്നുകൾ സൗജന്യമായി. രേഗികൻക്ക് നൽമകണ്ടരാണ്.
	നട്ടുട്ടുകളും തടങ്ങളും പെടുതുകൾ തടങ്ങുടെത്ത്. തീത്യൂട്ടകളും തടങ്ങളും പ്രത്യാക്കുള്ള കുന്നുകൾ തടങ്ങുടെത്ത്
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	ອາດາຍອາດາ ຄະແລະກາງລະ ລູຍສະດາຍອາດາ ພດສະກາງລະ ໂຫລາຍເຫຼົາ ພດດູ ເປັນ ເຫດຍາຍອາດາ ຄະແລະກາງລະ ລູຍສະດາຍອາດາ ແລະ ສະດາຍອາດາ ໂດຍເລະ ໂກຍເລຍາຍອາດາ ແລະ ກາງລະດາຍອາດາ ໂດຍເລຍາ ແລະ ສະດາຍອາດາ ໂດຍເລຍາຍີ່ ແລະ ແລະ ແລະ ແລະ ແລະ ແລະ ແລະ ແລະ ແລະ ກາງລະຫາຍອາດາ ໂດຍເລຍາຍີ່ ແລະ
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THE SERVICES REGISTERED UNDER PM-JAY ARE CLEARLY DEFINED & DISPLAYED IN PROMINENT PLACES IN UNDERSTANDABLE LANGUAGE



			GOVT TRIPAL OPPOINT
VAILABLE SERVICES	ઉપલબ્ધ સેવાઓ	SERVICES NOT AVAILABLE સેવાઓ ઉપલબ્ધ નથી	GOVT. TRIBAL SPECIALTY HOSPITAL
 ORTHOPAEDIC (SPINE) RELATED O.P.D. DEPARTMENT I.P.D. DEPARTMENT OPERATION THEATRE X-RAY DEPARTMENT LABORATORY (SAMPLE COLLECTION CENTRE) NURSING SERVICES PHYSIOTHERAPY DEPARTMENT OCCUPATIONAL THERAPY DEPT. PROSTHETIC & ORTHOTIC DEPT. MEDICAL SOCIAL DEPARTMENT SPEECH THERAPY /AUDIOGRAPH SERVICES CLINICAL PSYCHOLOGY DEPT. VOCATIONAL TRAINING CENTRE PSYCHOMOTOR LABORATORY JAIPUR FOOT CENTRE SAFARI - FOLLOW-UP PROGRAMME AND CAMPS INRURAL AREAS AMUBULANCE SERVICES CANTEEN SERVICES CANTEEN SERVICES CANTEEN SERVICES CANTEEN SERVICES C.M. SETU YOINA 	 આેથોપેડિક (સ્પાઇન) ને લગતી સુવિધાઓ ભલરના દર્દીઓનો વિભાગ (ઓ.પી.ડી.) અંદરના દર્દીઓનો વિભાગ (આઇ.પી.ડી.) આંધરેશન થીચેટર એક્સ-રે વિભાગ લેબોરેટરી વિભાગ (સેમ્પલ કલેક્શન સેન્ટર) નર્સિંગ સેવાઓ ફિઝીચોચેરાપી વિભાગ ફિઝીચોચેરાપી વિભાગ અંક્સ સે વિભાગ ક્રિઝીચોચેરાપી વિભાગ અંક્સ સે વાઓ અંક્સ સે વાઓ અંક્સ સે વિભાગ પર સેક્કલ સો શ્યલ વિભાગ પર સંપર્ક વિભાગ સ્વીચ ચેરાપી / ઓડિયોગ્રાફ સેવાઓ સ્પીય ચેરાપી / ઓડિયોગ્રાફ સેવાઓ કલીનીકલ સાચકોલોજી વિભાગ વપ્ત વોકેશનલ ટ્રેનિંગ સેન્ટર શ્ક સાચકોમોટર લેબોરેટરી જ્યપુર ફૂટ સેન્ટર જયપુર ફૂટ સેન્ટર જયપુર ફૂટ સેન્ટર અધ્યુલન્સ સેવાઓ કેન્ટીન સેવાઓ અમ્બ્યુલન્સ સેવાઓ કેન્ટી સેવાઓ કેન્ટીન સેવાઓ કેન્ટીન સેવાઓ કેન્ટીન સેવાઓ અમ્બ્યુલન્સ સેવાઓ કેન્ટીન સેવાઓ કેન્ટીન સેવાઓ કેન્ટીન સેવાઓ 	(A) Clinical : (અ) 중엽/허용역 : Emergency Services siszsnélon સેવાઓ General Medicine ਅਰਟਕ ਮੀ5 ਡਿ General Surgery सामाठ्य सर्थरी Obstetrics & प्रसुतिशास्त्र & Gynecology स्त्रीरोगविज्ञान Pediatric Surgery બाળકोला सर्थरी Pulmonary Medicine प्रक्षोनरी दिवा Psychiatry भलीखिडिल्सा Medical Oncology संदिक्ष ओन्डवोछ Eye आंख Dentistry इंन्डिस्ट्री Homoeopathic बीमिथोपेथिङ Ayurvedic आयुर्विडिक USG,CT Scan, MRI USG, सीटी स्डेल, Nuclear Medicine येमआरथाई Bone Marrow बुक्तियर ਮीडिसिन Densitometry બोन मेरो Serielal ਮੁੱਢੂ अन्तियर भीडिसिन	Principality Service Reserves Principality Service Reserves Bitterio Reserves Bitterio Reserves <t< th=""></t<>







DISPLAY OF FLOOR LAYOUT AT EACH FLOOR







DISPLAY OF PATIENTS' RIGHTS AND RESPONSIBILITY & OTHER RELATED IEC MATERIAL (OUTDATED AND TORN POSTERS/WALLPAPERS ETC. SHOULD NOT BE PUT ON DISPLAY













HOSPITAL HAS IEC SPECIFIC TO AB PM-JAY







LIST OF DOCTORS (AS PER SCOPE OF SERVICES) WITH THEIR DEPARTMENTS AND AVAILABILITY

CARDIOLOGIST	Onya.	Timing
Dr. Prem Aggarwal Dr. K. K. Srivastava Dr. D.S. Mathur Dr. Javed Dr. Sarita Gulati	Mon to Sat Mon to Sat Mon to Sat	01:00pm-04:00pm 11:00am-01:00pm 12:00pm-02:00pm On Cal On Cal
CHEST, TB & BROM	CHOSCOPIST	
Dr. Ajay Kochhar Dr. Mohit Garg Dr. Chaku Gorge	Mon,Wed,Fri Mon to Sat	08.00am-10.00am 11.00am-03.00pm On Call
CONSULTANT SUR	GEON	
Dr. A.N. Srivastav Dr. P. N. Sinha Dr. Ajay Scod	Mon, Wed, Fri Mon to Sat Tue, Thurs, Sat	01.00pm-03.00pm 06.00pm-08.00pm 06.00pm-08.00pm
DERMATOLOGIST		
Dr. Ratan Singh Dr. Amit Vij Dr. R. K. Bhatia Dr. Kamlender singh	Mon.Wed,Fri Mon to Sat Mon to Sat Mon.wed,Fri	11:00am-01:00pm 01:00pm-02:30pm 04:00pm-06:00pm 07:00pm-08:00pm
ENDOCRINOLOGIS	а т	
Dr. S. S. Rastogi	Sunday	10.00am-12.00noon
ENT SPECIALIST		
Dr. Adarsh Tarwar Dr. K. B. Puri Dr. Sanjay Gupta Dr. Rakesh Kumar	Mon to Set Mon to Set	02:00pm-05:00pn 03:00pm-05:00pn On Cal On Cal
GASTROENTROLO	GIST	
Dr. R. C. Mishra Dr. Deepak Lohati Dr. P. S. Gupta Dr. Munish Sachdev	Mon.Wed.Fn	06:00pm-07:00pm On Call On Call On Call
GASTRO SURGEO	N	
Dr. Dinesh Singhal		On Cal
GENERAL PHYSIC	IAN	
Dr. Manav Aggarwal Dr. Sanjay Sachdev Dr. 8. 8. Aggarwal Dr. Vinay Kumar Dr. Ashish Rontagi	Mon to Sat Mon to Sat Mon to Sat Mon to Sat	09:00am-11:00am 11:00am-01:00pm 11:00am-01:00pm 01:00pm-03:00pm On Call

DDDD	r. S. M. Kazim r. A. S. Dave r. M. M. Mittal r. Sarvesh Kumar r. Virendera Jain r. D. K. Chauhan		On Call On Call On Call On Call On Call On Call
	GYNECOLOGIST &	OBSTETRICIA	N
	r, Alka Vohra r. M. Khera	Mon to Sat Mon to Sat	09:00am-11:00am 11:00am-01:00pm 06:00pm-08:00pm
DDD	r, Deepika Rastogi r, Anjali Srivastava r, Hamrah Siddiqui r, Sarla Mukherjee r, Shalini Pal	Mon to Sat Mon to Sat Mon to Sat	11:00am-01:00pm 11:00am-01:00pm 12:00nbon-02:00pm On Call On Call
	NEPHROLOGIST		
D	r. Uma Kishor r. S. N. A. Rizvi r. Pradeop Chhatree	Mon to Sat Mon to Fri Mon to Sat	09:00am-11:00am 05:00pm-07:00pm 04:00pm-06:00pm
	NEUROLOGIST		
	r, B. C. Bansal r, Guru Bax Singh	Mon to Fri	03:00pm-05:00pm On Call
	NEURO SURGEON		
D	r. V. K. Rajoria r. K. K. Chawdhri r. Dhruv Chaturvedi		On Call On Call On Call
-	ONCOLOGIST		
D	. Ajay Mehta		On Call
1	ONCO SURGEON		
D	r. Sanjeev Chibbar	Mon Thur	01:00pm-03:00pm
1	ORTHOPAEDIC		— — — W
D D	r, Harvinder Singh r, Anmol Maria r, Vivek Aggarwał R, Sachin Yadav	Mon to Sat Mon to Sat Mon to Sat	11 00am-01.00pm 01.30pm-03.00pm 06.00pm-08.00pm On Call
	PEDIATRIC		
D	r. Girish Srivastava r. Sanjeev Sehgal r. Dinesh Rustogi	Mon to Sat	10:00am-12:00noon On Call 03:00pm-05:00pm
1.3	o muleziu konzio@i	Tue, Thurs, Fri	11:00am-01:00pm

Dr. K. K. Jain Dr. Sumit Jain Dr. P. Jain		On Call On Call On Call
PEDIATRICS SURGI	EON	Ortean
Dr. B. D. Diwedi		On Call
PLASTIC SURGEON	Ŕ	11,203,203
Dr. Pradeep Bhargava Dr. Charan Jeev sobli	Mon,Wed,Fri	09:00am-11:00am On Call
PSYCHIATRIST		
Dr. M. Mandhekar Dr. Dutta Ray Dr. Vikas Singhal	Mon to Sat Tue, Thurs, Sat Mon to Sat	03.00pm-05.00pm 05.00pm-07.00pm 04.00pm-08.00pm
RADIOLOGIST		
Dr. Nidhi Bhatnagar	Mon to Sat	10.00am-02.00pm
THYROID SPECIALI	ST	
Dr. Rejeev Sharma	Mon.Wed.Fri	09:00am-11:00am
URO SURGEON		
Dr. P. Gulati Dr. S.N. Bodhiraja Dr. Atul Bhatnagar Dr. Shilpi Tiwan	Mon,Wed,Fri	09:00am 11:00am 11:00am 01:00pm 12:00pm-02:00pm On Call
VASCULAR SURGE	ON	
Dr. Shohel Bukhari		On Cal
DENTAL SURGEON	00	
Dr. S. K. Dua Dr. Dilip Sukla Dr. Mahesh Chowhan Dr. Sameer Sachdeva Dr. A.S. Davey	Mon-Sat	11.00am-01.00pm 03.00pm-05.00pm On Cal On Cal On Cal On Cal
DIET & LIFE STYLE		
Ms. Upasna	Mon to Sat	10:00am-01:00pm
HOMEOPATHIC		
Dr. Kanchan Dr. Himani Jain		On Cal On Cal
PHYSIOTHERAPIST	d/	
Dr. M. M. Kumar Dr. Bharat	Mon to Sat Mon to Sat	09:00am-01:00pm 04:00pm-06:00pm





NO SMOKING SIGNAGE TO BE PRESENT WITHIN THE HOSPITAL PREMISES





DISPLAY OF HAND WASHING 44 INSTRUCTION AT THE POINT OF USE









DISPLAY OF EMERGENCY NUMBERS INCLUDING AMBULANCE, BLOOD BANK, POLICE AND REFERRAL CENTERS

Emergency Phone No. Ambulance:-----Blood Bank:------Police:-----Referral Centers:-----





PC 2 - ALL SIGNAGE'S THOSE ARE REQUIRED BY LAW SHOULD BE DISPLAYED AT ALL STRATEGIC LOCATION

Interpretation – All such signage which are compulsory by law for hospitals to display such as PC&PNDT Act, AERB and radian hazard, Bio hazard signage and Fire exit signage should be displayed in the hospitals at all strategic locations.

