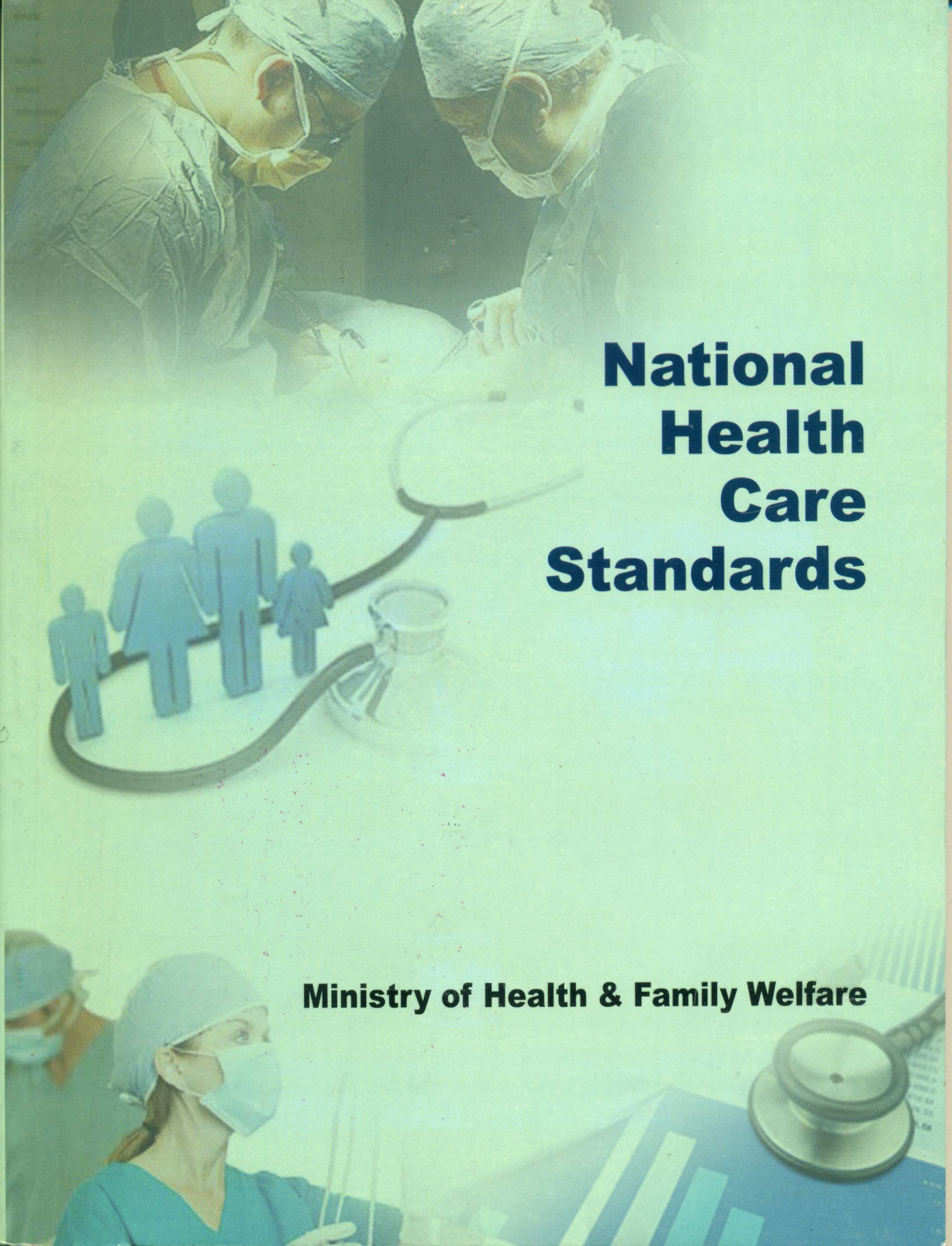

National Health Care Standards

Ministry of Health & Family Welfare

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Message

Universal access to quality health care is the overall goal of our health system, National Health Care Standards is an important tool for improving, measuring and sustaining the quality of care in health services. It sets out how best to achieve the quality which is usually defined as 'getting the best possible results with the available resources'.

Several and continuous initiatives are being implemented for improvement of quality of care in Bangladesh health services, However, the National Health Care Standards is designed to provide a common set of requirements across all health care organizations to ensure that health services are safe and of acceptable quality. It will also provide a framework for continuous quality improvement.

This document has included standards agreed through extensive consultations among the key stakeholders — practitioners, managers and health system experts, and covered five main areas:

- Standards for management.
- Standards for service delivery,
- Standard for support services including laboratory. radiology and pharmacy services,
- Standard for infection control and waste management, and
- Standard for safety.

It has also specified the all those standards for primary and secondary care settings. The standards are set in a way that is achievable with increased efforts and measureable against set criteria.

I hope that this document will lay the foundation of coordinated actions of developing protocols, guidelines and other quality instruments and help developing a quality culture in the health system, both public and private sector.

Syed Monjurul Islam
Secretary
Ministry of Health & Family Welfare

Message

The post MDG agenda, Universal health coverage is a broad concept that has been implemented in several ways. The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards.

Good service delivery is a vital element of any health system. Service delivery is a fundamental input to population health status along with other factors, including social determinants of health.

Strengthening service delivery is crucial to the achievement of the health-related development. Goals, which include the delivery of interventions to reduce child mortality, maternal mortality the burden of HIV/AIDS, tuberculosis and malaria and NCDs.

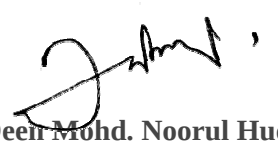
Service provision or delivery is an immediate output of the inputs into the health system, which should be minimum, attainable and measurable in nature and the inputs should lead to improved service delivery and enhanced access to services.

Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system

Health services will be well managed so as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results. The health care standards for service delivery will have the key characteristics like: Comprehensiveness, Accessibility, Appropriate Coverage, Continuity, Quality, Person-centeredness, Coordination &Accountability and efficiency:

Directorate General of Health services has responsibility for implementation of quality standards for health service delivery &clinical governance, which will provide an assurance that healthcare organizations are providing high quality healthcare. We also have responsibility for monitoring their compliance.

The service delivery standards is set at a strategic level as a generic approach and will be used to test the arrangements that healthcare organizations have in place to deliver against the Healthcare Quality Strategy quality ambitions.



Prof. Dr. Deen Mohd. Noorul Huq
Director General
Directorate General of Health Services
Ministry of Health & Family Welfare

Acknowledgements

Ministry of Health & Family Welfare has a core responsibility of setting quality standards for health service delivery and monitoring the performance of the system against the standards. It is one of the major areas relating to the stewardship role of the Ministry that everybody feels to be augmented. The growing realization across the sector that along with the horizontal expansion of the facilitates, programmes and services, we need to focus structurally more on the governance, quality and performance has led to different initiatives including the formulation of the National Health Care Standards.

This document tends to provide a comprehensive foundation for all the quality initiatives as it has included standards for facilities, services and clinical functions for primary, secondary and tertiary levels. It has been developed and finalized through extensive consultation and group work of the concerned experts and practitioners keeping the health systems realities into consideration.

I would like to acknowledge the outstanding contributions of the three Group Leaders- Dr Abdur Rahman Khan, Professor Shah Monir Hossain and Professor Md. Abul Faiz – three former Director Generals of Health Services for leading the three Groups formed with a mandate to develop draft standards for Primary, Secondary and Tertiary level health care. I would like to record our sincere gratefulness to the Group Members who came with skills in health systems management, medical teachings and clinical services of different specialties and worked tirelessly to develop the standards. I would also like to extend our thanks and gratitude to all the professionals and practitioners who made important contributions through taking part in the discussions and consultations and by providing inputs to the document.

We gratefully acknowledge the support of the Director General of Health Services and the Secretary, Ministry of Health and Family Welfare to finalize the document. I also owe to my colleagues in the Health Economics Unit for their initiatives and work to finalize the document.

Finally I like to extend my sincere thanks to the WHO Country Office Dhaka for its financial support to undertake the important work.

I hope that the document will be adequately used in planning, management and monitoring of health services specially for developing and implementing the next Sector Programme.

Md Ashadul Islam
Director General
(Additional Secretary)
Health Economics Unit
August 2015

Preamble

The National health care Standards for Health care services have been expressly created as a statement of what is expected, and required, to deliver decent, safe, quality care. Through a national process of certification, it will formally assess each health establishment for compliance against these National health care Standards. Where health establishments meet the standards, a process of continuous improvement will be encouraged to further enhance outcomes for patients. And for those not up to standard, the relevant governance structures and managers will be expected to make rapid improvements in service delivery to achieve compliance, or face progressive punitive measures.

The National health care Standards have been formulated through an extensive and participative consultation process. A diverse range of health care professionals and managers were involved, including the public health experts and clinicians.

The National Core Standards have been based on the existing policy environment and tailored to health care context, while also reflecting international best practice and a strong evidence base. However, the key challenge is to implement improvements at scale on the ground – to bridge the policy implementation gap. This gap is being addressed through a tool for managers, which makes clear what is expected of them both in terms of the systems that need to be in place and the outputs that should be delivered. It is hoped that this will achieve more than just better guidance – the tool is also provided so managers can assess themselves and close the gaps they find. It is believed that service providers will be further incentivised by the knowledge that at some stage they will be assessed and held accountable by an external body.

All of this is relevant not just for frontline health care providers in the establishments, but also for those who supervise and support them and whose job it is to enable them to deliver quality care.

However, the top priority is a process of culture change: achieving more positive values and attitudes among staff and managers is part of a bigger shift – towards a future where a caring and positive attitude to patients and their families, as well as one another, is the norm.

Dr Md Aminul Hasan
Co-ordinator & Focal Person
Development of National Health Care Standard

Standards for Primary Level Care:

Primary care involves the widest scope of health care, including all ages of patients, of all socioeconomic and geographic origins, individuals seeking to maintain optimal health, and patients with all range of acute and chronic physical, mental and social health issues, including multiple chronic diseases seek help . Consequently, a primary care services providers must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem.

Standards are the main driver for continuous improvements in quality. The performance of Primary Health Centres can be assessed against the set standards. In order to provide optimal level of quality health care, a set of standards are being recommended for Primary level care.

Primary level of care started from the ward level health services that are provided through a set of community-based health and family planning staff and the Community Clinics (CCs). CCs were designed to cater to 6000 population, but at present, the number of people each clinic provides services have been increased. A total of 13,500 Community Clinics (CC) have been constructed, out of which 12,248 are functional (Health Bulletin, 2012). CC is a static facility, staffed by one Health Assistant (DGHS) and one Family Welfare Assistant (DGFP), and one Community Health Care Providers (CHCP) from the project. They all provide similar services. When one is preoccupied with domiciliary services, the others staff take responsibility of providing services at the facility, which include health, family planning and nutrition services.

At the union level, DGHS operates 1,362 Union Sub-Centers (USC) and 87 Union Health and Family Welfare Centers (UH&FWC). Besides these, there are 10-bed (5 in number) and 20-bed (18 in number) hospitals at the union level under the DGHS. DGFP runs 3,827 Union Health and Family Welfare Centers (UH&FWC), of which 1,500 have been upgraded to provide primary care (Bangladesh Health Sector Profile, 2010). At the union level, 24 Mother and Child Welfare Centers (MCWC) mainly offer outdoor services, with a few providing Emergency Obstetrical Care (EmOC) services (Health Bulletin, 2012).

At the upazila level, DGHS operates 425 Upazila Health Complexes (UHC), where the number of beds varies (50 bed 248, 31bed 165, 20 bed 1, 10 bed 11). Furthermore, at the upazila level there are 34 hospitals with varying number of beds (10bed 5, 20 bed 18, 20 bed trauma 5, 30 bed 1 and 31 bed 5). The DGFP operates 427 Mother and Child Health (MCH) units in UHCs offering outdoor services. It also runs another 12 MCWCs, some of which also provides EmOC services (Health Bulletin, 2012).

The generic approach is used for developing the primary level standards which will be applicable for Community Clinic to Upazilla health complex. There are mainly three different categories of standards has developed, namely for community clinic, Union health and family welfare centre and Upazilla health complex.

This document will help the ministry of health & family welfare to monitor effectively as to how many of the primary level of cares are conforming to this standards and strive to upgrade the remaining to the desired level.

Dr Md Abdur Rahman Khan
Former DG, DGHS
Group Leader
Primary level Standards Development Working Group

Standards for Secondary Level Care:

Secondary health care is the intermediate level of health care that includes diagnosis and treatment, performed in a hospital having specialized equipment and laboratory facilities. In Bangladesh this level of care is provided by district level hospitals.

Its objective is to provide comprehensive secondary health care services to the people in the district at an acceptable level of quality and being responsive and sensitive to the needs of people. The services provided at secondary level should meet the need of referring patients from primary health care system.

To provide secondary level health care there are 53 District Hospitals with bed capacities ranging from 100 to 250 beds. Besides in nine districts where Medical College Hospital providing tertiary level services also operating a General hospital to provide secondary level services. There are also a number of clinics and hospitals in private sector providing secondary level services. Quality of services provided by the service providing institutions are mostly challenging and there are no standard benchmarks against that to be compared to achieve desirable services. Keeping that in mind this set of standards has developed for the secondary level health care after a series of brainstorming workshop

For developing the standards the main areas like General Management, Service delivery, Support services, Infection control & Safety were addressed.

This standards will provide a framework for continuous improvement in the overall quality of care people receive in the district hospitals.. The framework ensures that the extra resources being directed to the health system are used to help raise the level of performance.

Prof. Dr. Shah Monir Hossain
Former DG, DGHS
Group Leader
Secondary level Standards Development Working Group

Standards for Tertiary Level Care:

Health care standards are a means of describing a level of quality that the health care organizations are expected to meet or desire to. For the first time Government of the People's Republic of Bangladesh aims to develop guidelines for the services from the tertiary level hospitals. This document is a guideline for the medical colleges and specializedhospitals. A team of experts on tertiary level care prepared these service delivery standards. This is an effort to develop a standard guideline for both the government and private hospitals. This set of standards are common requirements applicable for all tertiary level facilities to ensure that health services are safe and of an acceptable quality.

Tertiary facilities provide specialized consultative health care both in the in-patient and outpatient departments usually referred from primary or secondary health facilities or professionals. Tertiary level health facilities possess qualified health professionals with advanced medical investigations and treatment. Support services of the tertiary health facilities should also be up to the mark.

This document prepared in a generic way, view with minimum acceptable standards for such components including building, instruments, equipments, drugs and other facilities. This document was reviewed by different hospital managers, program mangers, service providers from both government and private hospitals. The document is divided into four areas – management, service delivery, support services, infection control, hygiene and waste management, and safe and appropriate environment.

The services include out patient department, indoor and emergency service. Besides the basic specialty services, due importance has been given to Intensive care unit, High dependency unit, Accident and Trauma Services and also on Patient Safety and Infection control norms. Support services of hospital like laboratory services, radiology and imaging, pharmacy services, hospital waste management etc were also given due importance as these are usually not in focus.

Maintaining these minimum set of standards will increase the quality and efficiency of tertiary level hospitals.

Prof Dr M A Faiz
Former DG, DGHS
Group Leader
Tertiary level Standards Development Working Group

Contents

Executive Summary

Standards are a means of describing a level of quality that the health care organizations areexpected to meet or aspire to achieve.The standards has developed with two principal objectives.

First, they provide a common set of requirements applying across all health care organizations to ensure that health services are provided that are both safe and of an acceptable quality.

Second, they provide a framework for continuous improvement in the overall quality of care people receive. The framework ensures that the extra resources being directed to the health system are used to help raise the level of performance measurably year-on-year.

Initially Health Economics Unit developed a zero draft of National Health Care Standrads for achieving the Universal Health Coverage, is the next global agenda of WHO.Three working teams were formed with the aim to develop the standards for three different levels under the leadership of three former Director Generals of Health Service. The three working teams conducted multiple meetings with the members for finalization of draft. The final draft was validated by a national workshop with the presence of secretary, MOHFW and DG, DGHS .

National Health Care Standards has developed for three level of care services, Primary level care (Community Clinic UH & FWC/USC & UHC), Secondary level (District Hospitals) of care & the tertiary level (Medical College & Specialized Hospitals) of care with the aim to achieve the Quality of care.

The generic approach is used for developing the standards of level of services, Primary, 2ndary & tertiary level standards .

Primary Care: PHC is “Essential health care based onpractical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self determination”.

Secondary care: Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists etc .

It includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.

Tertiary care: Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.

The standards has developed for ensuring the Quality of Care in health service delivery, which contains five common parts for different level of care.

The first part conatin Mission, strategic Planning General Management, Risk and Quality Management, Financial Management, Human Resource Management, Client/Patients Right, Information for Client/Patient, Patient feedback on Services Privacy & Dignity .

Second part conatains Standards for Service Delivery on Care Continuum, Access to Health Service, Continuity of Care, Assessment on Care planning , Monitoring & Evaluation, Treatment Documentation of care, Discharge, Transfer and Referral, management of Operation theatere, management of casulty department, management of intensive care.

Third part contain the support services which overs the laboratory services, Radiology and imaging services and pharmacy services

Fourth part contains infection control, hygine anf waste management.

Part five contains Safe and apprropiate environment.

Appraisal will therefore be carried out of to assess the performance of health care facilities against the set standards, which will benchmark them against a set of criteria to determine whether performance is good, adequate or poor. Areas of basic patient safety and dignity, and essential management activities, will be weighted in determining poor performance, as these will have the greatest impact on outcomes.

The proposed National core standards will reflect the following areas

- Improve life expectancy
- Improve mother and child health and survival
- Improve health system effectiveness
- Improve Quality of care

Introduction

Health care is the diagnosis, treatment, prevention of disease, illness, injury, and other physical and mental impairments in human beings. Health care is delivered by practitioners in Physicians and other care providers. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

Primary care refers to the work of health care professionals/ hospital who act as a first point of consultation for all patients within the health care system. Such a professional would usually be a primary care physician.

Primary care is often used as the term for the health care services which play a role in the local community. It can be provided in different settings, such as emergency care centres which provide services to patients same day with appointment or walk-in bases.

Primary care involves the widest scope of health care, including all ages of patients, of all socioeconomic and geographic origins, individuals seeking to maintain optimal health, and patients with all range of acute and chronic physical, mental and social health issues, including multiple chronic diseases seek help. Consequently, a primary care services providers must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same doctors for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem.

Common chronic illnesses usually treated in primary care may include, for example: hypertension, diabetes,Cough,asthma, COPD, depression and anxiety, back pain, arthritis or thyroid dysfunction as well as abdominal and genito urnary problems. Primary care also includes many basic maternal and child health care services, such as family planning services and vaccinations.

In context of global population aging, with increasing numbers of older adults at greater risk of chronic non-communicable diseases, rapidly increasing demand for primary care services is expected around the world, in both developed and developing countries. The World Health Organization attributes the provision of essential primary care as an integral component of an inclusive primary health care strategy.

Primary Health Care Reform (WHO) : WHO adopted PHC reforms in four groups that reflect the convergence betweenthe evidence on what is needed for an effective response to the health challenges of today's world,the values of equity, solidarity and social justice that drive the PHC movement, and the growing expectations of the population in modernizing societies reforms that ensure :

That health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection -----**Universal coverage reforms.**

Reforms that reorganize health services as primary care, i.e. around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes. The health care services provided by medical specialists and other health professionals . **Service delivery reforms.**

Reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policiesacross sectors – **Public policy reforms.**

Reforms that replace disproportionate reliance on command and control on one hand,and laissez-faire disengagement of the state on the other, by the inclusive, participatory,negotiation-based leadership required by the complexity of contemporary health system--- **Leadership Reform.**

Secondary care: Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists etc .

It includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.

Tertiary care: Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.

Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

Allied health professionals, such as physical therapists, respiratory therapists, occupational therapists, speech therapists, and dietitians, also generally work in tertiary care, accessed through either patient self-referral or through physician referral.

National Health Care Standards: Bangladesh has been implementing sector wide approach (SWAp) in the health sector since 1998. The MOHFW has developed new next sector programme (HPNSDP) from July 2011 onwards, without any interruption between current and next sector programme. The goal of HPNSDP is to ensure Quality & Equitable health care for all citizens by improving access & utilization of health.

To ensure Quality & Equitable health care for all citizens with the aim to achieve the Universal Health Coverage, development of national health care standards is one of the important objective, which has developed and will be implemented under the directives of Quality of Care strategy.

Concerns with the quality and delivery of health services have been expressed in the media and other public forums with considerable frequency. Challenges that have been identified through the public & private survey, surveillance and monitoring systems, and from reports from others organization managers and staff as well as patients include:

- Lack of accountability & ownership of hospital service provider
- Lack of compliance with accepted guidelines or clinical practice
- instances of failures in technology
- Long queues and waiting times especially in Pharmacies and Outpatient Departments
- inadequate supervision of hospital staff
- Lengthy turnaround times for laboratory tests.
- Sub-optimal management systems and processes in many institutions

To address this situation, a National Strategic Planning of Quality of Care for health service delivery has already been developed. The implementation plan of the Quality of Care strategy will be coordinated by Quality Improvement Secretariate (QIS) under the Ministry of Health and Family Welfare. Quality Improvement Secretariate (QIS) will have the overall responsibility to implement QI plan of the strategic document with the close cooperation of line director of Hospital Service Management & Essential Service Delivery.

In Bangladesh while informal standards exist in some areas, in many other areas expected practice is expressed in broad policies and guidelines. The system is a complex one and often subjective.

Roles and accountabilities for establishing levels of performance against standards are also not well-defined. This is true both within departments, between different spheres of government, and between government and external bodies.

Under such circumstances, the availability of comparable and credible information on the achievement of a single set of national core standards becomes imperative; and is indeed would be linked in the National Health policy

Appraisal will therefore be carried out of to assess the performance of health care facilities against the set standards, which will benchmark them against a set of criteria to determine whether performance is good, adequate or poor. Areas of basic patient safety and dignity, and essential management activities, will be weighted in determining poor performance, as these will have the greatest impact on outcomes.

Rationale for dveloping National Health Care standard: It is a common set of requirements applying across all health care organizations to ensure that health services are provided that are both safe and of an acceptable quality, which provide a framework for continuous improvement in the overall quality of care. The framework ensures that the extra resources being directed to the health system are used to help raise the level of performance measurably year-on-year.

This aim can only be achieved if these benefits are delivered to all groups within our society. The standards must therefore be interpreted and implemented in ways which:

- Challenge discrimination
- Promote equality of access and quality of services
- Support the provision of services appropriate to individual needs, preferences and choices

Purpose : The main purpose of the National Core Standards is to:

Develop a common definition of quality care which should be found in all health service delivery level wise (Primary Secondary & Tertiary) in Bangladesh as a guide to the service providers in all levels;

Establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised;
Provide for the national certification of compliance of health establishments with mandatory standards.
Goal : To develop core national standards, and the tools for their assessment in health establishments.

Objectives :

- Embed and promote rights for people accessing services
- Assure the community that organisations are providing services that meet client's needs
- Develop a common and systemic approach to quality review processes
- Build greater transparency in quality requirements between the department, service provides clients and the community
- Enable service providers to select an independent review body from an approved panel that meets their requirements and expectations
- Foster a culture of continuous quality improvement that is embedded in everyday practice and supports the meaningful participation of people in giving feedback about the services they require and the quality of services they receive
- Reduce red tape to help ensure service providers have more time and resources to provide services by reducing the number of standards indicators and quality reviews.

Chapter-One

Standard for Commuinity Clinic care/services

Part 1 : Management Standards

- 1.1 Requirements for service management
- 1.2 Requirements for service provision

Part 2 : Service Delivery Standards

- 2.1 Care Continuum
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  - 2.1.3 Assessment.
  - 2.1.4 Care giving
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  - 2.2.2 Policies, Procedures and Records
  - 2.2.3 Facilities and Equipment

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- 3.1 Laboratory Service
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  - 3.1.2 Sample & Tests
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- 3.2 Pharmacy Services
  - 3.2.1 Management
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  - 3.2.3 Dispensing of Medicines

Part 4 : Infection Control, Hygiene and Waste Management Standards

- 4.1 Infection Control
- 4.2 Sterile Supplies
- 4.3 Cleanliness
- 4.4 Waste Management

Part 5 : Safe and Appropriate Environment Standards

- 5.1 Health and Safety
- 5.2 Safe & Appropriate Equipment
- 5.3 Safe & Appropriate Facilities

Part 1 : Management Standard:

1.1 Requirements for service management

1.1.1 Community Clinic Management Committee (Community Group)

There is a committee for each Community Clinic (CC) named Community Group (CG). Main activity of this committee is Management. CG will develop annual Action Plan, CC activities (based on local context) for raising fund and managing it,ensuring security, cleanliness,raising awareness among people for taking services from CC etc.

a. ll members of the committee will be oriented and trained in community clinic activities, processes for running meetings and in basic management skills.
b. The committee meets once a month according to a set agenda including follow-up of the last meeting.
c. Minutes of meetings should be kept for 3 years and will be available at the facility.

An Annual planning process shall adopt an Annual Action Plan which is implemented and reviewed on a regular basis. The annual action plan includes goals, planned actions, staffing and financial & physical resources to implement the planned actions.

1.1.2 Client/Patient information

Client/Patient information is documented registered, analyzed and used as a mechanism for monitoring and planning

a. Client/Patient registers are used, up to date, complete and accurate.
b. Written information in the registers includes date, client/patient characteristics (name, sex, age and address) and services provided(dosage, times/day, no. of days) and follow-up in line with operating procedures.

1.1.3 Registers used to document client/patient information include but are not limited to :

a. Maternal, ANC, PNC card (mother) which is maintained and used as a mechanism for informing the client/patient about their care;
b. Growth Monitoring Card which is maintained and used as a mechanism for informing the client/patient about their care;
c. Register of expected mothers and deliveries which is maintained and analyzed;

1.1.4 Notifiable diseases (Public Health Emergency of international concern, PHEIC)

a. A list of notifiable diseases is availableat the clinic office.
b. Notifiable diseases are reported within a specified time period.
c. Any outbreak condition to be informed to the higher office (UHC)

1.1.5 Provision of utility facilities and monitoring of equipment

Number of Equipment: Health worker providing services with the listed functioning equipments
ICT equipment (Lap-top and modem) functioning with regular on-line reporting

1.1.6 Waiting area

The waiting area is clean and protected including the following criteria -

a. The waiting area protects clients/patients from the sun, rain and extremes of temperature.
b. The waiting area has chairs or other seating arrangements.
c. The floor is clean,walls and ceiling are intact .

1.1.7 Toilet / Wash facility

The facility has clean running waterand separate toilets for male and female and must have hand washing facility

1.1.8 Work area

The facility compound is clean.

a. The compound is free from litter such as plastic bags, refuse and medical waste.
b. Medical wastes are disposed of in a way that are not accessible to children, animals and birds within the compound.

1.1.9 Operability of the procedures and guidelines

The staff work according to the written Operating Procedures for managing CC services, written guidelines for management of clients/patients and common illnesses.

a. Standard Operating Procedures for CC are used for managing the facility, finances, equipment, cleaning procedures, and stocks e.g. medicines.
b. Community Clinic protocols are available to determine which disease willget priority, forms the basis of regular training of relevant staffs and are followed while providing care to the patients/clients.
c. Written guidelines for the management of clients/patients exist and are used, e.g. registration, recording, health education, privacy .
d. The centre is operated by the staffs and visit of the MO‘s

1.1.10 Availability of staff

CC staffs are available for service delivery during all official times according to the position and post sanctioned by the authority.

a. List of Service Providers is available with their name, contact no. and name of post.
b. A qualified health care provider is available when ever the clinic is open.

1.1.11 Staff

Staffs are trained and evaluated in accordance with documented procedures, job descriptions and service needs.

a. All staffs (CHCP) are trained (3-month basic) on the Primary Health Care services..
b. All staffs have a copy of their job description that is kept up to date. The job description includes the responsibilities, accountabilities, tasks, performance measures and reporting relationships.
c. All staffs have a copy of their conditions of employment.
d. Staff performance is evaluated annually with the staff member against their job description and agreed targets and is used to identify strengths, areas for improvement and training needs.
e. Accurate and complete personnel records are kept.
f. Staff receive regular information relevant to their job and the healthcare services in their monthly meeting at UHC .
g. All staffs are supervised by the superior.

1.1.12 Health and Safety

The health and safety of clients/patients, staffs and visitors are protected. The Service is designed to allow the service delivery to be safe, accessible and respect clients’/patients’ need for privacy.

Complaint handling

- Clients/Patients have the right to complain about services and their complaints are investigated in a fair and timely manner.
- CG meeting will analyze complaints and and supportremedial measures

1.1.13 Continual improvement

The Service identifies opportunities to continuously improve its processes and services, makes improvements accordingly and evaluates their effectiveness.

a. Performance indicators are measured, reported and used for continuous improvement.
b. Performance data from activities such as timeliness, record writing, reporting, organizing monthly and other meetings of CG & writing minutes , complaints, are collected, analysed and used to identify improvement opportunities. This is coordinated by the approriate authority.
c. Improvements are planned, appropriate action is taken, the effectiveness of the action is evaluated and the results are fed back to staff and clients/patients.
d. All relevant legal requirements are identified and compliance is monitored.

1.2 Requirements for Service Provision

1.2.1 Accessibility to health services

The facility and the services provided are easily accessible to the catchments area population

a. Major obstacles affecting access for clients/patients to the facility and its services are addressed in the annual action plan and steps are taken to minimize them, e.g.
    i. The attitude of employees working at the facility;
    ii. The perception of the need and utility of health care by the community;
    iii. Cultural constraints on clients about using the facility and its services.

1.2.2 Accessibility to the information

A list of available services and applicable fees is posted where the clients/patients can see them.

a. A poster with listed services, opening times and emergency contacts during closing times is displayed in a prominent place where the clients/patients can see it. The text is in an understandable format (CC Citizen Charter and List of Service Providers).

1.2.3 Behaviour with client/patient and their attendant

Patients and their attendants are received in a friendly and respectful manner irrespective of their sex, age, race, religion or physical appearance

a. Patients are served in a kind, patient and respectful manner at all stages from registration through to the end of service.
b. The health care provider uses open ended questions (why, who, what, when, how) to obtain information from clients/patients.
c. The health care provider listens carefully to what the clients/patients say and does not jump to conclusions.
d. The health care provider explains to the client/patient about care and management of the problem and follow-up.
e. The health care provider takes feedback from the client/patient to ensure the client/ patient understands the message that is communicated.

1.2.4 Priority on service provision

Providers give priority to extremely sick clients/patients and those of extreme age (early newborns and elderly).and disabled

1.2.5 Emergency cases

Providers use a defined process for referring emergency cases (using referral slip).

a. SOPs exist for identification of types of clients/patients who need to be referred.
b. A referral form contains sufficient information to allow continuity of care. (In line with CC Algorithm)

1.2.6 Dealing with non-priority patient

Non-priority clients/patients wait no more than acceptable timeas determined by CG period for being seen by the care provider.

1.2.7 Privacy

The privacy of patients/clients is ensured during consultation and examination.

a. Using curtains/screens when necessary.
b. Healthcare providers ensure privacy at the time of consultation.

1.2.8 Assessment

a. All patients/clients receive appropriate assessment, symptomatic management and follow-up. Registration is completed promptly for all clients/patients.
b. Basic assessment is undertaken and includes temperature, blood pressure and symptom identification.
c. Basic assessment for children under five is undertakenwith special care and attentione.
d. A client/patient history is taken.
e. Symptomatic and care management is provided in accordance with the assessment.
f. Referrals to other services are made when required.

1.2.9 Protocol

Community Clinic protocols are available and used for listed services that offered.

a) Health care providers provide technically correct services according to the guidelines following CHCP Training Guide (Theoritical & Practical) and CC Algorithm.
b) Staffs are trained and persued to follow these guidelines.

1.2.10 Immunization status

All children who visit the clinic will have the following-

a. All under five children coming to the facility are weighed.
b. Weight is accurately plotted on the child's growth chart .
c. Immunization status is checked and missing immunizations identified and proper advice given.

1.2.11 Health Education

Health care providers regularly educate their clients on health issues in a way that is easy to understand.

a. Health care providers conduct group health education sessions at least once a week.
b. Health care providers use the supplied IEC materials during client/patient counselling/education sessions.
c. Health education messages (posters and charts with pictures and minimal text) are visibly posted in prominent areas within the facility.

1.2.12 Communication

Clients/Patients are given accurate information about their medication regime to enable them tofollow it.

a. The health care provider/dispenser instructs clients/patients about the medication, including the dose, frequency, timing and duration of treatment
b. The health care provider/dispenser checks that the client/patient understands the instructions.

1.2.13 All concerned Staff follows correct aseptic techniques:

a. Health workers perform the following aseptic procedures in line with SOPs or guidelines: wound dressing, suturing, catheterization, injections, intravenous infusion.

b. Soap (where possible liquid soap) and water or antiseptic materials are available at the washing point(s) in or near the consulting/examination room(s) and a clean hand towel or alternate is available.
c. Hand washing instructions are posted above the washing point(s).
d. Healthcare providers wash their hands properly.

1.2.14 Drugs

Essential drugs and supplies are available at all times during open hours.

a. Stock cards are up to date and correspond to physical stock.
b. There is a stock of the essential drugs.
c. There is a process for checking date of expiry.
d. No expired drugs are in stock.

1.2.15 Cold chain vaccine

The cold-chain for vaccines is maintained

a. A Cold Chain procedure for vaccines is used and includes clear directions on the following practices.
    i. Cold chain during immunization sessions One time Syringes, needles are used and aseptic precaution maintained.

Part 2 : Service Delivery Standard

2.1 Care Continuum

In Care Continuum, National Strategic Plan on Quality of Care will be introduced as per implementation plan in the document.

2.1.1 Access to Health Services

Services are continuously available and the facility minimizes physical, economic, social, cultural, organisational or linguistic barriers to access.

Sl. No.	Measurable Criteria
1.1.1	Campus Access ways and passage ways are kept clear at all times.
1.1.2	The clinic specifies the visiting hours from 9 am to 3 pm and communicates it to the public.

2.1.2 Continuity of Care

Clients/Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their job description.

Sl. No.	Measurable Criteria
2.1.2.1	Every patient/ clients seeking service or care at the clinic is registered and details of services provided will be recorded .
2.1.2.2	The service providers has primary responsibility to provide care to any patient until a specialist takes over.
2.1.2.3	A stock of essential drugs is available at all times in each service area.
2.1.2.4	Service providers are available on-site during office hour(9 am-3pm)

2.1.3 Assessment

All clients/patients have their health care needs identified through an established assessment process.

