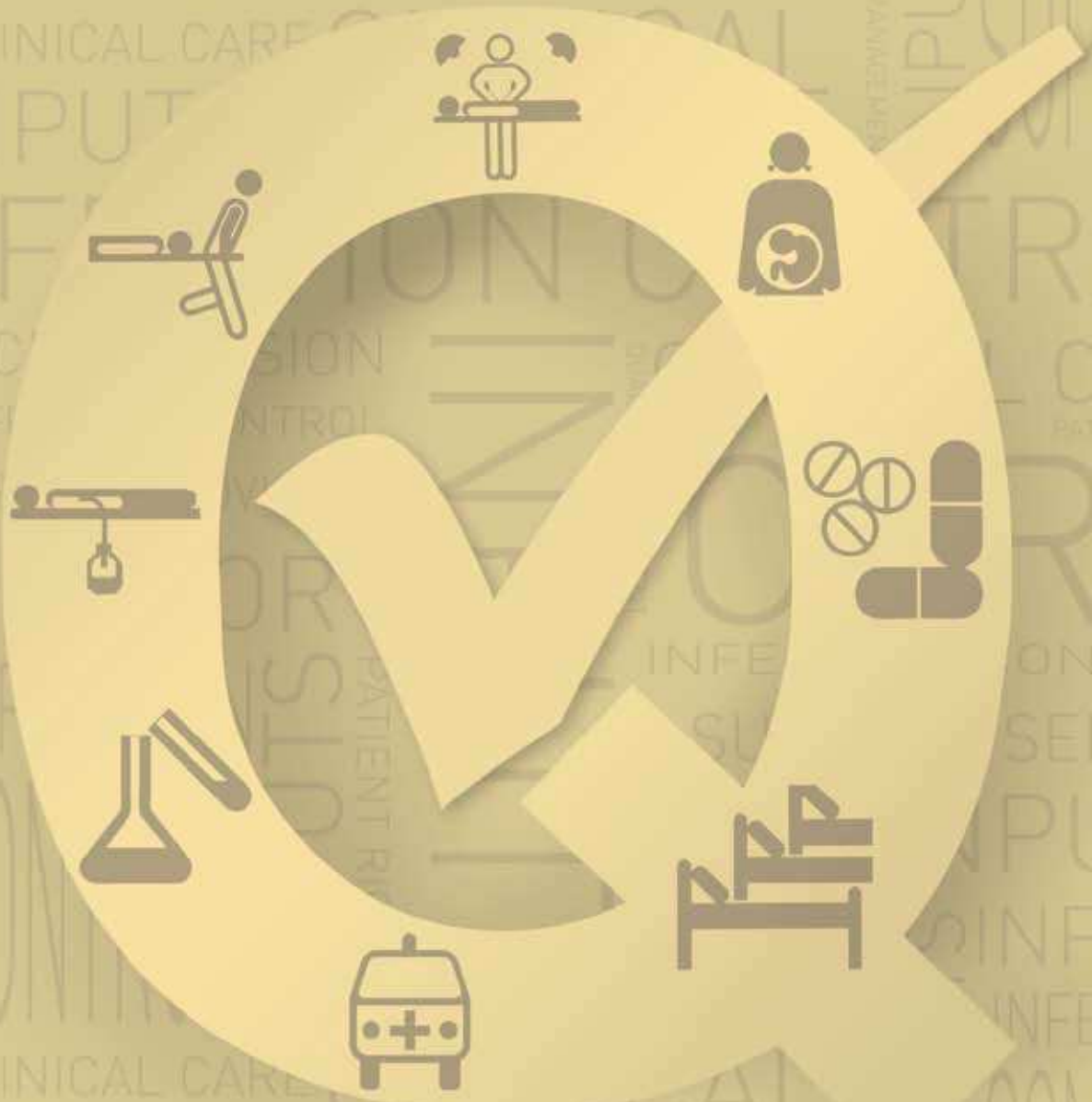
सत्यमेव जयते

NATIONAL RURAL HEALTH MISSION

OPERATIONAL GUIDELINES for QUALITY ASSURANCE in PUBLIC HEALTH FACILITIES

2013



Ministry of Health and Family Welfare
Government of India

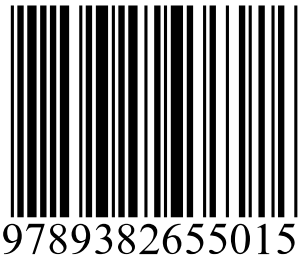
सत्यमेव जयते

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

OPERATIONAL GUIDELINES for QUALITY ASSURANCE in PUBLIC HEALTH FACILITIES

2013

Maternal Health Division
Ministry of Health and Family Welfare
Government of India