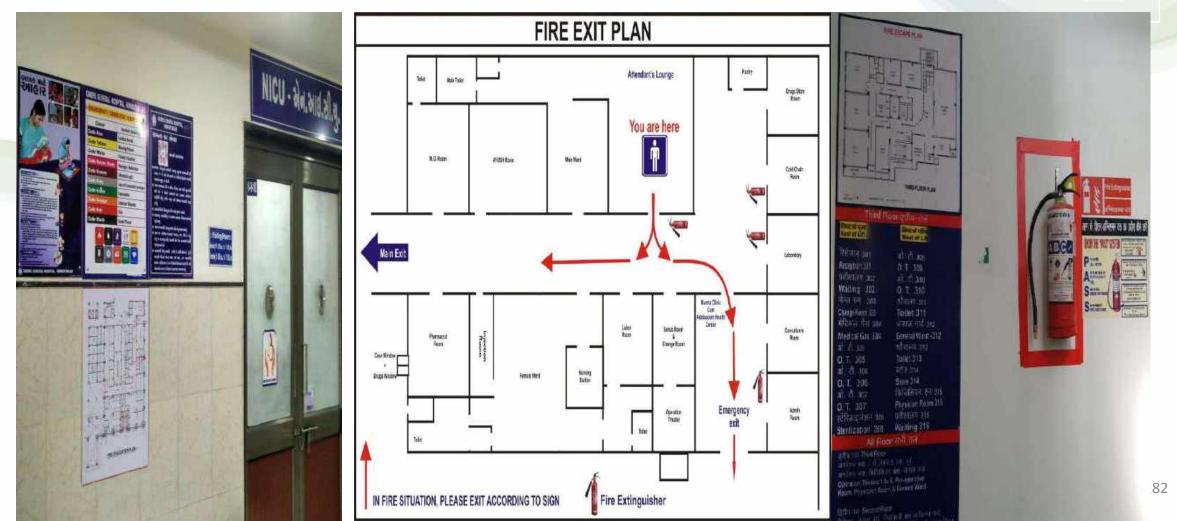
Means of verification:

- 1. Fire exit signage to be displayed at exit route plan along with the do's and don'ts in case of fire
- 2. PC&PNDT Act Signage board to be displayed at the waiting room and reception area
- 3. AERB and Radiation hazard signage
- 4. Bio-hazard signage to be present





FIRE EXIT SIGNAGE TO BE DISPLAYED AT EXIT ROUTE PLAN ALONG WITH THE DO'S AND DON'TS IN CASE OF FIRE







FIRE EXIT SIGNAGE TO BE DISPLAYED AT EXIT ROUTE PLAN ALONG WITH THE DO'S AND DON'TS IN CASE OF FIRE







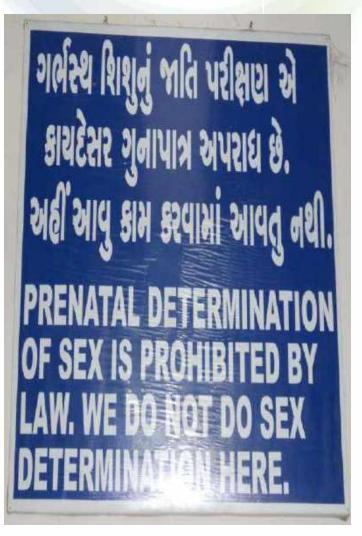
PC&PNDT ACT SIGNAGE BOARD TO BE DISPLAYED AT THE WAITING ROOM AND RECEPTION AREA



बेटियां आएंगी - खुशियां लाएंगी











AERB AND RADIATION HAZARD SIGNAGE

Radiation	Authorised
controlled	persons
area	only
X-rays and electrons Risk from external radiation	No entry when red light is on

Radiation Protection Supervisor





DO NOT X-RAY

Warning Symbol of Radiation Hazards



Radiation hazard Where MPD>1 mR/h



Caution radioactive material

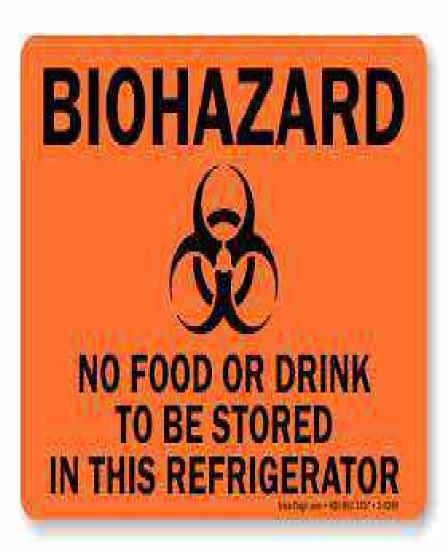
Telephone





BIO-HAZARD SIGNAGE TO BE PRESENT













PC 3 - CONTACT INFORMATION OF KEY MEDICAL STAFF AND SPECIALIST SHOULD BE READILY AVAILABLE IN THE EMERGENCY DEPARTMENT

Interpretation – The hospital must have accessible and readily available contact details of doctors and staff members. Also, a nurse call facility and at least one medical office should be available at all times in the hospital in case of emergencies.

Means of verification:

- 1. Check if the contact details (telephone or residence address) of doctors/staff are readily available
- 2. Nurse call facility should be available to address any patient emergency.
- 3. At least one medical officer and a nurse should be available all the time for the emergency cases.





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CHECK IF THE CONTACT DETAILS (TELEPHONE OR RESIDENCE ADDRESS) OF DOCTORS/STAFF ARE READILY AVAILABLE

S. No.	Name of Doctor / Staff	Telephone No.	Address
1			
2			
3			
4			
5			





NURSE CALL FACILITY SHOULD BE AVAILABLE TO ADDRESS ANY PATIENT EMERGENCY







AT LEAST ONE MEDICAL OFFICER AND A NURSE SHOULD BE AVAILABLE ALL THE TIME FOR THE EMERGENCY CASES







PC 4 - SERVICE COUNTERS FOR THE ENQUIRY ARE AVAILABLE AS PER THE PATIENT LOAD AND ARE DULY MANAGED BY HOSPITAL STAFF FOR THE REGISTRATION OF PATIENTS

Interpretation – There should be a dedicated area for enquiry as per the number of patients that visits the hospital and dedicated kiosk for AB PMJAY manned round the clock. Hospital must make sure that every patient is given a unique identification number at the time of registration of the first interaction if the patient with the organisation. To ensure continuity of care these numbers shall be linked to the unique number.

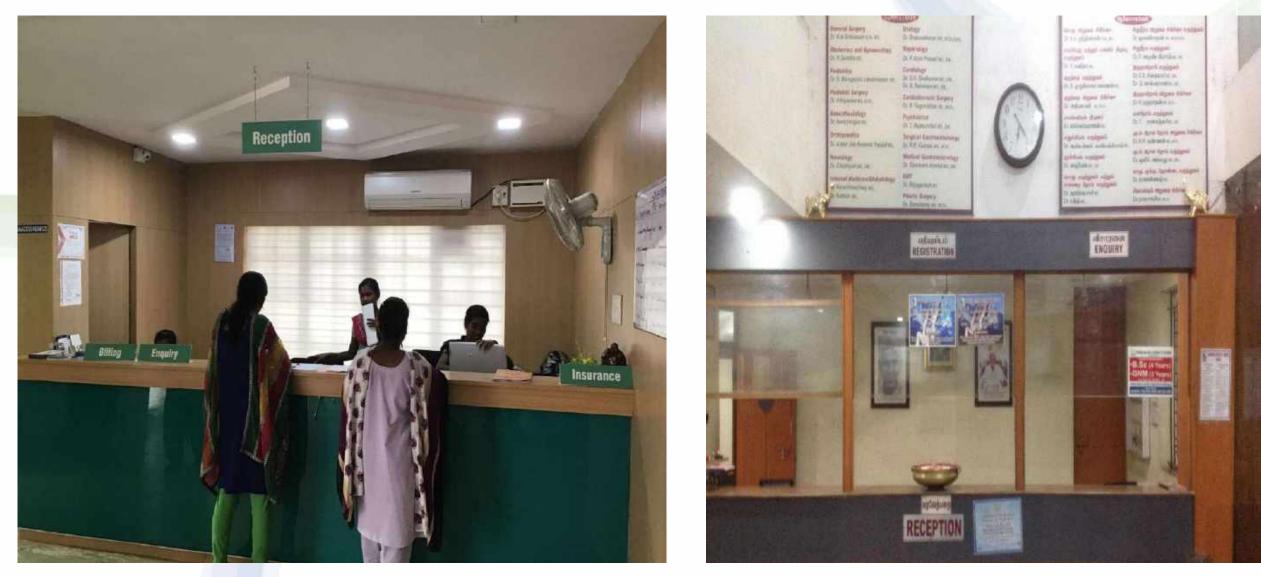
Means of verification:

- 1. Check availability of a dedicated enquiry area or reception
- 2. Unique identification number is given to each patient during the process of registration while also recording patient details such as name, age, sex, address and chief complaint etc.
- 3. Hospital has AB PM-JAY Kiosk manned 24*7





CHECK AVAILABILITY OF A DEDICATED ENQUIRY AREA OR RECEPTION







UNIQUE IDENTIFICATION NUMBER IS GIVEN TO EACH PATIENT DURING THE PROCESS OF REGISTRATION WHILE ALSO RECORDING PATIENT DETAILS SUCH AS NAME, AGE, SEX, ADDRESS AND CHIEF COMPLAINT ETC.

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HOSPITAL HAS AB PM-JAY KIOSK MANNED 24*7







PC 5 - HOSPITAL SHOULD HAVE ESTABLISHED PROCEDURE FOR ADMISSION OF PATIENTS

Interpretation – There should be documented procedures for registering and admitting the patient. All patients assessed in hospital shall be registered and all admissions must be authorized by a doctor. The policy should be defined with respect to documentation and intimation to police in case of Medico Legal Cases (MLC) as per statutory requirement.

Means of verification:

- 1. Admission is done by written order of a qualified doctor
- 2. There is an established criterion for admission through the emergency department
- 3. There is established procedure for admission of Medico-Legal Cases (MLC) as per prevalent laws and procedure to inform the police. Records for such patients are also maintained.





ADMISSION IS DONE BY WRITTEN ORDER OF A QUALIFIED DOCTOR

Chapter: Admission and Discharge (AD) Section 1: Admission of Adult Patients

Policy

- Civilly committed patients admitted to Utah State Hospital are screened through a community mental health center to determine the appropriateness of referral. Referrals are to be made to the hospital's Admissions Liaisons in the Admissions, Discharge and Transfer Office (ADT).
- Onteria for admission to Utah Sate Hospital are defined in the Utah State Code Annotated 1953, Title 62A, as amended, and the Utah State Board of Mental Health Policies. These general policy guidelines are interpreted as follows in determining eligibility for admission to the Utah State Hospital.
 - 2.1. The patient must be suffering from a major mental illness.
 - 2.2. The patient normally has a chronic mental illness, even though the current episode may be an acute exacerbation of the illness.
 - 2.3. Community based facilities have been utilized first and found not adequate to the need, or do not exist in the area of the state where the patient is found.
 - A longer hospitalization is anticipated than what is normally considered for short-term acute care.
 - 2.5. The severity of the illness makes management and treatment at Utah State Hospital the most reasonable alternative.
 - Dangerousness or violence of behavior factors makes management and treatment at Utah State Hospital the most reasonable alternative.
 - The patient's needs may be best met by a specialized treatment program only available at Utah State Hospital.
 - Referrals are made based on the availability of bed allocation for each Community Mental Health Center (CMHC).
 - 2.8.1. If a CMHC wishes to loan or sell a bed to another mental health center, the appropriate approval forms are signed through the Admissions Office.
 - 2.9. The referred individual is an established client of a community mental health center and has been referred by that center. The referred individual may also be committed to another state institution, and meet the criteria for inter-institutional transfer as defined in Utah Code Annotated 62A-15-801.
 - 2.10. The patient may be either voluntary or meet the criteria for civil commitment as defined in Utah Code Annotated, Title 62A. Voluntary admissions are discouraged if it seems likely that the patient will request release before treatment has been completed.



Admission and Discharge Policy in the Intensive Care Unit

Introduction

Intensive care refers to care provided in a separate, specially-staffed and equipped hopital unit dedicated to the observation, care and treatment of patients with life threatening illnesses, injuries or complications from which recovery is generally possible. An intensive care unit (ICU) provides special expertise and facilities with the aim to reatore vital organ function to normal in order to gain time to treat an underlying cause.

Principles

- Critically ill patients with reversible medical conditions with a reasonable prospect
 of meaningful recoveryshould be admitted to an ICU. In the event of unavailability
 of ICU beds in the hospital, an ICU bed should be sourced from another neighbouring hospital.
- Priority of admission shall be based on the urgency of patient's need for intensive care.
- Withdrawal of therapy is advocated when continuing intensive care is deemed medically futile.
- Triaging is the strategy used to select patients for admission when unit capacity is reached.