Sl. No.	Measurable Criteria
2.1.3.1	Criteria to prioritise emergency patients exist and are implemented. (following CC Algorithm)
2.1.3.2	An attendant is available when patients are being examined by members of the opposite sex.
2.1.3.3	Each and every patient is examined thoroughly

2.1.4 Care giving

The organisation delivers services to the clients/patients that meet their individual assessed needs, reflect current good practice and are co-ordinated to minimise potential risks and interruptions in provision.

Sl. No.	Measurable Criteria
2.1.4.1	Protocols are used to guide client/patient care processes (According to CC Algorithm).
2.1.4.2	Written procedures to ensure that the right dose of medication is administered to the right Client/patient at the right time are followed by staff and include: - Identification of the client/patient before medications are administered - Verification of the medication and the dosage , - Verification of the routes of administration - Verification of the time of administration.
2.1.4.3	Essential Equipments such as, B.P. Apparatus, Stethoscope, Thermometer, Glucometer. are available

2.1.5 Documentation of Care

The client/patient record contains sufficient information to identify the client/patient, support the care, justify the medication and care, document the course and results of the symptomatic management and care, and promote continuity of care among health care providers.

Sl. No.	Measurable Criteria
2.1.5.1	A record is initiated for every client/patient on the respective register.
2.1.5.2	Client / Patient records are maintained
2.1.5.3	The original client/patient record may not be removed from the CC except by court order. Policies and procedures are in place to prevent the loss and/or misuse of client/patient records.
2.1.5.4	The patient record is sufficiently detailed to enable the client/patient to receive effective coordinated management and care and includes: - Details of Serial no.Name, age, Sex, Services provided.Name of disease (when applicable)
2.1.5.5	Where referrals have been made, the client/patient record includes the referral letter, name of referred center and indications for referralare mentioned
2.1.5.6	There is a system for easy retrieval of records.

2.1.6 Referral

Referral of clients/patients is based on the client's/patient's health status and need for continuing care.

Sl. No.	Measurable Criteria
2.1.6.1	A written and dated procedure & referral tools for referral of clients/patients is used.

2.2 MCH Services

2.2.1 Service Management

Maternity services provide safe, timely and efficient maternity care for patients. In all CC ANC and PNC is provided. Only normal delivery is conducted where CHCPhas got CSBA training and/or CSBA trained FWA and female HA are available and where effective referral linkage is established with EmOCcenter to meet any emergency situation.

Sl. No.	Measurable Criteria
2.2.1.1	The maternity activity is managed by CHCP and HA & FWA having CSBA training
2.2.1.2	Data for clinical audits and reviews is collected, analyzed and used for quality improvement activities and includes: - Number of women received ANC - Number of women received PNC - Number of deliveries with duration of labour at the center - Number of live and still births - Maternal mortality figures - Number of transfers to specialist care during labour - Number of still births - Birth Registration records - No. of difficult labour cases

2.2.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the maternity unit, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.2.2.1	Written procedures and guidelines are used consistent with the policies and functions for: - ante natal care and booking/registration - post-natal care and booking/registration - counselling for parenthood (e.g. family planning, ,) including, for example, IEC material - identifying high risk pregnancy - planning mode of delivery - referral - birth record - labour register . - Advice for immunization for mother and baby - infection control - disposal of placentas
2.2.1.2	A guideline on summoning medical assistance at anytime during labour is used by CSBA personnel

2.2.3 Facilities and Equipment

Facilities and equipment are safe and adequate in design and number for the purpose and quantity of clients/patients attending for the maternity care where normal delivery is conducted.

Sl. No.	Measurable Criteria
2.2.3.1	The delivery room is equipped with functioning, safe and well maintained equipment specific for normal deliveries. including but not restricted to the following:

Sl. No.	Measurable Criteria
2.2.3.2	Privacy for mothers is available and provided , e.g. when breast-feeding.
2.2.3.3	The area for labour provides for: - Space for the woman and a female companion - Washing and toilet facilities for the comfort of the mother and companion
2.2.3.4	Lighting is versatile enough to provide a restful environment and allow birth procedures to be performed.

Part 3 : Support Services

3.1 Laboratory Services

3.1.1 Service Management

Measuring Blood Glucose by using Glucometer and Urine Sugar and Albumin using Uristix is available

Sl. No.	Measurable Criteria
3.1.1.1	The tests are done by CHCP and recorded in register.

3.1.2 Samples and Tests

Samples and tests are managed to maximize accuracy of testing and minimize risks topatients/clients and staff.

Sl. No.	Measurable Criteria
3.1.2.1	Staffs follow and communicate to clients/patients verbally for the clients'/patients' preparation for tests.
3.1.2.2	A laboratory register records: - Client/Patient name, location - Full name of the investigation(s) - Investigation results
3.1.2.3	Results are recorded in the register.
3.1.2.4	Client/Patient Results Registers are readily accessible to staff.
3.1.2.5	Separate containers are used for disposal of hazardous and infectious waste.

3.1.3 Safety

All persons are protected from potential hazards of testing

Sl. No.	Measurable Criteria
3.1.3.1	Appropriate equipment is used for the safe handling of hazardous materials.

3.1.4 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients served by the clinic.

Sl. No.	Measurable Criteria
3.1.4.1	Clinic spaces are sufficient to enable staff to carry out their jobs safely.
3.1.4.2	The clinic environment is well lit, ventilated and not underground.
3.1.4.3	Staffs have access to sufficient laboratory equipment to carry out their jobs safely.

3.2 Pharmacy Services

3.2.1 Management

The pharmaceutical service is managed and organised to provide efficient and effective pharmaceutical services through rational use of drugs in the clinic.

Sl. No.	Measurable Criteria
3.2.1.1	Drugs and Family Planning Commodities are dispensed in the CC by CHCP and Family Planning Commodities are supplied by FWA.
3.2.1.2	HA/FWA is designated in the absence of the CHCP.

3.2.2 Storage and Stock Management

Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

Sl. No.	Measurable Criteria
3.2.2.1	Medicines are stored on shelves enabling: - Protection from the adverse effects of light, dampness and temperature extremes - Freedom from vermin and insects - Adequate ventilation.
3.2.2.2	Adequate and secure storage facilities provided include: - A suitable metal cupboard or container for the storage of flammable and/or hazardous material.
3.2.2.3	Register is maintained regarding the stock .

3.2.3 Dispensing of Medicines

Dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

Sl. No.	Measurable Criteria
3.2.3.1	A system is in place to ensure that: - Medicines are dispensed rationally by competent persons..

Part 4 : Infection Control and Waste Management Standard

4.1. Infection control

Community clinic design and implements a coordinated program to reduce the risks of nosocomial infections in patients, visitors/attendants, contractors and staff.

Sl. No.	Measurable Criteria
4.1.1	National Infection Prevention & Control Guideline, National Hand Hygiene Guideline and Medical Waste Management Guideline will be used.
4.1.2	Staffs are appropriately inducted and trained in all aspects of infection control relevant to their work, including proper hand washing.
4.1.3	Gloves, , soap and disinfectants are available and correctly used in situations where there is a risk of infection.

4.2 Sterile Supplies

Equipment and supplies are sterilised to minimise risk of infection in clients/patients and staff. CC is supplied with Kerosene Stove for sterilization.

Sl. No.	Measurable Criteria
4.2.1	Sterilisation procedures are based on existing guidelines.

4.3 Cleanliness

The clinic, equipment and supplies are kept clean and safe for clients/patients, visitors/attendants and staff.

Sl. No.	Measurable Criteria
4.3.1	Clinic premise is free from litter and other refuse.
4.3.2	Equipment, floors and walls are free from bodily fluids, dust and grit.

4.4 Waste Management

Clinical and other infectious or injurious waste is handled, stored and disposed of to minimise harm and risk of infection /injury to patients/clients, visitors, contractors, staff and the community.

Sl. No.	Measurable Criteria
4.4.1	According to " The Medical Waste Management regulation 2008"., collection , segregation, inhouse management & outhouse management of waste done
4.4.2	Contaminated waste buried in land fills is done so in accordance with "The Medical Waste Management regulation 2008".
4.4.3	Prior to collection and disposal, waste is kept in a suitable place which does not cause a hazard.

Part 5 : Safe and Appropriate Evironment Satandard

5.1 Health & Safety

Promotion of health and safety and the avoidance of risk to human life as well as to the property of the clinic are integrated within the organisation and among all levels of staff.

Sl. No.	Measurable Criteria
5.1.1	The responsibility for health and safety of Clinical management and other relevant staff is included in their job descriptions and performance reviews.
5.1.2	Health and Safety policies and procedures are followed by staff and include: - Contamination incidents - Sharps and needle-stick injuries - Basic life support.
5.1.3	Organisation wide health and safety policies and procedures contain comprehensive information, instruction and safety protocols for - Control of waterborne diseases - Storing and handling of inflammable liquid - Personal protective equipment and clothing - Body fluid spillage - First aid procedures at work - Safe use of electrical equipment - Safe disposal of clinical waste

5.2 Safe and Appropriate Equipment

There are clear and documented responsibilities, policies and procedures for use, maintenance, repair and disposal of equipment to minimise the potential for harm.

Sl. No.	Measurable Criteria
5.2.1	Basic responsibilities regarding Equipment include: - Assessment of utilisation of equipment - Condemnation of equipment
5.2.2	Staffs are allowed to operate equipment or machinery after being appropriately trained and re-trained and no untrained person is allowed to operate the equipment.
5.2.3	Records of equipment are kept including equipment defects and failures, maintenance, repair and disposal.

Sl. No.	Measurable Criteria
5.2.4	Regular and routine checks of equipment (equipment audit) are carried out in accordance with the operational manual.
5.2.5	All condemned items are removed from the premises at the earliest

5.3 Safe and Appropriate Facilities

The Clinic's physical environment contributes to the safety and well-being of clients/patients, staff and visitors.

Sl. No.	Measurable Criteria
5.3.1	The clinic complies with relevant laws and regulations related to design and layout of the facility and inspection requirements are fulfilled.
5.3.2	Corridors, storage areas, passageways and stairways are well lit.
5.3.3	Access ways and exits are unobstructed at all times.
5.3.4	The environment in all client/patient areas is clean, well lit, ventilated with adjustable controls for lighting.
5.3.5	Floor surfaces are non-slip and even.

Chapter -TWO

Standard for

Union Health and Family Welfare Center (UH&FWC) / Union Sub Centre (USC)

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Part 1: Management

1.1 Requirements for Service Management:

1.1.1 Primary Care Management Committee

There will be a committe in each Union Sub-Center, who will be responsible for the management of its resources, support the service processes, implement national standards and communicate decisions and informations to the relevant persons and organizations.

a. Union health Management Committee will include representatives from Health & relative skakeholders lead by MO.
b. Users who will be the members of the committee are provided with information to enable them to contribute to the decisions of the health management committee.
c. All members of the committee will be oriented and trained in healthcare system, processes for running meetings and in basic management skills.
d. The committee meets regularly according to a set agenda that includes follow-up from the last meeting.
e. Minutes of meetings are kept for five years and are available at the facility.
f. An annual plan isdeveloped , adopted , implemented and reviewed on regular basis, which includes goals, planned actions, staffing, financial and physical resources to implement the planned actions.

1.1.2 Patient information

Patient information is registered, coded, analyzed and used as a mechanism for monitoring and planning.

a. Patient registers are used, updated and completed accurately.
b. Written information in the registers includes dates, patientparticulars (name, sex, age and address), diagnosis and treatment (medicationsdosage, times/day, no of days) and follow-up.
   Registers are used to document patient information including but are not limited to-
   i. Health card (mother and child) which is maintained and used as a mechanism for informing the patient about their care;
   ii. Immunization card which is maintained and used as a mechanism for informing the patient about their care;
   iii. Register of expectant mothers and deliveries which is maintained and analyzed;
   iv. OPD register.
c. A consistent disease coding system [ICD 10] is used and analyzed.
d. Analysis of the information is used by the staffs and results are provided back to the community.

1.1.3 Notifiable diseases

Notifiable diseases are reported promptly and appropriate action is taken to minimize the spread of the disease.

a. A list of notifiable diseases is availableat the facility .
b. Notifiable diseases are reported within a specified time period, but no longer than 24 hours.
c. Procedures for managing notifiable diseases based on infection control principles are used and roles and responsibilities of cocerned personsare clearly defined.

1.1.4 Provision of utility facilities and monitoring of equipment

The equipment and utilities are functional, meet the defined needs of planned services, and are properly maintained and used.

a. Equipment is registered, maintained, repaired and disposed of according to the equipment maintenance and replacement schedule.
b. The facility has functioning electricity and natural gas.
c. A backup generatoris available in working condition and the budget for its maintenance and for its fuel are provided.
d. A stretcher, a wheel chair and at least two examination couches are provided,
e. Each health worker providing curative services has the listed functioning equipment:
f. The following additional functioning equipments are available in the facility and ready to use:
    i. Baby weighing scale, neonatal weighing scale, speculum
    ii. Refrigerator, alternate lighting source such as solar lamps or torch, equipment for boiling/ sterilizer, timing device, stainless steel bowls, kidney bowls, dressing drum, gloves, masks, aprons
    iii. Adult weighing scale, nebuliser, suction machine, oxygen cylinder, x-ray viewbox , suture set, needle safety box, resuscitation kit
g. Additional equipments based on the defined needs of the planned services are available and functioning.

1.1.5 Water supply

There is a reliable, clean and safe supply of water from a protected water source.

a. Running water (pipe) is available within the facility
b. A supply line and storage system which will keep water clean and free from contamination.

1.1.6 Waiting area

The waiting area is clean and protected.

a. The waiting area protects clients/patients from the sun, rain and extremes of temperature.
b. There are designated separate male and female waiting areas.
c. The waiting area has chairs or other seating arrangements.
d. The floor is swept or mopped and the area is clean of debris/ trash.
e. The walls and ceiling are intact with no broken masonry and are free from dirt and stains.

1.1.7 Latrine facility

The facility has clean latrines or toilets.

a. Separate latrines or toilets for male and female exist within the facility or facility compound.
b. Staffs and patients have access to separate toilets which are clearly signed and are lockable from inside.
c. The patient toilet can not be locked from the outside.
d. The toilet bowl is clean and empty and toiletslab is clean.
e. Soap and water are available at the washing point near the toilet(s)

1.1.8 Work area

The facility compound is clean and uses a rubbish pit for disposal of refuse and medical waste according to medical waste management, and Colour coding .

a. The compound is free from litters such as plastic bags, refuse and medical waste.
b. There is a rubbishbin/pit within the compound (possibly a garbage bin in urban settings)
c. The bin/pit is not overflowing and is properly used, i.e. rubbish is not disposed anywhere else
d. Medical waste is disposed of in a functional covered bin/pit and not accessible to children and animals, within the compound.

1.1.9 Availability of staff

Primary Care staff are available for service delivery during all official times.

a. An updated duty roster is kept which includes name of the staff and duty time.
b. Qualified healthcare provider is available whenever the facility is open,

1.1.10 Staff

Staffs, trained and evaluated in accordance with documented procedures, job descriptions and service needs.

a. All staffs are oriented to the Primary Care services and their specific positions through a documented induction programme.
b. The induction programme includes:
    i. The Service's mission, values, goals and relevant planned actions for the year
    ii. Services provided
    iii. Roles and responsibilities
    iv. Relevant policies and procedures, including confidentiality
    v. Use of equipments
    vi. Safety
    vii. Emergency preparedness
    viii. Quality improvement.
c. All staffs have a copy of their job description that is kept current. The job description includes the responsibilities, accountabilities, tasks, performance measures and reporting relationships.
d. All staffs have a copy of their conditions of employment.
e. Well-maintained and secure staff housing with all utilities is provided as per staff terms and conditions.
f. Staff performance is evaluated annually with the staff member against their job description and agreed targets and is used to identify strengths, areas for improvement and training needs.
g. Accurate and complete personnel records are kept at the facility.
h. Staffs receive ongoing in-service training relevant to their job and the healthcare service and in areas such as health and safety, quality improvement and client/patient rights.
i. Documents guide the work of staff and cover staff appointments, performance evaluations, disciplinary procedures and terms and conditions of employment.

1.1.11 Health and safety

The health and safety of patients, staff and visitors are ensured.

a. The Service is designed to allow service delivery to be safe, accessible and respect patients' needs for privacy.
b. The Service is inspected annually by the Works and Services Department and

declared safe.

c. A current Safety Certificate has been issued and is displayed in the facility.
d. Chemicals, drugs and equipment are stored safely.
e. Risks and hazards are identified and eliminated, isolated or minimized as appropriate.
f. Guidelines exist for major risks and hazards and are known to the staff.
g. Incidents, accidents and near misses are reported and analysed to identify causes and the analysis is used to improve systems and processes, e.g. needleprick injuries.
h. Staffs are provided with and use protective equipments, e.g. gloves, aprons, masks.
i. Staffs are trained in fire safety and other emergencies and drills are practised regularly.
j. Staff health is protected by the provision of immunization against infections such as Hepatitis A and B and influenza.

1.1.12 Complaint handling

Patients have the right to complain about services and treatment and their complaints are investigated in a fair and timely manner.

a. Patients are informed of their right to express their concerns or complain either verbally or in writing.
b. A documented process which is fair and timely is used for collecting, reporting and investigating complaints.
c. Patients are informed about the progress of the investigation at regular intervals and are informed about the outcome.

1.1.13 Continual improvement

The Service identifies opportunities to continuously improve its processes and services, makes improvements and evaluates their effectiveness.

a. Performance indicators for priority diseases and key processes are measured, reported and used for continuous improvement.
b. Performance data from activities such as audits, complaints, incident reports, satisfaction surveys and risk assessments are collected, analysed and used to identify improvement opportunities. This is coordinated by the quality group.
c. Improvements are planned, appropriate action is taken, the effectiveness of the action is evaluated and the results are fed back to staff and patients.
d. All relevant legal requirements are identified and compliance is monitored.

1.2 Requirements For Service Provision

1.2.1 Accessibility to health services

The facility and the services provided are easily accessible to the catchment area population

a. Costs involved in using the services are addressed in the annual plan and steps are taken to minimize costs, such as fees, drugs and transportation costs.
b. Major obstacles affecting access for patients to the facility and its services are addressed in the annual plan and steps are taken to minimize them, e.g.
    i. The attitude of employees working at the facility;
    ii. The perception of the need and utility of health care by the community;
    iii. Cultural constraints on clients about using the facility and its services.

1.2.2 Accessibility to the information

A list of available services and applicable fees is posted where the patients can see them.

a. A poster with listed services, opening times and emergency contacts during closing

times is displayed in a prominent place where the clients/patients can see it. The text is in an understandable format, e.g. local or national language.

b. A list with all fees and possible exemptions is displayed in a prominent area where the clients/patients can see it. The text is in an understandable format.

1.2.3 Behaviour with patient and their attendant

Patients and their attendants are received in a friendly and respectful manner irrespective of their sex, age, race, religion or physical appearance

a. Patients are treated in a kind, patient and respectful manner at all stages from registration through to end of service.
b. The healthcare provider uses open ended questions (why, who, what, when, how) to obtain information from patients.
c. The healthcare provider listens carefully to what the patients say and does not jump to conclusions.
d. The healthcare provider explains to the patient the diagnosis, care management, and follow-up.
e. The healthcare provider takes feedback from the patient to ensure the patient understands the message communicated.

1.2.4 Priority on service provision

Providers give priority to extremely sick clients/patients and those of extreme age (newborns , childrenand elderly) and pregnant ladies.

a. A system using the time of arrival recorded on the registration chit is used to prioritize patients.
b. The order prioritizes extremely sick patients first, those of extreme ages (elderly and babies) second and then others.
c. Extremely sick patients are seen by the healthcare provider within five minutes, and those of extreme ages within 15 minutes.

1.2.5 Emergency cases

Providers use a defined process for referring emergency cases.

a. SOPs exist for identification of types of clients/patients who need to be referred.
b. A referral form provides sufficient information to allow continuity of care.
c. When possible transportation to the referral facility is provided.
d. In other cases, the Service provides some type of assistance for moving a sick client/patient to a referral facility such as communication to the next level, or arranging community transport.
e. A copy of the referral form is kept at the facility.

1.2.6 Dealing with non-priority patient

Non-priority patients wait no more than one hour after arrival at the facility before being seen by the provider.

a. A system is used to prioritize the order in which non-priority clients/patients are seen on a first-come first-serve basis.
b. Waiting times are no more than one hour and are monitored.
c. Waiting times are analyzed and results used to improve services.

1.2.7 Privacy

The privacy of patients is ensured during consultation and examination.

a. Consultations and examinations are held behind curtains/screens at all times.
b. Healthcare providers ensure privacy at the time of consultation.

1.2.8 Assessment

All patients receive appropriate assessment, diagnosis, plan of care, treatment and care management, and follow-up

a. The registration is completed promptly for all patients.
b. The time the patient arrives is documented on the registration and monitored
c. Basic assessment is undertaken and includes temperature, blood pressure, and symptom identification.
d. Basic assessment for children under five includes weight, immunization status, temperature, level of consciousness and symptom identification.
e. A patient history is taken and documented.
f. Treatment and care management is provided in accordance with the assessment, test results, diagnosis and care management guidelines.
g. Referrals to other services are made when required.
h. Appointments for future care are made.
i. Results of previous care are used in follow-up visits.

1.2.9 Protocol

National clinical protocols are available and used for those services listed as offered.

a. Healthcare providers provide technically correct services according to guidelines for but not limited to the following areas:
    i. First Aid and Emergency care, Injury management, minor surgical procedures
    ii. IMCI, ANC, Delivery, PNC, Family planning
b. Staffs are trained to follow these guidelines.
c. Availability of all relevant protocols are ensured.

1.2.10 Immunization status

All children who visit the facility have their weight plotted correctly on their health card and have their immunization status checked.

a. All under five children coming to the facility are weighed.
b. Weight is accurately plotted on the child's health card and follow-up action taken based on the plot.
c. Immunization status is checked and missing immunizations given
d. Weight and vaccination information are given to the parent/carer.

1.2.11 Health Education

Healthcare providers regularly educate their clients on health issues in a way that is easy to understand.

a. Healthcare providers conduct group health education sessions at least four times a month.
b. Healthcare providers use the following materials during patient counselling/education sessions: posters, family planning material, brochures, leaflets, flipcharts and cue cards.
c. Health education messages (posters and charts with pictures and minimal text) are visibly posted in prominent areas within the facility.
d. Health education written material is available for clients/patients to read and take home.

1.2.12 Communication

Patients are given accurate information about their medication regime to enable them to manage it.

a. The healthcare provider/dispenser instructs clients/patients about the medication, the amount of medication to take, what time to the day it should be taken and for how long it should be taken.
b. The healthcare provider/dispenser checks that the client/patient understands the instructions.
Staff follow correct aseptic techniques and wash their hands between clients/patients.
a. Health workers perform the following aseptic procedures in line with SOPs or guidelinesfor wound dressing, suturing, catheterization, injections, intravenous infusion.
b. Soap (where possible liquid soap) and water or antiseptic gel are available at the washing point(s) in or near the consulting/examination room(s) and a clean hand towel or alternate is available.
c. Hand washing instructions are posted above the washing point(s).
d. Healthcare providers wash their hands between clients/patients and between procedures.

1.2.13 Drugs

Essential drugs and supplies are available at all times during open hours.

e. Stock cards are up to date and correspond to physical stock.
f. There is a stock of the essential drugs.
g. There is a process for checking date of expiry.
h. No expired drugs are in stock.

1.2.14 Cold chain vaccine

The cold-chain for vaccines is maintained

a. A Cold Chain procedure for vaccines is used and includes clear directions on the following practices.
    i. Vaccine stock management including vaccine storage, potency, stock quantities, stock records, and arrival report
    ii. Equipment for vaccine transport and storage
    iii. Maintenance of equipment
    iv. Control and monitoring of temperature
    v. Cold chain during immunization sessions
    vi. Syringes, needles and sterilization and
    vii. Breakdown of equipment and emergency actions to minimize risks.

1.3 Patient Rights

1.3.1 Information for Patients

Patients have the right to receive all information relevant to their care management to enable them to make informed decisions.

Sl. No.	Measurable Criteria
1.3.1.1	A patient rights and responsibilities charter (Citizen Charter) is developed and displayed in all patient areas.
1.3.1.2	The health centre uses a documented process for patients not able to understand written information to inform them of their rights.
1.3.1.3	Guidance and advice is provided to the clients/patients at the registration / reception counter.
1.3.1.4	The reception area and wards display information about the organisation, including: - The rights of the patients - Services and facilities available in the hospital - Costs of services - Feedback and complaints pathways.

1.3.2 Patient Feedback on Services

Patients have the right to complain about the services and treatment and their complaints are investigated in a fair and timely manner.

Sl. No.	Measurable Criteria
1.3.2.1	Patients are informed of their right to express their concerns or complain either verbally or in writing
1.3.2.2	There is a documented process for collecting, prioritizing, reporting and investigating complaints which is fair and timely.

1.3.3 Privacy and Dignity of Clients/Patients

Patients' privacy and dignity are respected throughout the entire care process.

Sl. No.	Measurable Criteria
1.3.3.1	Consultation, treatment rooms and washing facilities allow privacy and separate toilets for male and female clients/patients are provided.

Part 2 : Service Delivery Standards

2.1 Care Continuum

In Care Continuum, National Strategic Plan on Quality of Care will be introduced as per implementation plan in the document.

2.1.1 Access to Health Services

Services are continuously available and the hospital minimises physical, economic, social, cultural, organisational or linguistic barriersto access**.**

Sl. No.	Measurable Criteria
2.1.1.1	Access ways and passage ways are kept clear at all times.
2.1.1.2	The health centre specifies visiting hours and communicates these to the public.
2.1.1.3	On admission to hospital, patients are introduced to the nurse on duty and given an orientation to the unit to which they are admitted including the location of toilets, pantry and other facilities and services.

2.1.2 Continuity of Care

Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care.

Sl. No.	Measurable Criteria
2.1.2.1	Every patient seeking treatment or care at the health centre is registered and issued the appropriate form for recording various details of symptoms, diagnosis, treatment and services being provided.
2.1.2.2	The doctor on duty has primary responsibility for the clinical care of any patient until a specialist takes over.
2.1.2.3	The nurse on duty is responsible for coordinating patient assessment, care planning and evaluation of care with other care providers and services.
2.1.2.4	A stock of essential drugs is available at all times in each treatment area.
2.1.2.5	Doctors, qualified nurses and appropriate support staff are available on-site 24 hours

2.1.3 Treatment

The organisation delivers services to the patients that meet their individual assessed needs, reflect current good practice and are co-ordinated to minimise potential risks and interruptions in provision.

Sl. No.	Measurable Criteria
2.1.3.1	Clinical guidelines/treatment protocols are used to guide patient care processes.
2.1.3.2	Written procedures to ensure that the right dose of medication is administered to the right patient at the right time are followed by staff and include: - Identification of the patient before medications are administered - Verification of the medication and the dosage with the prescription - Verification of the routes of administration

2.1.4 Documentation of Care

The patient record contains sufficient information to identify the patient, support the diagnosis, justify the treatment and care, document the course and results of the treatment and care, and promote continuity of care among health care providers

Sl. No.	Measurable Criteria
2.1.4.1	Patient records are maintained through the use of a unique number or other form of identification unique to each patient.
2.1.4.2	The patient record is sufficiently detailed to enable the patient to receive effective coordinated treatment and care and includes**:** - Patient assessment and medical examination - Sheet containing history pertinent to the condition being treated including details of present and past history and family history - Diagnosis by a registered health professional for each entry to the hospital - Treatment record
2.1.4.3	Where referrals have been made, the patient record includes the referral letter and reasonsfor referral
2.1.4.4	There is a system for easy retrieval of records.

2.1.5 Discharge and Referral

Safe and appropriate discharge, transfer or referral of patients is based on the client's/patient's health status and need for continuing care.

Sl. No.	Measurable Criteria
2.1.5.1	A written and dated procedure including criteria to determine readiness for discharge, transfer or referral of patients is used and specifies who is authorised to do it.
2.1.5.2	Follow up arrangements, agreed with the /patient and/or the family, are noted in the patient record prior to discharge.
2.1.5.3	Referral System Guideline, Referral Register & Referral Slip (Developed by Hospital & Clinic Section of DGHS) will be used for patient referral.

2.2 MCH Services

2.2.1 Service Management

Maternity services provide safe, timely and efficient maternity care for patients.

Sl. No.	Measurable Criteria
2.2.1.1	The maternity department is managed by a suitably qualified, registered and experienced nurse, doctor or senior midwife.
2.2.1.2	Data for clinical audits and reviews is collected, analyzed and used for quality improvement activities and includes: - Number of women in ante-natal clinics - Number of women with medical or surgical disorders in ante-natal clinics - Number of women transferred to higher-level care during pregnancy

	- Number of deliveries - Number of live and still births - Perinatal mortality figures - Maternal mortality figures - Number of transfers to specialist care during labour - Number of still births - Birth Registration records - No. of difficult labour cases

2.2.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the maternity unit, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.2.2.1	Written procedures and guidelines are used consistent with the hospital policies and functions for: - ante natal care and booking/registration - post-natal care - peri-natal care - counselling for parenthood (e.g. family planning, genetic referral,) including, for example, IEC material - identifying high risk pregnancy - planning, treatment and mode of delivery - plan for managed pain during labour and delivery - delivery monitoring process - referral - discharge including discharge summary - birth record and certificate - labour register - immunization for mother and baby - infection control - disposal of placentas
2.2.2.2	A record of regular training in maternal and neonatal resuscitation is kept in the department for medical and nursing staff attending deliveries
2.2.2.3	Separate records are initiated and used for each baby.
2.2.2.4	Records kept after discharge include the combined: - Maternity notes (including care plans) - Birth registration(s) - Labour register - Neonatal and perinatal morbidity - and mortality - Maternal morbidity and mortality

2.2.3 Facilities and Equipment

Facilities and equipment are safe and adequate in design and number for the purpose and quantity of patients attending the maternity department.

Sl. No.	Measurable Criteria
2.2.3.1	The delivery room is equipped with functioning, safe and well maintained equipment specific for deliveries including but not restricted to the following: - Delivery table which can be turned to the Trendelenburg position

Sl. No.	Measurable Criteria
	- An anaesthetic machine with emergency oxygen supplies - Endo-tracheal tubes, laryngoscope, tongue depressor and manual sucker - An incubator, with temperature adjustable for infants in need - Separate oxygen supply to the incubator - Resuscitation equipment and drugs for neonates and for adults - Intravenous crystalloid and plasma expanders - Weighing machine for the baby.
2.2.3.2	Privacy for mothers is possible, e.g. when breast-feeding.
2.2.3.3	The area for labour provides for: - Space for the woman and a female companion - Alternative birthing methods - Ambulation throughout labour - Washing and toilet facilities for the comfort of the mother and companion
2.2.3.4	Lighting is versatile enough to provide a restful environment and allow birthing procedures to be performed.

Part 3 : Support Services Standard

3.1 Pharmacy Services

3.1.1 Management

The pharmaceutical service is managed and organised to provide efficient and effective pharmaceutical services through rational use of drugs within the hospital.

Sl. No.	Measurable Criteria
3.1.1.1	The pharmaceutical service is managed by a qualified, graduate and registered pharmacist.
3.1.1.2	A suitably qualified deputy with specified duties and responsibilities is designated in the absence of the pharmacist.

3.1.2 Storage and Stock Management

Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

Sl. No.	Measurable Criteria
3.1.2.1	Medicines are stored on shelves enabling: - Protection from the adverse effects of light, e.g. glass windows painted white, dampness and temperature extremes - Freedom from vermin and insects - Adequate ventilation.
3.1.2.2	Medicines for emergency use are stored in sealed tamper evident containers in all patient areas.
3.1.2.3	Adequate and secure storage facilities provided include: - A suitable metal cupboard or container for the storage of flammable and/or hazardous material - A functioning pharmacy refrigerator.
3.1.2.4	A formal, written procedure is followed to action hazard warnings and medicine recalls.
3.1.2.5	A formal, written procedure is followed for retention of order forms, copy of delivery notes, stores receipt, and issue vouchers, and book of records (controlled drugs book/prescription drugs book) on the premises as provided for in the relevant laws.

3.1.3 Prescribing, Administration and Dispensing of Medicines

Prescribing, dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

Sl. No.	Measurable Criteria
3.1.3.1	A system is in place to ensure that: - Prescriptions are only issued by authorized prescribers - Administration of medicine is done by, or under the supervision of, competent health personnel.
3.1.3.2	All prescriptions are legible and duly and legibly signed by a doctor, including the following: - Name - Diagnosis - Dose - Dosage form - Strength of medications.

3.2 Laboratory Services

3.2.1 Service Management

Measuring Blood Glucose by using Glucometer and Urine Sugar and Albumin using Uristix is available

Sl. No.	Measurable Criteria
3.2.1.1	The tests are done and recorded in register.

3.2.2 Samples and Tests

Samples and tests are managed to maximize accuracy of testing and minimize risks topatients/clients and staff.

Sl. No.	Measurable Criteria
3.2.2.1	Staffs follow and communicate to clients/patients verbally for the clients'/patients' preparation for tests.
3.2.2.2	A laboratory register records: - Client/Patient name, location - Full name of the investigation(s) - Investigation results
3.2.2.3	Results are recorded in the register.
3.2.2.4	Client/Patient Results Registers are readily accessible to staff.
3.2.2.5	Separate containers are used for disposal of hazardous and infectious waste.

3.2.3 Safety

All persons are protected from potential hazards of testing

Sl. No.	Measurable Criteria
3.2.3.1	Appropriate equipment is used for the safe handling of hazardous materials.

3.2.4 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients served by the clinic.

Sl. No.	Measurable Criteria
3.1.4.1	Clinic spaces are sufficient to enable staff to carry out their jobs safely.
3.1.4.2	The clinic environment is well lit, ventilated and not underground.
3.1.4.3	Staffs have access to sufficient laboratory equipment to carry out their jobs safely.

Part 4 : Infection Control and Waste Management Standards

4.1 Infection Control

The organisation designs and implements a coordinated program to reduce the risks of nosocomial infections in patients, visitors/attendants and staff.

Sl. No.	Measurable Criteria
4.1.1	The infection control program includes all areas of the health centre and describes the scope, objectives, annual activities, surveillance methods, resources. Processes associated with infection risks, including respiratory tract, urinary tract and surgical wound infections, are identified and included in the infection control program..
4.1.2	Professional staff are appropriately inducted and trained in all aspects of infection control relevant to their work, including proper hand washing.
4.1.3	Gloves, gowns, masks, soap and disinfectants are available and correctly used in situations where there is a risk of infection.

4.2 Cleanliness

All hospital facilities, equipment and supplies are kept clean and safe for patients, visitors/attendants and staff.

Sl. No.	Measurable Criteria
4.2.1	Staff follow written policies and procedures and schedules for: - Disinfection and cleaning of all equipment, furniture, floors, walls, storage areas and other surfaces and areas - Cleaning of specialised areas, e.g. Labour Room, Emergency Ward, Dressing Room.
4.2.2	Health centre premises are free from litter and other refuse.
4.2.3	Equipment, floors and walls are free from bodily fluids, dust and grit and the masonry is intact.
4.2.4	Cleaners are trained and provided with sufficient appropriate equipment and cleaning material and work according to cleanliness and sanitation policies and procedures.