ISBN 978-93-82655-01-5

Ministry of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi, India

Designed by: Macro Graphics & Printed by: Mittal Enterprises

Keshav Desiraju
Secretary
Tel.: 23061863 Fax: 23061252
E-mail : secyhfw@nic.in
k.desiraju@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi - 110011

PREFACE

The National Rural Health Mission (NRHM) Strives to Provide Quality Health care to all citizens of the country in an equitable manner. The 12th five year plan has re-affirmed Government of India's commitment – *"All government and publicly financed private health care facilities would to expected to achieve and maintain Quality Standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements."*

Indian Pubic Health Standards (IPHS) developed during 11th Five Year Plan describe norms for health facilities at different levels of the Public Health System. However, It has been observed that while implementing these Standards, the focus of the states has been mostly on creating IPHS specified infrastructure and deploying recommended Human Resources. The requirement of national programmes for ensuring quality of the services and more importantly use's perspective are often overlooked.

The need is to create an inbuilt and sustainable quality for Public Health Facilities which not only delivers good quality but is also so perceived by the clients. The guidelines have been prepared with this perspective defining relevant quality standards, a robust system of measuring these standards and institutional framework for its implementation.

These operational guidelines and accompanying compendium of cheek-lists are intended to support the efforts of states in ensuring a credible quality system at Public Health Facilities. I do hope states would take benefit of this painstaking work.

(Keshav Desiraju)

Anuradha Gupta, IAS
Additional Secretary &
Mission Director, NRHM
Telefax : 23062157
E-mail : anuradha–gupta@outlook.com

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi - 110011

FOREWORD

The successful implementation of NRHM since its launch is 2005 is clearly evident by the many fold increase in OPD, IPD and other relevant services being delivered in the Public health institutions, however, the quality of services being delivered still remains an issue. The offered services should not only be judged by its technical quality but also from the perspective of service seekers. An ambient and bright environment where the patients are received with dignity and respect along with prompt care are some of the important factors of judging quality from the clients' perspective.

Till now most of the States' approach toward the quality is based on accreditation of Public Health Facilities by external organizations which at times is hard to sustain over a period of time after that support is withdrawn. Quality can only be sustained, if there is an inbuilt system within the institution along with ownership by the providers working in the facility As Aristotle said "Quality is not as act but a habit"

Quality Assurance (QA) is cyclical process which needs to be continuously monitored against defined standards and measurable elements. Regular assessment of health facilities by their own staff and state and 'action-planning' for traversing the observed gaps is the only way in having a viable quality assurance prgramme in Public Health. Therefore, the Ministry of Health and Family welfare (MOHFW) has prepared a comprehensive system of the quality assurance which can be operationalzed through the institutional mechanism and platforms of NRHM.

I deeply appreciate the initiative taken by Maternal Health division and NHSRC of this Ministry in preparing these guidelines after a wide range of consultations. It is hoped that States' Mission Directors and Programme Officers will take advantage of these guidelines and initiate quick and time bound actions as per the road map placed in the guidelines.

(Anuradha Gupta)

Manoj Jhalani, IAS
Joint Secretary
Telefax : 23063687
E-mail : manoj.jhalani@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi 110011

FOREWORD

The National Rural Health Mission (NRHM) was launched in the year 2005 with aim to provide affordable and equitable access to public health facilities. Since then Mission has led to considerable expansion of the health services through rapid expansion of infrastructure, increased availability of skilled human resources; greater local level flexibility in operations, increased budgetary allocation and improved financial management. However, improvement in Quality of health services at every location is still not perceived, generally.

Perceptions of poor quality of health care, in fact, dissuade patients from using the available services because health issues are among the most salient of human concerns. Ensuring quality of the services will result in improved patient/client level outcomes at the facility level

Ministry of Health and Family Welfare, Government of India is committed to support and facilitate a Quality Assurance Programme, which meets the need of Public Health system in the country which is sustainable. The present guidelines on Quality Assurance has been prepared with a focus on both the technical and perception of service delivery by the clients. This would enhance satisfaction level among users of the Government Health Facilities and reposing trust in the Public Health System.