Admission Policy

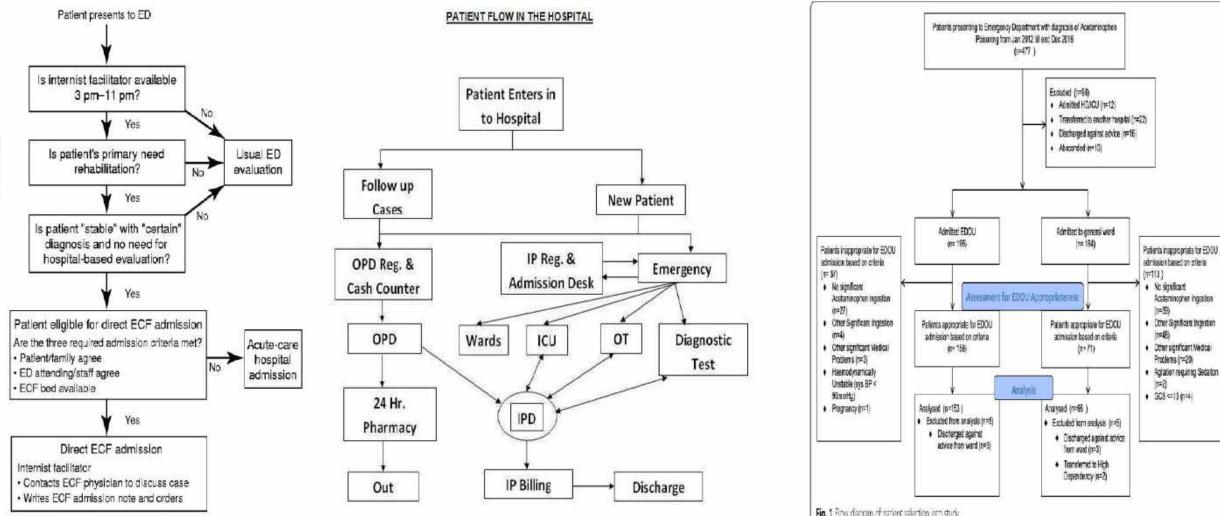
- It is the responsibility of the patient's attending clinician to request for ICU admission.
- b. It is the responsibility of the ICU specialist to decide if a patient meets eligibility requirements for ICU (refer to admission criteria for ICU).

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THERE IS AN ESTABLISHED CRITERION FOR ADMISSION THROUGH THE EMERGENCY DEPARTMENT







THERE IS ESTABLISHED PROCEDURE FOR ADMISSION OF MEDICO-LEGAL CASES (MLC) AS PER PREVALENT LAWS AND PROCEDURE TO INFORM THE POLICE. RECORDS FOR SUCH PATIENTS ARE ALSO MAINTAINED

ADMISSION AND DISCHARGE

TREATMENT OF MEDICO-LEGAL CASES

LAW AND MEDICINE

 Whenever a medico-legal case is admitted or discharged, the same should be intimated to the nearest police station at the earliest.

It is always better to inform the police through the casualty of the hospital where the medico-legal register is usually maintained and necessary entries can be made in it.
While discharging or referring the patient, care should be taken to see that he receives the Discharge Card/Referral Letter, complete with the summary of admission, the treatment given in the hospital and the instructions to the patient to be followed after discharge.

•Failure to do so renders the doctor liable for "negligence" and "deficiency of service" The patient should immediately be given treatment without waiting for the medico legal formalities of reporting.
Treatment to be started after examination and recording findings.

 First Aid to be given immediately without waiting for completion of MLC sheet

If specialist consultation is required, patient to be referred to concern specialist for further treatment

 All cases requiring constant observation and treatment to be admitted into the hospital. **1.Medical Jurisprudence** : It deals with legal aspects of medical practice of doctors.

2.Forensic Medicine : It deals with medical aspects of law and medico legal case management.





PC 6 - THE PATIENT SHOULD BE REFERRED TO ANOTHER FACILITY ALONG WITH THE DOCUMENTED CLINICAL INFORMATION, IN CASE OF NON-AVAILABILITY OF SERVICES AND/OR BEDS.

Interpretation – The documented procedure addressing the managing patients in case of non-availability of beds. Patients needing transfer including those who have come to the emergency but needs to be transferred after basic first-aid, the hospital shall have documented procedure for managing patients. The transferring/referring patients to another facility should be done through issuing referral slips. **Means of verification:**

- 1. There is an established procedure for managing patients in case beds are not available at the facility
- 2. Patient should be referred while issuing a referral slip and should be bi-directional referral system. The record of the same should be maintained
- 3. Adequate emergency facilities should be available to provide basic first aid before transfer/referral
- 4. AB PM-JAY Benefices referred to AB PM-JAY empaneled Hospitals





THERE IS AN ESTABLISHED PROCEDURE FOR MANAGING PATIENTS IN CASE BEDS ARE NOT AVAILABLE AT THE FACILITY

BED MANAGEMENT POLICY - ADULT ACUTE WARDS

1. INTRODUCTION

This policy clarifies action to be taken at Bassetlaw Hospital, as bed occupancy nears or exceeds full capacity. It describes the internal escalation principles to be considered by the Ward teams and Clinical Site Management teams (CSM) and the communication cascade to Managers and Clinicians, as well as to other organisations.

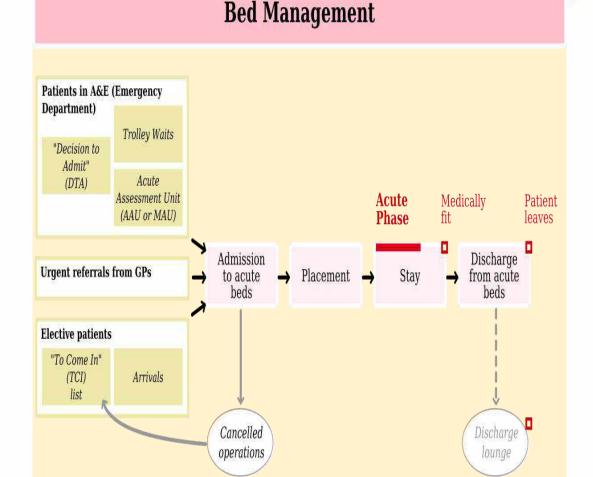
2. PRINCIPLES OF THE POLICY

This policy defines:

- 2.1 the circumstances for transferring existing in-patients within the hospital to create beds in appropriate locations for anticipated new admissions
- 2.2 the requirement of the clinical teams to undertake additional review of those patients who may be deemed fit for discharge, in order to create additional bed availability
- 2.3 the use and function of the designated discharge lounge in order to create additional bed availability
- 2.4 the communication within the hospital to alert teams with regard to the bed status, which may inform the decision to cancel non-urgent elective admissions
- 2.5 the communication necessary with other organisations e.g. the PCT and the Ambulance Services
- 2.6 the communication with the Manager on Call teams

3. MANAGEMENT RESPONSIBILITY

- 3.1 All adult beds within the Trust will be managed corporately under the direction of the Executive Team. The overall specialty bed allocation will be reviewed annually.
- 3.2 The 'bed holding' management teams are responsible for ensuring the efficient use of beds. This includes creating the capacity required to meet all elective and non-elective admissions and ensuring that all patients are regularly reviewed for discharge. The CSM is responsible for overviewing the appropriate use of the adult beds on site.







PATIENT SHOULD BE REFERRED WHILE ISSUING A REFERRAL SLIP AND SHOULD BE BI-DIRECTIONAL REFERRAL SYSTEM. THE RECORD OF THE SAME SHOULD BE MAINTAINED

Take feedback of Patient condition from the Hospital where you refer and documented.





ADEQUATE EMERGENCY FACILITIES SHOULD BE AVAILABLE TO PROVIDE BASIC FIRST AID BEFORE TRANSFER/REFERRAL

Provide basic first aid before transfer/referral.





AB PM-JAY BENEFICES REFERRED TO AB PM-JAY EMPANELED HOSPITAL

AB PM-JAY Benefices referred to nearest AB PM-JAY empaneled Hospital.





PC 7 - GENERAL CONSENT AND INFORMED CONSENT SHOULD BE TAKEN DURING THE ADMISSION AND BEFORE ANY PROCEDURES /SURGERY AND ANAESTHESIA/ SEDATION.

Interpretation – Patients and family rights include that hospital shall take informed consent, preferably in bi-lingual and language they can understand, signed by patient/relatives/caretaker at the time of admission and before undergoing any surgery or procedure which discuss about all the risks and benefits. The informed consents should be taken at all specific steps pf patient care involved with responsibility. **Means of verification:**

- 1. Consent forms available in bilingual language should be signed by the patients or any caretaker during admission and before surgery (separate forms)
- 2. All risks, benefits and alternatives about anaesthesia should be discussed and mentioned as part of the consent form signed by the patients or their caretaker.





CONSENT FORMS AVAILABLE IN BILINGUAL LANGUAGE SHOULD BE SIGNED BY THE PATIENTS OR ANY CARETAKER DURING ADMISSION AND BEFORE SURGERY (SEPARATE FORMS)

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જીએમદીઆરએસ મેદીકલ કોલેજ સંગ્રન્ન સરપ્રવાય જનરલ હોસ્પિટલ, ડિંગતનગર ખાતે પારી ઉપર /પારા ઉપર	
શરભદિયા થાટે અને ઔષધોપચાર / તપાસકોી માટે ખેટોશ કરવા તેમજ શસ્ત્રક્રિયા માટે નીચે પ્રધાણેની સંપતિ આપું છું.	
(૧) આ અરેપવોષપાલ / તપાસણો / ગસ્ત્રક્રિયા / ઇપપાર કરવાની યોગ્ય પ્રથ્વતિથી અને તેની આંડઅસરો અને તે પ્રક્રિયાની જરૂરિયાત કોવા છતાં ના કરવાથી ધનારા પરિણાય, સોયરેશન સિવાયના અન્ય ઉપચારો તથા તેનાથી થતું નુકશાન અને ભાષ વગેરે સર્વે બાબતોની મને સર્જન કૉકટર <u>Dhoved</u> <u>Post-vect</u> એ	
સમજવુ આવી છે.	
(૨) કોઇપણ ઓપરેલન અને એનેઓથીપા એપૂર્ટા રીતે સુરક્ષિત હોતું નથી અને એપણીપ્પાર / તપાસણો / સસ્વતિપા / ઇપ્પાર પ્રધ્યતિ અને બેહીલ કરવાની પચ્પતિને લીવે જીવને લપકે ઇજા પવાની શક્યતા તપાપ યોગ્ય અને જરૂરી પચલાં તેવા છતાં માર્ચ સાપાન્ય રીતે નીરોગી વ્યક્તિને પણ હોય છે. તેની પને યોગ્ય પાહિતી પણ આપવામાં આવી છે.	1
(૩) વધારે પડતો સ્ટતસ્પાલ, ચેપ લાગવો, શ્રદ્ધ બંધ પડવું, રેક્સામાં લોકીનાં માંડનું અટકવું આવી અને આના જેવી ઇતર અકલ્પિત આકસ્પિક બીજી કેટલીક તકલીક પરવક્ષિયામાંથી કે બેહોશ કરવાની દવા કાસ થઇ શકે છે અને તેની ભાણ મને ડોકટરે આપેલ છે.	
(x) ઔપધોષચાર / તપાસણી / શસ્ત્રાદિયા / ઉપચાર કરવાની પંચાતિ કરતી વખતે ડોક્ટરને કોઇ હારણચાર જરૂરી આધનોના	
ગ્રકાર તથા ઓપરેશનની પલ્યતિનું સ્વરૂપ બદલવું થયે તો, જરૂર થયે તો બીજી ડોકટરની મદદ લેવાની મંજૂરી આપું છું.	
જરૂર પડે લોકી ચડાવવાની સંપતિ આપું છું કે કેરણર કરવા માટે પણ મારી સંપતિ છે, અને તેની જાણ મને કરવામાં આવી છે. –	
પ) વધુ સુવિધા ધરાવતી મેડીકલ કોલેજ કલાની હોસ્પિટલમાં દ્રાન્સકર કરવાની જરૂર પડે તેની પણ હું સંઘતિ આપું છું.	
ઉપરની સર્વે વિચાલેને સંપૂર્ણ શાન, ભાન સાથે અને દબાણા વગરથી વાંચી છે. / મને વાંચી વિગતવાર સમજાવવામાં આવે (અને તે મળી સમજમાં આવી છે. તેપજ તે મને સંપૂર્ણ માન્ય પણ છે. તથા તમામ યોગ્ય અને જરૂરી સારવાર કરવા છતાં આવું ઇપણ થાય તો તે માટે ડોક્ટર, હોસ્પિટલાકે સ્ટાક જવાબદાર શકેરો નહીં.	
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	CONSENT FOR SURGICAL, INVASIVE, DIAGNOSTIC, MEDICAL, INTERVENTION PROCEDURE (To be taken by Doctor)		
Name of F Date:/_ Address:		Sex: Mole	/ Female
Diagnosis:	3	(
Operative	Procedure/ Operation:		
The star	aesthesia: Local/ General/ Spirial/ Epidural/ Nerve Block		

L	Patient's name), give my full consent/authorisation as an act
of my own tree will to undergo	the following medical treatment operation or intervention
procedures	at Government Spine Institute, Ahmedabad, under
Dr.	and his team of assistants, nurses, and hospital staff as
supervision and guidance of Dr.	deemed necessary.