4.3 Waste Management

Clinical and other infectious or injurious waste is handled, stored and disposed of to minimise harm and risk of infection /injury to patients, visitors, staff and the community.

Sl. No.	Measurable Criteria
4.3.1	The health centre has a written waste disposal plan specifying procedures, responsibilities, timetable for waste collection and necessary equipment such as bins and bags.(as per Medical Waste Management Regulation 2008)
4.3.2	The waste disposal plan includes written guidelines for the regulation, identification, containment and storage, transport, treatment and subsequent disposal of different categories of infectious waste, including if appropriate: - pathology waste - cytotoxic and chemical liquid waste (In accordance with the relevant law, as per Medical Waste Management Regulation 2008)
4.3.3	Contaminated waste buried in land fills is done so in accordance with the relevant laws . (as per Medical Waste Management Regulation 2008).
4.3.4	All staff are trained in and use procedures for different types of waste:

Sl. No.	Measurable Criteria
	- Collection - Segregation at source - Storage - Transportation - Disposal.
4.3.5	Prior to collection and disposal, waste is kept in a suitable location which does not cause a hazard.

Part 5 : Safe and Appropriate Environment Standards

5.1 Health & Safety

Promotion of health and safety and the avoidance of risk to human life as well as to the property of the Hospital are integrated within the organisation and among all levels of staff.

Sl. No.	Measurable Criteria
5.1.1	The responsibility for health and safety of hospital management and other relevant staff is included in their job descriptions and performance reviews.
5.1.2	All staff attend continuing training for health and safety and records are kept of the trainings
5.1.3	Organisation wide health and safety policies and procedures contain comprehensive information, instruction and safety protocols for: - Control of waterborne diseases - Storing and handling of inflammable liquid - Personal protective equipment and clothing - Review of pressure vessels and systems - Body fluid spillage - First aid procedures at work - Violence and aggression towards staff - Outbreak and prevention of fire - Other internal accidental events such as explosion - Safe use of electrical equipment - Safe disposal of clinical waste - Safe handling of gas cylinders - Safety precautions necessary when storing, handling and using liquefied gases, e.g. nitrogen and oxygen - Control and prevention of spillage of hazardous substances, like mercury and gluteraldehyde - Cytotoxic drugs - Introduction of new technology.

5.2 Fire Safety and Emergency Preparedness

The organisation minimises the risks of fire and protects clients/patients, visitors and staff in case of fire and is prepared for disasters and emergencies

Sl. No.	Measurable Criteria
5.2.1	A fire safety plan exists including prevention/risk reduction, early detection, suppression, abatement, and safe exit from fire.
5.2.2	The health centre building, e.g. doors, exits and corridors, is constructed in a way to minimise the risk of fire and conform to fire safety rules, including: - Doorways, corridors, ramps and stairways being wide enough for the evacuation of non-ambulatory patients

Sl. No.	Measurable Criteria
	- Fire and smoke doors being able to be opened and closed manually or by an electric release system - Doors to patient rooms and exit doors not being locked from the inside.
5.2.3	Access and exit ways are kept free of obstruction at all times to allow for safe evacuation in a fire or other emergency.

5.3 Safe and Appropriate Facilities

The Hospital's physical environment contributes to the safety and well-being of patients, staff and visitors.

Sl. No.	Measurable Criteria
5.3.1	The health centre complies with relevant laws and regulations related to design and layout of the facility and inspection requirements are fulfilled.
5.3.2	Corridors, storage areas, passageways and stairways are well lit.
5.3.3	Access ways and exits are unobstructed at all times.
5.3.4	Signage allows safe passage through the hospital and exit from the facility in case of an emergency, disaster or fire.
5.3.5	The environment in all patient areas is clean, well lit, ventilated with adjustable controls for lighting and heating, and decor is in good repair.
5.3.6	Floor surfaces are non-slip and even.
5.3.7	Separate male and female functioning, clean toilets are available for use by visitors/attendants.
5.3.8	Electrical, water, ventilation, medical gas, and other key systems are regularly inspected, maintained and improved, if necessary.

5.4 Safe and Appropriate Equipment

There are clear and documented responsibilities, policies and procedures for procurement, use, maintenance, repair and disposal of equipment to minimise the potential for harm.

Sl. No.	Measurable Criteria
5.4.1	Placement of supply orders of equipment is done in accordance with the hospital rules or GFR (Government Financial Rules) in case of public hospitals and a copy of supply orders for equipment is kept in the Hospital records.
5.4.2	A list of all electrical equipment that requires routine testing is used and a record of maintenance and testing of this equipment is kept for three years, e.g. generator, emergency lighting.
5.4.3	Regular and routine checks of equipment (equipment audit) are carried out in accordance with the operational manual, maintenance contract and/or a history sheet of the equipment by the Store in-charge.
5.4.4	A list of maintenance/backlog items is kept and reviewed regularly.
5.4.5	A list of approved external repair workshops is kept and regularly updated
5.4.6	An annual budget is provided for the maintenance and scheduled replacement of equipment.

Chapter-Three

Standards for Primary Level, Upazila Health Complex (UHC)

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Part 1: Management

1.1 Requirements for service management

Primary Care Management Committee

There will be a committe for Primary Care Management (In each UHC) who will develop strategic plan(1-3 years) for PHC (based on local context) for manages its resources, supports the Service's processes, implement national standards and communicates decisions and information to relevant persons and organizations.

a. The Primary Care Management Committee will include representatives from Health & relative stakeholders.
b. Clients/Users who will be the members of the committee will be provided with information to enable them to contribute to the decisions of the health committee.
c. All members of the committee will be oriented and trained in healthcare system, processes for running meetings and in basic management skills.
d. The committee meets regularly according to a set agenda that includes follow-up from the last meeting.
e. Minutes of the meeting will be kept for five years and will be available at the facility.
f. An annual planning process results in an annual plan which is implemented and reviewed on a regular basis.
g. The annual plan includes goals, planned actions, staffing and financial and physical resources to implement the planned actions.
h. Committee will overview financial management including budget allocation.
i. Decentralised decision making.

1.1.1 Client/Patient information

Client/Patient information is registered, coded, analyzed and used as a mechanism for monitoring and planning

a. Client/Patient registers are used, up to date, complete and accurate.
b. Written information in the registers includes dates, client/patient characteristics (name, sex, age and address), diagnosis and treatment (dosage, times/day, no of days) and follow-up in line with operating procedures.
    i. Registers used to document client/patient information include but are not limited to;
    ii. Health card (mother and child) which is maintained and used as a mechanism for informing the client/patient about their care;
    iii. Immunization card which is maintained and used as a mechanism for informing the client/patient about their care;
    iv. Register of expectant mothers and deliveries which is maintained and analyzed;
    v. OPD register.
c. A consistent disease coding system is used and analyzed
d. Analysis of the information is used by staff and results are fed back to the community.

1.1.2 Notifiable diseases

Notifiable diseases are reported promptly and appropriate action is taken to minimize the spread of the disease.

a. A list of notifiable diseases is available.
b. Notifiable diseases are reported within a specified time period, but no longer than 24 hours.
c. Procedures for managing notifiable diseases are based on infection control principles, are used and roles and responsibilities are clearly defined.
d. The ' Zero report' is completed and submitted weekly (for polio)

1.1.3 Provision of Utility facilities

1.1.3.1 Water supply

There is a reliable, clean and safe supply of water from a protected water source.

a. Running water (pipe) is available within the facility
b. A supply line and storage system keep water clean and free from contamination.

1.1.3.2 Electricity supply

a. The facility has functioning electricity and natural gas
b. A back up generator in working condition and the budget for it's maintenance and for it's fuel are available.

1.1.3.3 Waiting area

The waiting area is clean and protected.

a. The waiting area protects clients/patients from the sun, rain and extremes of temperature.
b. There are designated separate male and female waiting areas and toilets/latrines.
c. The waiting area has chairs or other seating arrangements.
d. The floor is swept or mopped and the area is clean of debris/ trash.
e. The walls and ceiling are intact with no broken masonry and are free from dirt and stains.

1.1.3.4 Toilet facility

The facility has clean toilets.

a. Latrines or toilets exist within the facility or facility compound. – seperate toilet facilities for male and female
b. Staff and clients/patients have access to separate latrines or toilets which are clearly signed and are lockable from the inside.
c. The client/patient latrine or toilet is not locked from the outside.
d. The toilet bowl is clean and empty and/or the latrine slab is clean.
e. Soap and water are available at the washing point near the toilet(s)/ latrine(s)

1.1.3.5 Work area

The facility compound is clean and uses a rubbish pit for disposal of refuse and medical waste.

a. The compound is free from litter such as plastic bags, refuse and medical waste.
b. There is a rubbish pit within the compound (possibly a garbage bin in urban settings)
c. The pit (bin) is not overflowing and is properly used, i.e. rubbish is not disposed of anywhere else
d. Medical waste is disposed of in a functional covered pit, e.g. not accessible for children and animals, within the compound.

1.1.3.6 Operability of the procedures and guidelines

The staff work to written Operating Procedures for managing Primary Care services, written guidelines for management of clients/patients and written guidelines for common illnesses.

a. Standard Operating Procedures are used for managing the facility, finances, equipment, cleaning procedures, and stocks, e.g. equipment maintenance
b. National clinical protocols for the priority illnesses are available at the facility, form the basis of regular training for relevant staff and are followed in providing care to the patients/clients.
c. Where National clinical protocols are not available they are developed and used by the Primary Care service.
d. Written guidelines for the management of clients/patients exist and are used, e.g. confidentiality, privacy, registration, recording and coding.

1.1.3.7 Availability of staff

Primary Care staff are available for service delivery during all official times.

a. An updated roster is kept of who is on duty at what time.
b. A qualified healthcare provider is available whenever the facility is open.

1.1.3.8 Staff

Staff are trained and evaluated in accordance with documented procedures, job descriptions and service needs.

a. All staff are oriented to the Primary Care services and their specific positions through a documented induction programme.
b. All staff have a copy of their job description that is kept current. The job description includes the responsibilities, accountabilities, tasks, performance measures and reporting relationships.
c. All staff have a copy of their conditions of employment.
d. Well-maintained and secure staff housing with all utilities is provided as per staff terms and conditions.
e. Staff performance is evaluated annually with the staff member against their job description and agreed targets and is used to identify strengths, areas for improvement and training needs.
f. Accurate and complete personnel records are kept at the facility.
g. Staff receive ongoing in-service training relevant to their job and the healthcare service and in areas such as health and safety, quality improvement and client/patient rights.
h. Documents guide the work of staff and cover staff appointments, performance evaluations, disciplinary procedures and terms and conditions of employment.

1.1.3.9 Health and safety

The health and safety of clients/patients, staff and visitors are protected.

a. The Service is designed to allow service delivery to be safe, accessible and respect clients'/patients' needs for privacy.
b. The Service is inspected annually by the Works and Services Department and declared safe.
c. A current Safety Certificate has been issued and is displayed in the facility.
d. Chemicals, drugs and equipment are stored safely.
e. Risks and hazards are identified and eliminated, isolated or minimized as appropriate.
f. Guidelines exist for major risks and hazards and are known to the staff.

g. Incidents, accidents and near misses are reported and analysed to identify causes and the analysis is used to improve systems and processes, e.g. needle stick injuries.
h. Staff are provided with and use protective equipment, e.g. gloves, aprons, masks.
i. Staff are trained in fire safety and other emergencies and drills are practised regularly.
j. Staff health is protected by the provision of immunization for infections such as Hepatitis A and B and influenza.

1.1.3.10 Complaint handling

Clients/Patients have the right to complain about services and treatment and their complaints are investigated in a fair and timely manner.

a. Clients/Patients are informed of their right to express their concerns or complain either verbally or in writing.
b. A documented process which is fair and timely is used for collecting, reporting and investigating complaints.
c. Clients/Patients are informed of the progress of the investigation at regular intervals and are informed of the outcome.

1.1.3.11 Continual improvement

The Service identifies opportunities to continuously improve its processes and services, makes improvements and evaluates their effectiveness.

a. Performance indicators for priority diseases and key processes are measured, reported and used for continuous improvement.
b. Performance data from activities such as audits, complaints, incident reports, satisfaction surveys and risk assessments are collected, analysed and used to identify improvement opportunities. This is coordinated by the quality group.
c. Improvements are planned, appropriate action is taken, the effectiveness of the action is evaluated and the results are fed back to staff and clients/patients.
d. All relevant legal requirements are identified and compliance is monitored.

1.2 Requirements for Service Provision

1.2.1 Accessibility to health services

The facility and the services provided are easily accessible to the catchment area population

a. Costs involved in using the services are addressed in the annual plan and steps are taken to minimize costs, such as fees, drugs, and transportation costs.
b. Major obstacles affecting access for clients/patients to the facility and its services are addressed in the annual plan and steps are taken to minimize them, e.g.
    i. The attitude of employees working at the facility;
    ii. The perception of the need and utility of health care by the community;
    iii. Cultural constraints on clients about using the facility and its services.

1.2.2 Accessibility to the information

A list of available services and applicable fees is posted where the clients/patients can see them.

a. A poster with listed services, opening times and emergency contacts during closing times is displayed in a prominent place where the clients/patients can see it. The text is in an understandable format, e.g. local or national language.
b. A list with all fees and possible exemptions is displayed in a prominent area where the clients/patients can see it. The text is in an understandable format, e.g. local or national language.

1.2.3 Behaviour with client/patient and their attendant

Clients/Patients and their attendants are received in a friendly and respectful manner irrespective of their sex, age, race, religion or physical appearance

a. Clients/Patients are treated in a kind, patient and respectful manner at all stages from registration through to end of service.
b. The healthcare provider uses open ended questions (why, who, what, when, how) to obtain information from clients/patients.
c. The healthcare provider listens carefully to what the clients/patients say and does not jump to conclusions.
d. The healthcare provider explains to the client/patient the diagnosis, care management, and follow-up.
e. The healthcare provider takes feedback from the client/patient to ensure the client/ patient understands the message communicated.

1.2.4 Priority on service provision

Providers give priority to extremely sick clients/patients and those of extreme age (early newborns and elderly).

a. A system using the time of arrival recorded on the registration chit is used to prioritize clients/patients.
b. The order prioritizes extremely sick clients/patients first, those of extreme ages (elderly and babies) second and then others.
c. Extremely sick clients/patients are seen by the healthcare provider within five minutes, and those of extreme ages within 15 minutes.

1.2.5 Emergency cases

Providers use a defined process for referring emergency cases.

a. SOPs exist for identification of types of clients/patients who need to be referred.
b. A referral form provides sufficient information to allow continuity of care.
c. When possible transportation to the referral facility is provided.
d. In other cases, the Service provides some type of assistance for moving a sick client/patient to a referral facility such as communication to the next level, or arranging community transport.
e. A copy of the referral form is kept at the facility.

1.2.6 Dealing with non-priority patient

Non-priority clients/patients wait no more than one hour after arrival at the facility before being seen by the provider.

a. A system is used to prioritize the order in which non-priority clients/patients are seen on a first-come first-serve basis.
b. Waiting times are no more than one hour and are monitored.
c. Waiting times are analyzed and results used to improve services.

1.2.7 Privacy

The privacy of patients/clients is ensured during consultation and examination.

a. Consultations and examinations are held behind curtains/screens at all times.
b. Healthcare providers ensure privacy at the time of consultation.

1.2.8 Assessment

All clients/patients receive appropriate assessment, diagnosis, plan of care, treatment and care management, and follow-up

a. The registration is completed promptly for all clients/patients.
b. The time the client/patient arrives is documented on the registration and monitored
c. Basic assessment is undertaken and includes temperature, blood pressure, and symptom identification.
d. Basic assessment for children under five includes weight, immunization status, temperature, level of consciousness and symptom identification.
e. A client/patient history is taken and documented.
f. Treatment and care management is provided in accordance with the assessment, test results, diagnosis and care management guidelines.
g. Referrals to other services are made when required.
h. Appointments for future care are made.
i. Results of previous care are used in follow-up visits.

1.2.9 Protocol

National clinical protocols are available and used for those services listed as offered.

a. Healthcare providers provide technically correct services according to guidelines for but not limited to the following areas:
    i. First Aid and Emergency care, Injury management, minor surgical procedures
    ii. IMCI, ANC, Delivery, PNC, Family planning
    iii. Malaria, TB & DOTS, HIV/ AIDS , STD, Diarrhoea, Polio, Hepatitis, HIV/AIDS, Measles, ARI, Hypertension, Diabetes, Anaemia, Common skin problems, EPI
    iv. Dental care.
b. Staff are trained to follow these guidelines.
c. Justification is available for variations from the guidelines.

1.2.10 Immunization status

All children who visit the facility have their weight plotted correctly on their health card and have their immunization status checked.

a. All under five children coming to the facility are weighed.
b. Weight is accurately plotted on the child's health card and follow-up action taken based on the plot.
c. Immunization status is checked and missing immunizations given
d. Weight and vaccination information are given to the parent/carer.

1.2.11 Health Education

Healthcare providers regularly educate their clients on health issues in a way that is easy to understand.

a. Healthcare providers conduct group health education sessions at least four times a month.
b. Healthcare providers use the following materials during client/patient counselling/education sessions: posters, family planning material, brochures, leaflets, flipcharts and cue cards.
c. Health education messages (posters and charts with pictures and minimal text) are visibly posted in prominent areas within the facility.
d. Health education written material is available for clients/patients to read and take home.

1.2.12 Communication

Clients/Patients are given accurate information about their medication regime to enable them to manage it.

a. The healthcare provider/dispenser instructs clients/patients about the medication, the amount of medication to take, what time to the day it should be taken and for how long it should be taken.
b. The healthcare provider/dispenser checks that the client/patient understands the instructions.

Staff follow correct aseptic techniques and wash their hands between clients/patients.

a. Health workers perform the following aseptic procedures in line with SOPs or guidelines: wound dressing, suturing, catheterization, injections, intravenous infusion and dental extraction.
b. Soap (where possible liquid soap) and water or antiseptic gel are available at the washing point(s) in or near the consulting/examination room(s) and a clean hand towel or alternate is available.
c. Hand washing instructions are posted above the washing point(s).
d. Healthcare providers wash their hands between clients/patients and between procedures.

1.2.13 Access of essential Drugs

Essential drugs and supplies are available at all times during open hours.

a. Availaibility of essential drugs at emergency, outdoor, indoor and operation theater.
b. Stock cards are up to date and correspond to physical stock.
c. There is a stock of the essential drugs.
d. There is a process for checking date of expiry.
e. No expired drugs are in stock.
f. Inventory control and management.
g. Formation of condemnation board.

1.2.14 Cold chain vaccine

The cold-chain for vaccines is maintained

a. A Cold Chain procedure for vaccines is used and includes clear directions on the following practices.
    i. Vaccine stock management including vaccine storage, potency, stock quantities, stock records, and arrival report
    ii. Equipment for vaccine transport and storage
    iii. Maintenance of equipment
    iv. Control and monitoring of temperature
    v. Cold chain during immunization sessions
    vi. Syringes, needles and sterilization and
    vii. Breakdown of equipment and emergency actions to minimize risks.

1.3 Patient Rights

1.3.1 Information for Clients/Patients

Clients/Patients have the right to receive all information relevant to their care management to enable them to make informed decisions.

Sl. No.	Measurable Criteria
1.3.1.1	A client/patient rights and responsibilities charter (Citizen Charter) is developed and displayed in all client/patient areas.
1.3.1.2	The hospital uses a documented process for clients/patients not able to understand written information to inform them of their rights.
1.3.1.3	Guidance and advice is provided to the clients/patients at the registration counter.
1.3.1.4	The reception area and wards display information about the organisation, including: - location map of Upazila Health complex - The rights of the clients/patients - Services and facilities available in the hospital - Costs of services - Feedback and complaints pathways by prominently displaying complain box. - List of the name and room number for every doctor - List of the drugs available on the daily basis

1.3.2 Client/Patient Feedback on Services

Clients/Patients have the right to complain about the services and treatment and their complaints are investigated in a fair and timely manner.

Sl. No.	Measurable Criteria
1.3.2.1	Clients/Patients are informed of their right to express their concerns or complain either verbally or in writing
1.3.2.2	There is a documented process for collecting, prioritizing, reporting and investigating complaints which is fair and timely.

1.3.3 Privacy and Dignity of Clients/Patients

Clients'/Patients' privacy and dignity are respected throughout the entire care process.

Sl. No.	Measurable Criteria
1.3.3.1	Consultation rooms and washing facilities allow privacy and separate toilets for male and female clients/patients are provided in all departments.
1.3.3.2	Registration desk, waiting room/space, pharmacy/drug dispensing corner (separate male and female)
1.3.3.3	There should be a lactation management corner/room and separate adolescent corner
1.3.3.4	Strictly follow the visiting hour in in-patient department.

Part 2 : Standards for Service Delivery

2.1 Care Continuum

In Care Continuum, National Strategic Plan on Quality of Care will be introduced as per implementation plan in the document.

2.1.1 Access to Health Services

Services are continuously available and the hospital minimises physical, economic, social, cultural, organisational or linguistic barriers to access.

Sl. No.	Measurable Criteria
2.1.1.1	Access ways and passage ways are kept clear at all times.
2.1.1.2	Disabled parking spaces are conveniently located, adequate parking areas are available for private and official vehicles and there is a designated area for public transport.
2.1.1.3	The hospital specifies visiting hours (6 hours) and communicates these to the public.

Sl. No.	Measurable Criteria
2.1.1.4	Rules for numbers and kind of visitors and attendees are clearly defined and visibly posted and facilities enable relatives to sit at the bedside and to stay overnight.
2.1.1.4	On admission to hospital, clients/patients are introduced to the nurse on duty and given an orientation to the unit to which they are admitted including the location of toilets, pantry and other facilities and services.
2.1.1.5	Clients/Patients admitted to the hospital have access to an allotted bed with fresh linen and do not have to double up with other clients/patients.

2.1.2 Continuity of Care

Clients/Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care. The client receiving the complete management of health services that he/she needs, without interruption or cessation. It includes the ability of the clients to see the same health care provider and the degree of keeping medical records.

Sl. No.	Measurable Criteria
2.1.2.1	Every client/patient seeking treatment or care at the hospital is registered and issued the appropriate form for recording various details of symptoms, diagnosis, treatment and services being provided.
2.1.2.2	The doctor on duty has primary responsibility for the clinical care of any client/patient until a specialist takes over.
2.1.2.3	The nurse on duty is responsible for coordinating client/patient assessment, care planning and evaluation of care with other care providers and services.
2.1.2.4	A stock of essential drugs is available at all times in each treatment area.
2.1.2.5	Doctors, qualified nurses and appropriate support staff are available on-site 24 hours per day.
2.1.2.6	Following referral protocol properly and keeping records by referral form and register.

2.1.3 Assessment

All clients/patients have their health care needs identified through an established assessment process.

Sl. No.	Measurable Criteria
2.1.3.1	Criteria to prioritise emergency patients exist and are implemented.
2.1.3.2	Clients'/Patients' choice regarding examination by a male or female is respected as far as possible.
2.1.3.3	An attendant is available when patients are being examined by members of the opposite sex.
2.1.3.4	The initial assessment includes the recording of vital signs, weight, height and significant findings.
2.1.3.5	Following examination, written as well as verbal information is provided for clients/patients regarding future visits, treatment and medication.

2.1.4 Treatment

The organisation delivers services to the clients/patients that meet their individual assessed needs, reflect current good practice and are co-ordinated to minimise potential risks and interruptions in provision.

Sl. No.	Measurable Criteria
2.1.4.1	Clinical guidelines/treatment protocols are used to guide client/patient care processes.
2.1.4.2	Written procedures to ensure that the right dose of medication is administered to the right Client/patient at the right time are followed by staff and include:

Sl. No.	Measurable Criteria
	- Identification of the client/patient before medications are administered - Verification of the medication and the dosage amount with the prescription - Verification of the routes of administration - Verification of the time of administration.
2.1.4.3	Appropriate and sufficient support services are available to allow nursing staff to meet the care needs of clients/patients. These include: - At least one Class IV employee around the clock - Equipment of at least B.P. Apparatus, Stethoscope, Thermometer, Oxygen cylinder with trolley, Suction machine, torch and nebuliser.

2.1.5 Documentation of Care

The client/patient record contains sufficient information to identify the client/patient, support the diagnosis, justify the treatment and care, document the course and results of the treatment and care, and promote continuity of care among health care providers

Sl. No.	Measurable Criteria
2.1.5.1	A clinical record is initiated for every client/patient admitted to the hospital and wherever possible there is only one set of case notes for each client/patient.
2.1.5.2	Client/Patient records are maintained through the use of a unique number or other form of identification unique to the patient.
2.1.5.3	The client's/patients' record can be used for research purposes only if the client/patient has given a written consent and/or if there is an approval by the Ethics Committee.
2.1.5.4	The original client/patient record may not be removed from the hospital premises, except by court order. Policies and procedures are in place to prevent the loss and/or misuse of client/patient records.
2.1.5.5	The client/patient record is sufficiently detailed to enable the client/patient to receive effective coordinated treatment and care and includes**:** - Details of admission, date and time of arrival - Client/Patient assessment and medical examination - Sheet containing history pertinent to the condition being treated including details of present and past history and family history - Treatment record - Observation charts, e.g. temperature chart, input and output chart, head injury chart, diabetic chart
2.1.5.6	- For surgical clients/patients, the clinical record additionally includes: - Anaesthetic notes - Operation record - Consent form.
2.1.5.7	Where referrals have been made, the client/patient record includes the referral letter and indications for referral
2.1.5.8	There is a system for easy retrieval of records.

2.1.6 Discharge and Referral

Safe and appropriate discharge, transfer or referral of clients/patients is based on the client's/patient's health status and need for continuing care.

Sl. No.	Measurable Criteria
4.1.6.1	A written and dated procedure including criteria to determine readiness for discharge, transfer or referral of clients/patients is used and specifies who is authorised to do it.
4.1.6.2	Follow up arrangements, agreed with the client/patient and/or the family, are noted in the client/patient record prior to discharge.

Sl. No.	Measurable Criteria
4.1.6.3	Availability of Functioning ambulance service or suitable transport mechanism to transfer the patient in need for referral care.
4.1.6.4	Identification of types of service to be provided through each level of institution and clear communication to assure that the patient receives optimal care at each level of the referral system.
4.1.6.5	Referral System Guideline, Referral Register & Referral Slip (Developed by Hospital & Clinic Section of DGHS) will be used for patient referral.

2.2 Quality Management

The Quality Improvement activities will be implemented by the directives of National Strategic Planning on Quality of Care for Health Service Delivery, Bangladesh.

Sl. No.	Measurable Criteria
2.2.1	The Quality Improvement Committee / team develops a quality plan which defines roles and responsibilities and sets priorities for quality improvement according to the National Strategic Planning on Quality of Care for Health Service Delivery, Bangladesh.
2.2.2	Clinical Management Protocols/Guideline/Tools/Standard Operating Procedure will be introduced as per National Strategic Plan on Quality of Care.
2.2.3	The Quality Improvement committee/team regularly assesses client/patient satisfaction in order to improve service provision.
2.2.4	Work Improvement Team (WIT) will be formed and developed action plan accordingly.
2.2.5	Key Performance Indicators and Facility level indicators for Quality of Care will be measured as per guideline of Quality Improvement Secretariat.
2.2.6	5S-CQI-TQM approach will be introduced for improvement for Quality of Care.
2.2.7	Monthly report will be sent to DGHS and QIS routinely (DHIS-2).

2.3 Operation Theatre Department

2.3.1 Service Management

Operating Theatres provide safe, hygienic and appropriate services for clients/patients and are co-ordinated with other services of the hospital to provide continuity of care.

Sl. No.	Measurable Criteria
2.3.1.1	The operating theatre and/or department is managed by a suitably qualified, registered and experienced nurse, doctor or senior operating department assistant.
2.3.1.2	Safe Surgery Check list is used for every surgery.
2.3.1.3	A list of hospital approved surgical procedures based on an annual assessment of qualified staff, equipment and other inputs and processes is communicated to staff
2.3.1.4	Anaesthetic services are provided by qualified, registered and experienced anaesthetists.
2.3.1.5	An anaesthetist is present for all surgical procedures 24 hours a day.
2.3.1.6	A signed agreement with a referral hospital offering more comprehensive services ensures provision of necessary surgeries.

2.3.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the operating theatre and/or department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.3.2.1	Written up-to-date procedures are available, followed by staff and include but are not limited to the following:

Sl. No.	Measurable Criteria
	- Signage of OT as a restricted area and identification of persons allowed in the OT - Sterilisation and identification of sterilised OT equipment - Separation and transport of dirty linen - Pre-operative assessment and instructions - Routine equipment check and preparation - Annual review of functioning equipment in line with the services offered by the OT - Sending for and the transportation of clients/patients from ward to OT - Admission to the operating department - Identification of clients/patients - Identification of operation site
2.3.2.2	The following formal documentation/records are available in the department: - Theatre register (anaesthesia register and surgeons' register) - Record of correct swab/instrument count - Controlled drugs - Record of weekly/monthly analyses of surgeries (including the ICD 10 code) - Next-day schedule for operations - Maintenance of stock levels of drugs and consumables - Duty roster.
2.3.2.3	There is a separate fully functioning and equipped recovery room.
2.3.2.4	A trained recovery nurse is present for each anaesthetic session and remains in the recovery area until the last client/patient has been discharged back to the ward.
2.3.2.5	Sufficient, qualified and experienced staff monitor clients/ patients in the recovery room to ensure individual client/patient supervision at all times.
2.3.2.6	Documented discharge criteria are used to assess clients'/patients' readiness to leave the recovery room.
2.3.2.7	A record of the operation for the client/patient record is made immediately following surgery and a copy is retained in the OT. The record includes the following: - Date and duration of operation - Anatomical site/place where surgery is undertaken - The name of the operating surgeon(s), operating assistants including scrub nurse and the name of the consultant responsible - The ICD 10 coded diagnosis made and the procedure performed - Description of the findings - Details of the sutures used - Swab and equipment count - Immediate post-operative instructions - The surgeon's and scrub nurse's signatures.
2.3.2.8	Anaesthetic records contain: - Date and duration of anaesthesia - Name of surgical operation performed - The name of the anaesthetist, anaesthesia assistant and, where relevant, the name of the consultant anaesthetist responsible - Intravenous fluid therapy - Post-anaesthetic instructions - Any complications or incidents during anaesthesia - Signatures of anaesthetist and anaesthesia assistant.

2.3.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients undergoing procedures in the operating theatre(s).

Sl. No.	Measurable Criteria
2.3.3.1	Arrangements are made so that hospital OTs are situated separately from areas accessible to the general public.
2.3.3.2	There is a clear separation of 'dirty' areas and OT (s) and only persons wearing theatre dress enter the OT(s).
2.3.3.3	The anaesthetic induction area/room and operating theatre are equipped with safe and well maintained equipment specific for OT activities including but not restricted to the following: - Anaesthetic machine and ventilator - Laryngoscopes - Endotracheal tubes/laryngeal masks - Airways - Nasal tubes - Suction apparatus and connectors - Oxygen - Drugs and IVs required for planned anaesthesia - Drugs for emergency situations
2.3.3.4	A list of functioning equipment available in the recovery room includes :- - Airways (Ambu bags) and other intubation material and equipment - Suction - Oximeter - ECG - Blood pressure measurement apparatus - Defibrillator - Anaesthesia machine - Oxygen concentrator - Emergency ventilator.

2.4 MCH Services

2.4.1 Service Management

Maternity services provide safe, timely and efficient maternity care for patients.

Sl. No.	Measurable Criteria
2.4.1.1	The maternity department is managed by a suitably qualified, registered and experienced nurse, doctor or senior midwife.
2.4.1.2	Deputising arrangements for suitably qualified and experienced deputies are documented and used.
2.4.1.3	Consultant obstetricians provide assistance and advice through a signed agreement.
2.4.1.4	Data for clinical audits and reviews is collected, analyzed and used for quality improvement activities and includes: -Number of women in ante-natal clinics -Number of women with medical or surgical disorders in ante-natal clinics -Number of women transferred to higher-level care during pregnancy -Number of deliveries -Number of live births -Perinatal mortality figures -Maternal mortality figures

	-Number of transfers to specialist care during labour -Number of still births -Birth Registration records -Number of Caesarian sections -No. of difficult labour cases

2.4.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the maternity unit, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.4.2.1	Written procedures and guidelines are used consistent with the hospital policies and functions for: - ante natal care and booking/registration - post-natal care - peri-natal care - counseling for parenthood (e.g. family planning, genetic referral,) including, for example, IEC material - identifying high risk pregnancy - admission to labour room/ward - planning, treatment and mode of delivery - plan for managed pain during labour and delivery - delivery monitoring process by following partograph - referral - discharge including discharge summary - birth record and certificate - labour register - immunization for mother and baby - infection control - disposal of placentas
2.4.2.2	A paediatrician is involved in the team developing and reviewing policies and procedures.
2.4.2.3	A record of regular training in maternal and neonatal resuscitation is kept in the department for medical and nursing staff attending deliveries
2.4.2.4	A guideline on summoning medical assistance at anytime during labour is used by nurses and midwives
2.4.2.5	A roster indicates 24 hour arrangements for on-site availability of a suitably qualified and experienced doctor and an anaesthesiologist in case of an emergency.
2.4.2.6	Separate records are initiated and used for each baby.
2.4.2.7	Records kept after discharge include the combined: - Maternity notes (including care plans) - Birth registration(s) - Labour register - Admission register - Neonatal and perinatal morbidity - Neonatal and perinatal mortality - Maternal morbidity and mortality
2.4.2.8	Written procedures are followed by staff to arrange for consulting physicians, surgeons and paediatric physicians and surgeons for women or babies with medical or surgical needs such as multiple, high risk deliveries, instrument deliveries or C-sections.

2.4.3 Facilities and Equipment

Facilities and equipment are safe and adequate in design and number for the purpose and quantity of clients/patients attending/in the maternity department.

Sl. No.	Measurable Criteria
2.4.3.1	The delivery room is equipped with functioning, safe and well maintained equipment specific for deliveries including but not restricted to the following: - Fetoscope - Ultrasound machine - Delivery table which can be turned to the Trendelenburg position - An anesthetics machine with emergency oxygen supplies - Endotracheal tubes, laryngoscope - An incubator, with temperature adjustable for infants in need - Separate oxygen supply to the incubator - Resuscitation equipment and drugs for infants and for adults - Intravenous crystalloid and plasma expanders - Weighing machine for the baby.
2.4.3.2	Privacy for mothers is possible, e.g. when breast-feeding.
2.4.3.3	A separate room for seriously ill or intensive patients e.g. eclampsia, is available.
2.4.3.4	The area for labour provides for: - Space for the woman and a female companion - Alternative birthing methods - Ambulation throughout labour - Washing and toilet facilities for the comfort of the mother and companion
2.4.3.5	Lighting is versatile enough to provide a restful environment and allow birthing procedures to be performed.
2.4.3.6	The post-natal ward provides sufficient room for babies to room-in with mothers.
2.4.37	Nursery facilities with an even temperature and humidity are available, and are adequate in size with appropriate supplies and equipment for teaching mothers about caring for their babies.