The Operational guidelines along-with standards and checklist are expected to facilitate the states in improving and sustaining quality services beginning with RMNCH-A services at our Health facilities so as to bring about a visible change in the services rendered by them. The guideline is broad based and has a scope for extending the quality assurance in disease control and other national programme. It is believed that states will adopt it comprehensively and extend in phases for bringing all services under its umbrella. Feedback from the patients about our services is single-most important parameter to assess the success of our endeavour.

I acknowledge and appreciate the contribution given by NRHM division and NHSRC to RCH division of this Ministry in preparing and finalizing the guidelines. I especially acknowledge proactive role and initiative taken by Dr. Himanshu Bhushan, Deputy Commissioner and I/C of Maternal Health Division, Dr. SK Sikdar Deputy Commissioner and I/C of family planning Division and Dr. JN Srivastava of NHSRC in framing these guidelines.

(Manoj Jhalani)
Joint Secretary (Policy)

Dr. Rakesh Kumar, I.A.S
JOINT SECRETARY
Telefax : 23061723
E-mail : rk1992uk@gmail.com
E-mail : rkumar92@hotmail.com

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi - 110011

ACKNOWLEDGEMENT

The Operational Guidelines for Quality Assurance have been developed by the Ministry of Health and family welfare GOI, under the guidance and support of Shri Keshav Desiraju, Secrelary, Health & Family Welfare, Gol. The contribution and insightful inputs given by Ms. Anuradha Gupta, Additional Secretary & Mission Director NRHM helped in firming up the guidelines within a set time period.

I must appreciate the efforts and initiatives of the entire team of Maternal Health, Family Planning & Child health Divisions, especially Dr. Himanshu Bhushan (DC MH I/C), Dr S K Sikdar (DC FP I/C), and Dr PK Prabhakar (DC CH), who have coordinated the process of developing these Operational Guidelines besides making substantial technical contributions in it.

The technical contribution by Dr J.N Srivastava, Head of QI Division and their team members Dr. Nikhil Prakash and Dr. Deepika Sharma of NHSRC need a special mention for their robust and sound contribution and collating all available information.

I would like to express my sincere gratitude to Mr. Vikas Kharge, Mission Director & Dr. Satish Pawar, DG (Health), Govt. of Maharashtra for their inputs and continued support. I would also like to place on record the contribution of development partners like WHO, UNICEF, UNFPA particularly Dr. Arvind Mathur, Dr Malalay, Dr. Ritu Agarwal and Dr. Dinesh Agarwal.

I would like to convey my special thanks to all the experts, particularly Dr. Poonam Shivkumar from MGIMS, Wardha, Dr. Neerja Bhatla from AIIMS, Dr. R Rajendran, Institute of OBGYN, Chennai, Dr R.P. Sridhar from MCH Gujart Dr. P. Padmanaban and Mr. Prashanth from NHSRC, MH Division Consultants Dr. Pushkar Kumar, Mr Nikhil Herur, Dr. Rajeev Agarwal and Dr. Anil Kashyap for putting their best efforts in preparing several drafts and final guidelines. Since it is difficult to acknowledge all those who contributed a list of contributors is attached in the guidelines.

I hope these Operational Guidelines and accompanying compendium of check-lists facilitate to build a sound and credible quality system at Public Health facilities at-least in provision of RMNCH-A services to start with.

(Dr. Rakesh Kumar)

Dr. H. BHUSHAN
Deputy Commissioner (MH)
Telefax : 23062930
E-mail : drhbhushan@gmail.com

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110008
Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi - 110008

Date: 24th October, 2013

Program Officer's Message

'Quality' is the core and most important aspect of services being rendered at any health facility. The Clinicians at the health facility particularly public health facilities mostly deliver their services based on their clinical knowledge. Mostly client's expectations goes beyond only cure & includes courtesy, behavior of the staff, cleanliness of the facility & delivery of prompt & respectful service. Few of these clinician's also take care of clients perspective however in many cases, it is overlooked. Those who can afford, can go to a private facility but the large mass particularly the poor and those living in rural areas do not have such means neither they have the voices which can be heard.

Government System particularly the policy makers, planners and programme officers have this responsibility to act upon the needs of the people, who cannot raise voices but needs equal opportunity, at par with those who can afford. Fulfilling the needs of sick and ailing is the responsibility of public health service provider.

We have several stand alone guidelines from IPHS to Technical aspects of service delivery but there is no standard guideline defining quality assurance and its different parameters. The present set of guidelines have been prepared comprehensively beginning with areas of concerns, defining its standards, measurable elements and checkpoints both from service provider and service seekers aspect. There is a prudent mix of technical, infrastructural and clients perspective while framing these guidelines.