I have been explained in the language known and understood by me about the nature of the medical treatment operation or procedure being performed, its benefits and costs; risks associated with it; other alternatives and its prognosis.

I am aware that the practice of medicine and surgery is not an exact science and I have not been given any guarantees about results of this procedure. If I develop any complications I hereby authorize the surgical team to take decisions on my behalf.

I agree to allow Government Spine Institute to keep use or properly dispose of any fissues or parts of

1001 CHI, HHIT 2000-04-2017	જીએમઈઆરએસ મેડીકલ કોલેજ સંલગ્ન સરપ્રતાપ જનરલ હોસ્પિટલ, દિંગતનગર.
	એનેસ્થેશિયા માટેનં સંમતિ પત્રક
દર્દીનું નામ : 🔄 ઝ ૨૪૦. નં. : 🛛 જે	966 ઉપર / જાતિ : શ્હ / f
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હું નીચે સહી કરનાર સંપૂર્ણ હોંશમાં સાબૂત મનથી મારા પર કોઇપણ પ્રકારના એનેસ્થેશિયા માટે સંપૂર્ણ સંમતિ આપું છું. આ માટે જરૂરી હોય તેવા પ્રકારનો એનેસ્થેશિયા વાપરવાની પરવાનગી આપું છું. મને થયેલ બિમારીની સંપૂર્ણ વિગત જેવી કે ડાયાબિટીસ, બલ્ડ પ્રેશર, હૃદયની બિમારી, શોક (લોહીનું ઓછું દબાણ), ડિડનીની બીમારી, કેકસાની બિમારી વિગેરે…. ડૉકટરે મને સમજાવેલ છે.

મને એનેસ્થેશિયા અને તેની વિપરીત અસરો (હૃદય બંધ પડી જવું, કેક્સામાં લોહીની ગાંઠો પડી જવી, ચાસનળીમાં દુરબીનથી તપાસ દરમ્યાન ઓક્સિજન ઓછો પહોંચતા મગન પર સોજો આવી જવો અને આના જેવી બીજી ઇત્તર અકલ્પિત આકસ્મિક ગુંચવણો) બેહોશ કરવાની દવા દ્વારા થઇ શકે છે તેની જાણ કરવામાં આવેલ છે.

હું કોઇપણ એનેસ્થેટીસ્ટ, મદદનીશ ડૉકટરો દ્રારા તથા નર્સો દ્વારા મદદ લેવા સંમતિ આપું છું.

ુ ઓપરેશન દરમ્યાન મને એનેસ્થેશિયા માટેની કોઇપણ દવાઓ અને લોહી આપવાની સંમતિ આપું છું અને તેનાથી થતી વિપરીત અસરો મને જાણ કરેલ છે.

આ લેખિત મંજૂરી દારા અમે હોસ્પિટલ સ્ટાક તેમજ ડૉક્ટરોને કોઇપણ અકસ્માત, વિપરીત અસર, કોમ્પલીકેશન તેમજ શારીરિક મુશ્કેલી અથવા ખોડખાંપણ અંગે જવાબદાર ઠેરવતા નથી. પ્રાપ્ત સુવિધાઓના અનુસંધાને પુરી કાળજી લેવા છતાં કોઇપણ પ્રકારનું જોખમ થવાનો સંભવ છે. તે અંગે ડૉક્ટર દારા વિગતવાર જણાવ્યું છે.

ઉપરની સંપૂર્ણ વિગતો મેં વાંચી છે, અને સમજી છે, મારી ભાષામાં સમજાવેલ છે. તે પ્રમાણે ઓપરેશનમાં અને શીશી સુંઘાડવામાં :

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ASA-I સામાન્ય પ્રકારનું જોખમ ASA-II ગણતરી પૂર્વકનું જોખમ ASA-III ગંભીર પ્રકારનું જોખમ

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ASA-V ટેબલ પર મૃત્યુના ભવનુ જાળન-



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ALL RISKS, BENEFITS AND ALTERNATIVES ABOUT ANAESTHESIA SHOULD BE DISCUSSED AND MENTIONED AS PART OF THE CONSENT FORM SIGNED BY THE PATIENTS OR THEIR CARETAKER

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ત્રેનેસ્થેટીસ્ટ	
હું નીચે સહી !	રનાર સંપૂર્ણ હોંશમાં સાબૂત મનથી મારા પર કોઇપણ પ્રકારના એનેસ્થેશિયા માટે સંપૂર્ણ સંમતિ આપું છું.
સમજાવેલ છે. મને એનેરચી તપાસ દરમ્યાન ઓવિ બેહોશ કરવાની દવા હું ક્રીઇપણ એ આપરેશન દર આસરો મને જાણ કરેલ આ લેખિત શારીરિક મુશેલી અ	શર, હદયની બિમારી, શોક (લોહીનું ઓછું દબાણ), ઉડનીની બીમારી, ઢેફસાની બિમારી વિગેરે ડૉકટરે મને દોયા અને તેની વિપરીત અસરો (હદય બંધ પડી જવું, કેઠસામાં લોહીની ગાંઠો પડી જવી, ચાસનળીમાં દુરબીનથી સ્પેજન ઓછો પહોંચતા મગન પર સોજો આવી જવો અને આના જેવી બીજી ઇત્તર અકલ્પિત આકસ્મિક ગુંચવણો) દારા થઇ શહે છે તેની જાણ કરવામાં આવેલ છે. તેરથેકીસ્ટ, મદદનીશ ડૉકટરો દારુ તથા નર્સો દારા મદદ લેવા સંમતિ આપું છું. રુપાન મને એનેસ્થેશિયા માટેની કોઇપણ દવાઓ અને લોહી આપવાની સંમતિ આપું છું અને તેનાથી થતી વિપરીત સછે. બંજૂરી દારા અમે હોસ્પિટલ સ્ટાફ તેમજ ડૉક્ટરીને કોઇપણ અકસ્માત, વિપરીત અસર, ક્રોમ્પલીકેશન તેમજ થવા ખોડખાંપણ અંગે જવાબદાર કેરવતા નથી. માપ્ત સુવિધાઓના અનુસંધાને પુરી કાળજી લેવા છતાં કોઇપણ તે સંભવ છે. તે અંગે ડૉક્ટર દારા વિગતવાર જણાવ્યું છે. [વિગતો મેં વાંથી છે, અને સમજી છે, મારી ભાષામાં સમજાવેલ છે. તે પ્રમાણે ઓપરેશનમાં અને શીશી સુધાડવામાં :
ઉપરની સંપૂર્ણ	િવિગતો મે વાચા છે, અને સમજી છે, મારા પા
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PC 8 - USER CHARGES ARE DISPLAYED AND COMMUNICATED TO PATIENTS EFFECTIVELY AT THE TIME OF REGISTRATION, ADMISSION TO THE WARD AND IN CASE OF A CHANGE IN MEDICAL AND SURGICAL PLAN.

Interpretation – The list of user charges must be displayed at strategic places (Reception, waiting areas, lobby) in the hospital premises for better communication to patients and to maintain transparency. The list must be updated in case of any change in medical and surgical plan.

Means of verification:

- 1. Facility prepares a comprehensive list of user charges and display at strategic points in the hospital.
- 2. AB PM-JAY beneficiaries are provided cashless services





FACILITY PREPARES A COMPREHENSIVE LIST OF USER CHARGES AND DISPLAY AT STRATEGIC POINTS IN THE HOSPITAL

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AB PM-JAY BENEFICIARIES ARE PROVIDED CASHLESS SERVICES





BIMAR NAHI RAHA LACHAAR, HO RAHA MUFT UPCHAAR World's largest healthcare scheme PM-JAY will make India, 'Ayushman'.

For the first time in the history of India, crores of poor and vulnerable Indians will benefit through the Pradhan Mantri Jan Arogya Yojana, PM-JAY. Now every entitled family will have access to cashless and paperless healthcare coverage for all critical diseases.

Benefits to over 10 crore poor and vulnerable families and more than 50 crore beneficiaries across the country

Annual healthcare benefits of up to Rs. 5 Lakh for every entitled family Access to healthcare services in all government and empanelled private hospitals



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PC 9 - PATIENT SHOULD BE PROPERLY EDUCATED ON ADDITIONAL CARE AS DEEMED REQUIRED AND ALL THE VITAL INFORMATION SHOULD BE RECORDED FOR CONTINUITY OF CARE.

Interpretation – Patient should be educated for additional care in respect to usage and effect of medication, diet and nutrition which can be done with the help of discharge summary and growth summary respectively. All the vital information must be recorded for reassessment of patients undergoing observation in the language the patient/ family members can understand.

Means of verification:

- 1. Patients should be educated for usage and effect of medication, diet and nutrition, immunizations and to prevent infections (as deemed appropriate)
- 2. Discharge summary should contain a diagnosis, history, physical examination, investigation details, treatment provided and instructions thereof in easy to understand manner (Check 3 samples)
- 3. There should be a fixed schedule for reassessment of patient under observation based on clinical need



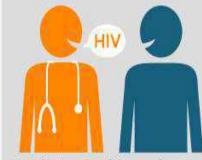


PATIENTS SHOULD BE EDUCATED FOR USAGE AND EFFECT OF **MEDICATION, DIET AND NUTRITION, IMMUNIZATIONS AND TO PREVENT INFECTIONS (AS DEEMED APPROPRIATE)**

How can I stay healthy with HIV?



Take antiretroviral treatment every day, as prescribed



Stay in touch with my doctor and follow their advice







Eat a balanced and nutritious diet Exercise and keep fit



family and others with HIV







DISCHARGE SUMMARY SHOULD CONTAIN A DIAGNOSIS, HISTORY, PHYSICAL EXAMINATION, INVESTIGATION DETAILS, TREATMENT PROVIDED AND INSTRUCTIONS THEREOF IN EASY TO UNDERSTAND MANNER

3. MEDICAL AUDIT COMMITTEE

- Chairperson : Medical Superintendent , GMERS General Hospital, Himmatnagar
- Member Secretary (AHA, GMERS General Hospital, Himmatinagar
- · Members:

Sr No.	Designation
1	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J Vyas)
6	AO
7	MO (Rajesh .K Varma)
8	Matron
9	Senior Head Nurse

Background

- Audit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may with to do in the future.
- Medical audit involves the study of some part of the structure, process and endrome of
 core clinical activities carried out by those personally engaged in the activity. It
 measures whether set objectives have been attained or not. It thus assessos the quality
 of care delivered.

Involves

- A systematic examination of performance parameters
- · Comparison of results against set criteria
- · Assessment of quality of care with a view to improvement

Why audit

- Educational value for participants
- Improve effectiveness and efficiency of care.
- Reassare Consumers.

How to audit

- Define standards you should realistically reach for the area which you intend to audit Standards should be
 - Realistic
 - Owned/Ownable
 - · Parallel to existing standards
- 2. Set the criteria by which you will measure those standards
- 3. Compare your results against your defined standard is change poeded
- 4. Review the results of any changes made

Objectives of the committees to use different performances parameters from various hospital departments to demonstrate that outcome are continuously being improved upon. All audits will be documented.

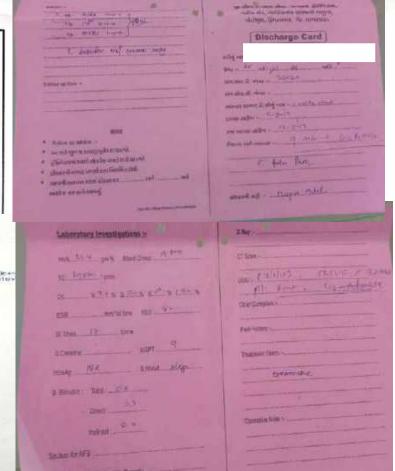
Meetings of the Committee: thrice in a Year, Minutes of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.