2.5 Emergency Dept.

2.5.1 Service Management

The Emergency Department provides safe, timely and efficient live-saving emergency care and minor treatment and surgery for patients.

Sl. No.	Measurable Criteria
2.5.1.1	Emergency Medical officers are available on duty 24 x7 Number of duty doctors are increased during peak hours as appears on annual/monthly audit
2.5.1.2	Standard operating procedure is used for emergency management
2.5.1.3	Adequate number of Nursing and auxiliary staff are present
2.5.1.4	Resuscitation instruments and drugs (Emergency Medical Tray) are cheeked at the beginning of each duty hour
2.5.1.5	Admitted patients are transferred to respective indoor units with all documents and investigation results available at hand
2.5.1.6	Patients requiring short period of observation are monitored closely
2.5.1.7	During discharge a prescription is give with written legible notes of clinical findings, management done and instructions for further treatment
2.5.1.8	A clinical note of patients conditions is handed over during patient transfer

2.5.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key functioning processes of the emergency department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.5.2.1	Written SOP and guidelines are used consistent with the policy for: - Identifying patients - How medical help is called during emergency - Dealing with life threatening emergencies before medical help arrives - The transfer of patients - The transfer of records - The use of tele-medical techniques. - Approach to patients who can not be admitted in the hospital
2.5.2.2	All patients are seen within fifteen minutes of arrival for initial assessment and treatment prioritisation.
2.5.2.3	Each patient is informed of the approximate waiting time after the need for treatment has been assessed.
2.5.2.4	A process is used to monitor patient waiting times.
2.5.2.5	Patients are examined in privacy by a doctor of the same sex as the client/patient (if available), or have the service of a chaperone if desired.
2.5.2.6	Relatives are kept informed of the patient's condition with the agreement of the patient where they are able to give such consent.
2.5.2.7	An individual record of attendance is completed which contains: - Name - Address - Age/Date of birth - Next of kin - Occupation/School - Case number - Telephone number - Date and time of arrival - Time of examination - Diagnoses - Treatment - Minor surgery carried out - [Specimens taken] Foreign body removed - Instructions for follow up - Doctor's or nurse's names and signatures - Medication given to/or taken away - Advice given on discharge.
2.5.2.8	A procedure exists for referral for specialist care if necessary.
2.5.2.9	A senior person should be available on call round the clock
2.5.2.10	A written, dated, signed policy on the referral, selection and treatment of patients' / clients for minor surgery is followed.
2.5.2.11	There will be no denial of any emergency services. Patient will be resuscitated and managed first and then transferred.

2.5.3 Facilities and Equipment

Easily accessible Safe and adequate facilities and equipment are provided round the clock to meet the needs of patients attending the emergency department.

Sl. No.	Measurable Criteria
2.5.3.1	Hospital Emergency room is easily accessible from different parts of catchment area and preferably separate from Out Patient Department (OPD)
2.5.3.2	The entrance is clearly signposted from outside the hospital.
2.5.3.3	Parking is available for patients, including designated space for the disabled.
2.5.3.4	There is a canopy over the casualty entrance used by ambulances.
2.5.3.5	The doorways and access are suitable for wheelchairs and trolleys.
2.5.3.6	Emergency alarms are strategically sited within the unit to call help.
2.5.3.7	There is appropriate equipment for: - Patient examination - Resuscitation - Monitoring - Minor operations - Sterilisation - X-rays and other imaging (either locally or by referral).
2.5.3.8	Treatment areas afford the patients' privacy.
2.5.3.9	A private area/room is available for interview and examination.
2.5.3.10	The waiting area: - has comfortable and adequate seating area - is clean and secure. - Food store /KIOSK
2.5.3.11	There are toilet facilities suitable and available for males, females and disabled.
2.5.3.12	A public telephone is available for the use of patients and relatives.
2.5.3.13	There is an accurate and functioning clock.

Part 3 : Support Services

3.1 Laboratory Services

3.1.1 Service Management

The medical testing laboratory is managed and organised to provide efficient and effective laboratory care to patients and support services to clinicians.

Sl. No.	Measurable Criteria
3.1.1.1	The medical testing laboratory is managed by a suitably qualified experienced medical technologist or other suitably qualified and registered laboratory personnel.
3.1.1.2	Sufficient and appropriately qualified staff are available to fulfil the job descriptions of the defined service.
3.1.1.3	Staff follow SOP for collection, transport and controlling, storing, reporting and disposing of all samples and tests in compliance with legal requirements.
3.1.1.4	The department has planned and systematic activities for the monitoring and evaluation of its services.

3.1.2 Samples and Tests

Laboratory samples and tests are managed to maximize accuracy of testing and minimise risks to patients/clients and staff.

Sl. No.	Measurable Criteria
3.1.2.1	A requisition form is used and includes the following: - Client/Patient information - Client/Patient location - Investigations required - Type of sample - Clinical history including clinical examination - Probable diagnosis - Requesting physician - Sample collection time - Name of phlebotomist.
3.1.2.2	Samples collected are labelled with the client's/patient's name, registration number, date and time of collection.
3.1.2.3	A laboratory register records: - Client/Patient name, age, sex, location - Identification of sample source(s) - Full name of the investigation(s) - Number of investigations - Investigation results
3.1.2.4	Results are recorded in the laboratory register and on the reporting/result form.
3.1.2.5	Signed and dated SOPs for each test and client/patient preparation for each test are readily available to staff in the laboratory.
3.1.2.6	Instructions are clearly displayed describing the safe disposal of clinical, toxic and radioactive waste.(MWM)
3.1.2.7	Clearly labelled, separate containers are used for disposal of hazardous and infectious waste.

3.1.3 Safety

All persons (Service providers and recipients) are protected from potential hazards in the laboratory.

Sl. No.	Measurable Criteria
3.1.3.1	Health and safety policies, current relevant hazard notices and safety action bulletins are displayed as required or are readily available to staff, including but not limited to: - Safety regulations - Fire precautions - AIDS/HIV/ - Hepatitis B and Hepatitis C.
3.1.3.2	Appropriate equipment is used for the safe handling of hazardous materials.

3.1.4 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients served by the laboratory.

Sl. No.	Measurable Criteria
3.1.4.1	Laboratory and office space are sufficient to enable staff to carry out their jobs safely.
3.1.4.2	The laboratory environment is well lit, ventilated and not underground.
3.1.4.3	Storage facilities for specimens and reagents are sufficient to enable staff easy access.
3.1.4.4	Refrigerated storage facilities are used for specified samples, specimens, and blood samples.
3.1.4.5	Inspection, calibration and maintenance schedules are completed and used for all laboratory equipment.

3.2 Radiology Services

3.2.1 Service Management

Radiology services are managed and organised to provide safe and efficient care for client/patients and support to clinical specialties.

Note: Radiology services cover all services provided by a radiology department.

Sl. No.	Measurable Criteria
3.2.1.1	A radiologist (either on site or visiting) is responsible for the clinical direction of the department and the safety of the client/patients.
3.2.1.2	Radiology services are administered by an identified qualified, registered radiologist or radiographer with clearly defined responsibility for all non-clinical aspects of the department.
3.2.1.3	Trained, qualified radiographers, or in some cases radiologists, are the only staff who may take images.
3.2.1.4	There are on-call staff for mobile radiography and other imaging at all times.
3.2.1.5	Radiation protection is supervised by the radiologist and monitored by the Hospital in-charge.
3.2.1.6	Radiology equipment's, reagents, X-ray films etc are available and maintained.

3.2.2 Service Provision

Clients/patients are systematically registered, receive radiological services in line with written requests and have their x-rays reported promptly and accurately.

Sl. No.	Measurable Criteria
3.2.1	Clients/Patients are registered, assigned a registration number and given special instructions in a systematic way.
3.2.2	Request Forms are of a standard format and contain: - Client's/Patient's name - Identification number - Address - Date of birth (if not available, age/ - Examination requested - History of allergy in red ink - For medico legal cases mark of identification of the client/patient and name of police official bringing the client/patient - Fee to be charged/not to be charged.
3.2.3	Diagnostic imaging is performed only upon a signed written request from a qualified medical practitioner.
3.2.4	Arrangements are in place for dealing with out of hours or emergency requests.
3.2.5	A written policy agreed with the radiologist defines the terms under which pregnant women may be subjected to radiological examination
3.2.6	For out-patients the radiology report is written on the OPD slip.
3.2.7	A duplicate report is kept on file in the department.
3.2.8	A copy of X-ray films and scans in medico-legal cases are retained by the department.

3.2.3 Safety

Radiological services are provided in accordance with current radiation rules and regulations, risks are minimised and the safety of client/patients and staff are protected.

Sl. No.	Measurable Criteria
3.2.3.1	Signs warning women of childbearing age of the dangers of radiation in pregnancy are prominently displayed.
3.2.3.2	All examinations using ionising radiation are performed by suitably trained personnel.
3.2.3.3	Staff provide services in accordance with current ionising radiation regulations and statutory requirements
3.2.3.4	All staff working in radiology services attend update courses on resuscitation, current radiology trends and evidence based practice.
3.2.3.5	Protective clothing is provided and used where biohazards or radiographic equipment are present.
3.2.3.6	Availability of Lead apron must be ensured.
3.2.3.7	Availability of Film Badge for each radiographer

3.2.4 Facilities and Equipment

Facilities and equipment are provided and maintained to maximise client/patient comfort and safety**.**

Sl. No.	Measurable Criteria
3.2.4.1	.A separate waiting area for males and females with adequate seating and separate male and female toilets and washing facilities are provided for the comfort of clients/patients waiting for services and for their families.
3.2.4.2	All equipment is subject to tests on installation to ensure the equipment meets with contract specifications and confirms mechanical, electrical and radiation safety.
3.2.4.3	Records of these tests are kept in the department for reference.
3.2.4.4	The workload of each piece of diagnostic equipment and staff is defined and used for determining the resources needed for the department.
3.2.4.5	Radiology equipment is stable, functioning and installed only in properly lead protected rooms.

3.3 Pharmacy Services

3.3.1 Management

The pharmaceutical service is managed and organised to provide efficient and effective pharmaceutical services through rational use of drugs within the hospital.

Sl. No.	Measurable Criteria
3.3.1.1	The pharmaceutical service is managed by a qualified, graduate and registered pharmacist.
3.3.1.2	A suitably qualified deputy with specified duties and responsibilities is designated in the absence of the pharmacist.

3.3.2 Storage and Stock Management

Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

Sl. No.	Measurable Criteria
3.3.2.1	Medicines are stored on shelves enabling: - Protection from the adverse effects of light, e.g. glass windows painted white, dampness and temperature extremes - Freedom from vermin and insects - Adequate ventilation.
3.3.2.2	Medicines for emergency use are stored in sealed containers in all patient areas.
3.3.2.3	A formal, written procedure is followed to action hazard warnings and medicine recalls.

Sl. No.	Measurable Criteria
3.3.2.4	A formal, written procedure is followed for retention of order forms, copy of delivery notes, stores receipt, and issue vouchers, and book of records (controlled drugs book/prescription drugs book) on the premises as provided for in the relevant laws.
3.3.2.5	Inventory is kept and maintained up-to-date.

3.3.3 Prescribing, Administration and Dispensing of Medicines

Prescribing, dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

Sl. No.	Measurable Criteria
3.3.3.1	A system is in place to ensure that: - Prescriptions are only issued by authorized prescribers - Administration of medicine is done by, or under the supervision of, competent health personnel.
3.3.3.2	All prescriptions are legible and duly signed by a doctor, including the following: - Name - Diagnosis - Dose - Dosage form - Strength of medications.

Part 4 : Infection Control and Waste Management

4.1 Infection Control

The organisation designs and implements a coordinated program to reduce the risks of nosocomial infections in clients/patients, visitors/attendants, contractors and staff.

Sl. No.	Measurable Criteria
4.1.1	National Infection Prevention & Control Guideline, National Hand Hygiene Guideline and Medical Waste Management Guideline will be used.
4.1.2	The health complex establishes an infection control program designed to prevent or reduce the incidence of nosocomial infection, based on current scientific knowledge and accepted practice guidelines and developed and monitored with multidisciplinary involvement. Infection control committee is functioning.
4.1.3	The infection control program includes all areas of the health complex and describes the scope, objectives, annual activities, surveillance methods, resources and processes associated with infection risks, including respiratory tract, urinary tract and surgical wound infections, are identified and included in the infection control program..
4.1.4	The infection control committee is linked with Waste Management Control
4.1.5	Infection risks, rates and trends are tracked, analyzed and reported.
4.1.6	Surveillance of multiple resistant organisms and organisms associated with antimicrobial use is conducted as part of the infection control program.
4.1.7	Professional staff are appropriately inducted and trained in all aspects of infection control relevant to their work, including proper handwashing.
4.1.8	Gloves, gowns, masks, soap and disinfectants are available and correctly used in situations where there is a risk of infection.

4.2 Sterile Supplies

Equipment and supplies are sterilised to minimise risk of infection in clients/patients and staff.

Sl. No.	Measurable Criteria
4.2.1	The Infection Control Committee oversees the provision of sterile supplies.
4.2.2	There is a defined department or area for sterilisation which physically separates the functions of cleaning, processing and sterile storage and distribution.
4.2.3	In all areas where instruments are cleaned there is airflow to prevent cross-contamination and to keep material within the area.
4.2.4	Sterilisation procedures are based on existing national guidelines.
4.2.5	The sterilisation status of sterilised goods is assessed by the use of temperature sensitive tapes, using indicators as recommended by the manufacturer.
4.2.6	Reports of quality control tests on sterilisers are reported to the infection control committee at least quarterly.
4.2.7	The person using sterilised equipment checks that the decontamination of the equipment has been done before using that equipment.
4.2.8	Stock levels of sterilised goods are checked by an ongoing inventory management process.
4.2.9	All trays/packs/containers are stored in conditions that preserve the integrity of their packaging to prevent damage and/or contamination.

4.3 Cleanliness

All hospital facilities, equipment and supplies are kept clean and safe for clients/patients, visitors/attendants and staff.

Sl. No.	Measurable Criteria
4.3.1	Standard Operating Procedure (SOP) for house keeping will be followed for ensuring cleanliness of the facility.
4.3.2	Staff follow written policies and procedures and schedules for: - Disinfection and cleaning of all equipment, furniture, floors, walls, storage areas and other surfaces and areas - Cleaning of specialised areas, e.g. OT, Labour Room, Emergency Ward, Dressing Room, Laboratory.
4.3.3	Hospital premises are free from litter and other refuse.
4.3.4	Sufficient covered, clean dustbins are provided for clients/patients, visitors/attendants and staff and the dustbins are emptied on a regular basis.
4.3.5	Equipment, floors and walls are free from bodily fluids, dust and grit and the masonry is intact.
4.3.6	Cleaners are trained and provided with sufficient appropriate equipment and cleaning material and work according to cleanliness and sanitation policies and procedures.
4.3.7	Kitchen staff and/or those handling food are trained and work according to policies and procedures including but not limited to the following: - cleaning of all areas and surfaces on which food is stored and prepared, e.g. all preparation surfaces are cleaned and dried between uses for different activities - food storage, e.g. all food is stored separately from non-foods, cooked food is stored separately from uncooked/raw food and the covering and labelling of food - use and cleaning of equipment for food preparation, handling and transport, e.g. separate cutting boards are used for raw and cooked foods - testing and monitoring of safe temperatures for cooked food - testing and monitoring of refrigerator temperatures for safe food storage,
4.3.8	Access to the kitchen is restricted to staff members and a sign exists at all entrances

Sl. No.	Measurable Criteria
	stating this.
4.3.9	All staff handling food have health checks prior to appointment and at regular intervals during their employment and records are kept.
4.3.10	A written Dress Code for those working in the kitchen is enforced including wearing of head cover for hair, clean uniforms and appropriate footwear.
4.3.11	The kitchen and food stores have proper ventilation.
4.3.12	All windows in food preparation and storage areas have suitable fly screens insectocutors (ultra-violet electric flying insect removers) are present in designated problem areas.
4.3.13	Kitchen waste is put in covered secure containers and removed immediately from places where food is prepared pending disposal.
4.3.14	Chlorine solution for disinfection is available at all times.

4.4 Waste Management

Clinical and other infectious or injurious waste is handled, stored and disposed of to minimise harm and risk of infection /injury to patients/clients, visitors, contractors, staff and the community.

Sl. No.	Measurable Criteria
4.4.1	The hospital has a written waste disposal plan specifying procedures, responsibilities, timetable for waste collection and necessary equipment such as bins and bags. (as per Medical Waste Management Regulation 2008)
4.4.2	The waste disposal plan includes written guidelines for the regulation, identification, containment and storage, transport, treatment and subsequent disposal of different categories of infectious waste, including if appropriate: - Colour code for specific wastes are maintained - pathology waste - cytotoxic and chemical liquid waste) - heavy metals, radio-active or any other form of high-risk waste in accordance with the relevant law .(as per Medical Waste Management Regulation 2008)
4.4.3	Contaminated waste buried in land fills is done so in accordance with the relevant national laws.
4.4.4	All staff are trained in and use procedures for different types of waste: - Collection - Segregation at source - Storage - Transportation - Disposal.

Part 5 : Safe and Appropriate Environment Standard

5.1 Health & Safety

Promotion of health and safety and the avoidance of risk to human life as well as to the property of the Hospital are integrated within the organisation and among all levels of staff.

Sl. No.	Measurable Criteria
5.1.1	Health and Safety Committee meetings follow a set agenda that includes follow-up from the last meeting, minutes of each meeting are kept and the agendas and minutes are readily available to all staff.

Sl. No.	Measurable Criteria
5.1.2	The Health and Safety Committee participates in the development of the Risk Management Plan.
5.1.3	All staff attend continuing training for health and safety and records are kept of the trainings.
5.1.4	All emergency telephone numbers concerned with Health and Safety are displayed prominently.
5.1.5	Organisation wide health and safety policies and procedures contain comprehensive information, instruction and safety protocols for: - Control of waterborne diseases - Storing and handling of inflammable liquid - Personal protective equipment and clothing - Review of pressure vessels and systems - Body fluid spillage - First aid procedures at work - Violence and aggression towards staff - Outbreak and prevention of fire - Other internal accidental events such as explosion - Safe use of electrical equipment - Safe disposal of clinical waste - Safe handling of gas cylinders

5.2 Fire Safety and Emergency Preparedness

The organisation minimises the risks of fire and protects clients/patients, visitors and staff in case of fire and is prepared for disasters and emergencies

Sl. No.	Measurable Criteria
5.2.1	A fire safety plan exists including prevention/risk reduction, early detection, suppression, abatement, and safe exit from fire.
5.2.2	The hospital building, e.g. doors, exits and corridors, is constructed in a way to minimise the risk of fire and conform to fire safety rules, including: - Doorways, corridors, ramps and stairways being wide enough for the evacuation of non-ambulatory clients/patients - Fire and smoke doors being able to be opened and closed manually or by an electric release system - Doors to client/patient rooms and exit doors not being locked from the inside.
5.2.3	Access and exit ways are kept free of obstruction at all times to allow for safe evacuation in a fire or other emergency.
5.2.4	All new hospital buildings above 15 metres have an alarm system complying with national standards (riser system, control panel and alarm); old hospital buildings above 15 metres should have at least manual call points or smoke/heat detectors/alarm system (1-2 per floor).
5.2.5	Pictorial diagrams indicating fire exits and escape routes are properly illuminated, clearly visible, unobstructed and are displayed at appropriate locations.
5.2.6	Fire extinguisher are available at all relevant sites

5.3 Safe and Appropriate Equipment

There are clear and documented responsibilities, policies and procedures for procurement, use, maintenance, repair and disposal of equipment to minimise the potential for harm.

Sl. No.	Measurable Criteria
5.3.1	An Equipment committee is formed .An Equipment Committee and condemnation board meets regularly with clearly defined roles as required and includes those in charge of the hospital, nursing, maintenance and stores and other relevant departmental representatives.
5.3.2	Basic responsibilities of the Equipment Committee include: - Assessment of need for new equipment - Consultation with the requesting department on their requirements and specifications for the equipment - Procurement of equipment - Assessment of utilisation of equipment - Condemnation of equipment - Conducting regular equipment audits.
5.3.3	Placement of supply orders of equipment is done in accordance with the hospital rules or GFR (Government Financial Rules) in case of public hospitals and a copy of supply orders for equipment is kept in the Hospital records.
5.3.4	A list of all electrical equipment that requires routine testing is used and a record of maintenance and testing of this equipment is kept for three years, e.g. generator, emergency lighting.
5.3.5	Regular and routine checks of equipment (equipment audit) are carried out in accordance with the operational manual, maintenance contract and/or a history sheet of the equipment by the Store in-charge.
5.3.6	A list of maintenance/backlog items is kept and reviewed regularly.
5.3.7	A list of approved external repair workshops is kept and regularly updated
5.3.8	An annual budget is provided for the maintenance and scheduled replacement of equipment.

5.4 Safe and Appropriate Facilities

The Hospital's physical environment contributes to the safety and well-being of clients/patients, staff and visitors.

Sl. No.	Measurable Criteria
5.4.1	The hospital complies with relevant laws and regulations related to design and layout of the facility and inspection requirements are fulfilled.
5.4.2	Corridors, storage areas, passageways and stairways are well lit.
5.4.3	Access ways and exits are unobstructed at all times.
5.4.4	Signage allows Signboards to show safe passage through the hospital and exit from the facility in case of an emergency, disaster or fire.
5.4.5	The environment in all client/patient areas is clean, well lit, ventilated with adjustable controls for lighting and heating, and decor is in good repair.
5.4.6	Floor surfaces are non-slip and even.
5.4.7	Separate male and female functioning, clean toilets are available for use by visitors/attendants.
5.4.8	Some toilets available to seriously ill or disabled clients/patients: - Allow a nurse to stand at each side to manoeuvre a client/patient - Admit a wheelchair - Have washbasins and a mirror at a suitable height for both able and disabled clients/patients.
5.4.9	Potable water and electrical power are available 24 hours a day, seven days a week.
5.4.10	Alternate sources of water and power for heat and lighting in case of breakdown of the systems are identified, functioning and regularly tested. Operating Theatres are identified.

Chapte -Four

Secondary Level (District Hospital) Standards

Content of Secondary level standards:

Part 1 : Management Standards

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- 1.2 Client/Patients Right
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Part 3 : Support Services Standards

- 3.1 Laboratory Service
  - 3.1.1 Service Management

Part 1: Management Standard

1.1 Managing Organisation

A 5-7 members Committee formed by the Hospital authority will develop a strategic Plan (2-3 years duration) based on the resources allocation and, SWOT analysis using the supplied format.

1.1.1 Mission and Strategic Planning

The hospital is directed and managed effectively and efficiently, in accordance with its objectives and mission statement.

Sl. No.	Measurable Criteria
1.1.1.1	Hospital Mission, Vision and Objectives will be developed.
1.1.1.2	The mission and values are available and disseminated to the staffs and general people.
1.1.1.3	A strategic plan developed in consultation with the staffs and other relevant stakeholders
1.1.1.4	An annual plan is developed in line with the strategic plan and mention objectives, action plan and staffing, financial and physical resources to implement the action plan the planned actions.
1.1.1.5	Progress against the objectives and planned actions set out in the annual plan is reviewed regularly according to a defined monitoring and evaluation process.
1.1.1.6	The strategic and annual planning is based upon a SWOT analysis.
1.1.1.7	A coded hospital management information system is in place and provides data for the action plan

1.1.2 General Management

Responsibilities for operating the organisation, managing its resources and transparent up-to-date documentations for complying with applicable laws and regulations.

Sl. No.	Measurable Criteria
1.1.2.1	The Hospital authority provides leadership and is responsible for: - establishing and reviewing the mission, vision and strategic direction of the hospital - fostering a culture of quality improvement - monitoring and evaluating the achievement of strategic and annual results.
1.1.2.2	Organisational chart identifies the lines of accountability and reporting for all staff and the governing authority .
1.1.2.3	The organisational chart is regularly reviewed and clearly communicated to all staff within the Hospital and other relevant persons.
1.1.2.4	Clear unambiguous and effective mechanisms exist for internal and external communication. These include: - Two-way communicationbetween staff and management - Communication between different departments and wards - Communications with the press and media - Communication with patients/carers - Communications with external organisations
1.1.2.5	Staffs follow a open policy on confidentiality and release of information which complies with the local acts and rules.
1.1.2.6	The scope and limits, roles and functions of each clinical service/unit/department are clearly defined and known to staff and are determined with the input of staff.
1.1.2.7	Duty roster reflect the appropriate skill mix and health authority requirements and are available at least two weeks in advance.

1.1.3 Financial Management

Financial resources are managed efficiently and effectively in order to optimise the services that can be provided and results that can be achieved.

Sl. No.	Measurable Criteria
1.1.3.1	The Hospital in-charge and unit heads are involved in setting annual targets and budgets for the following financial year based on LLP.
1.1.3.2	An internal control and audit system is in place.
1.1.3.3	An external financial audit is undertaken annually.

1.1.4 Human Resources Management

Staffs are trained and evaluated in accordance with documented procedures, job descriptions and service needs.

Sl. No.	Measurable Criteria
1.1.4.1	The hospital develops and implements policies and procedures for the management of staffs, which includes training & appraisal of appropriately qualified staffs to meet the objectives of the organisation.
1.1.4.2	Staffs availability and skill mix are consistent with the on-going role and functions of each unit/ department
1.1.4.3	Records are available which show: - Staff levels and skill mix - Workload and complexity - Sickness and absence - Training.
1.1.4.4	Current job descriptions and responsibilities for all staffs are available and all staffs have a copy of their job description.
1.1.4.5	The induction programme includes: - Services provided - Roles and responsibilities - Relevant policies and procedures, including confidentiality - Use of equipment - Safety - Emergency preparedness - Quality improvement.
1.1.4.6	Every staff in the hospital can be identified by appropriate mechanisms, e.g. uniforms, name tags, caps.
1.1.4.7	Staff performance is evaluated annually against their job description and agreed targets and is used to identify strengths, areas for improvement and training needs.
1.1.4.8	A mechanism exists to monitor that all doctors, nurses, midwives and other health staffs have had sufficient recent practice to maintain competence and to address any competence issues through additional supervision, training or other procedures.
1.1.4.9	There are appropriate facilities for staff's representatives including access to a meeting room.
1.1.4.10	A training needs assessment exercise is conducted every two years with the objective of developing training plans for all staff groups in order to meet the development needs of individual health professionals and the service needs of the organisation.
1.1.4.11	Key indicators such as absenteeism and staff turnover are measured and the results analysed and used for improvement.

1.2 Client/Patient Rights

1.2.1 Information for Clients/Patients

Patients/Clients have the right to receive all information relevant to their care and management as well as enable them to make informed decisions.

Sl. No.	Measurable Criteria
1.2.1.1	A patient/client rights and responsibilities charter (Citizen Charter) is developed and displayed in all client/patient areas.
1.2.1.2	The hospital uses a documented process for clients/patients not able to understand written information to inform them of their rights.
1.2.1.3	Guidance and advice is provided to the clients/patients at the registration counter.
1.2.1.4	The reception area and wards display information about the organisation, including: - The rights of the clients/patients - Services and facilities available in the hospital - Costs of services - Feedback and complaints pathways.
1.2.1.5	Information about the hospital services and how best to use them is made available to the public and displayed in a easily noticeable place.
1.2.1.6	Patient/client consent is obtained for the proposed care or treatment. Written consent is obtained for any invasive procedures or operations.
1.2.1.7	Information related to referral to a different hospital such as cost, travel, time, duration of treatment and expected outcome is provided to the client/patient and their family.
1.2.1.8	Up-to-date and evidence based information and education are given on: - Disease prevention - Health promotion
1.2.1.9	The hospital has determined its level of responsibility for clients'/patients' possessions and patient/clientreceive information about the hospital's responsibility for protecting personal belongings.

1.2.2 Patient Feedback on Services

Patients have the right to complain about the services and treatment and their complaints are investigated in a fair and timely manner.

Sl. No.	Measurable Criteria
1.2.2.1	Patients /clients are informed of their right to express their concerns or complain either verbally or in writing
1.2.2.2	There is a routine documented process for collecting, prioritizing, reporting and fair investigation for addressing the complaints.
1.2.2.3	Patients /client s are informed of the progress of the investigation at regular intervals and are informed of the outcome.
1.2.2.4	The results of the complaints investigations are used as part of the quality improvement process

1.2.3 Privacy and Dignity

Patients' privacy and dignity are respected throughout the entire care process.

Sl. No.	Measurable Criteria
1.2.3.1	Consultation, treatment rooms and washing facilities allow privacy and separate toilets for male and female clients/patients are provided.

1.2.3.2	Appropriate in-patient and changing facilities for clients/patients allow privacy and dignity to be maintained.
1.2.3.3	A given intervention may be carried out only in the presence of those persons who are necessary for the intervention unless the client/patient consents or requests otherwise.
1.2.3.4	There is a process to identify and respect the client's/patient's values and beliefs.
1.2.3.5	Patients /clients are relieved of pain and suffering according to the current state of knowledge.
1.2.3.6	The needs of dying clients/patients are assessed and documented.
1.2.3.7	Staffs are made aware of the needs of dying clients/patients and provide respectful and compassionate care and services to dying clients/patients and their families.

Part 2: Service Delivery Standard

2.1 Care Continuum

In Care Continuum, National Strategic Plan on Quality of Care will be introduced as per implementation plan in the document.

2.1.1 Access to Health Services

Services are continuously available and the hospital minimises physical, economic, social, cultural, organisational or linguistic barriers to access.

Sl. No.	Measurable Criteria
2.1.1.1	Access ways and passage ways are kept clear at all times.
2.1.1.2	Disabled parking spaces are conveniently located, adequate parking areas are available for private and official vehicles and there is a designated area for public transport.
2.1.1.3	Functional wheel chairs and stretchers are available at the gate/reception for patients who are unable to walk.
2.1.1.4	All patient areas of the hospital are easily accessible by wheelchair.
2.1.1.5	Multi-storey buildings have ramps or functional lifts with an operator.
2.1.1.6	The hospital and its departments are clearly signposted and a site plan is displayed at a central place for orientation of staff and patients.
2.1.1.7	A reception area with a male and female receptionist to guide the patients is open during operating hours.
2.1.1.8	The hospital specifies visiting hours and communicates these to the public.
2.1.1.9	On admission to hospital, patients /clients are introduced to the nurse on duty and given an orientation to the unit to which they are admitted including the location of toilets, pantry and other facilities and services.
2.1.10	Patients /clients admitted to the hospital have access to an allotted bed with fresh linen and do not have to double up with other clients/patients.

2.1.2 Continuity of Care

Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care

Sl. No.	Measurable Criteria
2.1.2.1	Every patient/client seeking treatment or care at the hospital is registered and issued the appropriate form for recording various details of symptoms, diagnosis, treatment and services being provided.
2.1.2.2	All patients /clients and visitors to the hospital receive courteous and prompt attention from

Sl. No.	Measurable Criteria
	the staff at reception and any ward or department.
2.1.2.3	The doctor on duty has primary responsibility for the clinical care of any client/patient until a specialist takes over.
2.1.2.4	The nurse on duty is responsible for coordinating client/patient assessment, care planning and evaluation of care with other care providers and services.
2.1.2.5	A stock of essential drugs is available at all times in each treatment area.
2.1.2.6	Doctors, qualified nurses and appropriate support staff are available on-site 24 hours per day.
2.1.2.7	Regular meetings of different care providers are held to share information on clients'/patients' progress and client/patient care is formally handed over with the transfer of all relevant information when staff change duties.

2.1.3 Assessment

All clients/patients have their health care needs identified through an established assessment process.

Sl. No.	Measurable Criteria
2.1.3.1	Criteria to prioritise emergency patients exist and are implemented.
2.1.3.2	Patient/client choice regarding examination by a male or female is respected as far as possible.
2.1.3.3	An attendant is available when patients are being examined by members of the opposite sex.
2.1.3.4	The initial assessment includes the recording of vital signs, weight, height and significant findings.
2.1.3.5	The Patient/clients relatives and carers are included in the assessment by providing information wherever possible.
2.1.3.6	Except in an emergency, admission notes are completed prior to any surgical procedure.
2.1.3.7	Following examination, written as well as verbal information is provided for clients/patients regarding future visits, treatment and medication.

2.2 Care Planning, Monitoring and Evaluation

Health Care Providers develop and implement a written, up to date plan of care/service for each client/patient and monitor the care provided against this plan.

Sl. No.	Measurable Criteria
2.2.1	A written care plan for each patient/client is prepared in collaboration with the patient/client, carers/relatives and other appropriate health professionals.
2.2.2	The care plan addresses the patient /client individual choices and preferences .
2.2.3	The care plan is evaluated and updated in accordance with the findings of re-assessment and progress in meeting identified goals.
2.2.4	The care plan is used by doctors, nurses and other health professionals to facilitate continuity of care and on-going appropriate treatment.

2.2.1 Treatment

The organisation delivers services to the clients/patients that meet their individual assessed needs, reflect current good practice and are co-ordinated to minimise potential risks and interruptions in provision.

Sl. No.	Measurable Criteria
2.2.1.1	Clinical guidelines /treatment protocols are used to guide patient/client care processes.
2.2.1.2	Written procedures to ensure that the right dose of medication is administered to the right patient /client at the right time and are followed by staff and include:

Sl. No.	Measurable Criteria
	- Identification of the patient before medications are administered - Verification of the medication and the dosage amount with the prescription - Verification of the routes of administration - Verification of the time of administration.
2.2.1.3	Appropriate and sufficient support services are available to allow nursing staff to meet the care needs of patients. These include: - At least one Class IV employee round the clock - Equipment includingB.P. Apparatus, Stethoscope, Thermometer, Oxygen cylinder with trolley, Suction machine, torch and nebuliser areavailable and operational.
2.2.1.4	Patients are not disturbed during meal times for medical rounds, nursing or other treatments, other than in an emergency.