The programme divisions of RCH, NRHM, NHSRC and other experts along with team from Govt. of Maharashtra, representative from Govt. Of Karnataka, Gujarat, Tamil Nadu and Bihar along with institutional experts had extensive deliberations before firming up each and every aspects of these guidelines.

It is an earnest request to all the States and District Programme Officers to utilize these guidelines for placing the services as per the expectations of those who do not have means to afford treatment and services from a private health facility. Protecting the dignity and rendering timely services with competency to the clients is our moral duty but we also need to assess the quality of services sitting on the opposite side of the chair. Implementing these guidelines in letter and spirit will help us in achieving our desired outcomes.

Ensuring standard practices and adherence to the technical protocols, changing behavior and attitude of a staff is not an easy task. It needs rigorous monitoring, continuous support and encouragement by the supervisors and most importantly the ownership of the staff working at the facility for implementation and sustainability of quality efforts. The guidelines are only a tool and its success will depend upon actions envisaged under these guidelines.

(Dr. Himanshu Bhushan)

List of Contributors for Quality ASSURANCE GUIDELINES

1	Ms. Anuradha Gupta	AS&MD (NRHM), MoHFW
2	Dr. Rakesh Kumar	JS, RCH, MoHFW
3	Mr Manoj Jhalani	JS, Policy, MoHFW
4	Dr. Himanshu Bhushan	DC (I/c MH), MoHFW
5	Dr. Manisha Malhotra	DC (MH), MoHFW
6	Dr. Dinesh Baswal	DC (MH), MoHFW
7	Dr. S.K. Sikdar	DC (I/c FP), MoHFW
8	Dr. P.K. Prabhakar	DC (CH), MoHFW
9	Dr. Poonam Varma Shivkumar	Prof. of OBGY, MGIMS, Wardha
10	Dr. R. Rajendran	State Nodal Officer, Anaesthesia, Tamil Nadu
11	Dr. Arvind Mathur	WHO, SEARO
12	Dr. Dinesh Agarwal	UNFPA
13	Dr. Pavitra Mohan	UNICEF
14	Dr. Neerja Bhatla	Prof of OBGY, AIIMS, New Delhi
15	Dr. Somesh Kumar	Jhpiego
16	Dr. Archana Mishra	DD (MH), GoMP
17	Dr. Ritu Agrawal	UNICEF
18	Dr. Aparajita Gogoi	CEDPA, India
19	Dr. Sridhar R.P.	State Health Consultant (MCH), Gujarat
20	Dr. Pushkar Kumar	Lead Consultant, MH, MoHFW
21	Mr. Nikhil Herur	Consultant MH, MoHFW
22	Dr. Rajeev Agarwal	Sr. Mgt. Consultant, MH, MoHFW
23	Dr. Ravinder Kaur	Senior Consultant, MH, MoHFW
24	Dr. Renu Srivastava	SNCU Co-ordinator, CH, MoHFW
25	Dr. Anil Kashyap	Consultant NRHM, MoHFW
26	S. Chandrashekhar	JD(QA & IEC, KHSDRP, Karnataka
27	Ms. Jyoti Verma	DD & Nodal Officer, QA, Govt. of Bihar
28	Ms. Laura Barnitz	CEDPA, India
29	Ms. Priyanka Mukherjee	CEDPA, India

NHSRC Team		
1	Dr. T Sundararaman	ED, NHSRC
2	Dr. J N Srivastava	Advisor – QI, NHSRC
3	Dr. P. Padmanaban	Advisor (PHA Div.), NHSRC
4	Mr. Prasanth K.S.	Sr. Consultant (PHA Div.), NHSRC
5	Dr. Nikhil Prakash	Consultant NHSRC (QI Div)
6	Dr. Deepika Sharma	Consultant NHSRC (QI Div)
Maharashtra Team		
1	Shri Vikas Kharage	Ex MD, NRHM, Govt. of Maharashtra
2	Dr. Satish Pawar	Director, Health Services, Govt. of Maharashtra
3	Dr. M. S. Diggikar	Ex Principal, Public Health Institute, Nagpur, Maharashtra
4	Mr. Shridhar Pandit	PO, NRHM, Govt. of Maharashtra

TABLE OF CONTENTS

1

Using THESE **GUIDELINES**

A Quality based approach helps in identifying the gaps in service delivery and tracing its roots and linking them to organisational processes. It builds a system of taking effective actions for traversing the gaps, periodic assessment and improving the quality. The Quality Assurance Guidelines have been developed by the Ministry of Health & Family Welfare for addressing the concerns of public, and also the technical components of service delivery in a comprehensive manner.