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THERE SHOULD BE A FIXED SCHEDULE FOR REASSESSMENT OF PATIENT UNDER OBSERVATION BASED ON CLINICAL NEED

Table 3.1 - Components of the comprehensive diabetes medical evaluation at initial and follow-up visits

		VISIT	FOLLOW-	ANNUAL
	 Height, weight, and BMI: growth/bubertal development in children 	~	~	~
	and adolescents	1.20	1.1	
	Blood pressure determination	1	*	-
	 Orthostatic blood pressure measures (when indicated) Fundoscopic examination (refer to eye specialist) 	× .		1
	Thyroid palpation	× 1		~
PHYSICAL	 Skin examination (e.g. acanthosis nigricans, insulin injection or insertion sites, lipodystrophy) 	1111	~	~
	 Comprehensive foot examination Visual inspection (e.g., skin integrity, callous formation, foot deformity or ulcer, toenails) 	-	~	~
	 Screen for PAD (pedal pulses; refer for ABI if climinished) 	1		1
	 Determination of temperature, vibration or pinorick sensation, and 10-g monofilament exam 	~		~
	AIC, if the results are not available within the past 3 months	~	-	-
	 If not performed/available within the past year 	392	1.1	100 m
	 Upid profile, including total, LDL, and HDL cholesterol and triglycerides# 	1		~^
and a second	Liver function tests	1		1
EVALUATION	 Spot urinary aloumin-to-creatinine ratio 	1		1
	 Serum creatinine and estimated glomerular fibration rate¹ 	-		~
	 Thyroid-stimulating hormone in patients with type 1 diabetes[#] 	1111		1
	 Vitemin B12 if on metformin (when indicated) Serum potassium levels in patients on ACE inhibitors, ARBs, or diurctics[†] 	5		~
	Goal setting			
	 Set AIC/blood glucose target and monitoring frequency 	× .	1	-
	 If hypertension diagnosed, establish blood pressure goal 	× .	1.00	~
	 Incorporate new members to the care team as needed Diabetes education and self-management support needs 	× 1		× 1
	 Liabetes education and sets-management support needs. 	*		×
SSESSMENT	Cardiovascular risk assessment and staging of CKD	100	100	2
AND PLAN	History of ASCVD	× 1	-	1
Constantine Constantine of	 Presence of ASCVD risk factors (see Table 9.2) 		1	1
	 Staging of CKD (see Table 10.1)[†] 	Y	*	
	Therapeutic treatment plan	2020	0.27	
	 Lifestyle management 	1	~	1
	Phermecologic therapy	1	~	~
	 Referrals to specialists (including distitian and diabetes educator) 	1	~	1
	as needed Use of glucose monitoring and insulin delivery devices 	1	1	1

ABI, ericle-brechial pressure index; ABBs, angiotensin receptor blockers; ASCVD, stimscaderotic cordiovescular disease; CGM, continuous glucose monitoring; CKD, chronic kidney disease; PAD, peripheral atomial disease.

*265 years:

Imay be needed more frequently in patients with known chronic kickey disease or with changes in medications that affect kidney function and serum potasskim (see Table 10.2).

fmay and need to be checked after itilitation or dose shanges of medications that affect these laboratory values (i.e., diabetes medications, blood pressure medications, chelesterol medications, or thyroid medications);

*in acoste without dysfinidemia and not on cholesteral-lowering thermax testing may be less frequent.

		VISIT	FOLLOW-	ANNUAL
	Diabetes history - Characteristics at onset (s.g. age, symptoms) - Review of previous breatment regimens and response - Assest requency/cause/soverity or past hospitalizations	111		
2.722	Family history - Family history of diabetes in a first-degree relative - Family history of autoimmune disorder	1		
PAST MEDICAL AND FAMILY HISTORY	Personal history of complications and common comorbidities Macroveroular and microvesoular Common comorbidities Presence of hemoglobinopathies or anemias High blood preserve or abnormal lipids Last clinated eye exam Visit to specialists	111111	*	***
	Interval history Changes in medical/family history since last visit		1	~
SOCIAL HISTORY	Assess lifestyle and behavior patterns • Eating patterns and weight history • Sieep behaviors and physical activity • Familiarity with carbodydrate counting in type 1 diabetes • Tobacco, alcohot, and substance use • Identify existing social supports	11111	11	**
	Interval bistory Onanges in social history since last visit		1	~
IRDICATIONS AND SCCINATIONS	Medication-taking behavior Modication Intolarance or side affects Complementary and alternative medicine use Vaccination history and needs	1111	111	****
ECHNOLOGY USE	 Assess use of health apps, online education, patient portals, etc. Glucose monitoring (mater/CGM); results and data use Review insulin pump settings 	111	5	***
	Psychosocial conditions • Sorteen for depression, anxiety, and disordered eating; refer for further assessment or intervention if warranted • Cansider assessment for cognitive impairment.*	1		* *
	Diabetes self-management education and support History of distitian/diabetes aducator visits Scrieen for barriers to diabetes self-management Refer or offer local resources and support as needed	111	1	111
	Hypoglycemia • Timing of episodes, awareness, frequency and causes	1	1	1
	Pregnancy planning • For women with childbearing capacity, review contraceptive needs and preconception blanning		~	~

Table 3.1 - Components of the comprehensive diabetes medical evaluation at initial and follow-up visits





PC 10 - HOSPITALS SHOULD ENSURE THAT ALL MEDICATIONS AND ASSOCIATED INSTRUCTIONS ARE WRITTEN IN THE PRESCRIPTION

Interpretation – The organization shall ensure that the at the minimum the prescription shall have the name of the patient, unique patient number, name of medicine with the frequency of administration, name and signature of the doctor. All hand written prescription should be legible, clear and understandable by the patient/ family member i.e. preferably in capital letters.

Means of verification:

- 1. Prescription should be legible, clear and be explained in the language understood by the patients and is comprehendible by the clinical staff
- 2. Every medical advice and procedure is accompanied with date, time and signature, unique patient number.





PRESCRIPTION SHOULD BE LEGIBLE, CLEAR AND BE EXPLAINED IN THE LANGUAGE UNDERSTOOD BY THE PATIENTS AND IS COMPREHENDIBLE BY THE CLINICAL STAFF

R	K Age Gender		Prescription Date 25-01-2010
Descri	ption ; gend anal Comments: None		
SI.No.	Prescribed Medicines	Dosage	Instructions
1.	CAPSULE NEXPRO L ESOMEPRAZOLE+LEVOSULPIRIDE(40)	0-0 t	TO Days Days; Before Meal;
2	SYRUP ULGEL ELAICHI FLAV MAGALDRATE+SIMETHICONE(10 ML)	1741-1	5 Days Days; Before Meal; After Meal;
LAB T 1. Bloc FOLLO 1 Woo	od Sugar - Fasting test(FBS) tsh. ugi an histopy OW UP		





EVERY MEDICAL ADVICE AND PROCEDURE IS ACCOMPANIED WITH DATE, TIME AND SIGNATURE, UNIQUE PATIENT NUMBER







PC 11 - MEDICAL RECORDS SHOULD BE RETAINED AS PER THE POLICIES OF HOSPITAL BASED ON NATIONAL AND LOCAL LAW

Interpretation – Hospital must abide by the national and local laws for retaining medical records for each category of records: Out-patient, in-patient and MLC. The retention and destruction process should be included in the process to maintain confidentiality and security of both manual and electronic records system. Also, there should be a documented process for medical records of AB PMJAY scheme beneficiaries.

Means of verification:

- 1. Hospital has a policy of retention period with respect to different kinds of records and their disposal.
- 2. Confidentiality of patient records should be maintained by keeping them properly in the record room or digitally saved on a secure network
- 3. Hospital has process documentation for AB PM-JAY scheme





HOSPITAL HAS A POLICY OF RETENTION PERIOD WITH RESPECT TO DIFFERENT KINDS OF RECORDS AND THEIR DISPOSAL

		MRD CHECH	GSI -IPD- FF-32			
U of I	D Book o	nd its booklet no				
SR No	Form NO	Indoor Booklet	Mark (Yes-Y or N If yes Complete-C Incomplete-IC	io) Mark No- 27 N- if forms not present	Page No	
1	1	Information Form				
2	2	Registration Form				
3	3A	General Consent Form (English)				
4	38	General Consent Form(Gujarati)				
5	4	Initial assessment by Nurse				
6	5	Initial assessment by Doctor				
7	*	Initial assessment by physiotherapist & occupation therapist				
8	7	Initial assessment by p&o				
9	8	Initial assessment by dietician				
10	9	MSW assessment form				
11	10	Initial assessment by clinical psychologist				
12	11	Initial assessment by vocational				
13	12	Continuous sheet Reassessment by nurse				
14	13	Reassessment by Doctor				
15	14	Reassessment by Physiotherapist & occupational therapist				
16	15	physiotherapy Treatment				
17	16	Occupational therapy Treatment Sheet				
18	17	Pre anaesthesia assessment				
19	18A	moderate sedation form Anaesthesia consent form (English)				
20	18B	(English) Anaesthesia consent form (Gujarati)				
21	19	Pre induction Assessment by surgeon & anaesthesia				
22	20	Monitoring of patients during Anaesthesia				
23	21	Anaesthesia notes				
24	22	Recovery criteria				
25	23	Anaesthesia note for				

	<u>م</u>			
		epidural injection		_
26	24A	Consent for surgical, invasive, diagnostic, medical, intervention procedure		
27	248	Consent for surgical, invasive, diagnostic, medical, intervention procedure		-
28	25	Surgical check list		-
29	26	operation note by surgeon		1
30	27	Appliance Prescription P & O		-
31	28	Input out put chart		-
32	29	Nursing Modication Chart		-
33	30	discharge card		-
34	31A	Blood and blood products administration/ High risk medication menitoring form		-
35	318	Blood and blood products administration Consent form		-
36	32	MRD checklist		-
	arks of iture: e:	MRD:	Date: Tíme:	
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3. MEDICAL AUDIT COMMITTEE

Chairporton : Medical Superintendent , CMERS General Hospitol, Himmatnagar
 Member Secretary (AHA, GMERS General Hospital, Himmatnagar
 Members

Sr No.	Designation
1	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J Vyas)
6	60
7	MO (Rajesh K Varma)
8	Matron
9	Senior Head Nurse

Background

- Addit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may with to do in the future.
 Medical addit involves the study of some part of the structure, process and outcome of
- core clinical activities carried out by those personally engaged in the activity. It measures whether set objectives have been attained or not. It thus assesses the quality of tare delivered.

Involves

- A systematic examination of performance parameters
- Comparison of results against set criteria
 Assessment of quality of circ with a view to improvement

Why audit

- Educational value for participants
- · Improve effectiveness and efficiency of care.
- Reassure Consumers.
 How to audit
- Define standards you should realistically reach for the area which you intend to audit
 - Standards should be
 - Realistic
 - Owned/Ownable
 - Parallel to existing standards
 - Set the criteria by which you will measure those standards
 Compare your results against your defined standard is change needed
 - Compare your resells against your desired standard is chan;
 Review the results of any changes made

Objectives of the committees to use different performances parameters from various huspital departments to demonstrate that outcome are continuously being improved upon. All audits will be documented.

Meetings of the Committee: thrice in a Year, Minutes of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.



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CONFIDENTIALITY OF PATIENT RECORDS SHOULD BE MAINTAINED BY KEEPING THEM PROPERLY IN THE RECORD ROOM OR DIGITALLY SAVED ON A SECURE NETWORK

POLICY FOR SECURITY, PROTECTION FROM LOSS, TAMPERING OR UNAUTHORIZED USE

• The MRD shall apply various methods and tools to prevent any damage /tampering to the medical records occurring due misplacement, pests, fire or any other factor.

Specific Information:

•No files will be taken out of department except for the conditions mentioned in the policy for access.

•Files are issued outside the department in accordance to process mentioned in the policy for access to

•medical record.

•A reminder dummy is placed in the filing cabinet.

•A retrieval process is in place to take care of files issued.

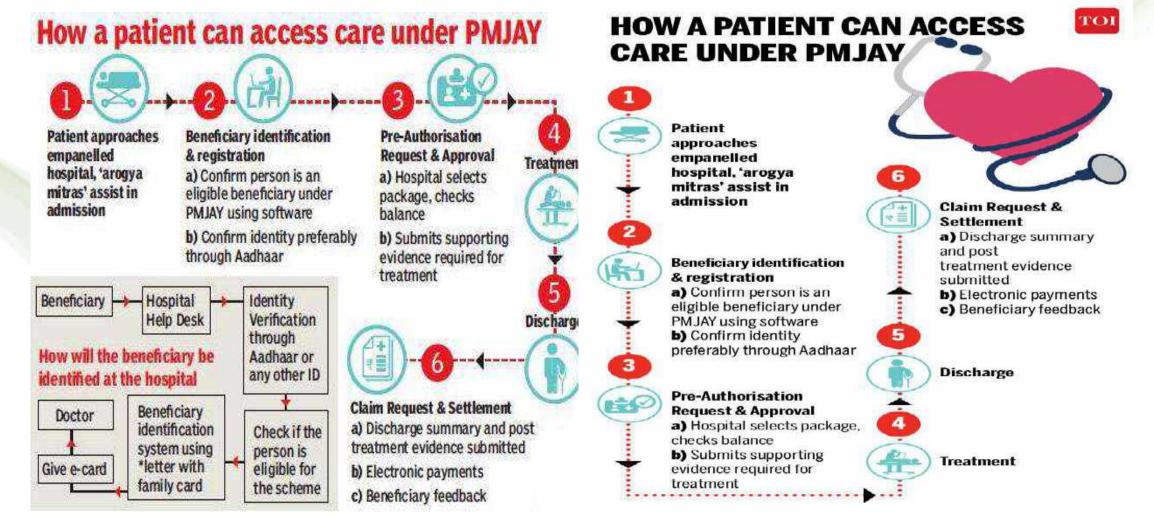
- A record issue slip is filled by the person taking out the file which includes the purpose as well as the expected
- date of return.
- - Telephone call is made to the person on the expected date of return and a request is made to return the file.
- If any extension is to be made, the same is noted down on the same issue slip.
- In case the file is still not returned and no extension has been sought, the medical record technician goes to the person to collect the documents.