2.2.2 Documentation of Care

The client/patient record contains sufficient information to identify the client/patient, support the diagnosis, justify the treatment and care, document the course and results of the treatment and care, and promote continuity of care among health care providers

Sl. No.	Measurable Criteria
2.2.2.1	A clinical record is initiated for every patient admitted to the hospital and wherever possible there is only one set of case notes for each client/patient.
2.2.2.2	Patient/client records are maintained through the use of a unique number or other form of identification unique to the patient.
2.2.2.3	The patient/client record can be used for research purposes only if the patient/client has given a written consent and/or if there is an approval by the Ethics Committee.
2.2.2.4	The original patient/client record may not be removed from the hospital premises, except by court order. Policies and procedures are in place to prevent the loss and/or misuse of client/patient records.
2.2.2.5	The patient/clientrecord is sufficiently detailed to enable the patient to receive effective coordinated treatment and care and includes**:** - Details of admission, date and time of arrival - Patient assessment and medical examination - Sheet containing history pertinent to the condition being treated including details of present and past history and family history - Diagnosis by a registered health professional for each entry to the hospital - Details of the client/patient care or treatment plan and follow-up plans - Diagnostic test orders and results of these tests - Progress notes written by medical, nursing and allied health staff to record all significant events such as alterations in the client's/patient's condition and responses to treatment and care - Record of any near misses, incidents or adverse events - Medication sheet recording each dose given - Treatment record - Observation charts, e.g. temperature chart, input and output chart, head injury chart, diabetic chart - Mode of discharge, e.g. left against medical advice or discharge on will - In case of death, details of circumstances leading to the death of patients
2.2.2.6	- For surgical patients, the clinical record additionally includes:

Sl. No.	Measurable Criteria
	- Anaesthetic notes - Operation record - Consent form.
2.2.2.7	Where referrals have been made, the client/patient record includes the referral letter and indications for referral
2.2.2.8	A completed discharge summary signed legibly by the doctor (full name) who certified the discharge is submitted to the records department within 72 hours of the client's/patient's discharge.
2.2.2.9	All diagnoses/procedures are coded using ICD 10 and a yearly summary report is prepared and used for planning.
2.2.2.10	Patient records (hard copies) are preservedfor a minimum of 7 years and disposed according to existing rules and legislation.
2.2.2.11	There is a system for easy retrieval of records.

2.2.3 Discharge and Referral

Safe and appropriate discharge, transfer or referral of clients/patients is based on the client's/patient's health status and need for continuing care.

Sl. No.	Measurable Criteria
2.2.3.1	A written and dated document including criteria to determine readiness for discharge, transfer or referral of clients/patients is used and specifies who is authorised to do it.
2.2.3.2	Follow up arrangements, agreed with the client /patient and/or the family, are noted in the client/patient record prior to discharge.
2.2.3.3	On discharge, the attending doctor summarises in the client /patient record the primary (and secondary) diagnosis, any complications, any operative procedures undertaken and any follow up arrangements agreed with the patient/family.
2.2.3.4	A discharge certificate containing relevant information such as reason for admission, findings, diagnosis, treatment, medication, condition at discharge, date of discharge and name of attending practitioner is signed and given to the client/patient and/or his family prior to discharge, with a copy retained in the client/patient record.
2.2.3.5	The authority discharging the client/patient ensures that the following are given to the client/patient or relative/carer on discharge: - Medications, dressings or appliances - Instructions in a clear understandable manner on follow up, including as appropriate written advice and counselling regarding medications, diet, health problem management and exercise - Written details of out future appointments - Personal belongings.
2.2.3.6	The patient and/or the appropriate carer or attendant is advised on any necessary skills for care after discharge such as moving and handling techniques or catheter care.
2.2.3.6	Referral System Guideline, Referral Register & Referral Slip (Developed by Hospital & Clinic Section of DGHS) will be used for patient referral.

2.3 Quality Management

The Quality Improvement activities will be implemented by the directives of National Strategic Planning on Quality of Care for Health Service Delivery, Bangladesh.

Sl. No.	Measurable Criteria
2.3.1	The Quality Improvement Committee / team develops a quality plan which defines roles and responsibilities and sets priorities for quality improvement according to the National Strategic Planning on Quality of Care for Health Service Delivery, Bangladesh.
2.3.2	Clinical Management Protocols/Guideline/Tools/Standard Operating Procedure will be introduced as per National Strategic Plan on Quality of Care.
2.3.3	The Quality Improvement committee/team regularly assesses client/patient satisfaction in order to improve service provision.
2.3.4	Work Improvement Team (WIT) will be formed and developed action plan accordingly.
2.3.5	Key Performance Indicators and Facility level indicators for Quality of Care will be measured as per guideline of Quality Improvement Secretariat.
2.3.6	Quality Improvement committee/team which meets on a regular, documented basis to analyze reports, and to monitor, support, advise and lead on quality improvement.
2.3.7	A risk management committee developed and risk management plan for the Hospital: - is based on information from business planning and results, client/patient feedback, clinical indicators and events, staffing and resource provision, and environmental data - identifies, assesses and prioritises all risks in terms of likelihood and consequences of harm/damage - includes strategies to manage those risks and - is available and disseminated to staff.
2.3.8	Incidents, accidents, near misses and adverse events are: - reported on the appropriate form - investigated promptly according to a set procedure - used to make improvements in line with any findings and - communicated to staff.
2.3.9	Staff are trained to follow the guidelines and there is evidence that they do.
2.3.10	A clinical audit team has formed and schedule is agreed between management and clinical staff and implemented.
2.3.11	Improvements are planned, appropriate action is taken, the effectiveness of the action is evaluated and the results are fed back to staff and clients/patients.
2.3.12	5S-CQI-TQM approach will be introduced for improvement for Quality of Care.
2.3.13	Monthly report will be sent to DGHS and QIS routinely.

2.4 Operation Theatre Department

2.4.1 Service Management

Operating Theatres provide safe, hygienic and appropriate services for clients/patients and are co-ordinated with other services of the hospital to provide continuity of care.

Sl. No.	Measurable Criteria
2.4.1.1	The operating theatre and /or department is managed by a suitably qualified, registered and experienced nurse, doctor or senior operating department assistant.
2. 4.1.2	Safe Surgery check list is used for performing each & every surgery

Sl. No.	Measurable Criteria
2. 4.1.3	Standard operating procedure (SOP) is used for effective OT management
2. 4.1.4	A list of hospital approved surgical procedures based on an annual assessment of qualified staff, equipment and other inputs and processes is communicated to staff
2. 4.1.5	Anaesthetic services are provided by qualified, registered and experienced anaesthetists.
2. 4.1.6	An anaesthetist is present for all surgical procedures 24 hours a day.
2. 4.1.7	A designated, suitably trained member of staff (Operating Theatre Assistant, anaesthesia technician) is available to assist the anaesthetist at all times.
2. 4.1.8	A signed agreement with a referral hospital offering more comprehensive services ensures provision of necessary surgeries.

2.4.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the operating theatre and/or department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.4.2.1	Written up-to-date SOP, procedures are available, followed by staff and include but are not limited to the following: - Signage of OT as a restricted area and identification of persons allowed in the OT - Sterilisation and identification of sterilised OT equipment - Separation and transport of dirty linen - Pre-operative assessment and instructions - Routine equipment check and preparation - Annual review of functioning equipment in line with the services offered by the OT - Sending for and the transportation of clients/patients from ward to OT - Admission / handover to the operating department - Identification of clients/patients - Identification of operation site - Recovery - Inoculation injury - Staff protection against exhaust from anaesthetic gases - Post-operative care - Handover procedures for pre-operative and post-operative clients/patients - Diathermy use, Tourniquet use - X-ray use, Laser use - Swab, needle and instrument count - Infected clients/patients.
2.4.2.2	The following formal documentation/records are available in the department: - Theatre register (anaesthesia register and surgeons' register) - Electro medical equipment register - Record of correct swab/instrument count - Controlled drugs - Specimens register containing time, number, preservative used and despatch for histopathology - Record of weekly/monthly analyses of surgeries (including the ICD 10 code) - Next-day schedule for operations - Maintenance of stock levels of drugs and consumables - Duty roster.

Sl. No.	Measurable Criteria
2.4.2.3	Specific safety rules and instructions are displayed and followed by staff for the following: - Storage and use of hazardous chemicals, e.g. glutaraldehyde, formalin - Storage and use of compressed gases - Appropriate shielding and protective clothing, e.g. for image intensification - Emergency electrical power supply (UPS, inverters, generators and emergency electric lights)
2.4.2.4	There is a separate fully functioning and equipped recovery room.
2.4.2.5	A trained recovery nurse is present for each anaesthetic session and remains in the recovery area until the last client/patient has been discharged back to the ward.
2.4.2.6	Sufficient, qualified and experienced staff monitors clients/ patients in the recovery room to ensure individual client/patient supervision at all times.
2.4.2.7	Documented discharge criteria are used to assess clients'/patients' readiness to leave the recovery room.
2.4.2.8	The anaesthetist is available in the hospital until the client patient has recovered from anaesthetic.
2.4.2.9	The anaesthetist provides the final authorization for the client/ patient to leave the recovery area.
2.4.2.10	There are clear, formal instructions on how to contact a doctor in an emergency.
2.4.2.11	A record of the operation for the client/patient record is made immediately following surgery and a copy is retained in the OT. The record includes the following: - Date and duration of operation - Anatomical site/place where surgery is undertaken - The name of the operating surgeon(s), operating assistants including scrub nurse and the name of the consultant responsible - The ICD 10 coded diagnosis made and the procedure performed - Description of the findings - Details and serial numbers of prosthetics used - Details of the sutures used - Swab and equipment count - Immediate post-operative instructions - The surgeon's and scrub nurse's signatures.
2.4.2.12	Anaesthetic records contain: - Date and duration of anaesthesia - Name of surgical operation performed - The name of the anaesthetist, anaesthesia assistant and, where relevant, the name of the consultant anaesthetist responsible - Pre-operative assessment by the anaesthetist - Drugs and doses given during anaesthesia and route of administration - Monitoring data - Intravenous fluid therapy - Post-anaesthetic instructions - Any complications or incidents during anaesthesia - Signatures of anaesthetist and anaesthesia assistant.

2.4.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients undergoing procedures in the operating theatre(s).

Sl. No.	Measurable Criteria
2.4.3.1	Arrangements are made so that hospital OTs is situated separately from areas accessible to the general public.

Sl. No.	Measurable Criteria
2.4.3.2	Hazard and/or warning notices are clearly displayed before restricted and high risk areas.
2.4.3.3	Separate male and female changing and rest rooms are available.
2.4.3.4	There is a clear separation of 'dirty' areas and OT (s) and only persons wearing theatre dress enter the OT(s).
2.4.3.5	The anaesthetic induction area/room and operating theatre are equipped with safe and well maintained equipment specific for OT activities including but not restricted to the following: - Anaesthetic machine and ventilator - Laryngoscopes - Endotracheal tubes/laryngeal masks - Airways - Nasal tubes - Suction apparatus and connectors - Oxygen - Drugs and IVs required for planned anaesthesia - Drugs for emergency situations - Monitoring equipment including ECG, ETCO2, temperature monitoring, pulse oximeter and blood pressure - Accessible defibrillator - Anaesthetic gas scavenger system - Tipping/tilting trolleys/beds - Multi positioned table with radiolucent tops - Suction machine - Instrument cleaning/decontamination facilities - Temperature and humidity control - IV canulas and CV lines in different sizes - Blood warmer - Adequate light sources - Special equipment for particular age groups, e.g. neonate resuscitation table.
2.4.3.6	A list of functioning equipment available in the recovery room includes :- - Airways (Ambu bags) and other intubation material and equipment - Suction - Oximeter - ECG - Tipping/tilting trolleys/beds - Blood pressure measurement apparatus - Defibrillator - Anaesthesia machine - Oxygen concentrator - Emergency ventilator.

2.5 Emergency Department

2.5.1 Service Management

The Emergency Department / units provides safe, timely and efficient live-saving emergency care and minor treatment and surgery for clients/patients.

Sl. No.	Measurable Criteria
2.5.1.1	Data and others indicators are systematically recorded and aggregated for analysis. These include a documented review of volume of activity, source and appropriateness of referrals and adverse events.
2.5.1.2	Data available for clinical review includes: - Number of attendances - Repeat visits - Clients/Patients who died in the casualty department.

2.5.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the casualty department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.5.2.1	Written SOP and guidelines are used consistent with the policy for: - Identifying which clients/patients should be seen immediately by a doctor in the department - How medical help is summoned in emergency - Dealing with life threatening emergencies before medical help arrives - The transfer of clients/patients - The transfer of records - The use of tele-medical techniques.
2.5.2.2	The hospital disaster plan clearly identifies the role, procedures and individual staff responsibilities within the casualty department in the event of a nearby major incident or disaster.
2.5.2.3	All patients are seen within fifteen minutes of arrival for initial assessment and treatment prioritisation.
2.5.2.4	Each patient is informed of the approximate waiting time after the need for treatment has been assessed.
2.5.2.5	A process is used to monitor client/patient waiting times.
2.5.2.6	Patients are examined in privacy by a doctor of the same sex as the client/patient (if available), or have the service of a chaperone if desired.
2.5.2.7	Relatives are kept informed of the client's/patient's condition with the agreement of the client/patient where they are able to give such consent.
2.5.2.8	An individual record of attendance is completed which contains: - Name - Address - Age/Date of birth - Next of kin - Occupation/School - Case number - Telephone number - Date and time of arrival - Time of examination - Diagnoses - Treatment - Minor surgery carried out - Specimens taken - Instructions for follow up - Doctor's or nurse's names and signatures - Medication given to/or taken away - Advice given on discharge.
2.5.2.9	A formal mechanism (roster) known to all staff is used for identifying medical staff on duty and on call and is prominently displayed in the emergency care area.
2.5.2.10	A procedure exists for referral for specialist care if necessary.
2.5.2.11	A written, dated, signed policy on the referral, selection and treatment of clients/patients for minor surgery is followed.

2.5.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients attending the casualty department.

Sl. No.	Measurable Criteria
2.5.3.1	The casualty entrance is clearly signposted from outside the hospital.
2.5.3.2	Parking is available for patients, including designated space for the disabled.
2.5.3.3	There is a canopy over the casualty entrance used by ambulances.
2.5.3.4	The doorways and access are suitable for wheelchairs and trolleys.
2.5.3.5	Emergency alarms are strategically sited within the unit to summon help.
2.5.3.6	There is appropriate equipment for: - Resuscitation - Monitoring - Minor operations - Sterilisation - X-rays and other imaging (either locally or by referral).
2.5.3.7	Clinical and public areas are clear of equipment, beds or other obstructions.
2.5.3.8	Treatment areas afford the clients'/patients' privacy.
2.5.3.10	There are toilet facilities suitable and available for males, females and disabled.
2.5.3.11	A public telephone is available for the use of clients/patients and relatives.
2.5.3.12	There is an accurate and functioning clock.

2.6 Intensive Care Unit

2.6.1 Service Management

The Intensive Care Unit is managed by suitably qualified staff and organised to provide safe and efficient care for seriously ill clients/patients who need to be continuously monitored.

Sl. No.	Measurable Criteria
2.6.1.1	A qualified professional with relevant training in intensive care is responsible for overall co-ordination of the unit and is accessible for specialist advice.
2.6.1.2	One specialist each from the Dept. of Medicine and Anesthesiology will overall supervise implementation of patient care & administrative issues.
2.6.1.3	Specialists of different disciplines will take care of patients admitted in CCU under them as Visiting and on referral during day –on-call, as they do usually in other wards.
2.6.1.4	There should be a formal mechanism for obtaining specialist advice.
2.6.1.5	A suitably experienced doctor is immediately available at all times.
2.6.1.6	An appropriately qualified, registered and experienced nurse is responsible for the day to day management of nursing care in the unit.
2.6.1.7	Standard Operating Procedure (SOP) is used for ICU management
2.6.1.8	All staff working in the unit are appropriately qualified and experienced for the work they do and have attended specialist high dependency care courses and continuous medical education for updating their skills.
2.6.1.9	Appropriate persons are approached for infection control issues (Microbiologist).

2.6.2 Policies and Procedures

Operational policies and procedures which clearly describe the key processes of the ICU, the responsibility of the staff and expected results are followed by staff.

Sl. No.	Measurable Criteria
2.6.2.1	There is a written, agreed document describing clinical protocols and SOP on i) Admission/ Discharge/ Shifting of patient, ii) Management of patient & iii) Infection Control and other operations of ICU. Specific policies and procedures include emergency admission to ICU from: - Theatres - Wards - Other departments - Outside.
2.6.2.2	Management policies and procedures are available and followed by staff for the following: - Airway management - Ventilators /respirators - Central oxygen supply and oxygen cylinders use - CVP monitoring (central venous pressure) - Infusion pump management - Pulse oximeters use - Cardiac monitors use - Arterial lines monitoring - X-ray and other imaging investigations - Epidural care - Recovery facilities for all surgical cases where there is no dedicated recovery unit - Recovery care of major surgical cases.
2.6.2.3	Specific emergency procedures are available and followed for: - Apnoea /respiratory arrest - Inhalation of vomit - Cardiac arrest - Laryngeal spasm /stridor.
2.6.2.4	There are written criteria defining who is authorised to perform the following emergency clinical procedure - Intubation - Tracheotomy - Insertion of central lines - Defibrillation.
2.6.2.5	There are written policies and procedures agreed and followed for the following: - Clothing of staff and visitors - Filtering of clients'/patients' respired air - Changing of catheters, humidifiers and ventilator tubing - Isolation of at-risk or infected clients/patients - Cleaning of the unit.
2.6.2.6	Standardized hand over procedure for patient discharge
2.6.2.7	Regular meetings take place to review cases and client/patient management, both within the unit and in conjunction with other departments.
2.6.2.8	Visiting hour should be strictly maintained.

2.6.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients in the ICU.

Sl. No.	Measurable Criteria
2.6.3.1	There is sufficient space for storing disposable and consumable items.
2.6.3.2	A functional resuscitation trolley and defibrillator are available on the unit
2.6.3.3	Each bed has a central line facility for: - Oxygen - Suction - Compressed air - Central ECG monitoring.
2.6.3.4	Adequate (at least three) numbers of power sockets are available for each bed.
2.6.3.5	Facilities in the unit include: - CVP monitoring - Pulse oximetry - Blood pressure monitoring (automatic) - Urometry - Ambient and client/patient temperature monitoring - Arterial blood gases - Glucometer - Electrolyte machine.
2.6.3.6	All equipments must conform to the relevant safety standards and regularly serviced
2.6.3.7	Staff should be trained, competent, and familiar with the equipments

Part 3: Support Services

3.1 Laboratory Services

3.1.1 Service Management

The pathological laboratory is managed and organised to provide efficient and effective laboratory care to patients and support services to clinicians.

Sl. No.	Measurable Criteria
3.1.1.1	The pathology laboratory is managed by a suitably qualified and registered pathologist, experienced medical technologist.
3.1.1.2	Sufficient and appropriately qualified staffs are available to fulfil the job descriptions of the defined service.
3.1.1.3	Laboratory staff participates in the health and safety committee, hospital quality committee and other relevant committees.
3.1.1.4	Departmental head attend meetings of appropriate advisory /consultative bodies and have input into decisions affecting the laboratory.
3.1.1.5	A pamphlet outlines the list and prices of services offered, the types of specimens required and approximate reporting time for tests.
3.1.1.6	Laboratory staff inform in writing the designated hospital infection control committee of any infection identified in in-patient samples that could provide a risk to the hospital staff or clients/patients.
3.1.1.7	The service has a continuing education programme for staff development enabling staff to meet the needs of the hospital, the department, the individual and the clients/ patients.
3.1.1.8	Staffs follow written policies and procedures for collection, transport and controlling, storing, reporting and disposing of all samples and tests in compliance with legal requirements.
3.1.1.9	Staff are involved on a regular basis in a quality management programme to monitor and improve the laboratory quality

3.1.1.10	Any outstation laboratory equipment is subject to the same quality control procedures as in the main laboratory. (is applicable for private sector)
3.1.1.11	The department has planned and systematic activities for the monitoring and evaluation of its services.
3.1.1.12	Standard Operating Procedure (SOP) will be followed for laboratory service.

3.1.2 Samples and Tests

Laboratory samples and tests are managed to maximize accuracy of testing and minimise risks to patients/clients and staff.

Sl. No.	Measurable Criteria
3.1.2.1	A requisition form is used for laboratory services and includes the following: - Patient information - Investigations required - Type of sample - Clinical history including clinical examination - Probable diagnosis - Name and Designation of Referring Physician - Sample collection time - Name of phlebotomist.
3.1.2..2	Staffs follow and communicate to clients/patients, verbally and in writing, procedures for the patients' preparation for tests.
3.1.2.3	Samples collected are labelled with the patient's name, registration number, date and time of collection.
3.1.2.4	Separate labels are used for high risk samples.
3.1.2.5	Specimen trays are designed to enable safe transport.
3.1.2.6	A laboratory register records: - Client/Patient name, location - Identification of sample source(s) - Full name of the investigation(s) - Number of investigations - Investigation results
3.1.2.7	Samples are safely and accurately distributed to the respective sections of the laboratory.
3.1.2.8	Patient Results Registers are readily accessible to laboratory staff.
3.1.2.9	Results are made available to the main reception of the laboratory to enable picking up by OPD, wards or clients/patients.
3.1.2.10	Signed and dated SOPs for each test and client/patient preparation for each test are readily available to staff in the laboratory.
3.1.2.11	Staff follow written, dated and signed procedures for: - Patient preparation for tests - Completion of test request forms - Reporting of test results - The reporting procedure shall be clearly established. Any verbal report should not be provided to the patients but in emergency may be provided to the attending physician. Reporting via e-mail may be allowed. - Investigating transfusion reactions - Emergency and urgent requests - Storage of specimens and blood in the wards and in other departments - sending samples to other laboratories

Sl. No.	Measurable Criteria
3.1.2.12	Staff follow written procedures for samples: - Sample collection - Handling - Labelling - Transportation - Retention - Storage - Disposal of samples, including blood and body fluids.
3.1.2.13	Instructions are clearly displayed describing the safe disposal of clinical, toxic and radioactive waste.
3.1.2.14	Clearly labelled, separate containers are used for disposal of hazardous and infectious waste.
3.1.2.16	The laboratory shall have a policy and procedures for the resolution of complaints or feedback received from clinicians, patients or other parties.

3.1.3 Safety

All health personnel's and patients are protected from potential hazards in the laboratory.

Sl. No.	Measurable Criteria
3.1.3.1	A mechanism is in place to restrict access to the laboratory other than authorised laboratory personnel.
3.1.3.2	Health and safety policies, current and relevant hazard notices and safety action bulletins are displayed as required including but not limited to: - Safety regulations - Fire precautions - AIDS/HIV - Hepatitis.
3.1.3.3	Appropriate logistics are available for the safe handling of hazardous materials.
3.1.3.4	Actions to be taken in the event of an emergency is known to all staff and is clearly stated in writing.
3.1.3.5	Staffs are offered immunisations relevant to their type of work and emergency immunisations based on written policies.

3.1.4 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients served by the laboratory.

Sl. No.	Measurable Criteria
3.1.4.1	Laboratory and office space are sufficient to enable staff to carry out their jobs safely.
3.1.4.2	The laboratory environment is well lit, ventilated and not underground.
3.1.4.3	Storage facilities for specimens and reagents are sufficient to enable staff easy access.
3.1.4.4	Refrigerated storage facilities are used for specified samples, specimens, and blood samples.
3.1.4.5	Inspection, calibration and maintenance schedules are completed and used for all laboratory equipment.
3.1.4.6	Staff facilities include: - Locker space - Toilet and washing/shower facilities - Staff rest room - Overnight accommodation for on call staff.

3.2 Radiology

3.2.1 Service Management

Radiology services are managed and organised to provide safe and efficient care for client/patients and support to clinical specialties.

Note: Radiology services cover all services provided by a radiology department.

Sl. No.	Measurable Criteria
3.2.1.1	A radiologist (either on site or visiting) is responsible for the clinical direction of the radiology department and the safety of the patients.
	Standard Operating Procedure (SOP) is used in radiology department
8.1.2	Radiology services are administered by an identified qualified, registered radiologist and radiographer with clearly defined responsibility for all non-clinical aspects of the department.
8.1.3	List of all available tests with charges are display at visible area
8.1.4	There are on-call staffs for mobile radiography and other imaging at all times.
8.1.5	Staff follow written policies and procedures for all aspects of radiology services, including: - Reception and registration of the client /patient - Preparation of the client/patient for imaging - Processing the film or scan - Reporting on the film or scan - Documentation and despatch of reports .
8.1.6	Up to date reference manuals, radiation regulations and guidelines, radiation safety reports, are available within the department.
9.1.7	The department participates in the Hospital's quality improvement system and monitors the quality of its services using an internal quality control programme which includes: - Equipment utilisation review - Periodical performance checks on equipment, including processors - A record of maintenance checks for all items of equipment - Film and scan reject rates - Clinical audit - Turnaround times for the reporting of films and scans.

3.2.2 Service Provision

Clients/patients are systematically registered, receive radiological services in line with written requests and have their x-rays reported promptly and accurately.

Sl. No.	Measurable Criteria
3.2.2.1	Patients are registered, assigned a registration number and given special instructions in a systematic way.
3.2.2.2	Request Forms are of a standard format and contain: - Client's/Patient's name - Identification number - National identity card number - Address - Date of birth if not available age & sex of the patient - Examination requested - Previous examinations/ investigations - Clinical diagnosis/indications/relevant history
3.2.2.3	Diagnostic imaging is performed by the designated / authorized staff only upon a signed written request from a qualified medical practitioner.
3.2.2.4	Arrangements are in place for dealing with out of hours or emergency requests.

Sl. No.	Measurable Criteria
3.2.2.5	A written policy/ guideline is available defining the terms under which pregnant women may be subjected to radiological examination
3.2.2.6	Required reporting times are based on the urgency of the situation, e.g. films or scans for emergency client/patients are reported within one hour and routine reports are reported within 24 hours.
3.2.2.7	Critical or unexpected findings are discussed with the referring doctor Automated tracking of critical findings are arranged. - Mobile device delivery of critical findings
3.2.2.8	Radiology reports or copies of the reports are filed in in-patients' medical files in the wards.
3.2.2.9	For out-patients the radiology report is written on the OPD radiologyrequest slip.
3.2.2.10	A duplicate report is kept on file in the department / record room
3.2.2.11	A copy of X-ray films and scans in medico-legal cases are retained by the department (with history and requisition)
3.2.2.12	The reporting procedure shall be clearly established. Any verbal report should not be provided to the patients but in emergency may be provided to the reguesting physician. Reporting via e-mail may be allowed.

3.2.3 Safety

Radiological services are provided in accordance with current radiation rules and regulations, risks are minimised and the safety of client/patients and staff are protected.

Sl. No.	Measurable Criteria
3.2.3.1	Signs (diagrams / poster / banner) warning women of childbearing age of the dangers of radiation in pregnancy are prominently displayed. Signs (diagrams / poster / banner) warning general patients, their accompanying persons and visitors about the radiation area and radiation hazard of staying within the radiation area and performing the tests should be properly displayed.
3.2.3.2	Staffs provide services in accordance with current ionising radiation regulations and statutory requirements. .
3.2.3.3	Emergency drugs and equipment including all resuscitation equipment are functioning, not expired, are readily accessible and are monitored frequently.
3.2.3.4	An effective written procedure to summon help in an emergency is displayed prominently in the department and used by staff.
3.2.3.5	All staff working in radiology services attend update courses on resuscitation, current radiology trends and evidence based practice.
3.2.3.6	Protective clothing is provided and used where biohazards or radiographic equipment are present.
3.2.3.7	The radiologist in charge is responsible for ensuring that compliance with national guidelines is monitored: - Staff working with radiological equipment wear radiation monitoring devices - These devices are assessed and maintained in accordance with statutory regulations - Records of these tests are kept for the working lifetime of staff employed by the service.

3.2.4 Facilities and Equipment

Facilities and equipment are provided and maintained to maximise client/patient comfort and safety.

Sl. No.	Measurable Criteria
3.2.4.1	A separate registration area, waiting area for males and females with adequate seating and separate male and female toilets and washing facilities are provided for the comfort of

Sl. No.	Measurable Criteria
	clients/patients waiting for services and for their families.
3.2.4.2	All equipment is subject to tests on installation to ensure the equipment meets with contract specifications and confirms mechanical, electrical and radiation safety. Records of these tests are kept in the department for reference.
3.2.4.3	Radiology equipment is stable, functioning and installed only in properly lead protected rooms.

3.3 Pharmacy Services

3.3.1 Management

The pharmaceutical service is managed and organised to provide efficient and effective pharmaceutical services through rational use of drugs within the hospital.

Sl. No.	Measurable Criteria
3.3.1.1	The pharmaceutical service is managed by a qualified, graduate and registered pharmacist.
3.3.1.2	A copy of the professional Code of Ethics is readily available, known to the staff and followed.
3.3.1.3	Staff follow written policies and procedures for ordering and purchasing, controlling, storing, dispensing and disposing of all medicines within the hospital in compliance with legal requirements.
3.3.1.4	The department monitors the quality of its services using an internal quality control program and staff participate in the Hospital's quality improvement system.
3.3.1.5	The pharmacy service provides a regular prescription monitoring service, locally, to ensure the safe, effective and economic use of medicines. This includes: - Identifying inappropriate medication - Monitoring adverse reactions - Monitoring dispensing errors - Checking adequacy of labelling of drugs and information on package inserts - Physical examination of drugs to assess their quality and expiry dates - A mechanism to encourage prescription of cost-effective and economical drugs.

3.3.2 Selection, Ordering and Purchasing of Medication

Selection and procurement of medication is appropriate to the scope of service, client/patient needs, and cost-effectiveness.

Sl. No.	Measurable Criteria
3.3.2.1	The hospital has prepared in a collaborative process considering patient/client needs, services provided in the hospital, cost-effectiveness and evidence-based criteria.
3.3.2.2	Written policies and procedures exist and are implemented for the following processes: - Tendering - Evaluation of tenders - Selection - Ordering - Reception and physical examination of delivered drugs.
3.3.2.3	The quality, quantity and expiry date of purchased medicines are checked upon receipt.
3.3.2.4	The list of medications available in the hospital pharmacy is available to all units and displayed at the counter.
3.3.2.5	A process exists to obtain required medications not stocked or normally available in the hospital pharmacy.

3.3.3 Storage and Stock Management

Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

Sl. No.	Measurable Criteria
3.3.3.1	Medicines are stored on shelves enabling: - Protection from the adverse effects of light, e.g. glass windows painted white, dampness and temperature extremes - Freedom from vermin and insects - Adequate ventilation.
3.3.3.2	Adequate and secure storage facilities provided include: - A suitable metal cupboard or container for the storage of flammable and/or hazardous material - A functioning pharmacy refrigerator.
3.3.3.3	Separate cupboards are provided for medicines for internal use, external use and reagents.
3.3.3.4	Stocks of medicine are supplied against a written order or by a pharmacy top up service.
3.3.3.5	Medicines required in an emergency are available and replaced promptly after use.
3.3.3.6	All expired or recalled medicines, including unwanted medicines returned by clients/patients and unused controlled medicines, are safely disposed of in accordance with a written procedure.
3.3.3.7	A formal, written procedure is followed for retention of order forms, copy of delivery notes, stores receipt, and issue vouchers, and book of records (controlled drugs book/prescription drugs book) on the premises as provided for in the relevant laws.

3.3.4 Prescribing, Administration and Dispensing of Medicines

Prescribing, dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

Sl. No.	Measurable Criteria
3.3.4.1	All prescriptions are legible and duly signed legibly by a doctor, including the following: - Name - Diagnosis - Dose - Dosage form - Strength of medications.
3.3.4.2	Medicines are dispensed by, or under the supervision of, a pharmacist in accordance with a written prescription from a qualified registered medical practitioner.
3.3.4.3	The client/patient is provided with written and verbal information on the prescribed medicine including: - The costs - The potential benefits and adverse effects - Risks of ignoring instructions - How to use the medicine safely and properly.
3.3.4.4	There is an approved hospital prescription/medication chart on which all medicines for an individual client/patient are prescribed and their administration recorded.
3.3.4.5	A pharmacy register records: - Client/Patient name and registration number - Date - Diagnosis

Sl. No.	Measurable Criteria
	- Medicine dispensed.
3.3.4.6	Staff follow written, dated and signed procedures on the following: - What medicines may be administered without a prescription and under what circumstances - Self medication - Use of antibiotics - Administration of IV drugs, narcotics, psychotropic substances and cytotoxics - Obtaining medicines after hours from hospital pharmacy - How to obtain medicines not available within the hospital pharmacy - Dealing with clients'/patients' own medicines.
3.3.4.7	Medical practitioners follow policies for antibiotic prescribing which include: - Restricting the use of broad-spectrum agents to minimise the development of resistant viruses and bacteria - Using prophylactic antibiotics only where their efficacy has been established.

3.3.5 Facilities

Facilities and equipments are safe and adequate for the purpose and the number of clients/patients attending the pharmacy.

Sl. No.	Measurable Criteria
3.3.5.1	All doors, windows and hatches within the pharmacy can be locked.
3.3.5.2	There is a designated area for: - The receipt and unpacking of goods in wards - Segregation of expired and recalled drugs - Dispensing of medicines.
3.3.5.3	The pharmacy has an administrative area, which includes a desk, filing cabinet, telephone and other necessary equipment. designated waiting area for clients/patients.
3.3.5.4	There is a specific drug information/reference area for use by hospital staff.
3.3.5.5	A box or trolley containing those medicines which may be urgently required in the event of a cardiac arrest is available.
3.3.5.6	Lockable medicine refrigerators with maximum and minimum thermometers are provided for medicines requiring cool storage. They are used solely for this purpose.

Part 4: Infection Control, Hygiene And Waste Management

4.1 Infection Control

The organisation designs and implements a coordinated program to reduce the risks of nosocomial infections in clients/patients, visitors/attendants, contractors and staff.

Sl. No.	Measurable Criteria
4.1.1	National Infection Prevention & Control Guideline, National Hand Hygiene Guideline and Medical Waste Management Guideline will be used.
4.1.2	The hospital establishes an infection control committee and program is designed to prevent or reduce the incidence of nosocomial infection, based on current scientific knowledge and accepted practice guidelines and developed and monitored with multidisciplinary involvement.
4.1.3	Responsibility for coordinating the infection control program is assigned to an infection control committee with representatives of all relevant disciplines and departments including medical, nursing, microbiology/pathology, kitchen and laundry staff.
4.1.4	The infection control committee has clear written Terms of Reference that include the following responsibilities:

Sl. No.	Measurable Criteria
	- Coordination of infection control activities - Development, implementation and monitoring of the infection control program - Approval of infection control policies and procedures - Approval of surveillance activities - Reviewing and analysing infection control data - Following up identified infection control issues with relevant action, including education - Evaluating the effectiveness of actions taken.
4.1.5	Surveillance of multiple resistant organisms and organisms associated with antimicrobial use is conducted as part of the infection control program.
4.1.6	There is evidence of regular infection control audit.
4.1.7	Non Professional staff and-professional staff are appropriately inducted and trained in basic aspects of infection control relevant to their work including: - Basic concept of microbes - Proper hand washing - Segregation of waste and hazards associated with waste.
4.1.8	Written and dated organisation wide infection control and waste management policies and procedures are used by staff. Procedures include, but are not limited to, the following topics: - Use of standard precautions including handwashing techniques - Sterilisation and decontamination of equipment - Food hygiene - Laundry and linen management - Identification and management of organisation-acquired infections - Management of outbreaks of infection - High risk and communicable diseases - Operation of the mortuary - Collection, storage and disposal of infectious waste, body fluids, tissues, blood and blood products - Disposal of sharps and needles - Cleaning of all hospital surfaces, supplies and equipment, e.g. floor, walls, ceilings, beds and basins - Management and cleaning of spillage - Vaccination of staff.

4.2 Sterile Supplies

Equipment and supplies are sterilised to minimise risk of infection in clients/patients and staff.

Sl. No.	Measurable Criteria
4.2.1	There is a defined department or area for sterilisation which physically separates the functions of cleaning, processing and sterile storage and distribution.
4.2.2	In all areas where instruments are cleaned there is airflow to prevent cross-contamination and to keep material within the area.
4.2.3	There is at least one functioning steriliser with a drying cycle.
4.2.4	The responsibilities of relevant staff members managing the provision of sterile supplies are clearly defined and specified in writing.
4.2.5	Staff responsible for the decontamination, inspection, function testing, assembly and packaging, terminal processing, storage and distribution of supplies are adequately trained.
4.2.6	Current written policies and procedures covering the functions of sterilisation, including the following, are available with documented evidence of routine compliance:

Sl. No.	Measurable Criteria
	- Receiving, cleaning and disinfection of used items - Preparation and processing of sterile packs - Storage of sterile supplies and expiry dates - Decontamination of instruments prior to sending for repair, maintenance or servicing - Handling of instruments following an infected case - Handling of equipment identified as “bio-hazard" - Product labelling, batch numbering and identification - Restricted personnel access to the clean production area - Cleaning procedures, manual methods - Housekeeping procedures
4.2.7	Sterilisation procedures are based on existing provincial or national/international guidelines.
4.2.8	Reports of quality control tests on sterilisers are reported to the infection control committee at least quarterly.
4.2.9	The person using sterilised equipment checks that the decontamination of the equipment has been done before using that equipment.
4.2.10	Stock levels of sterilised goods are checked by an ongoing inventory management process.
4.2.11	Records are available for: - Acceptance of load procedures - Plant history records - Sterile goods issued to wards/departments - Sterilisers and autoclaves (history and servicing) - Servicing and calibration.

4.3 Cleanliness

All hospital facilities, equipment and supplies are kept clean and safe for clients/patients, visitors/attendants and staff.

Sl. No.	Measurable Criteria
4.3.1	Staff follow written policies, procedures and SOP and schedules for: - Disinfection and cleaning of all equipment, furniture, floors, walls, storage areas and other surfaces and areas - Cleaning of specialised areas, e.g. OT, Labour Room, Emergency Ward, Dressing Room, Laboratory and ICU.
4.3.2	Hospital premises are free from litter and other refuse.
4.3.3	Sufficient covered, clean dustbins are provided for clients/patients, visitors/attendants and staff and the dustbins are emptied on a regular basis.
4.3.4	Equipment, floors and walls are free from bodily fluids, dust and grit and the masonry is intact.
4.3.5	Cleaners are trained and provided with sufficient appropriate equipment and cleaning material and work according to cleanliness and sanitation policies and procedures.
4.3.6	Kitchen staff and/or those handling food are trained and work according to policies and procedures including but not limited to the following: - cleaning of all areas and surfaces on which food is stored and prepared, e.g. all preparation surfaces are cleaned and dried between uses for different activities - food storage, e.g. all food is stored separately from non-foods, cooked food is stored separately from uncooked/raw food and the covering and labelling of food - use and cleaning of equipment for food preparation, handling and transport, e.g. separate cutting boards are used for raw and cooked foods.

Sl. No.	Measurable Criteria
4.3.7	All staff handling food have health checks prior to appointment and at regular intervals during their employment and records are kept.
4.3.8	A written Dress Code for those working in the kitchen is enforced including wearing of head cover for hair, clean uniforms and appropriate footwear.
4.3.9	The kitchen and food stores have proper ventilation.
4.3.10	All windows in food preparation and storage areas have suitable fly screens and insectocutors (ultra-violet electric flying insect removers) are present in designated problem areas.
4.3.11	Kitchen walls are made of material that is waterproof, non-absorbent and non-toxic and kitchen floors, walls and ceilings are easily cleaned.
4.3.12	Kitchen waste is put in covered secure containers and removed immediately from places where food is prepared pending disposal.
4.3.13	Kitchens are arranged to be away from waste storage, ward areas, laboratories and other areas of risk of contamination and infection.

4.4 Waste Management

Clinical and other infectious or injurious waste is handled, stored and disposed of to minimise harm and risk of infection /injury to patients/clients, visitors, contractors, staff and the community.

Sl. No.	Measurable Criteria
4.4.1	The hospital has a written waste disposal plan specifying procedures, responsibilities, timetable for waste collection and necessary equipment such as bins and bags as per "Medical Waste Management regulation 2008".
4.4.2	The waste disposal plan includes written guidelines for the regulation, identification, containment and storage, transport, treatment and subsequent disposal of different categories of infectious waste n accordance with " Medical Waste Management regulation 2008"
4.4.3	Contaminated waste buried in landfills is done so in accordance with the "Medical Waste Management regulation 2008"
4.4.4	Suitably qualified and experienced person(s) with designated responsibility lead the development and regular updating of plans and policies and procedures for waste management and the process is overseen by the Infection Control Committee and infection control personnel.
4.4.5	Responsibilities for waste management are defined in all job descriptions.
4.4.6	All staff are trained in and use procedures for different types of waste: - Collection - Segregation at source - Storage - Transportation - Disposal.
4.4.7	All staff who work in areas where infectious waste is handled are trained on hazards of waste, management of waste and infection control.
4.4.8	Outhouse management of medical waste by city corporation/ pouroshova authority
4.4.9	Monthly coordination meeting with city coorporation/pourosova
4.4.10	All waste is protected from theft, vandalism or scavenging by persons or animals.
4.4.11	A clear guide for waste segregation and storage is visibly posted in area(s) where this waste is generated and includes waste segregation in clearly labelled coded bins in accordance with the relevant national/provincial laws.

Part 5: Safe And Appropriate Environment

5.1 Health and Safety

Promotion of health and safety and the avoidance of risk to human life as well as to the property of the Hospital are integrated within the organisation and among all levels of staff.

Sl. No.	Measurable Criteria
5.1.1	The responsibility for health and safety of hospital management and other relevant staff is included in their job descriptions and performance reviews.
5.1.2	A Health and Safety Committee will be developed on a regular basis, includes representatives of management and staff from different departments and enables two-way communication between management and employees on issues of interest and concern related to health and safety.
5.1.3	Health and Safety Committee meetings follow a set agenda that includes follow-up from the last meeting, minutes of each meeting are kept and the agendas and minutes are readily available to all staff.
5.1.4	The Health and Safety Committee participates in the development of the Risk Management Plan.
5.1.5	All new employees are trained in Health and Safety procedures relevant to their duties within one month of taking up their post.
5.1.6	All staff attend continuing training for health and safety and records are kept of the trainings
5.1.7	Each department uses a systematic process to: - Regularly identify and record actual and potential hazards in a hazard register (at least half yearly) - Assess identified hazards to determine which are significant - Eliminate, isolate or minimise the impact of the significant hazards.
5.1.8	Staffs review significant hazards that have been isolated or minimised in accordance with a set timetable appropriate for the identified hazards.
5.1.9	All emergency telephone numbers concerned with Health and Safety are displayed prominently.
5.1.10	Health and Safety policies and procedures are followed by staff and include: - Contamination incidents - Sharps and needle-stick injuries - Drug dependence - HIV/AIDS - Hepatitis B and C - Lifting and manual handling of client/patients and equipment - Basic life support.
5.1.11	Current health and safety notices, including hazard notices, and key extracts from the Health and Safety manual are prominently displayed in relevant areas and brought to the attention of staff.
5.1.12	There is a procedure for ensuring that all contractors are provided with relevant information regarding health and safety issues within the hospital .
5.1.13	Staffs sign a form that documents that they have read and understood Health and Safety policies and procedures.
5.1.14	A written policy and procedure on pest control including measures to prevent, detect and remove pests is available and implemented.

5.2 Fire, Safety and Emergency Preparedness

The organisation minimises the risks of fire and protects clients/patients, visitors and staff in case of fire and is prepared for disasters and emergencies.

Sl. No.	Measurable Criteria
5.2.1	A fire safety plan exists including prevention/risk reduction, early detection, suppression, abatement, and safe exit from fire.
5.2.2	The hospital building, e.g. doors, exits and corridors, is constructed in a way to minimise the risk of fire and conform to fire safety rules, including: - Doorways, corridors, ramps and stairways being wide enough for the evacuation of non-ambulatory clients/patients - Fire and smoke doors being able to be opened and closed manually or by an electric release system - Doors to client/patient rooms and exit doors not being locked from the inside.
5.2.3	Access and exit ways are kept free of obstruction at all times to allow for safe evacuation in a fire or other emergency.
5.2.4	An annual inspection of fire safety in the Hospital by the Fire Department results in identification of fire risks and strategies to minimise the risks and prevent fire.
5.2.5	A person responsible for Hospital Safety carries out and records regular tests of alarm systems, fire extinguishers and other facilities and equipment for fire prevention and control.
5.2.6	Action is taken to address any recommendations made during inspections and testing.
5.2.7	A process ensures that furniture and furnishings are of limited flammability and toxicity and comply with approved safety standards.
5.2.8	Waste materials are stored in fire resistant containers.
5.2.9	Pillar and post type of hydrants are provided in new hospitals.
5.2.10	The electrical wiring in the Hospitals is changed every 20 years or when testing indicates.
5.2.11	Staffs are trained at least annually in fire safety and other emergency procedures.
5.2.12	Fire procedures and evacuations are tested and disaster and emergency drills are practised regularl

5.3 Safe and Appropriate Equipment

There are clear and documented responsibilities, policies and procedures for procurement, use, maintenance, repair and disposal of equipment to minimise the potential for harm.

Sl. No.	Measurable Criteria
5.3.1	An Equipment Committee will be formed with clearly defined roles meets as required and includes those in charge of the hospital, nursing, maintenance and stores and other relevant departmental representatives.
5.3.2	Basic responsibilities of the Equipment Committee include: - Assessment of need for new equipment - Consultation with the requesting department on their requirements and specifications for the equipment - Procurement of equipment - Assessment of utilisation of equipment - Condemnation of equipment - Conducting regular equipment audits.
5.3.3	The procurement policy for equipment and supplies includes the criteria that equipment and

Sl. No.	Measurable Criteria
	supplies purchased are consistent in type and brand with others in the hospital to facilitate maintenance and repair.
5.3.4	A written procedure is used for receiving ordered equipment and includes at least the following activities: - At time of delivery the equipment is inspected as per specifications given in the supply order by the equipment committee/user department. - On satisfactory receipt, installation and commissioning of the equipment a certificate to that effect is given by the equipment committee/user department. - Payment of the supplier is only made on production of such a certificate - Originals or a copy of the service contract and operational manual are kept in the maintenance department or other designated department.
5.3.5	Equipment is certified as conforming to health and safety requirements and regulations.
5.3.6	For costly equipment annual maintenance contracts are made including: - Regular service and maintenance for at least five years after the warranty period - Warranty with cost-free provision of spares - Continuous supply of consumables - Training of staff to handle the equipment - Reliable and prompt after-sale service - Penalty clause if any delay occurs due to the negligence of the supplier.
5.3.7	The suppliers contact details and emergency telephone number is available.
5.3.8	Staff allowed to operate equipment or machinery are appropriately trained and re-trained and no untrained person operates the equipment.
5.3.9	Records of equipment are kept including procurement, equipment defects and failures, maintenance, repair and disposal.
5.3.10	A maintenance workshop with qualified and experienced persons having basic knowledge of physics and electronics has defined responsibilities for maintenance and repair of smaller equipment.
5.3.11	A list of all electrical equipment that requires routine testing is used and a record of maintenance and testing of this equipment is kept for three years, e.g. generator, emergency lighting.
5.3.12	Regular and routine checks of equipment (equipment audit) are carried out in accordance with the operational manual, maintenance contract and/or a history sheet of the equipment by the Store in-charge.
5.3.13	Safeguards for electronic equipment are used such as: - Voltage stabilizer - Automatic switch over for emergency (generator).
5.3.14	For life-saving equipment a three-phased supply of electricity is provided.
5.3.15	A logbook for all critical equipment is kept and a record of incidence of defects and failures in equipment is maintained
5.3.16	There is a form known to all staff and used to request equipment repairs and defects.
5.3.17	An adequate and sufficiently large room and supplies are available for maintenance and minor repairs. Supplies include but are not limited to: - A bank of spare parts

Sl. No.	Measurable Criteria
	- Toolkit.
5.3.18	A list of maintenance/backlog items is kept and reviewed regularly.
5.3.19	Written procedures exist for - Requests for repair from outside agencies if equipment cannot be repaired in-house - Condemnation and disposal of obsolete equipment.
5.3.20	A list of approved external repair workshops is kept and regularly updated
5.3.21	All requests for repair, work carried out and response time to reported defects is monitored and documented.
5.3.22	The procedure for condemnation and disposal of obsolete equipment includes criteria for defining 'condemned' and 'obsolete' equipment, such as: - Non-functional and beyond economical repair - Non-functional and obsolete - Functional but obsolete - Functional but hazardous - Functional but no-longer required.
5.3.23	An annual budget is provided for the maintenance and scheduled replacement of equipment.

5.4 Safe and Appropriate Facilities

The Hospital's physical environment contributes to the safety and well-being of clients/patients, staff and visitors.

Sl. No.	Measurable Criteria
5.4.1	The hospital complies with relevant laws and regulations related to design and layout of the facility and inspection requirements are fulfilled.
5.4.2	Corridors, storage areas, passageways and stairways are well lit.
5.4.3	Access ways and exits are unobstructed at all times.
5.4.4	Signage allows safe passage through the hospital and exit from the facility in case of an emergency, disaster or fire.
5.4.5	The environment in all client/patient areas is clean, well lit, ventilated with adjustable controls for lighting and heating, and decor is in good repair.
5.4.6	Floor surfaces are non-slip and even.
5.4.7	Facilities and equipment for the safety and comfort of clients/patients and visitors are available and functioning and include: - Refreshment facilities and canteen - Quiet rooms for consultations - A public telephone - Baby changing/feeding facilities - Wheel chair / stretcher - Defined and understandable signage system
5.4.8	Each nursing area has a clean storage and preparation space and is separate from soiled materials, domestic equipment and sluice areas.
5.4.9	Separate male and female toilets and bathrooms are available and adequate for the number

Sl. No.	Measurable Criteria
	of clients/patients in the ward or department (at least one toilet for every twelve clients/patients). The toilets and bathrooms: - Are kept clean - Are lockable by the client/patient from the inside but unlockable from the outside - Have doors that open outwards - Ensure privacy at all times - Have a non-slip base - Have grab rails positioned on either side of the toilet - Have an alarm-call within easy reach of the bath and toilet.
5.4.10	Separate male and female functioning, clean toilets are available for use by visitors/attendants.
5.4.11	Each client/patient has access to an area in which to keep personal possessions.
5.4.12	Potable water and electrical power are available 24 hours a day, seven days a week.
5.4.13	Alternate sources of water and power for heat and lighting in case of breakdown of the systems are identified, functioning and regularly tested. Priority areas such as ICU and Operating Theatres are identified.
5.4.14	Electrical, water, ventilation, medical gas, and other key systems are regularly inspected, maintained and improved, if necessary.

Chapter -FIVE

Tertiary Level Standards

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Part 5 : Safe And Appropriate Environment Standards

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5.3 Safe and Appropriate Equipment
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Part 1 : Management Stanadard

1.1 Managing The Organisation

The Hospital authority will form a committee (5-7 members) who will develop strategic Plan (1-3 years) based on the allocated resources, SWOT analysis, based on the supplied format.

1.1.1 Mission and Strategic Planning

The hospital is directed and managed effectively and efficiently, in accordance with its objectives and mission statement.

Sl. No.	Measurable Criteria
1.1.1.1	There is a universal mission statement for the Hospital, which sets out the principal aims of the Hospital and which is developed together with staff, patient representatives, and other relevant stakeholders.
1.1.1.2	A defined set of values guides the behaviour of the hospital staff
1.1.1.3	The mission and values are available and disseminated to the staff and general public in languages and forms appropriate to the local population and their needs.
1.1.1.4	A strategic plan developed in consultation with the staff and other relevant stakeholderssets out the long-term goals, objectives and strategies for the hospital and its services.
1.1.1.5	An annual work plan is developed in line with the strategic plan and contains objectives, planned actions and staffing, financial and physical resources to meet the planned actions.
1.1.1.6	Progress against the objectives and planned actions set out in the annual plan is reviewed regularly according to a defined monitoring and evaluation process.
1.1.1.7	The strategic and annual planning is based upon a SWOT analysis, including an analysis of community and patient/client needs, service delivery and evaluation data, current health policies and other relevant information.
1.1.1.8	A coded hospital management information system is in place and provides data for the annual planning process

1.1.2 General Management

Responsibilities for operating the organisation, managing its resources and for complying with applicable laws and regulations are clearly documented.

Sl. No.	Measurable Criteria
1.1.1	The Hospital is overseen by Director/Superintendent
1.1.2	The Hospital is managed by a Hospitalin-charge with appropriate qualifications and experience.
1.1.3	The job description of the Hospital in-charge clearly defines responsibility and accountability for the efficient and effective operation of the hospital, including responsibility for risk and quality management, infection control and health and safety.
1.1.4	A current organisational chart identifies the lines of accountability and reporting for all staff and the governing authority/owners
1.1.5	The organisational chart is regularly reviewed and clearly communicated to all staff within the Hospital and other relevant persons.
1.1.6	Clear and effective mechanisms exist for internal and external communication. These include: - Two-way communicationbetween staff and between staff and management - Communication between different departments and wards - Communications with the press and media

Sl. No.	Measurable Criteria
	- Communication with patients/carers - Communications with external organisations
1.1.7	Staff follow a clear policy on confidentiality and release of information which complies with the local acts and rules.
1.1.8	The scope and limits, roles and functions of each clinical service/unit/department are clearly defined and known to staff and are determined with the input of staff.
1.1.9	Each service within the hospital is led by an identified manager with appropriate qualifications and experience who is responsible for the organisation and management of this service.
1.1.10	Duty roster reflect the appropriate skill mix and health authority requirements and are available at least two weeks in advance.

1.1.3 Financial Management

Financial resources are managed efficiently and effectively in order to optimise services that can be provided and results that can be achieved.

Sl. No.	Measurable Criteria
1.1.3.1	A qualified financial manager / Accounts officer is responsible for financial management and developing rules and procedures which are followed and monitored.
1.1.3.2	The Hospital in-charge and departmental heads are involved in setting annual targets and budgets for the following financial year by forming Local level plan (LLP)
1.1.3.3	The accounting system produces reliable financial information on all sources of revenues (line budget, grant in aid, user fees, zakat, donations, health insurance fees or others) and all expenditure, and provides timely and accurate financial reports for decision making.
1.1.3.4	An internal control and audit system is in place.
1.1.3.5	An external financial audit is undertaken annually.
1.1.3.6	A mechanism is used to control the acquisition, use, disposal and safeguarding of assets in accordance with financial rules and regulations.

1.1.4 Human Resources Management

Staff are appointed, trained and evaluated in accordance with documented procedures, job descriptions and service needs.

Sl. No.	Measurable Criteria
1.1.4.1	The recruitment rules in place / The hospital develops and implements policies and procedures for the management of staff, which includes appointment, selection, training, appraisal, promotion, and retention of appropriately qualified staff to meet the service objectives of the organisation.
1.1.4.2	Staff availability and skill mix are consistent with the on-going role and functions of each unit
1.1.4.3	Records are available which show: - Staff levels and skill mix - Workload and complexity - Sickness and absence - Training.
1.1.4.4	Staffs are treated in accordance with an equal opportunities policy and as per Government rules.

Sl. No.	Measurable Criteria
1.1.4.5	Current job descriptions and responsibilities for all staff are available and all staff have a copy of their job description.
1.1.4.6	All staff are oriented to the hospital and their specific positions through a documented induction program.
1.1.4.7	The orientation programme includes: - The hospital's mission, values, goals and relevant planned actions for the year - Services provided - Roles and responsibilities - Relevant policies and procedures, including confidentiality - Use of equipment - Safety - Emergency preparedness - Quality improvement.
1.1.4.8	Every staff member in the hospital can be identified by appropriate mechanisms, e.g. uniforms, name tags, hats.
1.1.4.9	Staff performance is evaluated annually with the staff member against their job description and agreed targets and is used to identify strengths, areas for improvement and training needs.
1.1.4.10	A mechanism exists to monitor that all doctors, nurses, midwives and other health professionals have had sufficient recent practice to maintain competence and to address any competence issues through additional supervision, training or other procedures.
1.1.4.11	The hospital identifies staff authorised as competent to undertake admissions, carry out assessments, provide treatment in different services and maintain and manage waiting lists.
1.1.4.12	Staff facilities include: - Rest room - Changing facilities - Personal lockable storage area - Washing/shower facilities - Toilets - Refreshment facilities - Accommodation for on-call staff in the Hospital premises - Staff housing.
1.1.4.13	A training needs assessment exercise is conducted every two years with the objective of developing training plans for all staff groups in order to meet the development needs of individual health professionals and the service needs of the organisation.
1.1.4.14	A continuing education programme is accessible to all staff. Participation is encouraged and monitored by the hospital.
1.1.4.15	There is a training budget, which is calculated to allow appropriate training to take place.
1.1.4.16	Key indicators such as absenteeism and staff turnover are measured and the results analysed and used for improvement.

1.2 Client/Patient Rights

1.2.1 Information for Clients/Patients

Clients/Patients have the right to receive all information relevant to their care management to enable them to make informed decisions.

Sl. No.	Measurable Criteria
1.2.1.1	A client/patient rights and responsibilities charter (Citizen Charter) is developed and displayed in all client/patient areas.
1.2.1.2	The hospital uses a documented process for clients/patients not able to understand written information to inform them of their rights.
1.2.1.3	Guidance and advice is provided to the clients/patients at the registration counter.
1.2.1.4	The reception area and wards display information about the organisation, including: - The rights of the clients/patients - Services and facilities available in the hospital - Costs of services - Feedback and complaints pathways.
1.2.1.5	Information about the hospital services and how best to use them is made available to the public and displayed in a prominent place.
1.2.1.6	Clients/Patients and their families are fully informed about the client's/patient's health status, including the clinical facts about their condition, unless they explicitly request not to be informed.
1.2.1.7	Appropriate information is provided to clients/patients and their families, in a way that they can understand, on the proposed treatment, the costs, the risks and benefits of the proposed treatment or investigation, and the alternatives available.
1.2.1.8	Client/Patient consent is obtained for the proposed care or treatment. Written consent is obtained for any invasive procedures or operations.
1.2.1.9	Information related to referral to a different hospital such as cost, travel, time, duration of treatment and expected outcome is provided to the client/patient and their family.
1.2.1.10	Up-to-date and evidence based information and education are given on: - Disease prevention - Health promotion
1.2.1.11	Relevant health messages are prominently displayed within the hospital and written information is available for clients/patients to take home.
1.2.1.12	Client/Patient choices and preferences are considered when care and services are being provided and ward activities arranged.
1.2.1.13	The hospital has determined its level of responsibility for clients'/patients' possessions and clients/patients receive information about the hospital's responsibility for protecting personal belongings.

1.2.2 Client/Patient Feedback on Services

Clients/Patients have the right to complain about the services and treatment and their complaints are investigated in a fair and timely manner.

Sl. No.	Measurable Criteria
1.2.2.1	Clients/Patients are informed of their right to express their concerns or complain either verbally or in writing
1.2.2.2	There is a documented process for collecting, prioritizing, reporting and investigating complaints which is fair and timely.
1.2.2.3	Clients/Patients are informed of the progress of the investigation at regular intervals and are informed of the outcome.
1.2.2.4	The results of the complaints investigations are used as part of the quality improvement process

1.2.3 Privacy and Dignity

Clients'/Patients' privacy and dignity are respected throughout the entire care process.

Sl. No.	Measurable Criteria
1.2.3.1	Clients/Patients have (a right to) individual beds.
1.2.3.2	Consultation, treatment rooms and washing facilities allow privacy and separate toilets for male and female clients/patients are provided.
1.2.3.3	Appropriate in-patient and changing facilities for clients/patients allow privacy and dignity to be maintained.
1.2.3.4	A given intervention may be carried out only in the presence of those persons who are necessary for the intervention unless the client/patient consents or requests otherwise.
1.2.3.5	Clients/Patients are relieved of pain and suffering according to the current state of knowledge.
1.2.3.6	The needs of dying clients/patients are assessed and documented.
1.2.3.7	Staff are made aware of the needs of dying clients/patients and provide respectful and compassionate care and services to dying clients/patients and their families.

Part 2: Service Delivery Standard

2.1 Care Continuum

In Care Continuum, National Strategic Plan on Quality of Care will be introduced as per implementation plan in the document.

2.1.1 Access to Health Services

Services are continuously available and the hospital minimises physical, economic, social, cultural, organisational or linguistic barriers to access.

Sl. No.	Measurable Criteria
2.1.1.1	Access ways and passageways are kept clear at all times.
2.1.1.2	Functional wheel chairs and stretchers are available at the gate/reception for patients who are unable to walk.
2.1.1.3	All patient areas of the hospital are easily accessible by wheelchair.
2.1.1.4	Multi-storey buildings have ramps or functional lifts with an operator.
2.1.1.5	The hospital and its departments are clearly signposted and a site plan is displayed at a central place for orientation of staff and patients.
2.1.1.6	A reception with a male and female receptionist to guide the patients is open during operating hours.
2.1.1.7	The hospital specifies visiting hours and communicates these to the public.
2.1.1.8	Rules for numbers and kind of visitors and attendees are clearly defined and visibly posted and facilities enable relatives to sit at the bedside and to stay overnight.
2.1.1.9	On admission to hospital, clients/patients are introduced to the nurse on duty and given an orientation to the unit to which they are admitted including the location of toilets, and other facilities and services.
2.1.1.10	Clients/Patients admitted to the hospital have access to an allotted bed with fresh linen.
2.1.1.11	Elective admissions, including waiting list management , appointments and cancellations are managed in accordance with documented policies and procedures and based on client/patient need.

2.1.2 Continuity of Care

Clients/Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care.

Sl. No.	Measurable Criteria
2.1.2.1	Every client/patient seeking treatment or care at the hospital is registered and issued the appropriate form for recording various details of symptoms, diagnosis, treatment and services being provided.
2.1.2.2	All clients/patients and visitors to the hospital receive courteous and prompt attention from the staff at reception and any ward or department.
2.1.2.3	The doctor on duty has primary responsibility for the clinical care of any client/patient until a specialist takes over.
2.1.2.4	The nurse on duty is responsible for coordinating client/patient assessment, care planning and evaluation of care with other care providers and services.
2.1.2.5	A stock of essential drugs is available at all times in each treatment area.
2.1.2.6	A staff/patient ratio based on international good practice is used for determining the number and mix of clinical staff on each shift.
2.1.2.7	Doctors, qualified nurses and appropriate support staff are available on-site 24 hours per day.
2.1.2.8	Regular meetings of different care providers are held to share information on clients'/patients' progress and client/patient care is formally handed over with the transfer of all relevant information when staff change duties.
2.1.2.9	The client's/patient's record is available to all care providers.
2.1.2.10	Planning for discharge or end of service begins at admission and involves the client/patient and their family and potential providers of follow-up services.

2.1.3 Assessment

Health care needs identified through an established assessment process.

Sl. No.	Measurable Criteria
2.1.3.1	Based on developing Triage, Criteria to prioritise emergency patients exist and are implemented.
2.1.3.2	Patients' / clients choice regarding examination by a male or female is respected as far as possible.
2.1.3.3	An attendant is available when patients are being examined by members of the opposite sex.
2.1.3.4	An assessment of the patient's/client's needs is systematically completed on a form including, for example, medical, psychological, social, physical, environmental, educational, spiritual and cultural needs.
2.1.3.5	The initial assessment includes the recording of vital signs, weight, height and significant findings.
2.1.3.6	The Patients' / Clients relatives and carers are included in the assessment by providing information wherever possible.
2.1.3.7	A history and full medical examination is entered in the patient records by a member of the medical staff as soon as possible but at the latest 6 hours after admission.
2.1.3.8	After examining the client/patient, the doctor legibly endorses the assessment findings, records the provisional diagnosis and the course of action on the OPD slip/ticket ,the

Sl. No.	Measurable Criteria
	Patients' / clients register and dates and signs it and puts the name in BLOCK letter.
2.1.3.9	Except in an emergency, admission notes are completed prior to any surgical procedure.
2.1.3.10	Following examination, written as well as verbal information is provided for clients/patients regarding future visits, treatment and medication.
2.1.3.11	Patients' / clients are re-assessed at certain intervals to determine their response to treatment and to plan for continued treatment or discharge and re-assessment results are documented in the client's/patient's record

2.2 Care Planning, Monitoring and Evaluation

Service Providers develop and implement a written, up to date plan of care/service for each client/patient and monitor the care provided against this plan.

Sl. No.	Measurable Criteria
2.2.1	A written care plan for each patients' / clients is prepared in collaboration with the patients' / clients, carers/relatives and other appropriate health professionals.
2.2.2	Care plans identify the goals of care and treatment and reflect the patients' / clients assessed needs, perceptions and priorities, agreed philosophy of care, current practice guidelines and evidence-based practice.
2.2.3	The care plan includes how the patients' / clients individual choices and preferences are to be addressed.
2.2.4	The care plan is evaluated and updated in accordance with the findings of re-assessment and progress in meeting identified goals.
2.2.5	The care plan is used by doctors, nurses and other health professionals to facilitate continuity of care and on-going appropriate treatment.
2.2.6	Outcome indicators, e.g. hospital acquired infections, bed sore, leg ulcers, client/patient complaints, are systematically monitored, recorded, analysed and used to improve care.

2.2.1 Treatment

Hospitals / Clinics delivers services to the patients' / clients that meet their individual assessed needs, reflect current good practice and are co-ordinated to minimise potential risks and interruptions in provision.

Sl. No.	Measurable Criteria
2.2.1.1	Clinical guidelines/treatment protocols are used to guide client/patient care processes.
2.2.1.2	Policies and procedures guide the care of high-risk patients' / clients, such as: - emergency patients' / clients - those who are comatose or on life support - those with communicable diseases or who are immune suppressed - patients' / clients on dialysis - vulnerable elderly and children - seriously ill patients' / clients. - Pregnancy
2.1.3	Written procedures to ensure that the right dose of medication is administered to the right patients' / clients at the right time are followed by staff by introducing a checklist: - Identification of the patients' / clients before medications are administered - Verification of the medication and the dosage amount with the prescription - Verification of the routes of administration - Verification of the time of administration.

Sl. No.	Measurable Criteria
2.1.4	Medication effects (including adverse effects) and medication errors are monitored, reported and analysed.
2.1.5	Appropriate and sufficient support services are available to allow nursing staff to meet the care needs of clients/patients. These include: - At least one Class IV employee around the clock - Equipment of at least B.P. Apparatus, Stethoscope, Thermometer, Oxygen cylinder with trolley, Suction machine, torch and nebuliser.
2.1.6	patients' / clients are not disturbed during meal times for medical rounds, nursing or other treatments, other than in an emergency.

2.2.2 Documentation of Care

The patients' / clients record contains sufficient information to identify the patients' / clients, support the diagnosis, justify the treatment and care, document the course and results of the treatment and care, and promote continuity of care among health care providers

Sl. No.	Measurable Criteria
2.2.2.1	A clinical record is initiated for every patients' / clients admitted to the hospital and wherever possible there is only one set of case notes for each client/patient.
2.2.2.2	patients' / clients records are maintained through the use of a unique number or other form of identification unique to the patient.
2.2.2.3	Entries in the patients' / clients records are legible, dated, signed and identifiable.
2.2.2.4	The use of symbols and abbreviations is kept to a minimum in accordance with an agreed list of abbreviations within the hospital.
2.2.2.5	There is a locally agreed format for filing of information within the client/patient record.
2.2.2.6	The hospital respects information about a patients' / clients health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind as confidential, even after death. Confidential information is only disclosed if the patients' / clients gives explicit consent or if the law expressly provides for this.
2.2.2.7	The patients' / clients record can be used for research purposes only if the patients' / clients has given a written consent and/or if there is an approval by the Ethics Committee.
2.2.2.8	The original patients' / clients record may not be removed from the hospital premises, except by court order. Policies and procedures are in place to prevent the loss and/or misuse of client/patient records.
2.2.2.9	The **patients' / clients** record is sufficiently detailed to enable the **patients' / clients** to receive effective coordinated treatment and care and includes**:** - Details of admission, date and time of arrival - patients' / clients assessment and medical examination - Sheet containing history pertinent to the condition being treated including details of present and past history and family history - Diagnosis by a registered health professional for each entry to the hospital - Details of the patients' / clients care or treatment plan and follow-up plans - Diagnostic test orders and results of these tests - Progress notes written by medical, nursing and allied health staff to record all significant events such as alterations in the client's/patient's condition and responses to treatment and care - Record of any near misses, incidents or adverse events - Medication sheet recording each dose given

Sl. No.	Measurable Criteria
	- Treatment record - Observation charts, e.g. temperature chart, input and output chart, head injury chart, diabetic chart - Specialist consultation reports - Mode of discharge, e.g. left against medical advice or discharge on will - In case of death, details of circumstances leading to the death of patients
2.2.2.10	- For surgical patients' / clients, the clinical record additionally includes: - Consent form. - Anaesthetic notes - Operation record
2.2.2.11	Where referrals have been made, the patients' / clients record in the referral register includes the referral slip and indications for referral
2.2.2.12	An 'alert' notation for conditions such as allergic responses to medications or food, adverse drug reactions, radioactive hazards and infection risks is prominently displayed in the record. For allergies, the case sheet and folder are stamped in bold red with the word ALLERGY
2.2.2.13	A completed discharge summary signed by the doctor (full name) who authorized the discharge is submitted to the records department within 72 hours of the client's/patient's discharge.
2.2.2.14	All diagnoses/procedures are coded using ICD 10 and a yearly summary report is prepared and used for planning.
2.2.2.15	Patients' / clients records (hard copies) are retained for a minimum of 7 years and disposed of according to existing rules and legislation.
2.2.2.16	Appropriate policies and procedures are in place to govern access to and storage of patient records.
2.2.2.17	There is a clear policy which allows patients access to their records.
2.2.2.18	All patient records are filed in a central medical records filing system. There is a provision of a separate storage area for keeping medico-legal case records.
2.2.2.19	There is a system for easy retrieval of records.
2.2.2.20	A tracking system monitors the removal, movement and replacement of client/patient records between internal users and the Medical Records Department.