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HOSPITAL HAS PROCESS DOCUMENTATION FOR AB PM-JAY SCHEME







CHAPTER 5: HEALTH OUTCOMES (OVERVIEW)

The importance of measuring and reporting the healthcare outcomes is to improve patient experience of care and fosters improvement and adoption of best practices, thus further improving outcomes. This chapter has standards for measuring healthcare outcomes like OPD and IPD census, mortality rate, average length of stay, Surgical Site Infection, Urinary Tract Infection, Blood Stream Infection, Ventilator Associated (VAP) Infection / Hospital Acquired Pneumonia, Transfusion reaction, Bed occupancy, Patient and employee satisfaction, reporting of adverse events, theft and security related events etc. The data provided by health outcomes guide decision and effective policy making process.





CHAPTER 5: HEALTH OUTCOMES

HO 1	Monthly Out Patient Department (OPD) and In-Patient Department (IPD) census
HO 2	Mortality Rate and average length of stay
HO 3	Infection Rates - Surgical Site, Urinary Tract, Blood Stream, Ventilator Associated (VAP)/ Hospital Acquired Pneumonia
HO 4	Transfusion reaction (if applicable)
HO 5	Bed occupancy
HO 6	Percentage of Patient satisfaction
HO 7	Percentage of Employee satisfaction
HO 8	Waiting time - Out Patient Department (OPD) and discharge
HO 9	Reporting of Adverse events
HO 10	Reporting of Thefts / Security related incidents
HO 11	Reporting of needle stick injuries





HO 1 - MONTHLY OUT-PATIENT DEPARTMENT (OPD) AND IN-PATIENT DEPARTMENT (IPD) CENSUS

Interpretation: A monthly Out-Patient Department (OPD) and In-Patient Department (IPD) census data can help to monitor how much OPD patients are converting into IPD, how many patients visited the OPD and IPD and track the trend of OPD to IPD conversion. The rate is generally affected by poor patient satisfaction, high cost of IPD or low motivation of doctors to admit OPD patient.

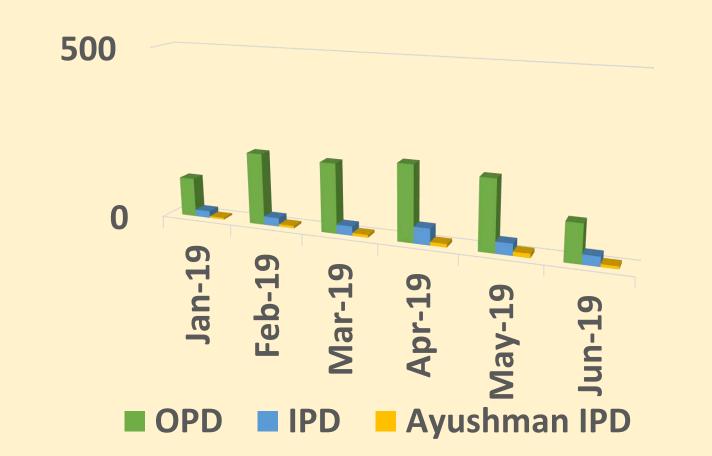
Means of verification:

- 1. Out Patient Department (OPD) census for last 6 months
- 2. In-Patient Department (IPD) census for last 6 months
- 3. AB PM-JAY In-Patient Department (IPD) census for last 6 months





MONTHLY OUT-PATIENT DEPARTMENT (OPD), IN-PATIENT DEPARTMENT (IPD) AND AB PM-JAY IN-PATIENT DEPARTMENT (IPD) CENSUS



324





HO 2- MORTALITY RATE AND AVERAGE LENGTH OF STAY (ALS)

Interpretation: Mortality statistics provide a valuable measure for assessing community health status. The importance of mortality statistics derives both from the significance of death in an individual's life as well as their potential to improve the public's health when used to systematically assess and monitor the health status of a whole community. ALS is a very common performance measure which is used not only important for hospital performance but also for clinical quality and infection control.

Means of verification:

- 1. Mortality Rate (from the data of last 6 months)
 - = Number of Patient died/ Total number of patient admitted *100 Average
- 2. Length of Stay (from the data of for last 6 months)
- = Sum of days spend by each patient/ Total number of patient admitted



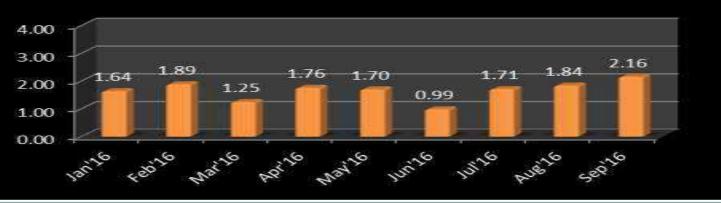
MORTALITY RATE



Jan'16	1.64%	11/670
Feb'16	1.89%	13/688
Mar'16	1.25%	9/721
Apr'16	1.76%	12/682
May'16	1.70%	12/704
Jun'16	0.99%	7/709
Jul'16	1.71%	13/759
Aug'16	1.84%	15/814
Sep'16	2.16	21/974

No of deaths X 100 No of discharges and death for the month





RCA –

1.Most of the deaths were associated with the multi-organ involvement / failure, supra added infection, pneumonia, septicaemia etc. 2.Sick patients being referred from near by RMP's & small nursing home/clinics who have very less chance of survival. given the short duration of treatment protocol to be followed in view of their deteriorating condition.

CAPA –

1. Prevention of hospital acquired infection.

2.Regular mortality meet to review the delivery of care/ adequacy of treatment or deficiencies so that remedial measures can be taken.



AVERAGE LENGTH OF STAY (ALS)

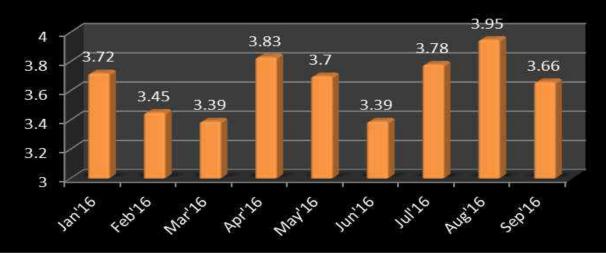


	BOR	ALOS
Jan'16	71.28%	3.72
Feb'16	72.44%	3.45
Mar'16	69.94%	3.39
Apr'16	77.07%	3.83
May'16	74.42%	3.7
Jun'16	71.06%	3.39
Jul'16	83.43%	3.78
Aug'16	91.10%	3.95
Sep'16	99.16%	3.66

BOR



ALOS





HO 3 - INFECTION RATES



Interpretation: An infection rate is the probability or risk of infection in a population. It is used to measure the frequency of occurrence of new instances of infection within a population during a specific time period. It will help to identify if any recurrent infections persist and improve infection control in the hospital. **Means of verification:**

- 1. Surgical Site Infection (from the data of for last 6 months)
 - = Number of surgical site infections/ Number of patients operated *100
- 2. Urinary Tract Infection (from the data of for last 6 months)
 = Sum of Urinary Tract Infection Complaints/ Total Number of patients admitted *100
 3. Blood Stream Infection (BSI) (from the data of for last 6 months)
 = Number of Catheter related BSI/ Number of patients on IV line * 100
- 4. Ventilator Associated Pneumonia (VAP)/ Hospital Acquired Pneumonia (HAP) (from the data of last 6 months)
 - = Sum of Ventilator Associated Pneumonia/ Number of patients on ventilator *100



SURGICAL SITE INFECTION

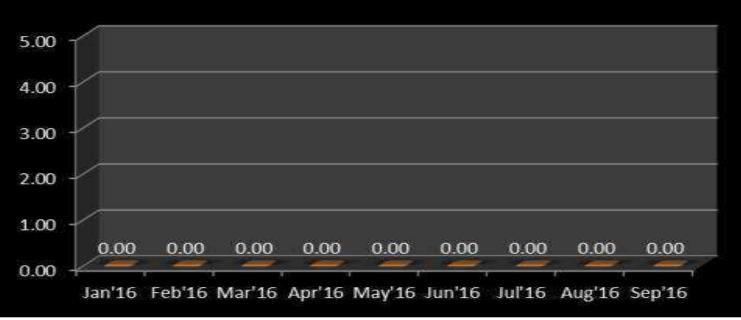


Bench mark

1	Criteria		Target	
2	% of Compliance		Not > 4.2 %	
Jan'16		0.00%	0/168	
Feb'16		0.00%	0/173	
Mar'16	~	0.00%	0/193	
Apr'16		0.00%	0/216	
May'16		0.00%	0/204	
Jun'16		0.00%	0/187	
Jul'16		0.00%	0/153	
Aug'16		0.00%	0/175	
Sep'16		0.00%	0/180	

No of surgical site infections in a given month X 100 No of surgeries performed in that month

Surgical Site Infection



Observation – No incidences of SSI was observed during Jan'16 to Sep'16. CAPA:-



URINARY TRACT INFECTION

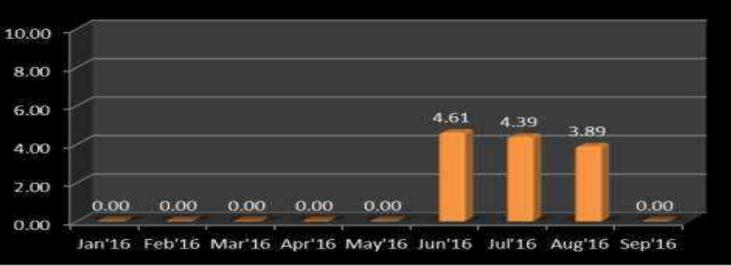


Bench mark

1	Criteria	Target
2 % c	f Compliance	Not > 6.5%
Jan'16 0.00%		0/269
Feb'16	0.00%	0/320
Mar'16	0.00%	0/229
Apr'16	0.00%	0/272
May'16	0.00%	0/281
Jun'16	4.61%	1/217
Jul'16	4.39%	1/228
Aug'16	3.89%	1/257
Sep'16	0.00%	0/239

No of urinary catheter associated UTIs in a month X 1000 No of urinary catheter days in that month

Catheter Associated Urinary Tract Infection Rate



RCA – Reasons for incidences of CAUTI might have been–

- 1. Proper catheter care might not given in each shift
- 2.Prolonged catheterization

CAPA - changing of Antibiotics & foleys catheter done as corrective actions and training of staff regarding Catheter care is being imparted regularly.



BLOOD STREAM INFECTION

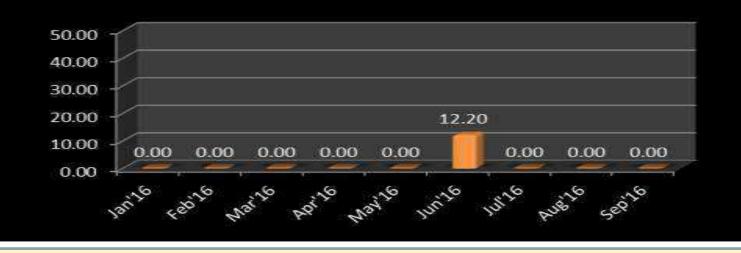


Bench mark

1	Criteria	Target	
2 %	of Compliance	Not > 6.1%	
Jan'16 0.00% 0/159			
Feb'16	0.00%	0/107	
Mar'16	0.00%	0/94	
Apr'16	0.00%	0/94	
May'16	0.00%	0/39	
Jun'16	12.2%	1/82	
Jul'16	0.00%	0/121	
Aug'16	0.00%	0/129	
Sep'16	0.00%	0/86	

No of central line associated blood stream infections in a month X 1000 No of central line days in that month

Central Line Associted Bloodstream infection rate



- RCA most possible causes of the same found to be as -
- 1. Underlying heart & lung disease ARDS, Septic Shock & AKI.
- 2. Proper sterile techniques were not followed and emergency insertion was done
- 3. Prolong catheterization
- **CAPA** antibiotic changed according to the sensitivity pattern and training of staff on preventive bundle





VENTILATOR ASSOCIATED PNEUMONIA (VAP)/ HOSPITAL

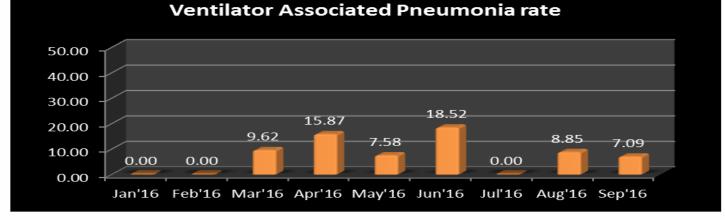
Bench mark

1	Criteria	Target
2	% of Compliance	Not > 19.5%

Jan'16	0.00	0/108
Feb'16	0.00	0/152
Mar'16	9.62	1/104
Apr'16	15.87	2/126
May'16	7.58	1/132
Jun'16	18.52	2/108
Jul'16	0.00	0/128
Aug'16	8.85	1/113
Sep'16	7.09	1/141

No of Ventilator Associated pneumonias in a month X <u>1000</u>

No of ventilator days in that month



RCA – Most possible causes of VAP were found as -

- 1. underlying debilitating disease / neurologic disease or trauma
- 2. Asepsis not followed during insertion.
- 3. Prolonged duration of ET/tracheal tube.

CAPA - Antibiotic was changed according to the sensitivity pattern





Interpretation: They are responsible for completing blood request forms, administering blood, monitoring transfusions and being vigilant for the signs and symptoms of adverse reactions. These guidelines are intended to enhance the implementation of standard clinical transfusion practices for improved patient safety.