2.2.3 Discharge and Referral

Considering the patient health status Safe and appropriate discharge, transfer or referral of patients' / clients

Sl. No.	Measurable Criteria
2.2.3.1	A written and dated procedure including criteria to determine readiness for discharge, transfer or referral of patients' / clients is used and specifies who is authorised to do it.
2.2.3.2	Reasonable time, preferably 12 hours, of notice of discharge or transfer is given to patients' / clients and carers.
2.2.3.3	Follow up arrangements, agreed with the patients' / clients and/or the family, are noted in the patients' / clients record prior to discharge.
2.2.3.4	On discharge, the attending doctor summarises in the patients' / clients record the primary (and secondary) diagnosis, any complications, any operative procedures undertaken and any follow up arrangements agreed with the patient/family.
2.2.3.5	A discharge certificate containing relevant information such as reason for admission, findings, diagnosis, treatment, medication, condition at discharge, date of discharge and name of attending practitioner is signed and given to the patients' / clients and/or his family prior to

Sl. No.	Measurable Criteria
	discharge, with a copy retained in the client/patient record.
2.2.3.6	The doctors discharging the patients' / clients ensures that the following are given to the patients' / clients or relative/carer on discharge: - Medications, dressings or appliances - Instructions in a clear understandable manner on follow up, including as appropriate written advice and counselling regarding medications, diet, health problem management and exercise - Written details of out future appointments - Personal belongings.
2.2.3.7	The patients' / clients and/or the appropriate carer or attendant is advised on any necessary skills for care after discharge such as moving and handling techniques or catheter care.
2.2.3.8	If patients' / clients are transferred to another hospital or doctor, copies of their clinical notes and the discharge slip accompany them to provide sufficient information for continuity of care and feedback
2.2.3.9	patients' / clients being transferred to other facilities are provided with necessary resources such as transport, walking aids and documentation.
2.2.3.10	Before transfer the facility to which the patients' / clients is being transferred is informed about receiving the patients' / clients, their status and the time of arrival and afterwards the hospital checks with the facility that the transfer has been safely made.
2.2.3.11	Referral System Guideline, Referral Register & Referral Slip (Developed by Hospital & Clinic Section of DGHS) will be used for patient referral.

2.3 Quality Management

The Quality Improvement activities will be implemented by the directives of National Strategic Planning on Quality of Care for Health Service Delivery, Bangladesh.

Sl. No.	Measurable Criteria
2.3.1	The Quality Improvement Committee / team develops a quality plan which defines roles and responsibilities and sets priorities for quality improvement according to the National Strategic Planning on Quality of Care for Health Service Delivery, Bangladesh.
2.3.2	Clinical Management Protocols/Guideline/Tools/Standard Operating Procedure will be introduced as per National Strategic Plan on Quality of Care.
2.3.3	The Quality Improvement committee/team regularly assesses client/patient satisfaction in order to improve service provision.
2.3.4	Work Improvement Team (WIT) will be formed and developed action plan accordingly.
2.3.5	Key Performance Indicators and Facility level indicators for Quality of Care will be measured as per guideline of Quality Improvement Secretariat.
2.3.6	Quality Improvement committee/team which meets on a regular, documented basis to analyze reports, and to monitor, support, advise and lead on quality improvement.
2.3.7	A risk management committee developed and risk management plan for the Hospital: - is based on information from business planning and results, client/patient feedback, clinical indicators and events, staffing and resource provision, and environmental data - identifies, assesses and prioritises all risks in terms of likelihood and consequences of harm/damage - includes strategies to manage those risks and - is available and disseminated to staff.

Sl. No.	Measurable Criteria
2.3.8	Incidents, accidents, near misses and adverse events are: - reported on the appropriate form - investigated promptly according to a set procedure - used to make improvements in line with any findings and - communicated to staff.
2.3.9	Incident, accident, near miss and adverse event data are collated into a central record, analysed and reported to the Health and Safety and/or Infection Control and/or Quality Improvement Committee for information and action as required.
2.3.10	Staff are educated on how to reduce risk by forming risk management committee, including: - detecting, assessing and reporting risk situations - managing unsafe behaviour or situations - preventing and controlling infection - using equipment and supplies safely - safe transferring and lifting techniques.
2.3.11	Staff are trained to follow the guidelines and there is evidence that they do.
2.3.12	A clinical audit team has formed and schedule is agreed between management and clinical staff and implemented.
2.3.13	Improvements are planned, appropriate action is taken, the effectiveness of the action is evaluated and the results are fed back to staff and clients/patients.
2.3.14	5S-CQI-TQM approach will be introduced for improvement for Quality of Care.
2.3.15	Monthly report will be sent to DGHS and QIS routinely.

2.3 Operation Theatre Department

2.3.1 Service Management

Standard Operating Theatres provide safe and appropriate services for patients and are co-ordinated with other services of the hospital to provide continuity of care.

Sl. No.	Measurable Criteria
2.3.1.1	The operating theatre and/or department is managed by a suitably qualified OT incharge / manager & using SOP for OT
2.3.1.2	A safe surgery check list, is used for every surgical patient before any type of surgery
2.3.1.3	A list of hospital approved surgical procedures based on an annual assessment of qualified staff, equipment and other inputs and processes is communicated to staff
2.3.1.4	Responsibilities of each of OT nurse and attendants are made explicit
2.3.1.5	A qualified individual conducts a pre anesthesia assessment and pre induction assessment.
2.3.1.6	A pre anesthesia assessment is performed for each patient. by an individual(s) qualified to do so and documented in the patient record.
2.3.1.7	A separate pre induction assessment is performed to re evaluate patients immediately before the induction of anesthesia. by an individual(s) qualified to do so and documented in the patient record.
2.3.1.8	Anaesthetic services are provided by qualified, registered and experienced anaesthetists.
2.3.1.8	Each patient's anesthesia care is planned and documented, and the anesthesia and technique used are documented in the patient's record.
2.3.1.9	The anesthesia care of each patient is planned and documented in the patient's record.
2.3.1.10	The anesthesia agent, dose (when applicable), and anesthetic technique are documented in

Sl. No.	Measurable Criteria
	the patient's anesthesia record.
2.3.1.11	The anesthesiologist and/or nurse anesthetist and anesthesia assistants are identified in the patient's anesthesia record
2.3.1.12	An consultant anaesthetist will supervise all surgical procedures 24 hours a day.
2.3.1.13	A designated, suitably trained member of staff (Operating Theatre Assistant, anaesthesia technician) is available to assist the anaesthetist at all times.
2.3.1.14	A signed agreement with a referral hospital offering more comprehensive services ensures provision of necessary surgeries.
2.3.1.15	*Each patient's surgical care is planned and documented based on the results of the assessment*
2.3.1.16	The assessment information used to develop and to support the planned invasive procedure is documented in the patient's record by the responsible physician before the procedure is performed.
2.3.1.17	Each patient's surgical care is planned based on the assessment information.
2.3.1.18	*The risks, benefits, and alternatives are discussed with the patient and his or her family or those who make decisions for the patient*
2.3.1.19	The patient, family, and decision makers are educated / informed on the risks, benefits, potential complications, and alternatives related to the planned surgical procedure.
2.3.1.20	*Information about the surgical procedure is documented in the patient's record to facilitate continuing care.*
2.3.1.21	Surgical reports, templates { forms }, or operative progress notes include at least a) through h) from the intent.
2.3.1.22	The hospital identifies information that may routinely be recorded in ~~other~~ specific areas of the record.
2.3.1.23	The surgical report, template, or operative progress note is available immediately after surgery before the patient is transferred to the next level of care
2.3.1.24	*Patient care after surgery is planned and documented.*
2.3.1.25	The postsurgical care provided by medical, nursing, and others meets the patient's immediate postsurgical needs
2.3.1.26	The continuing postsurgical plan(s) is documented in the patient's record within 24 hours by the responsible surgeon or verified by a co-signature from the responsible surgeon on the documented plan entered by the surgeon's delegate.
2.3.1.27	The continuing postsurgical plan of care includes medical, nursing, and others as needed based on the patient's needs.
2.3.1.28	When indicated by a change in the patient's needs, the postsurgical plan of care is updated or revised based on the reassessment of the patient by the health care practitioners
2.3.1.29	*Surgical care that includes the implanting of a medical device is planned with special consideration of how standard processes and procedures must be modified*
2.3.1.30	The hospital's surgical services define the types of implantable devices that are included within its scope of services.
2.3.1.31	Policies and practices include a) through g) in the intent.
2.3.1.32	Medical device implants are included in the department's monitoring priorities

2.3.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key processes of the operating theatre and/or department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.3.2.1	Written up-to-date operating procedures are available and followed by staff and include but are not limited to the following: - Signage [SIGNPOST] of OT as a restricted area and identification of persons allowed in the OT - Sterilisation and identification of sterilised OT equipment - Separation and transport of dirty linen - Pre-operative assessment and instructions - Routine equipment check and preparation - Annual review of functioning equipment in line with the services offered by the OT - Sending for and the transportation of clients/patients from ward to OT - Admission to receiving patients in the operating department - Identification of clients/patients - Identification of operation site - Recovery - Inoculation injury - Staff protection against exhaust from anaesthetic gases - Post-operative care - Handover procedures for pre-operative and post-operative clients/patients - Diathermy use - Tourniquet use - X-ray use - Laser use - Swab, needle and instrument count - Infected clients/patients.
2.3.2.2	The following formal documentation/records are available in the department: - Theatre register (anaesthesia register and surgeons' register) - Safe surgery check list - Prosthesis register - Electro medical equipment register - Record of correct swab/instrument count - Controlled drugs - Specimens register - Record of weekly/monthly analyses of surgeries (including the ICD 10 code) - Next-day schedule for operations - Maintenance of stock levels of drugs and consumables - Duty roster.
2.3.2.3	Specific safety rules and instructions are displayed and followed by staff for the following: - Storage and use of hazardous chemicals, e.g. glutaraldehyde, formalin - Storage and use of compressed gases - Appropriate shielding and protective clothing, e.g. for image intensification - Emergency electrical power supply (UPS, inverters, generators and emergency electric lights)
2.3.2.4	A trained recovery nurse is present for each anaesthetic session and remains in the recovery

Sl. No.	Measurable Criteria
	area until the last patients' / clients has been discharged back to the ward.
2.3.2.5	Sufficient, qualified and experienced staff monitor patients' / clients in the recovery room to ensure individual client/patient supervision at all times.
2.3.2.6	Documented criteria are used to assess patients' / clients readiness to leave the recovery room.
2.3.2.7	The anaesthetist is available in the hospital until the patients' / clients has recovered from anaesthetic.
2.3.2.8	The anaesthetist provides the final authorization for the client/ patient to leave the recovery area.
2.3.2.9	There are clear, formal instructions on how to contact a doctor in an emergency.
2.3.2.10	A record of the operation for the patients' / clients record is made immediately following surgery and a copy is retained in the OT. The record includes the following: - Date and duration of operation - Anatomical site/place where surgery is undertaken - The name of the operating surgeon(s), operating assistants including scrub nurse and the name of the consultant responsible - The ICD 10 coded diagnosis made and the procedure performed - Description of the findings - Details and serial numbers of prosthetics used - Details of the sutures used - Swab and equipment count - Immediate post-operative instructions - The surgeon's and scrub nurse's signatures.
2.3.2.11	Anaesthetic records contain: - Date and duration of anaesthesia - Name of surgical operation performed - The name of the anaesthetist, anaesthesia assistant and, where relevant, the name of the consultant anaesthetist responsible - Pre-operative assessment by the anaesthetist - Drugs and doses given during anaesthesia and route of administration - Monitoring data - Intravenous fluid therapy - Post-anaesthetic instructions - Any complications or incidents during anaesthesia - Signatures of anaesthetist and anaesthesia assistant.

2.3.3 Facilities and Equipment

Amenities and equipments required for Operation Theatre, Pre-anesthetic and post-operative recovery room, Sterilization area, Anesthesiologist and Surgeons room , Nurses and OT managers room, Areas for medical and instruments Store.

Standard Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients undergoing surgical procedures in the operating theatre(s).

Sl. No.	Measurable Criteria
2.3.3.1	**Arrangements are made so that** hospital Operation Theatres are situated separately segregated from areas accessible to the general public. (Mandatory)
2.3.3.2	Hazard and/or warning notices are clearly displayed before / in front of restricted areas. Dirty areas are also clearly separated and marked
2.3.3.3	There is provision for SEPTIC / DIRTY OPERATION THEATRE inaccessible from clean OT with separate access

Sl. No.	Measurable Criteria
2.3.3.4	Obstetrics OT have defined area for resuscitation of newborn with equipments and medications all at hand
2.3.3.5	Specialized Operation theatres like Ophthalmology, Orthopedic prosthesis, Neurosurgery , Cardiac surgery and transplantation procedures must have separate theatre governed by specific protocol
2.3.3.6	Changing facilities for theatre staff
2.3.3.7	Separate male and female changing and rest rooms are available.
2.3.3.8	Staff use a separate space for maintaining records and other office activities.
2.3.3.9	There is provision for Recovery room close to but separated from OT with adequate number of beds proportionate to patient load
2.3.3.10	The anaesthetic induction area/room and operating theatre are equipped with safe and well maintained equipment specific for OT activities including but not restricted to the following: - Anaesthetic machine and ventilator - Laryngoscopes - Endotracheal tubes/laryngeal masks - Airways - Nasal tubes - Suction apparatus and connectors - Oxygen preferably central supply - Drugs and IVs required for planned anaesthesia - Drugs for emergency situations - Monitoring equipment including ECG, ETCO2, temperature monitoring, pulse oximeter and blood pressure - Accessible defibrillator - Anaesthetic gas scavenger system - Tipping/tilting trolleys/beds - Multi positioned table with radiolucent tops - Suction machine - Instrument cleaning/decontamination facilities - Temperature and humidity control - IV canulas and CV lines in different sizes - Blood warmer - Adequate light sources - Special equipment for particular age groups, e.g. neonate resuscitation table.
2.3.3.11	A list of functioning equipment available in the recovery room includes :- - Airways (Ambu bags) and other intubation material and equipment - Suction - Oximeter - ECG - Tipping/tilting trolleys/beds - Blood pressure measurement apparatus - Defibrillator - Anaesthesia machine - Oxygen concentrator - Emergency ventilator.

2.4 Emergency Department

2.4.1 Service Management

The Emergency Department provides safe, timely and efficient live-saving emergency care and minor treatment and surgery for patients.

Sl. No.	Measurable Criteria
2.4.1.1	Emergency Medical officers are available on duty 24x7 Number of duty doctors are increased during peak hours as appears on annual/monthly audit
2.4.1.2	Standard operating procedure is used for emergency management
2.4.1.3	Adequate number of Nursing and auxiliary staff are present
2.4.1.4	Resuscitation instruments and drugs are cheeked at the beginning of each duty hour
2.4.1.5	On arrival patient is placed on examination table according to TRIAGE
2.4.1.6	Admitted patients are transferred to respective indoor units with all documents and investigation results available at hand
2.4.1.7	Patients requiring short period of observation are monitored closely
2.4.1.8	Patients requiring minor surgical intervention are taken to Emergency OT to facilitate the procedure in a complete aseptic technique.
2.4.1.9	During discharge a prescription is give with written legible notes of clinical findings, management done and instructions for further treatment
2.4.1.10	Patients attending emergency with sudden severe illness like AMI, LVF, Cardiac arrest, Sudden unconsciousness , Head injury, Severely injured or ecclampsia are managed immediately and admitted and sent to CCU / ICU / Eclampsia room
2.4.1.11	Sick children and pregnant mother are given high priority
2.4.1.12	Patients requiring immediate attention is transferred after telephonic contact with on duty physician.
2.4.1.13	A clinical note of patients conditions is handed over during patient transfer

2.4.2 Policies, Procedures and Records

Operational policies and procedures clearly describe the key functioning processes of the casualty department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Sl. No.	Measurable Criteria
2.4.2.1	Written SOP and guidelines are used consistent with the policy for: - Identifying patients - How medical help is called during emergency - Dealing with life threatening emergencies before medical help arrives - The transfer of patients - The transfer of records - The use of tele-medical techniques. - Approach to patients who can not be admitted in the hospital
2.4.2.2	The hospital adopts a disaster plan for mass casualty. The hospital disaster plan clearly identifies the role, procedures and individual staff responsibilities within the casualty department in the event of a nearby major incident or disaster.
2.4.2.3	All patients are seen within fifteen minutes of arrival for initial assessment and treatment prioritisation.
2.4.2.4	Each patient is informed of the approximate waiting time after the need for treatment has been assessed.
2.4.2.5	A process is used to monitor patient waiting times.
2.4.2.6	Patients are examined in privacy by a doctor of the same sex as the client/patient (if available), or have the service of a chaperone if desired.
2.4.2.7	Relatives are kept informed of the patient's condition with the agreement of the patient

Sl. No.	Measurable Criteria
	where they are able to give such consent.
2.4.2.8	An individual record of attendance is completed which contains: - Name - Address - Age/Date of birth - Next of kin - Occupation/School - Case number - Telephone number - Date and time of arrival - Time of examination - Diagnoses - Treatment - Minor surgery carried out - [Specimens taken] Foreign body removed - Instructions for follow up - Doctor's or nurse's names and signatures - Medication given to/or taken away - Advice given on discharge.
2.4.2.9	A formal mechanism (roster) known to all staff is used for identifying medical staff on duty and on call and is prominently displayed in the emergency care area.
2.4.2.10	A procedure exists for referral for specialist care if necessary.
2.4.2.11	A senior person should be available on call round the clock
2.4.2.12	A written, dated, signed policy on the referral, selection and treatment of patients' / clients for minor surgery is followed.
2.4.2.13	Data and others indicators are systematically recorded and aggregated for analysis. These include a documented review of volume of activity, source and appropriateness of referrals and adverse events
2.4.2.14	There will be no denial of any emergency services. Patient will be resuscitated and managed first and then transferred.

2.4.3 Facilities and Equipment

Easily accessible Safe and adequate facilities and equipment are provided round the clock to meet the needs of patients attending the emergency department.

Sl. No.	Measurable Criteria
2.4.3.1	Hospital Emergency room is easily accessible from different parts of catchment area and preferably separate from Out Patient Department (OPD)
2.4.3.2	The entrance is clearly signposted from outside the hospital.
2.4.3.4	Parking is available for patients, including designated space for the disabled.
2.4.3.5	There is a canopy over the casualty entrance used by ambulances.
2.4.3.6	The doorways and access are suitable for wheelchairs and trolleys.
2.4.3.7	Emergency alarms are strategically sited within the unit to call help.
2.4.3.8	Emergency area shall have dedicated triage, resuscitation and observation area. Number of beds for reception and examination of patients are proportionate to work load Adequate number of functioning trolleys and wheel chair are available all the time
2.4.3.9	There is appropriate equipment for: - Patient examination

Sl. No.	Measurable Criteria
	- Resuscitation - Monitoring - Minor operations - Sterilisation - X-rays and other imaging (either locally or by referral).
2.4.3.10	Hallways, clinical and public areas are clear of equipment, beds or other obstructions.
2.4.3.11	Treatment areas afford the patients' privacy.
2.4.3.12	A private area/room is available for interview and examination.
2.4.3.13	The waiting area: - has comfortable and adequate seating area - is clean and secure. - Food store /KIOSK with phone card
2.4.3.14	There are toilet facilities suitable and available for males, females and disabled.
2.4.3.15	A public telephone is available for the use of patients and relatives.
2.4.3.16	There is an accurate and functioning clock.
2.4.3.17	ATM booth accessible for multiple banks is available

2.5 Intensive Care Unit

2.5.1 Service Management

The Intensive Care Unit is managed by suitably qualified staff and organised to provide safe and efficient care for seriously ill clients/patients who need to be continuously monitored.

There should be-

- Medical and Surgical ICU
- Paediatric ICU
- Gynae and Neonatal ICU

High Dependency Unit (HDU): In addition to ICU every hospital should have HDU of

- Medical
- Surgical
- Paediatric
- Gynae and Neonatal

Sl. No.	Measurable Criteria
2.5.1.1	A qualified professional with relevant training in intensive care is responsible for overall co-ordination of the unit and is accessible for specialist advice.
2.5.1.2	An appropriately qualified, registered and experienced nurse is responsible for the day to day management of nursing care in the unit.
2.5.1.3	All staff working in the unit are appropriately qualified and experienced for the work they do and have attended specialist high dependency care courses and continuous medical education for updating their skills.
2.5.1.4	A suitably experienced doctor is immediately available at all times.
2.5.1.5	The Unit has a named person who leads on infection control issues (Microbiologist).
2.5.1.6	Medications and consumables are available and ready for use
2.5.1.7	Records of management decisions, monitoring ,medications and any other intervention are recorded with time and reasons for action
2.5.1.8	Standard Operating Procedure (SOP) will be used for Patient Management.

2.5.2 Policies and Procedures

Operational policies and procedures which clearly describe the key processes of the ICU, the responsibility of the staff and expected results are followed by staff.

Sl. No.	Measurable Criteria
2.5.2.1	Specific policies and procedures include emergency admission to ICU from: - Theatres - Wards - Other departments - Outside.
2.5.2.2	ICU follow the standard operating procedure.
2.5.2.3	ICU consultant and admitting sub specialty consultant jointly remains responsible for management
2.5.2.4	Management policies and procedures are available and followed by staff for the following: - Airway management - Ventilators/respirators - Central oxygen supply and oxygen cylinders - CVP readings (central venous pressure) - Infusion pump management - Pulse oximeters - Cardiac monitors - Arterial lines - X-ray and other imaging investigations - Epidural care - Recovery facilities for all surgical cases where there is no dedicated recovery unit - Recovery care of major surgical cases.
2.5.2.5	Specific emergency procedures are available and followed for: - Apnoea/respiratory arrest - Inhalation of vomit - Cardiac arrest - Laryngeal spasm/stridor
2.5.2.6	There are written criteria defining who is authorised to perform the following emergency clinical activities: - Intubation - Tracheotomy - Insertion of central lines - Defibrillation.
2.5.2.7	There are written policies and procedures agreed and followed for the following: - Clothing of staff and visitors - Filtering of clients'/patients' respired air - Changing of catheters, humidifiers and ventilator tubing - Isolation of at-risk or infected clients/patients - Cleaning of the unit.
2.5.2.8	Regular meetings take place to review cases and client/patient management, both within the unit and in conjunction with other departments.
2.5.2.9	Patient's relations are kept informed about physical condition and changes
2.5.2.10	The Unit discourages open visiting.
2.5.2.11	Notes , charts, investigation results are recorded with date time and legible sign of doctor , nurse or attendants

2.5.3 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of clients/patients in the ICU.

Sl. No.	Measurable Criteria
2.5.3.1	ICU should be easily accessible to the departments from which patients are usually admitted, such as the accident and emergency department, recovery room, surgical and medical wards
2.5.3.2	There should be easy access to the high dependency unit(s) to ease a step-up or step-down facility
2.5.3.3	Elevators and corridors attached to ICU are extra-wide
2.5.3.4	Size of ICU. Matches the Number of acute beds in hospital , catchment area · Number of operating theatres , · Surgical specialties serviced and case mix (e.g. vascular, cardiac, thoracic, emergency, urgent, elective) ,· Medical specialties (e.g. respiratory, cardiology)· A & E departments load
2.5.3.5	Patient areas and staff rooms have large windows to permit natural lighting
2.5.3.6	The ICU accommodation consists of the patient areas and management base, equipment and consumables storage areas and rooms, separate clean and dirty utility rooms , Nurses office, Doctor's office(s), staff sitting room, doctor's retiring room, laboratory relatives' waiting rooms, reception area a procedure room
2.5.3.7	There is sufficient space for storing disposable and consumable items
2.5.3.8	A functional resuscitation trolley and defibrillator are available on the unit
2.5.3.9	Each bed has a central line facility for: - Oxygen - Suction - Compressed air Central ECG monitoring.
2.5.3.10	Adequate (at least three) numbers of power sockets are available for each bed.
2.5.3.11	Facilities in the unit include: CVP monitoring Pulse oximetry Blood pressure monitoring (automatic) Urometry Patient temperature monitoring Arterial blood gases analyzer Glucometer Electrolyte machine.

2.6 Resuscitation

2.6.1 Service Management

All professional staff are trained in resuscitation at least to basic life support levels. Those working in higher risk areas, e.g. casualty department, operating theatres and ICU are trained in advanced life support.

Sl. No.	Measurable Criteria
2.6.1.1	There is a written, agreed description of the scope and operation of resuscitation services provided within the Hospital.
2.6.1.2	A resuscitation training team exists within the Hospital and is responsible for the co-ordination of procedures, equipment and training of health staff both in the hospital and in the community.
2.6.1.3	The provision of resuscitation conforms to the recommendations of the Health Department and/or international guidelines.
2.6.1.4	There is a formal mechanism for obtaining specialist clinical advice on resuscitation issues.
2.6.1.5	There is a programme for regular in-service training of clinical staff in handling equipment and procedures for resuscitation throughout the hospital.
2.6.1.6	Records on training status are maintained for individual staff members.
2.6.1.7	All medical staffhave received advanced resuscitation training at least every three years, by a trainer who has undertaken a recognised course and documentation is provided to show evidence of this.

2.6.2 Policies and Procedures

Policies and procedures related to resuscitation exist and are known to the staff.

Sl. No.	Measurable Criteria
2.6.2.1	Policies and procedures are reviewed as necessary but at least once a year.
2.6.2.2	An agreed, defined clinical procedure for resuscitation of adults (and children, if appropriate) exists and is followed by the staff.
2.6.2.3	An agreed, defined policy for when to use a defibrillator exists and is followed.
2.6.2.4	There is an agreed and written policy on the training of staff in the use of a defibrillator.
2.6.2.5	There is a policy for providing paramedic and medical assistance for resuscitation to the community.
2.6.2.6	There is an agreed policy for the management of anaphylaxis.

2.6.3 Facilities and Equipment

The Hospital provides adequate and functioning equipment for resuscitation in emergencies.

Sl. No.	Measurable Criteria
2.6.3.1	All staff providing resuscitation services carry pocket mask equipment.
2.6.3.2	Within the hospital, a designated member of staff is responsible for the checking and recording daily and after each use: - Resuscitation equipment - Stockholding and date of resuscitation drugs
2.6.3.3	Facilities available for resuscitation include: Mechanical - Resuscitation trolley containing equipment and medication for advanced life support - Defibrillator - Laryngoscopes (including for children, if appropriate) - Suction apparatus - Manual ventilation equipment e.g. bag, valve-mask, pocket mask - ECG monitor and leads Supplies (including for children if relevant) - Intravenous infusion sets - Endotracheal tubes and/or laryngeal masks

Sl. No.	Measurable Criteria
	- Oral airways - IV Cannulae Medications - Oxygen - Intravenous fluid - Resuscitation drugs.
2.6.3.4	equipment is checked on a daily basis and after each use by suitably qualified staff. Records of the checks are kept with the equipment and monitored.
2.6.3.5	Endotracheal Intubation, cricothyroidotomy set and chest drainage equipment is only used by those experienced and trained in their use.
2.6.3.6	Facilities (equipment) are conveniently located within the hospital to be accessible to highest risk patients.

Part 3: Support Services

3.1 Laboratory Services

3.1.1 Service Management

The Pathological laboratory is managed and organised to provide efficient and effective laboratory care to patients and support services to clinicians.

Sl. No.	Measurable Criteria
3.1.1.1	The pathological laboratory is managed by a suitably qualified and registered pathologist, experienced medical technologist or other suitably qualified and registered laboratory scientist. [credential and privileging of the laboratory head]
3.1.1.2	Standard operating Procedure is followed in pathological service management.
3.1.1.3	A suitably qualified deputy is designated in the temporary absence of the laboratory manager.
3.1.1.4	Sufficient and appropriately qualified staff are available to fulfil the job descriptions of the defined service.
3.1.1.5	Laboratory staff participates in the health and safety committee, hospital quality improvement committee and other relevant committees.
3.1.1.6	Departmental staff attend meetings of appropriate advisory /consultative bodies and have input into decisions affecting the laboratory.
3.1.1.7	A pamphlet outlines the list and prices of services offered, the types of specimens required and approximate reporting time for tests.
3.1.1.8	Laboratory staff inform in writing the designated hospital infection control committee of any infection identified in in-patient samples that could provide a risk to the hospital staff or clients/patients.
3.1.1.9	The service has a continuing education programme for staff development enabling staff to meet the needs of the hospital, the department, the individual and the clients/ patients.
3.1.1.10	Staff follow written policies and procedures for collection, transport and controlling, storing, reporting and disposing of all samples and tests in compliance with legal requirements.
3.1.1.11	Staff are involved on a regular basis in a quality management programme to monitor and improve the laboratory quality
3.1.1.12	The department has planned and systematic activities for the monitoring and evaluation of its services.

3.1.2 Samples and Tests

Laboratory samples and tests are managed to maximize accuracy of testing and minimise risks to patients/clients and staff.

Sl. No.	Measurable Criteria
3.1.2.1	A requisition form is used and includes the following: - Client/Patient information - Client/Patient location - Investigations required - Type of sample - Clinical history including clinical examination - Probable diagnosis - Requesting physician - Sample collection time - Name of phlebotomist.
3.1.2.2	Staff follow and communicate to clients/patients, verbally and in writing, procedures for the clients'/patients' preparation for tests.
3.1.2.3	Samples collected are labelled with the client's/patient's name, registration number, date and time of collection.
3.1.2.4	Separate labels are used for high risk samples.
3.1.2.5	Specimen trays are designed to enable safe transport.
3.1.2.6	The sample reception area receives, records, and verifies the samples or specimens.
3.1.2.7	A laboratory register records: - Client/Patient name, location - Identification of sample source(s) - Full name of the investigation(s) - Number of investigations - Investigation results
3.1.2.8	Samples are safely and accurately distributed to the respective sections of the laboratory.
3.1.2.9	Results are recorded in the laboratory register and on the reporting/result form.
3.1.2.10	Client/Patient Results Registers are readily accessible to staff.
3.1.2.11	Results are made available to the main reception of the laboratory to enable picking up by OPD, wards or clients/patients.
3.1.2.12	Signed and dated SOPs for each test and client/patient preparation for each test are readily available to staff in the laboratory.
3.1.2.13	Staff follow written, dated and signed procedures for: - Client/Patient preparation for tests - Completion of test request forms - Reporting of test results - Dealing with out-of-hours test requests - Investigating transfusion reactions - Emergency and urgent requests - Storage of specimens and blood on the wards and in other departments - Posting of samples - Acceptable parameters for response to test requests and reporting times.
3.1.2.14	Staff follow written procedures for samples: - Sample collection - Handling - Labelling

Sl. No.	Measurable Criteria
	- Transportation - Retention - Storage - Disposal of samples, including blood and body fluids.
3.1.2.15	The service is able to give immediate expert clinical advice on: - The appropriateness of tests - The samples required - The interpretation of results (expected and unexpected) - Further recommended tests.
3.1.2.16	Instructions are clearly displayed describing the safe disposal of clinical, toxic and radioactive waste.
3.1.2.17	Clearly labelled, separate containers are used for disposal of hazardous and infectious waste.
3.1.2.18	A written agreement exists, and staff follow this agreement, between the hospital and external laboratory covering all aspects of tests including time scales for reporting results.

3.1.3 Safety

All persons are protected from potential hazards in the laboratory.

Sl. No.	Measurable Criteria
3.1.3.1	A mechanism is in place to restrict access to the laboratory to authorised personnel only.
3.1.3.2	Health and safety policies, current relevant hazard notices and safety action bulletins are displayed as required or are readily available to staff, including but not limited to: - Safety regulations, Hand hygiene - Fire precautions - AIDS/HIV/ - Hepatitis.
3.1.3.3	Appropriate equipment is used for the safe handling of hazardous materials.
3.1.3.4	Action to be taken in the event of an infection emergency is known to all staff and is clearly stated in writing.
3.1.3.5	Staff are offered immunisations relevant to their type of work and emergency immunisations based on written policies.

3.1.4 Facilities and Equipment

Safe and adequate facilities and equipment are provided to meet the needs and volume of patients' / clients served by the laboratory.

Sl. No.	Measurable Criteria
3.1.4.1	Laboratory and office space are sufficient to enable staff to carry out their jobs safely.
3.1.4.2	The laboratory environment is well lit, ventilated and not underground.
3.1.4.3	Staff have access to sufficient laboratory equipment to carry out their jobs safely.
3.1.4.4	Storage facilities for specimens and reagents are sufficient to enable staff easy access.
3.1.4.5	Refrigerated storage facilities are used for specified samples, specimens, and blood samples.
3.1.4.6	Functioning emergency electrical supply for refrigerators is available and there is a procedure in place to regularly assess its readiness.
3.1.4.7	Inspection, calibration and maintenance schedules are completed and used for all laboratory equipment. There should be a preventive maintenance program for the equipment, recording of down time of equipment along with alternatives
3.1.4.8	Staff facilities include:

	- Locker space - Toilet and washing/shower facilities - Staff rest room - Overnight accommodation for on call staff. [need to discuss with other key stakeholders for such requirement]

3.2. Radiology and Imaging Service

3.2.1 Service Management

Radiology services are managed and organised to provide safe and efficient care for patients' / clients and support to clinical specialties.

Note: Radiology services cover all services provided by a radiology department.

Sl. No.	Measurable Criteria
3.2.1.1	A radiologist (either on site or visiting) is responsible for the clinical direction of the department and the safety of the client/patients. [credential and privileging of the radiologist]
3.2.1.2	Radiology services are administered by an identified qualified, registered radiologist or radiographer with clearly defined responsibility for all non-clinical aspects of the department.
3.2.1.3	Trained, qualified radiographers, or in some cases radiologists, are the only staff who may take images.
3.2.1.4	There are on-call staff for mobile radiography and other imaging at all times.
3.2.1.5	Staff follow written policies and procedures for all aspects of radiology services, including: - Reception and registration of the patients' / clients - Preparation of the patients' / clients for imaging - Processing and interpreting the film or scan - Reporting on the film or scan - Documentation and despatch.
3.2.1.6	SOP, up to date reference manuals, radiation regulations and guidelines, radiation safety reports, are available within the department.
3.2.1.7	The department participates in the Hospital's quality improvement system and monitors the quality of its services using an internal quality control programme which includes: - Equipment utilisation review - Periodical performance checks on equipment, including processors - A record of maintenance checks for all items of equipment - Film and scan reject rates - Clinical audit - Turnaround times for the reporting of films and scans.
3.2.1.8	Radiology staff review the results of its quality control programme, take action on them in a radiology quality committee and participate in the hospital health and safety committee and other relevant committees.