Means of verification:

1. Number of Transfusion Reactions in last 6 months





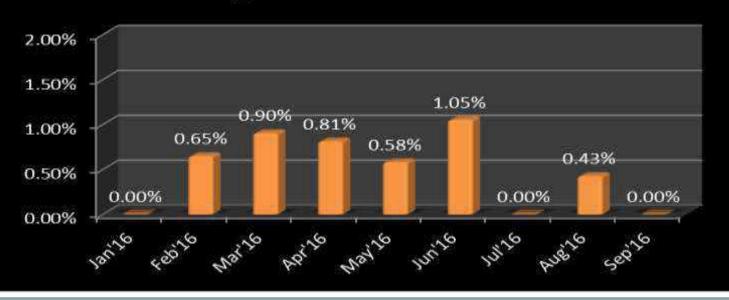
REPORTING OF TRANSFUSION REACTION

1	Criteria		Target
2	% of Compliance		Not > 2.0%
Jan'16		0.00%	0/208
Feb'16		0.65%	1/154
Mar'16	~	0.90%	2/221
Apr'16		0.81%	1/123
May'16		0.58%	1/172
Jun'16		1.05%	2/190
Jul'16		0.00%	0/222
Aug'16		0.43%	1/234
Sep'16		0.00%	0/234

Bench mark

No of transfusion reactions X 100 Total no of transfusions

Percentage of transfusion reactions



RCA – In most of the cases, minor reactions were observed as Itching, redness & in a few of cases severing has also been observed which might have occurred cause of inadequate temperature of blood unit and irregularity to antigen & antibodies of human body. **CAPA** - Continuous supervision & adequate monitoring of patients & regular training of staff regarding transfusion reactions are being done.



HO 5 - BED OCCUPANCY



Interpretation: A good hospital management includes an effective allocative planning for beds in a hospital. Bed-occupancy rates and length of stay are the measures that reflect the functional ability of a hospital.

Means of verification:

1. Bed Occupancy = Inpatient days of care/ Total number of beds available *100

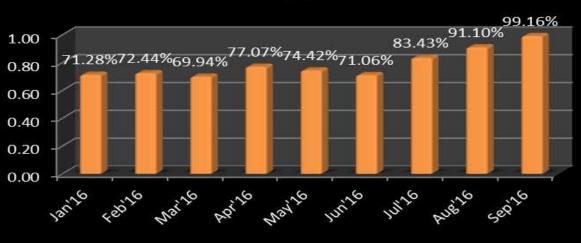


BED OCCUPANCY

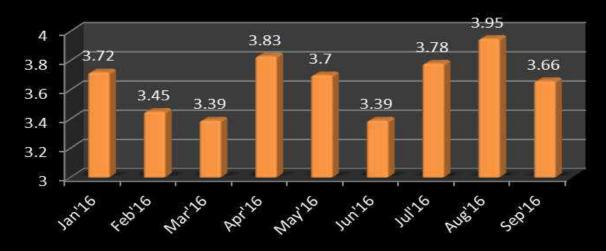


	BOR	ALOS
Jan'16	71.28%	3.72
Feb'16	72.44%	3.45
Mar'16	69.94%	3.39
Apr'16	77.07%	3.83
May'16	74.42%	3.7
Jun'16	71.06%	3.39
Jul'16	83.43%	3.78
Aug'16	91.10%	3.95
Sep'16	99.16%	3.66

BOR



ALOS





HO 6 - PERCENTAGE OF PATIENT SATISFACTION



Interpretation: Patient satisfaction is an important and commonly used indicator for measuring the quality in health care. A measure of care quality, patient satisfaction gives providers insights into various aspects of medicine, including the effectiveness of their care and their level of empathy.

Means of verification:

1. Copy of the filled feedback form clearly showing the questions asked (at least 5 samples)

2. Patient Satisfaction = Number of patients responding extremely satisfied/ Total number of patients surveyed *100





COPY OF THE FILLED FEEDBACK FORM CLEARLY SHOWING THE QUESTIONS ASKED

[Your Clinic Name Here]

Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Your Age:	Your Race/Ethnicity:	Asian
Your Sex: Male		Pacific Islander
Native		Black/African American
		American Indian/Alaska
Hispanic or Latino)		White (Not
Female		Hispanic or Latino (All

Please circle how well you think we are doing in the following areas:	GREAT	4 4	э	FAIR 2	POOR 1
Ease of getting care:		h			
Ability to get in to be seen	5	4	3	2	1
Hours Center is open	5	4	з	2	1
Convenience of Center's location	5	4	з	2	1
Prompt return on calls	5	4	3	2	1
Waiting:				1	
Time in waiting room	5	4	3	2	1

Patient Satisfaction Survey

Dear Palvert .-

beathrouse. We are interested in knewing what you think about our services. You performance by completing the bird (Sinsha) a svey regarding you visit.

Thank you for taking time to share your experience with us.

Cate of your Pascedure _____

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PATIENT SATISFACTION





Figure 1 Assessing Satisfaction Before & After Fast Track Implementation

The figure below compares patient satisfaction scores before and after implementation of an ED Fast Track program:



SAMPLE EXECUTIVE HEALTHCARE DASHBOARD

- Drill down into a specific questions (e.g., amount of time the care provider spent with you and overall rating of care received)
- Filter the question by date, campus, service type, location or section
 Analyze performance of selected questions side by side, trended over time





Interpretation: Strong employee satisfaction is linked with significant improvements in patient care and satisfaction therefore it becomes crucial to study the percentage of employees who are satisfied and perform to their best of efforts in the hospital.

Means of verification:

1. Copy of the filled feedback form clearly showing the questions asked (at least 5 samples)

2. Employee Satisfaction = Number of employees responding extremely satisfied/ Total number of employees surveyed *100





COPY OF THE FILLED FEEDBACK FORM CLEARLY SHOWING THE QUESTIONS ASKED

Satisfaction Survey Template

Employee Satisfaction Survey

This is a survey for the employees of [Write Name of Company Here]. This survey is intended to give the management of the company guidance to improve the workplace environment. This survey is to be answered anonymously.

Ratings:

Please give your assessment of the Company on the following matters by circling one the numbers from one to ten where one is for awful and then for being great.

Compensation to Employees	1	2	3	4	5	6	1	8	9	10
Opportunity for Advancement	1	2	3	1	5	6	7	в	9	10
Benefits	1	2	3	4	5	6	1	8	9	10
Friendly Environment Work	1	2	3	4	5	6	7	8	9	10
Training	1	2	3	4	5	6	7	8	9	10
Performance Evaluation	1	2	3	4	5	6	7	8	9	10
Supervision	1	2	3	4	5	6	7	8	9	10
Culture	1	2	3	4	5	6	7	8	9	10
Job Security	1	2	з	4	5	6	7	8	9	10
Flexibility in Job Performance	1	.2	3	4	5	6	7	8	9	10
Overall Satisfaction with Job	1	25	3	4	5		Z	8	9	10

Employee Morale:

Describe general employee morale:

Any recommendations to improve employee morale:

Guidance:

Are you given proper guidance to perform your job?

Employee Satisfaction Survey Sample¹ [2.1.2.b.1] NOTE: Personalize the list of programs, job positions, shift, or departments to be surveyed and

checked by respondent.

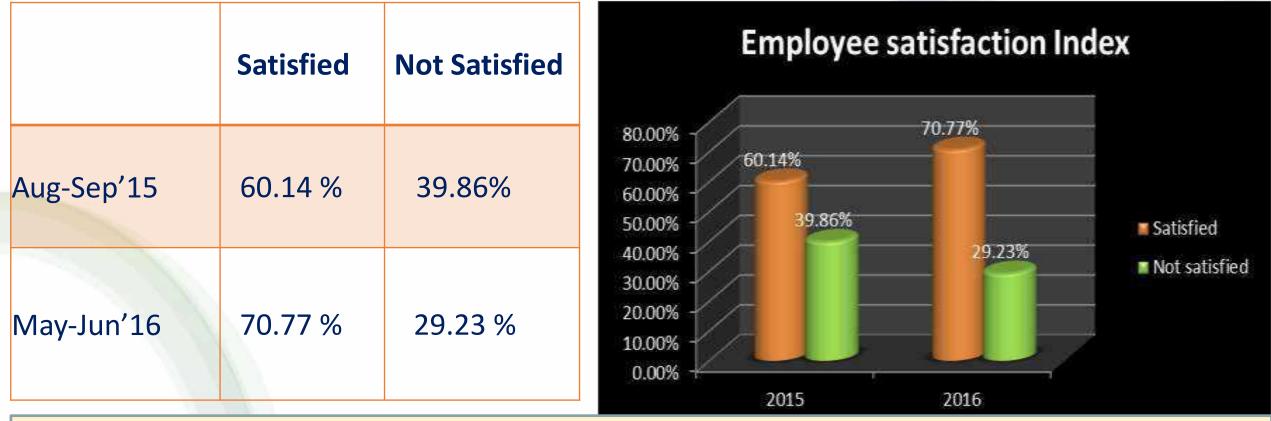
Division	© X Program	Administration	D Prevention staff	Destra:	
Program	U Y Program	Management	D Treatment staff	FOR OFFICE USE	
Position	D Z Program	Professional	Mental health staff	Respondent number:	

Evaluation Component Please circle your level of agreement with the following:	Strongly	Disagree	Agree nor Disagree	Agree	Strongh
I believe management encourages and recognizes new ideas.	1	2	3	4	5
I am committed to staying at the organization for the next 12 months.	1	2	3	4	5
I am satisfied with the opportunities for growth within the organization.	1	2	3	4	8
I am satisfied with the product or service I provide.	1	2	3	4	5
I am satisfied with the products or services the organization provides.	1	2	3	4	5
I believe clients/consumers are treated with respect by staff.	1	2	3	a	5
Members of my team pull logether to complete a task.	1	2	3	4	5
My team will utilize constructive suggestions or criticism.	1	2	3	4	5
Management's expectations are consistent with the level of resources given.	1	2	3	4	5
I am satisfied with how the organization addresses external issues impacting our services and products.	1	2	3	4	5
I am satisfied with how the organization addresses internal issues impacting our services and products.	1	2	а	4	5
The organizational lines of communication flow easily.	1	2	3	4	5
If I share my work problems with my direct supervisor he/she would respond appropriately.	1	2	3	4	5
am satisfied with the level and amount of supervision I receive.		2	3	4	5
I am satisfied with how my supervisor has worked with me to identify strengths and development areas.	1	2	3	4	5
My supervisor provides me resources to improve my work:	1	2	3	4	5
My supervisor encourages high achievement by reducing the fear of failure.	1	2	з	4	5
receive fair and honest performance evaluations.	1	2	3	4	5
I believe that I receive the recognition I deserve for my contribution.	1	2	3	4	5
I am satisfied with the amount of training I receive to do my ob.	1	2	3	4	5
My work environment is comfortable and adequate to the needs of the program/department.	1	2	3	4	5
My team utilizes appropriate problem solving skills.	1	2	3	4	5
am given the tools I need to provide the services or products assigned to me.	1	2	3	4	5
The salary is competitive to similar organizations providing similar services.	1	2	э	1	5
The benefite are competitive to similar organizations providing similar services.	1	2	3	4	5



EMPLOYEE SATISFACTION





Observation – Satisfaction level of employee was found to be higher than previous survey.

PA –Suggestions made in the survey have been considered by the management as the same is in process.





HO 8 - WAITING TIME - OUT PATIENT DEPARTMENT (OPD) AND DISCHARGE

Interpretation: Delay in discharge of the patient increases the pressure on beds of the hospital and delay in discharge is bad for both hospitals and the patients. Thus it becomes important to calculate the waiting time in the hospital in order to decrease the waiting time and increase patient safety by providing prompt services. **Means of verification:**

- 1. Out-Patient Department Waiting Time = Sum of time from when the patient entered the outpatient clinic to the time the patient actually leaves the OPD/ Total Number of Out-Patients
- 2. Discharge Waiting Time = (Total time taken for medical record to reach the billing department from the ward + Total time taken in the billing department)/Total Number of Inpatients





OUT-PATIENT DEPARTMENT WAITING TIME

	Dept:	Dept: Ortho	Dept: Int.	Dept:	Dept. Resp.
	Cardiology		Medicine	Cardiology	Medicine
	(Dr A)			(Dr B)	
Benchmark	(20 mins)	(20 mins)	(20 mins)	(20 mins)	(20 mins)
Jan'16	21.01	9.62	18.85	-	-
Feb'16	19.53	9.45	16.14	16.92	-
Mar'16	17.50	9.53	16.12	14.07	-
Apr'16	15.59	10.78	17.14	15.19	12.35
May'16	18.27	15.35	18.02	23.38	11.76
Jun'16	15.56	15.38	17.26	14.04	12.72
Jul'16	16.81	11.27	34.61	14.12	13.73
Aug'16	17.00	10.00	32.23	15.02	16.56
Sep'16	17.23	8.98	38.56	16.20	17.45

Observation – Average waiting time for Medicine Speciality was found to be in higher side due to increased number of patient during last 3 months however waiting time for other speciality was found to be within satisfactory range.