3.2.2 Service Provision

Patients' / clientsare systematically registered, receive radiological services in line with written requests and have their x-rays reported promptly and accurately.

Sl. No.	Measurable Criteria
3.2.2.1	Patients' / clients are registered, assigned a registration number and given special instructions in a systematic way.

Sl. No.	Measurable Criteria
3.2.2.2	Request Forms are of a standard format and contain: - Patients' / clients name - Identification number - National identity card number - Address - Date of birth if not available age & sex of the patient - Examination requested - Previous examinations/ investigations - Clinical diagnosis/indications/relevant history - Information relating to the pregnancy rule in women of childbearing age - Identity of requesting physician - History of allergy in red ink - For medico legal cases mark of identification of the client/patient and name of police official bringing the client/patient - Fee to be charged/not to be charged (with proper receipt)
3.2.2.3	Diagnostic imaging is performed only upon a signed written request from a qualified medical practitioner by the designated / authorized staff.
3.2.2.4	Arrangements are in place for dealing with out of hours or emergency requests.
3.2.2.5	A written policy agreed with the radiologist and the referring physician defining the terms under which pregnant women may be subjected to radiological examination
3.2.2.6	All films are read by a radiologist and the written radiologists' reports are received by the hospital within a defined time after examination.
3.2.2.7	Required reporting times are based on the urgency of the situation, e.g. films or scans for emergency client/patients are reported within one hour and routine reports are reported within 24 hours.
3.2.2.8	If a radiologist is unable to report on the film in a timely manner a written, signed interpretation of the radiograph is made by an appropriate clinician whose skills are relevant to the area radio graphed, e.g. chest radiography by a chest physician or bone/joint radiography by an orthopaedic surgeon.
3.2.2.9	Critical or unexpected findings are discussed with the referring doctor.
3.2.2.10	Radiology reports or copies of the reports are filed in in-patients' medical files in the wards.
3.2.2.11	For out-patients the radiology report is written on the OPD slip.
3.2.2.12	A duplicate report is kept on file in the department / record room
3.2.2.13	A copy of X-ray films and scans in medico-legal cases are retained by the department (with history and requisition)

3.2.3 Safety

Radiological services are provided in accordance with current radiation rules and regulations, risks are minimised and the safety of client/patients and staff are protected.

Sl. No.	Measurable Criteria
3.2.3.1	Signs (diagrams/poster/banner) warning women of childbearing age of the dangers of radiation in pregnancy are prominently displayed. Signs (diagrams/poster/banner) warning general patients, their accompanying persons and visitors about the radiation area and radiation hazard of staying within the radiation area and performing the tests should be properly displayed.
3.2.3.2	All examinations using ionising radiation are performed by suitably trained personnel.

Sl. No.	Measurable Criteria
3.2.3.3	Staff provide services in accordance with current ionising radiation regulations and statutory requirements.
3.2.3.4	A written resuscitation procedure for the department is agreed with a radiologist, the radiographers and the medical staff and is implemented when required.
3.2.3.5	Emergency drugs and equipment including all resuscitation equipment are functioning, not expired, are readily accessible and are monitored.
3.2.3.6	An effective written procedure to summon help in an emergency is displayed prominently in the department and used by staff.
3.2.3.7	All staff working in radiology services attend update courses on resuscitation, current radiology trends and evidence based practice.
3.2.3.8	Protective clothing is provided and used where biohazards or radiographic equipment are present.
3.2.3.9	The radiologist in charge is responsible for ensuring that compliance with national guidelines is monitored: - Staff working with radiological equipment wear radiation monitoring devices - These devices are assessed and maintained in accordance with statutory regulations - Records of these tests are kept for the working lifetime of staff employed by the service.

3.2.4 Facilities and Equipment

Facilities and equipment are provided and maintained to maximise client/patient comfort and safety.

Sl. No.	Measurable Criteria
3.2.4.1	A separate registration area for patients' / clients is provided and a toilet with washing facilities for special investigations is located adjacent to the examination room.
3.2.4.2	.A separate waiting area for males and females with adequate seating and separate male and female toilets and washing facilities are provided for the comfort of patients' / clients waiting for services and for their families.
3.2.4.3	All equipment is subject to tests on installation to ensure the equipment meets with contract specifications and confirms mechanical, electrical and radiation safety.
3.2.4.4	Records of these tests are kept in the department for reference.
3.2.4.5	The workload of each piece of diagnostic equipment and staff is defined and used for determining the resources needed for the department.
3.2.4.6	Radiology equipment is stable, functioning and installed only in properly lead protected rooms.
3.2.4.7	A planned preventative maintenance programme which includes photo monitoring is followed to keep equipment in sound working order.
3.2.4.8	There is a programme that provides for the replacement of imaging equipment on a timely basis according to a defined schedule.

3.3 Pharmacy Services

3.3.1 Management

The pharmaceutical service is managed and organised to provide efficient and effective pharmaceutical services through rational use of drugs within the hospital.

Sl. No.	Measurable Criteria
3.3.1.1	The pharmaceutical service is managed by a qualified, graduate and registered pharmacist.
3.3.1.2	A suitably qualified deputy with specified duties and responsibilities is designated in the absence of the pharmacist.
3.3.1.3	Sufficient and appropriately qualified staff are available to fulfil the job descriptions and the defined services.
3.3.1.4	A copy of the Professional Code of Ethics is readily available, known to the staff and followed.
3.3.1.5	A qualified pharmacist or designated deputy is on duty or on call outside normal working hours to provide a pharmaceutical service.
3.3.1.6	Staff follow written policies and procedures for ordering and purchasing, controlling, storing, dispensing and disposing of all medicines within the hospital in compliance with legal requirements.
3.3.1.7	There is a defined mechanism by which doctors and nurses can influence the level of pharmacy services provided.
3.3.1.8	The department monitors the quality of its services using an internal quality control program and staff participate in the Hospital's quality improvement system.
3.3.1.9	The pharmacy service provides a regular prescription monitoring service, locally, to ensure the safe, effective and economic use of medicines. This includes: - Identifying inappropriate medication - Monitoring adverse reactions and reporting to authorised regulatory body - Monitoring dispensing errors - Checking adequacy of labelling of drugs and information on package inserts - Physical examination of drugs to assess their quality and expiry dates - A mechanism to encourage prescription of cost-effective and economical drugs.

3.3.2 Storage and Stock Management

Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

Sl. No.	Measurable Criteria
3.3.2.1	Medicines are stored on shelves enabling: - Protection from the adverse effects of light, e.g. glass windows painted white, dampness and temperature extremes - Separate shelving management for LASA [Look alike, sound alike] drugs for reducing dispensing error - Freedom from vermin and insects - Adequate ventilation.
3.3.2.2	Medicines for emergency use are stored in sealed tamper evident containers in all patient areas.
3.3.2.3	Adequate and secure storage facilities provided include: - A suitable metal cupboard or container for the storage of flammable and/or hazardous material - A functioning pharmacy refrigerator.
3.3.2.4	Controlled drugs are stored separately in a metal cupboard, securely fixed to the wall or floor, to comply with drugs regulations.
3.3.2.5	A storage area is used for outpatient prescriptions, controlled medicines register and all other records required.

Sl. No.	Measurable Criteria
3.3.2.6	Separate cupboards are provided for medicines for internal use, external use and reagents.
3.3.2.7	Stocks of medicine are supplied against a written order or by a pharmacy top up service.
3.3.2.8	Stocks of controlled medicines are ordered by an authorized doctor using a controlled medicines order book for internal use.
3.3.2.9	A formal stock control system is used by the department and for the hospital.
3.3.2.10	There is a stock list with agreed par levels for all wards and departments.
3.3.2.11	Medicines required in an emergency are available and replaced promptly after use.
3.3.2.12	All expired or recalled medicines, including unwanted medicines returned by patients' / clients and unused controlled medicines, are safely disposed of in accordance with a written procedure.
3.3.2.13	A formal, written procedure is followed to action hazard warnings and medicine recalls.
3.3.2.14	A formal, written procedure is followed for retention of order forms, copy of delivery notes, stores receipt, and issue vouchers, and book of records (controlled drugs book/prescription drugs book) on the premises as provided for in the relevant laws.
3.3.2.15	Maintenance cold chain vaccine

3.3.3 Prescribing, Administration and Dispensing of Medicines

Prescribing, dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

Sl. No.	Measurable Criteria
3.3.3.1	A system is in place to ensure that: - Prescriptions are only issued by authorized prescribers - Administration of medicine is done by, or under the supervision of, competent health personnel.
3.3.3.2	All prescriptions are legible and duly signed by a doctor, including the following: - Name, address, date, (diagnosis?), drug name, strength, quantity, refill times or unit to be taken. - Instruction for taking medication, warning
3.3.3.3	Staff follow a written policy for the verbal ordering of medicines in emergencies which has been agreed by medical, nursing and pharmacy staff.
3.3.3.4	Medicines are dispensed by, or under the supervision of, a pharmacist in accordance with a written prescription from a qualified registered medical practitioner.
3.3.3.5	The patients' / clients is provided with written and verbal information on the prescribed medicine including: - The costs - The potential benefits and adverse effects - Risks of ignoring instructions - How to use the medicine safely and properly.
3.3.3.6	There is an approved hospital prescription/medication chart on which all medicines for an individual client/patient are prescribed and their administration recorded.
3.3.3.7	A pharmacy register records: - Client/Patient name and registration number - Date - Diagnosis - Medicine dispensed.
3.3.3.8	Staff follow written, dated and signed procedures on the following: - What medicines may be administered without a prescription and under what circumstances - Self medication

Sl. No.	Measurable Criteria
	- Use of antibiotics - Administration of IV drugs, narcotics, psychotropic substances and cytotoxics - Obtaining medicines after hours from hospital pharmacy - How to obtain medicines not available within the hospital pharmacy - Dealing with clients'/patients' own medicines.
3.3.3.9	Medical practitioners follow policies for antibiotic prescribing which include: - Restricting the use of broad-spectrum agents to minimise the development of resistant viruses and bacteria - Using prophylactic antibiotics only where their efficacy has been established.
3.3.3.10	Where procedures are in place for patients' / clients to self medicate, the medicines are stored in a locked cupboard or drawer in the client's/patient's room, child proof container to be provided if necessary

3.3.4 Facilities and Equipment

Facilities and equipments are safe and adequate for the purpose and the number of clients/patients attending the pharmacy.

Sl. No.	Measurable Criteria
3.3.4.1	All doors, windows and hatches within the pharmacy can be locked.
3.3.4.2	There is a designated area for: - The receipt and unpacking of goods in wards - Segregation of expired and recalled drugs - **Dispensing of medicines. medications of chronic diseases i.e hypertension ,diabetes ,asthma and chemotherapeutics for cancer**
3.3.4.3	The pharmacy has an administrative area, which includes a desk, filing cabinet, telephone and other necessary equipment.
3.3.4.4	There is a specific drug information/reference area for use by hospital staff.
3.3.4.5	There is a designated waiting area for clients/patients.
3.3.4.6	A box or trolley containing those medicines which may be urgently required in the event of a cardiac arrest is available.
3.3.4.7	Where a medicine trolley is used to store medicines, it is lockable and secured to the wall when not in use.
3.3.4.8	Lockable medicine refrigerators with maximum and minimum thermometers are provided for medicines requiring cool storage. They are used solely for this purpose.
3.3.4.9	Temperatures are regularly monitored and recorded and action is taken where a temperature varies from an acceptable range, **24 hours electic supply backup/IPS/generator**
3.3.4.10	Medicine keys are kept separate from other keys by a named member of staff

Part 4: Infection Control, Hygiene and Waste Management

4.1 Infection Control

The hospitals/clinics designs and implements a coordinated program to reduce the risks of nosocomial infections in clients/patients, visitors/attendants, contractors and staff.

Sl. No.	Measurable Criteria
4.1.1	National Infection Prevention & Control Guideline, National Hand Hygiene Guideline and Medical Waste Management Guideline will be used.
4.1.2	The hospital will establishes an infection control committee & program designed to prevent or reduce the incidence of nosocomial infection, based on current scientific knowledge and

Sl. No.	Measurable Criteria
	accepted practice guidelines and it should be monitored with multidisciplinary team.
4.1.3	The infection control program should includes all areas of the hospital and describes the scope, objectives, annual activities, surveillance methods, resources and processes associated with infection risks, including respiratory tract, urinary tract and surgical wound infections, are identified and included in the infection control program..
4.1.4	Responsibility for coordinating the infection control program will be assigned to an infection control committee with representatives of all relevant disciplines and departments including medical, nursing, microbiology/pathology, kitchen and laundry staff.
4.1.5	The infection control committee should have a clear written Terms of Reference that include the following responsibilities: - Coordination of infection control activities - Development, implementation and monitoring of the infection control program - Approval of infection control policies and procedures - Approval of surveillance activities - Reviewing and analysing infection control data - Following up identified infection control issues with relevant action, including education - Evaluating the effectiveness of actions taken.
4.1.6	The infection control committee should have a linke with Waste Management Control
4.1.7	The infection control program must be adequately resourced and staffed with appropriately qualified health professionals (nurses and/or doctors) with responsibilities defined in a job description for: - Implementing the infection control program in consultation with staff and clients/patients - Implementing policies - Educating staff - Providing infection control advice - Developing and implementing methods of surveillance, including reviewing infection control practices - Providing reports and making recommendations to the infection control committee.
4.1.8	Infection risks, rates and trends are to be tracked, analyzed and reported.
4.1.9	Surveillance of multiple resistant organisms and organisms associated with antimicrobial use should be conducted as part of the infection control program.
4.1.10	There should have regular infection control audit.
4.1.11	Cultures are to be obtained regularly from designated sites in the hospital with significant infection risks and action taken to minimise any identified infection.
4.1.12	Non-professional staffs should be appropriately inducted and trained in basic aspects of infection control relevant to their work including: - Basic concept of microbes - Proper handwashing - Segregation of waste and hazards associated with waste.
4.1.13	Professional staff are to be appropriately inducted and trained in all aspects of infection control relevant to their work, including proper handwashing.
4.1.14	Written and dated organisation wide infection control and waste management policies and procedures are to be used by staff. Procedures include, but are not limited to, the following topics:

Sl. No.	Measurable Criteria
	- Use of standard precautions including handwashing techniques - Sterilisation and decontamination of equipment - Food hygiene - Laundry and linen management - Identification and management of organisation-acquired infections - Management of outbreaks of infection - High risk and communicable diseases - Operation of the mortuary - Collection, storage and disposal of infectious waste, body fluids, tissues, blood and blood products - Disposal of sharps and needles - Cleaning of all hospital surfaces, supplies and equipment, e.g. floor, walls, ceilings, beds and basins - Management and cleaning of spillage - Vaccination of staff.
4.1.15	Gloves, gowns, masks, soap and disinfectants should be available and correctly used in situations where there is a risk of infection.
4.1.16	All staff who work in client/patient related care and services must have appropriate vaccinations and carrier status and records are to be kept.
4.1.17	Procedures should be used for the isolation of patients specific to the reason for isolation.

4.2 Sterile Supplies

Equipment and supplies are sterilised to minimise risk of infection in clients/patients and staff.

Sl. No.	Measurable Criteria
4.2.1	The Infection Control Committee should oversees the provision of sterile supplies.
4.2.2	There must be a defined department or area for sterilisation which physically separates the functions of cleaning, processing and sterile storage and distribution.
4.2.3	In all areas where instruments are cleaned there should be airflow to prevent cross-contamination and to keep material within the area.
4.2.4	There must be at least one functioning steriliser with a drying cycle.
4.2.5	The responsibilities of relevant staff members managing the provision of sterile supplies are to be clearly defined and specified in writing.
4.2.6	Staff responsible for the decontamination, inspection, function testing, assembly and packaging, terminal processing, storage and distribution of supplies must be adequately trained.
4.2.7	Current written policies and procedures covering the functions of sterilisation, including the following, are available with documented evidence of routine compliance: - Receiving, cleaning and disinfection of used items - Preparation and processing of sterile packs - Storage of sterile supplies and expiry dates - Decontamination of instruments prior to sending for repair, maintenance or servicing - Handling of instruments following an infected case - Handling of equipment identified as “bio-hazard” - Product labelling, batch numbering and identification - Restricted personnel access to the clean production area - Cleaning procedures, manual methods - Housekeeping procedures

Sl. No.	Measurable Criteria
	- Infestation control - Personal hygiene - Microbiological and environmental monitoring - Criteria for testing and replacing air filters - Recall procedures.
4.2.8	Sterilisation procedures must be based on existing national/international guidelines.
4.2.9	The sterilisation status of sterilised goods is assessed by the use of temperature sensitive tapes, using indicators as recommended by the manufacturer.
4.2.10	Records should be made available for: - Acceptance of load procedures - Plant history records - Sterile goods issued to wards/departments - Sterilisers and autoclaves (history and servicing) - Servicing and calibration.
4.2.11	All trays/packs/containers are to be stored in conditions that preserve the integrity of their packaging to prevent damage and/or contamination.
4.2.12	All packs are marked with: - Name of the article - Contents of the pack - Initials of the person who packed it - Date and initials of the person who sterilised it.

4.3 Cleanliness and Sanitation (Premises, Laundry & Kitchen)

All hospital facilities, equipment and supplies must be kept clean and safe for clients/patients, visitors/attendants and staff.

Sl. No.	Measurable Criteria
4.3.1	Staff follow written policies and procedures and schedules for: - Disinfection and cleaning of all equipment, furniture, floors, walls, storage areas and other surfaces and areas - Cleaning of specialised areas, e.g. OT, Labour Room, Emergency Ward, Dressing Room, Laboratory and ICU.
4.3.2	Hospital premises must be made free from litter and other refuse.
4.3.3	Sufficient covered, clean dustbins must be provided for clients/patients, visitors/attendants and staff and the dustbins must be emptied on a regular basis.
4.3.4	Equipment, floors and walls are to be made free from bodily fluids, dust and grit and the masonry is intact.
4.3.5	Cleaners must be trained and provided with sufficient appropriate equipment and cleaning material and work according to cleanliness and sanitation policies and procedures.
4.3.6	Laundry staff are to be trained and work according to linen and laundry policies and procedures including but not restricted to the following: - Collection of sluied and dirty linen from the individual departments - Transportation with clear separation of clean and dirty laundry - Separate storage of clean and dirty linen - Sorting of linen into soiled, infected and foul linen and washing processes and washing processes for this linen - Removal of blood stains/sluicing

Sl. No.	Measurable Criteria
	- Disinfection/autoclaving - Washing / hydro extraction - Drying - Repairs of linen if required - Pressing - Distribution to individual departments - Storage in individual departments - Record keeping for receipt and distribution of clean linen.
4.3.7	Kitchen staff and/or those handling food are trained and work according to policies and procedures including but not limited to the following: - cleaning of all areas and surfaces on which food is stored and prepared, e.g. all preparation surfaces are cleaned and dried between uses for different activities - food storage, e.g. all food is stored separately from non-foods, cooked food is stored separately from uncooked/raw food and the covering and labelling of food - use and cleaning of equipment for food preparation, handling and transport, e.g. separate cutting boards are used for raw and cooked foods - testing and monitoring of safe temperatures for cooked food - testing and monitoring of refrigerator temperatures for safe food storage,
4.3.8	Access to the kitchen should be restricted to staff members and a sign exists at all entrances stating this.
4.3.9	All staff handling food have health checks prior to appointment and at regular intervals during their employment and records are kept.
4.3.10	A written Dress Code for those working in the kitchen is enforced including wearing of head cover for hair, clean uniforms and appropriate footwear.
4.3.11	The kitchen and food stores have proper ventilation.
4.3.12	All windows in food preparation and storage areas have suitable fly screens and insectocutors (ultra-violet electric flying insect removers) are present in designated problem areas.
4.3.13	Kitchen walls are made of material that is waterproof, non-absorbent and non-toxic and kitchen floors, walls and ceilings are easily cleaned.
4.3.14	Kitchen waste is put in covered secure containers and removed immediately from places where food is prepared pending disposal.
4.3.15	Kitchens are arranged to be away from waste storage, ward areas, laboratories and other areas of risk of contamination and infection.

4.4 Waste Management

Clinical and other infectious or injurious waste is handled, stored and disposed of to minimise harm and risk of infection /injury to patients/clients, visitors, contractors, staff and the community. Every hospital should follow the policy of Hospital waste management.

Sl. No.	Measurable Criteria
4.4.1	The hospital has a written waste disposal plan specifying procedures, responsibilities, timetable for waste collection and necessary equipment such as bins and bags as per "Medical waste Management law 2008".
4.4.2	The waste disposal plan includes written guidelines for the regulation, identification, containment and storage, transport, treatment and subsequent disposal of different categories of infectious waste n accordance with " Medical waste Management law 2008"
4.4.3	Contaminated waste buried in landfills is done so in accordance with the "Medical waste

Sl. No.	Measurable Criteria
	Management law 2008"
4.4.4	Suitably qualified and experienced person(s) with designated responsibility lead the development and regular updating of plans and policies and procedures for waste management and the process is overseen by the Infection Control Committee and infection control personnel.
4.4.5	Responsibilities for waste management are defined in all job descriptions.
4.4.6	All staff are to be trained in and use procedures for different types of waste: - Collection - Segregation at source - Storage - Transportation - Disposal.
4.4.7	All staff who work in areas where infectious waste is handled must be trained on hazards of waste, management of waste and infection control.
4.4.8	Outhouse management will be done by city corporation/ pourosova authority
4.4.9	Monthly coordination meeting with city coorporation/pourosova
4.4.10	If contractors are used for the removal and incineration of clinical waste, a written contractual agreement and consignment procedure is used which includes identification of the origin, contents and quantity of the waste.
4.4.11	All waste must be protected from theft, vandalism or scavenging by persons or animals.
4.4.12	A clear guide for waste segregation and storage should be visibly posted in area(s) where this waste is generated and includes waste segregation in clearly labelled coded bins in accordance with the relevant national/provincial laws.

Part 5 : Safe and Appropriate Environment

5.1 Health and Safety

Promotion of health and safety and the avoidance of risk to human life as well as to the property of the Hospital are integrated within the organisation and among all levels of staff.

Sl. No.	Measurable Criteria
5.1.1	The responsibility for health and safety committee of hospitals and clinics and other relevant staff is included in their job descriptions and performance reviews.
5.1.2	A health and safety committee of hospitals and clinics meets on a regular basis, includes representatives of management and staff from different departments and enables two-way communication between management and employees on issues of interest and concern related to health and safety.
5.1.3	Health and safety committee of hospitals and clinics meetings follow a set agenda that includes follow-up from the last meeting, minutes of each meeting are kept and the agendas and minutes are readily available to all staff.
5.1.4	The Health and Safety Committee participates in the development of the Risk Management Plan.
5.1.5	All new employees are trained in Health and Safety procedures relevant to their duties within one month of taking up their post.
5.1.6	All staff attend continuing training for health and safety, basic life supports and records of the trainings should be kept properly
5.1.7	Each department uses a systematic process to: - Regularly identify and record actual and potential hazards in a hazard register (at lest annually)

Sl. No.	Measurable Criteria
	- Prioritize the hazards according to the vulnerability - Eliminate, isolate or minimise the impact of the significant hazards.
5.1.8	Staff review significant hazards that have been isolated or minimised in accordance with a set timetable appropriate for the identified hazards.
5.1.9	All emergency telephone numbers concerned with Health and Safety are displayed prominently.
5.1.10	Health and Safety policies and procedures are followed by staff and include: - Contamination incidents - Sharps and needle-stick injuries - Drug dependence - HIV/AIDS - Hepatitis B and C - Lifting and manual handling of client/patients and equipment - Basic life support.
5.1.11	Current health and safety notices, including hazard notices, and key extracts from the Health and Safety manual are prominently displayed in relevant areas and brought to the attention of staff.
5.1.12	There is a procedure for ensuring that all contractors are provided with relevant information regarding health and safety issues within the hospital .
5.1.13	Staff sign a form that documents that they have read and understood Health and Safety policies and procedures.
5.1.14	A written policy and procedure on pest control including measures to prevent, detect and remove pests is available and implemented.
5.1.15	Security measures are taken in accordance with written policies and procedures to protect: - staff working alone or in isolation - clients/patients, visitors and staff from assault and loss of property during the day and at night - drugs from being taken illegally - the hospital's facilities and assets from damage and loss.
5.1.16	A procedure ensures that all hospital keys are available at all times to the staff on duty.
5.1.17	An internal communication system connecting all units of the hospital enables a continuous flow of communication and immediate reporting of any incident.

5.2 Fire Safety and Emergency Preparedness

The organisation minimises the risks of fire and protects clients/patients, visitors and staff in case of fire and is prepared for disasters and emergencies

Sl. No.	Measurable Criteria
5.2.1	A fire safety plan exists including prevention/risk reduction, early detection, suppression, abatement, and safe exit from fire.
5.2.2	The hospital building, e.g. doors, exits and corridors, is constructed in a way to minimise the risk of fire and conform to fire safety rules, including: - Doorways, corridors, ramps and stairways being wide enough for the evacuation of non-ambulatory clients/patients - Fire and smoke doors being able to be opened and closed manually or by an electric release system - Doors to client/patient rooms and exit doors not being locked from the inside.
5.2.3	Access and exit ways are kept free of obstruction at all times to allow for safe evacuation in

Sl. No.	Measurable Criteria
	a fire or other emergency.
5.2.4	An annual inspection of fire safety in the Hospital by the Fire Department results in identification of fire risks and strategies to minimise the risks and prevent fire.
5.2.5	A person responsible for Hospital Safety carries out and records regular tests of alarm systems, fire extinguishers and other facilities and equipment for fire prevention and control.
5.2.6	Action is taken to address any recommendations made during inspections and testing.
5.2.7	A process ensures that furniture and furnishings are of limited flammability and toxicity and comply with approved safety standards.
5.2.8	All new hospital buildings above 15 metres have an alarm system complying with national standards (riser system, control panel and alarm); old hospital buildings above 15 metres should have at least manual call points or smoke/heat detectors/alarm system (1-2 per floor).
5.2.9	Potentially explosive, flammable or highly combustible material are clearly identified, securely stored and storage areas are clearly signed .
5.2.10	Areas where smoking is dangerous, restricted and allowed are clearly signed and monitored.
5.2.11	Waste materials are stored in fire resistant containers.
5.2.12	Pillar and post type of hydrants are provided in new hospitals.
5.2.13	The electrical wiring in the Hospitals is changed every 20 years or when testing indicates.
5.2.14	Staff are trained at least annually in fire safety and other emergency procedures.
5.2.15	Fire procedures and evacuations are tested and disaster and emergency drills are practised regularly.
5.2.16	The Hospital develops a disaster plan with all departments/services. The plan is consiste with the national disaster plan and is reviewed and revised at least every two years.
5.2.17	The plan outlines individual responsibilities, linkages with external institutions, resources required in the case of a disaster and individuals within the hospital who must be informed in the case of a disaster.
5.2.18	Rehearsals of the disaster plan are carried out in association with the emergency services and local authorities .
5.2.19	Pictogram indicating fire exists and escape are properly illuminated, clearly visible, unobstructed and are displayed at appropriate locations.

5.3 Safe and Appropriate Equipment

There are clear and documented responsibilities, policies and procedures for procurement, use, maintenance, repair and disposal of equipment to minimise the potential for harm.

Sl. No.	Measurable Criteria
5.3.1	An Equipment Committee with clearly defined roles meets as required and includes those in charge of the hospital, nursing, maintenance and stores and other relevant departmental representatives.
5.3.2	Basic responsibilities of the Equipment Committee include: - Assessment of need for new equipment - Consultation with the requesting department on their requirements and specifications for the equipment - Procurement of equipment - Assessment of utilisation of equipment - Condemnation of equipment - Conducting regular equipment audits.

Sl. No.	Measurable Criteria
5.3.3	The procurement policy for equipment and supplies includes the criteria that equipment and supplies purchased are consistent in type and brand with others in the hospital to facilitate maintenance and repair.
5.3.4	A written procedure is used for receiving ordered equipment and includes at least the following activities: - At time of delivery the equipment is inspected as per specifications given in the supply order by the equipment committee/user department. - On satisfactory receipt, installation and commissioning of the equipment a certificate to that effect is given by the equipment committee/user department. - Payment of the supplier is only made on production of such a certificate - Originals or a copy of the service contract and operational manual are kept in the maintenance department or other designated department.
5.3.5	Equipment is certified as conforming to health and safety requirements and regulations.
5.3.6	For costly equipment annual maintenance contracts are made including: - Regular service and maintenance for at least five years after the warranty period - Warranty with cost-free provision of spares - Continuous supply of consumables - Training of staff to handle the equipment - Reliable and prompt after-sale service - Penalty clause if any delay occurs due to the negligence of the supplier.
5.3.7	The suppliers contact details and emergency telephone number is available.
5.3.8	Staff allowed to operate equipment or machinery are appropriately trained and re-trained and no untrained person operates the equipment.
5.3.9	Records of equipment are kept including procurement, equipment defects and failures, maintenance, repair and disposal.
5.3.10	A maintenance workshop with qualified and experienced persons having basic knowledge of physics and electronics has defined responsibilities for maintenance and repair of smaller equipment.
5.3.11	A list of all electrical equipment that requires routine testing is used and a record of maintenance and testing of this equipment is kept for three years, e.g. generator, emergency lighting.
5.3.12	Regular and routine checks of equipment (equipment audit) are carried out in accordance with the operational manual, maintenance contract and/or a history sheet of the equipment by the Store in-charge.
5.3.13	Safeguards for electronic equipment are used such as: - Voltage stabilizer - Automatic switch over for emergency (generator).
5.3.14	For life-saving equipment a three-phased supply of electricity is provided.
5.3.15	A logbook for all critical equipment is kept and a record of incidence of defects and failures in equipment is maintained
5.3.16	There is a form known to all staff and used to request equipment repairs and defects.
5.3.17	An adequate and sufficiently large room and supplies are available for maintenance and minor repairs. Supplies include but are not limited to: - A bank of spare parts - Toolkit.
5.3.18	A list of maintenance/backlog items is kept and reviewed regularly.
5.3.19	Written procedures exist for - Requests for repair from outside agencies if equipment cannot be repaired in-house

Sl. No.	Measurable Criteria
	- Condemnation and disposal of obsolete equipment.
5.3.20	A list of approved external repair workshops is kept and regularly updated
5.3.21	All requests for repair, work carried out and response time to reported defects is monitored and documented.
5.3.22	The procedure for condemnation and disposal of obsolete equipment includes criteria for defining 'condemned' and 'obsolete' equipment, such as: - Non-functional and beyond economical repair - Non-functional and obsolete - Functional but obsolete - Functional but hazardous - Functional but no-longer required.
5.3.23	An annual budget is provided for the maintenance and scheduled replacement of equipment.

5.4. Safe and Appropriate Facilities

The Hospital's physical environment contributes to the safety and well-being of clients/patients, staff and visitors.

Sl. No.	Measurable Criteria
5.4.1	The hospital complies with relevant laws and regulations related to design and layout of the facility and inspection requirements are fulfilled.
5.4.2	Corridors, storage areas, passageways and stairways are well lit.
5.4.3	Access ways and exits are unobstructed at all times.
5.4.4	Signage allows safe passage through the hospital and exit from the facility in case of an emergency, disaster or fire.
5.4.5	The environment in all client/patient areas is clean, well lit, ventilated with adjustable controls for lighting and heating, and decor is in good repair.
5.4.6	Floor surfaces are non-slip and even.
5.4.7	Facilities and equipment for the safety and comfort of clients/patients and visitors are available and functioning and include: - Refreshment facilities and canteen - Quiet rooms for consultations - A public telephone - Baby changing/feeding facilities - Wheel chair / stretcher - Defined and understandable signage system - Adequate Chairs - Cooling device, fans - Separate queues for male and females wherever required - Safe drinking water facilities - Sheltered outside areas with planting and greenery. - Separate male and female prayer room
5.4.8	A functional call bell system is available for use in private and isolated wards (single occupancy rooms), within easy reach of the client/patient.
5.4.9	Each nursing area has a clean storage and preparation space and is separate from soiled materials, domestic equipment and sluice areas.
5.4.10	Separate male and female toilets and bathrooms are available and adequate for the number

Sl. No.	Measurable Criteria
	of clients/patients in the ward or department (at least one toilet for every twelve clients/patients). The toilets and bathrooms: - Are kept clean - Are lockable by the client/patient from the inside but unlockable from the outside - Have doors that open outwards - Ensure privacy at all times - Have a non-slip base - Have grab rails positioned on either side of the toilet - Have an alarm-call within easy reach of the bath and toilet.
5.4.11	Shower facilities are available, with warm water for winter months.
5.4.12	Separate male and female functioning, clean toilets are available for use by visitors/attendants.
5.4.13	Some toilets available to seriously ill or disabled clients/patients: - Allow a nurse to stand at each side to manoeuvre a client/patient - Admit a wheelchair - Have washbasins and a mirror at a suitable height for both able and disabled clients/patients.
5.4.14	Each client/patient has access to an area in which to keep personal possessions.
5.4.15	Bed tables are available.
5.4.16	Potable water and electrical power are available 24 hours a day, seven days a week.
5.4.17	Alternate sources of water and power for heat and lighting in case of breakdown of the systems are identified, functioning and regularly tested. Priority areas such as ICU and Operating Theatres are identified.
5.4.18	Electrical, water, ventilation, medical gas, and other key systems are regularly inspected, maintained and improved, if necessary.

Annexure-1

Working groups for development of National Health Care Standards

Primary level

Dr. Md. Abdur Rahman Khan-Former DG, DGHS, Group Leader.
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Dr. Md Alamgir Ahmed, DD, PHC, DGHS, Member
Dr. Sabrina Flora, Associate Professor, Epid, NIPSOM, Member
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Dr Asrafi Ahmed, DPM, IHSM, DGHS, Member
Dr. KM Azad, DPM, Community clinic programme, Member
Dr. Md Zahidur Rahman, Asst. prof. Hospital Management. NIPSOM- Member Secretary

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Dr. Golam Mowla Mugni. Asst. prof Med. DMC, Member
Dr. Rezaul Islam, DD. HSM.DGHS, Member
Dr. Afroza Kutubi, Asst prof Gyne , DMC
Dr. Ayesha Afroz Chowdhury, DPM, HSM, DGHS
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Tertiary level

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Prof Dr Margub Hossain, Member
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Dr. Ali Akbar Asrafi- DPM, MIS, DGHS, Member
Dr. Sabbir Haider, DD, HEU- Member Secretary

Co-ordination & facilitation

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Annexure-2

References

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2. International Principles for Healthcare Standards. 3rd Edition. December 2007. Published by International Society for Quality in Healthcare (ISQua)
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