Jan'16	18.79
Feb'16	17.4
Mar'16	19.57
Apr'16	17
May'16	19.30
Jun'16	18.28
Jul'16	19.24
Aug'16	18.00
Sep'16	18.28

Observation – Average waiting time for ultrasound was found within the limit.

•Some case are excluded from the data which have taken more time to maintain the pressure for the requisite procedure however they were already informed for the preparation.

PA - counselling of patient for the same is being reinforced along with written preparation guidelines in the dept.



DISCHARGE WAITING TIME



	Cash (3 - 4 hrs.)	TPAs (5 – 6 hrs.)	Others (4 - 5 hrs.)
Jan'16	4	5.76	4.21
Feb'16	3.14	5.24	4.05
Mar'16	4.11	6.35	4.52
Apr'16	2.37	6	4.23
May'16	3.37	6.18	4.03
Jun'16	3.51	6.29	3.52
Jul'16	4.06	6.4	4.35
Aug'16	3.31	6.5	4.06
Sep'16	3.56	5.57	4.15

Discharge Time (in Hrs)



Observation –
Time for discharges were found to be little high in cash patients fron
the period of Jan '16 to Sep'16; most possible reasons for the same
were :
1.Time taken in billing activity.
2.Bill after being ready is sent to respective departments i.e. lab,
imaging and pharmacy to verify the same.
3.Refund of medicine from pharmacy takes time

CAPA-

Concept for planned discharges is followed strictly, summary of the potential discharges is prepared by the Duty doctor in night and typed by the night MT /early morning so that the same can be available to the consultant during morning rounds.,
 Reduction of discharge TAT due to introduction of Apex (HIS) as entry of all investigations are made directly when the requisition is raised, which ensures early billing and reduced billing errors; leading to early preparation of accurate bill.
 Refund of medicines in during night hrs.





HO 9 - REPORTING OF ADVERSE EVENTS

Interpretation: Adverse events are usually defined as an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death caused by healthcare management rather than by the patient's underlying disease. A substantial part of these events are avoidable and it is important to report them in order to prevent such events in future.

Means of verification:

1. Data for last 6 months

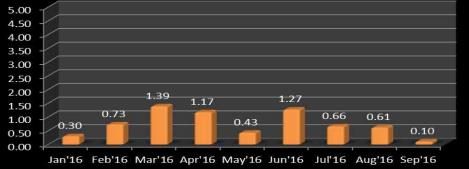




REPORTING OF ADVERSE EVENTS

	Bench ma	rk	No. of adverse drug reactions X 100
1	Criteria	Target	No. of discharges and deaths
2	% of Compliance	Not > 2.0%	 RCA – on analysing it was found that most of the medications errors were due to : 1.In most of the cases Rights of medication were not followed :
Jan'16	0.30	2/670	a.wrong time
Feb'16	0.73	5/688	b.wrong dose c.wrong route
Mar'16	1.39	10/721	d.wrong documentation
Apr'16	1.17	8/682	1.delayed documentation
May'16	0.43	3/704	2.early documentation 3.missed documentation i.e. medicine given but not documented
Jun'16	1.27	9/709	4.Patient refused but not documented.
Jul'16	0.66	5/759	2.Wrong transcribing due to lack of cross checking.
Aug'16	0.61	5/814	3.4. In a few cases – prescription error by doctor.
Sep'16	0.10	1/974	4.Non – availability of drugs in pharmacy lead to delayed administration.
	Adverse drug re	actions	CAPA –

Adverse drug reactions



1. Staff was counselled to follow the rights of drug administration and cross check the doctor's orders while transcribing and administration of drugs.

2.Staff was instructed to follow the right procedure of drug administration and to document after administration.

3. The pharmacy was told to ensure the availability of the drugs at right time.

4. Checking & updating of drugs as required.

5. Training regarding "Management of Medication" in order to prevent such medication errors are reinforced as preventive

action.





HO 10 - REPORTING OF THEFTS / SECURITY RELATED INCIDENTS

Interpretation: Thefts of medical equipment or medical records is a major concern in hospitals. Health records are being digitized and hence there is the danger of health information becoming compromised or stolen outright. It is important to decrease the number of such incidents by enhancing security in the facility.

Means of verification:

1. Data for last 6 months



REPORTING OF THEFTS / SECURITY RELATED INCIDENTS



OYes ONo

OYes ONo

SECURITY INCIDENT REPORT

Tim	e of Incident:
	·
DTheft	DDamage
	20 CW-0.438
	UTheft

CAMPUS SECURITY INCIDENT REPORTING PROTOCOL

Objective

The Campus Security Incident Report Form should be used to record details of serious incidents that occur on the UL campus. Examples of serious incidents include activities that result in significant damage to property, physical assault, theft, riotous behaviour or any incident that causes serious distressibilisruption to others.

A formal mechanism for reporting of incidents is currently used by campus security staff. However, security staff might not have been requested to attend, or alerted to, all serious incidents that occur on campus. The attached form is intended to address this and it provides a standard procedure for the recording of serious incidents. This process is to be adopted by stafflma ragers of campus facilities in order to ensure that the University is officially advised, in a timely manner, of all serious incidents that occur on campus.

Submission

Staff/managers are required to complete this form within 24 hours of the occurrence of a serious incident. Hard copies of this form to be submitted as soon as possible to UL Security (Vistors Car Park) where it will be logged and circulated to the relevant personnel for information and/or action.

Electronic copies of this form should be to be sent to: UniversitySecurity@UL.ie

In addition to the above all incidents resulting in accidents involving injury to people or dangerous occurrences (i.e. near -misses) should also be reported to the UL Health and Safety Department.

Bias Relat	ed Event	
Definition	Bias Related Events can be reported online. A bias related event is "A criminal offense committee property which is hate/bias based on race, national or ethnic origin, language, color, religion, sex, disability, sexual orientation or any other similar factor. Bias Related Event-RCW: To see Washing click: <u>here</u>	age, mental or physica
Examples	A swastika symbol spray painted on your front door.	
Confirm Q	uestion(s)	HIAN
Are you fan	niliar with: Bias Related Event-RCW.	OYes ONo
s this situa	tion still in progress?	OYes ONo
Did the dan	nage or mischief involve the use of a gun (including BB gun, pellet gun, paintball gun, etc.)?	OYes ONo
understan	d that filing a false police report is a criminal offense.	OYes ONo

Identity Theft

Discord Descel Fromt

Identity Theft

- Definition Obtaining someone else's personal identifying information and using it to obtain credit, goods or services.
- Examples Someone obtains a credit card using your S.S.N. or obtains phone service using your personal information.

Confirm Question(s)

Reports may only be filed where there are no known suspects or security video. Are there any suspects or any security video?

Reports may not be filed by a third party. Falsely reporting an incident or pretending to be someone else in order to file a report can be investigated and charged as a criminal offense. Are you filing this report for yourself?

Start Report





HO 11 - REPORTING OF NEEDLE STICK INJURIES

Interpretation: Needle stick injury is defined as a penetrating wound typically induced by a needle point or other sharp instrument or object which could be infected with another person's secretion. These injuries can lead to transmission of blood-borne viral infections. A continuous follow-up and reporting of needle stick injuries in surgeons is important to prevent future events of needle stick injuries for higher patient safety.

Means of verification:

1. 6 months at least or annual



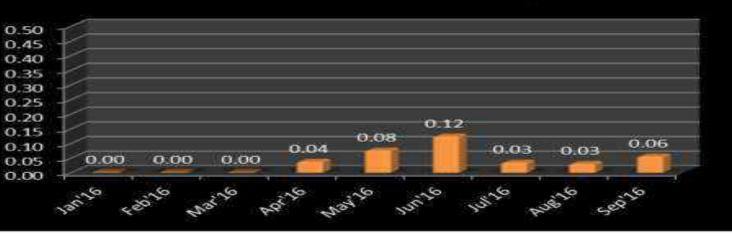


REPORTING OF NEEDLE STICK INJURIES

Cr	it and a	
	riteria	Target
2 % of Compliance		Not > 2.0%
	0.00	0/2497
	0.00	0/2374
	0.00	0/2450
	0.04	1/2613
	0.08	2/2607
1	0.12	3/2409
	0.03	1/2871
	0.03	1/3223
	0.06	2/3570
		% of Compliance 0.00 0.00 0.00 0.00 0.00 0.00 0.012 0.03

No. of parenteral exposures x 100 No. of in-patient days

Incidence of needle stick injuries



RCA – Reasons for the same were found as –

1. Recapping of needles.

2. Improper handling of sharps material

3. Accidental prick after sample collection.

CAPA – Measures taken as per NSI protocol

Education & regular training regarding NSI protocol and prevention of NSI.

Training on Bio Medical Waste Management.







AB PM-JAY QUALITY CERTIFICATION

S. No.	Name of The Hospital	Type of Certificate (AB PM-JAY Gold/Silver/Bronze)	Name of State	S. No.	Name of The Hospital	Type of Certificate (AB PM-JAY Gold/Silver/Bronze)	Name of State
1	U. N. Mehta Institute of Cardiology & Research Centre	AB PM-JAY Gold Quality Certificate	Gujarat	14	Shri Balaji Aarogyam Hospital	AB PM-JAY Gold Quality Certificate	Haryana
				15	Sterling Hospital, Vadodara	AB PM-JAY Gold Quality Certificate	Gujarat
2	Cygnus Super specialty Hospital	AB PM-JAY Gold Quality Certificate	Haryana	16	Sal Hospital, Ahmedabad	AB PM-JAY Gold Quality Certificate	Gujarat
3	Government Spine Institute	AB PM-JAY Gold Quality Certificate	Gujarat	10		Ab FINISAT Gold Quality certificate	Gujarat
4	Sanjiv Bansal Cygnus Hospital	AB PM-JAY Gold Quality Certificate	Haryana	17	MGM Hospital & Research Centre	AB PM-JAY Silver Quality Certificate	Madhya Pradesh
5	Kashyap memorial Eye Hospital	AB PM-JAY Gold Quality Certificate	Jharkhand	an Aroga 18 84	SKR Hospitals & Trauma Centre Pvt. Ltd.	AB PM-JAY Silver Quality Certificate	Punjab
6	VK Neurocare and Trauma Research Hospital	AB PM-JAY Gold Quality Certificate	Haryana		GCS Medical College Hospital, Ahmedabad	AB PM-JAY Silver Quality Certificate	Gujarat
7	Apollo Hospitals International Ltd	AB PM-JAY Gold Quality Certificate		20 JAY	Geetanjali Hospital, Hisar	AB PM-JAY Silver Quality Certificate	Haryana
8	Felix Hospital	AB PM-JAY Gold Quality Certificate	Uttar Pradesh	21	Jaspal Nursing Home	AB PM-JAY Silver Quality Certificate	Haryana
9	Cygnus Super Specialty Hospital, Kurukshetra	AB PM-JAY Gold Quality Certificate	Haryana	22	Advanta Super Specialty Hospital	AB PRI-JAY Silver Quality Certificate	Haryana
10	Sidharth Hospital	AB PM-JAY Gold Quality Certificate	Haryana	23	Thakur Eye and Maternity Hospital	AB PM-JAY Silver Quality Certificate	Haryana
11	Leelawati Hospital	AB PM-JAY Gold Quality Certificate	Haryana	24	Sterling Cancer Hospital, Vadodara	AB PM-JAY Silver Quality Certificate	Gujarat
12	Saraswati Nethralaya	AB PM-JAY Gold Quality Certificate	Haryana	25	Ambujanagar Multispecialty Hospital	AB PINI-JAY Silver Quality Cert/ficate	Gujarat
13	Neelam Hospital	AB PM-JAY Gold Quality Certificate	Punjab	26	Balaji Hospital, Karnal	AB PM-JAY Silver Quality Certificate	Haryana

Total Application:- 61 Total Certified:- 0

Total Application:- 52 Total Certified:- 16 Total Application:- 62 Total Certified:- 10





LINKS FOR ACHIEVE AB PM-JAY BRONZE / SILVER / GOLD QUALITY CERTIFICATE:-

- 1. <u>http://www.pmjay.qcin.org/tools</u>
- 2. <u>http://www.pmjay.qcin.org/assets/img/nha-img/docs/Bronze%20Quality%20Certificate%20Standards.pdf</u>
- 3. <u>http://www.pmjay.qcin.org/assets/img/nha-</u> <u>img/docs/Guideline%20for%20How%20to%20Achieve%20Bronze%20Quality%20Certificate.pdf</u>

4. <u>http://www.pmjay.qcin.org/assets/img/nha-img/docs/Guideline%20for%20Self-Assessment%20Quality%20-</u> %20Checklist_V2.pdf

- 5. <u>http://www.pmjay.qcin.org/assets/img/nha-img/docs/Silver%20Quality%20Certificate.pdf</u>
- 6. <u>http://www.pmjay.qcin.org/assets/img/nha-img/docs/Tech%20FAQs%20for%20bronze%20certificate.pdf</u>

7. <u>http://www.pmjay.qcin.org/assets/img/nha-</u> <u>img/docs/Tech%20FAQs%20for%20already%20certified%20Hospitals.pdf</u>





THANKS

"Want your support for Improvement"