The guidelines define 'road-map' for implementing quality assurance in the States. The QA approach suggested in these documents will help in improving the quality standards of public health facilities in the country. The States are required to meet the minimum standards defined in the guidelines. Once these standards are met, subsequently they may go for higher standards.

The guidelines have two parts the first one is for organisational framework, while the second volume is an assessment tool.

a. **Operational Guidelines for Quality Assurance** is best used for strengthening Quality Assurance System, from state level to facility level, which would essentially include a supportive institutional framework & organisational structure, adoption of the standards, a system of continuous assessment of health facilities, action planning for closure of 'gaps'/ 'deficiencies', supportive supervision and lastly, external assessment of the facilities for certification.

b. **Assessors' Guidebook (Volume I & II)** is compendium of the check list for each department of a health facility, which would be used for internal assessment by the facility, the DQAC/ DQAU, and by the SQAC/SQAU for arriving at a quality score for each facility. Same check-lists would also be used for certification by the external/internal assessors. The State Quality Assurance Committee may make certain check-points as optional to have 'flexibility'; and in subsequent years it could be converted into mandatory and included into the Quality plan. Completion of the check-lists would generate a scorecard for each facility. These check list include a client feedback form (exit interview) to assist the assessors and understand how

closely the services fulfil the 'felt need' of the people. The score-cards could also be used for having intra-state and inter-state comparison.

The purpose of these guidelines is to enable all personnel working in the Public Health System to have a credible quality assurance programme, so that health facilities not only provide full range of services, which are committed in the National Health Programmes, but also ensure that the services meet verifiable and objective quality standards.

The state/districts/facilities may phase activities under quality assurance programme, both in term of number of facilities, and within a facility, certain areas could be identified for ensuring quality assurance initially within a given time-frame. All efforts should be made in achieving these targets and sustaining them in subsequent years.

Scope of the Guidelines

'Operational Guidelines on Quality Assurance' and accompanying volumes of '*Assessment Tools*' have been prepared for minimum health services, which should be available at a District Hospital, including those in the arena of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCH+A) and Disease control programmes. While the structure of QA proposed here is for all areas of health services, however the check-list for assessing health facility is at present focussed on RMNCH+A and related support services. *It is open for expansion and inclusion of other areas in the course of laying down a roadmap for QA in the states*.

Operational Guidelines on Quality Assurance has following four sections:

1. **Section A: 'Understanding Quality Assurance'** describes concept of Quality Assurance, as relevant to Public Health System, framework of Quality of Care and generic description of the approach.
2. **Section B: 'Organisational Structure for Quality Assurance'** dwells into the proposed organisational structure for supporting QA at state and district level along with their ToRs.
3. **Section C: 'Road Map'** describes the sequential steps, which need to be taken by the States, districts and health facilities for implementing the Quality Assurance Programme.
4. **Section D: 'Standards & Measurable Elements'** describes minimum standards, which a district hospital should meet. Each standard has sub-components for measuring them. While standards will remain the same but the check points will vary for the facilities below the district hospital i.e. CHC, PHC etc.

SECTION A

UNDERSTANDING QUALITY ASSURANCE

2

Introduction to QUALITY

The National Rural Health Mission (NRHM) was launched in the year 2005 with the goal "*to improve the availability of and access to quality health care for people, especially for those residing in rural areas, the poor, women and children.*" The Mission has led to considerable expansion of health services through rapid expansion of infrastructure, increased availability of skilled human resources and greater local level flexibility in operations, increased budgetary allocation and improved financial management. However, improvement in Quality of health services at every location has not been perceived, generally.

Perceptions of poor quality of health care may, in fact, dissuade patients from using the available services because health issues are among the most salient of human concerns. Ensuring quality of the services will result in improved patient / client level outcomes at the facility level.

Ministry of Health and Family Welfare, Government of India is committed to support and facilitate a Quality Assurance Programme, which meets needs of Public Health System in the country and is sustainable. Main focus of proposed Quality Assurance Programme would be enhancing satisfaction level among users of the Government Health Facilities and reposing trust in the Public Health System.

2.1 Quality in Health Care

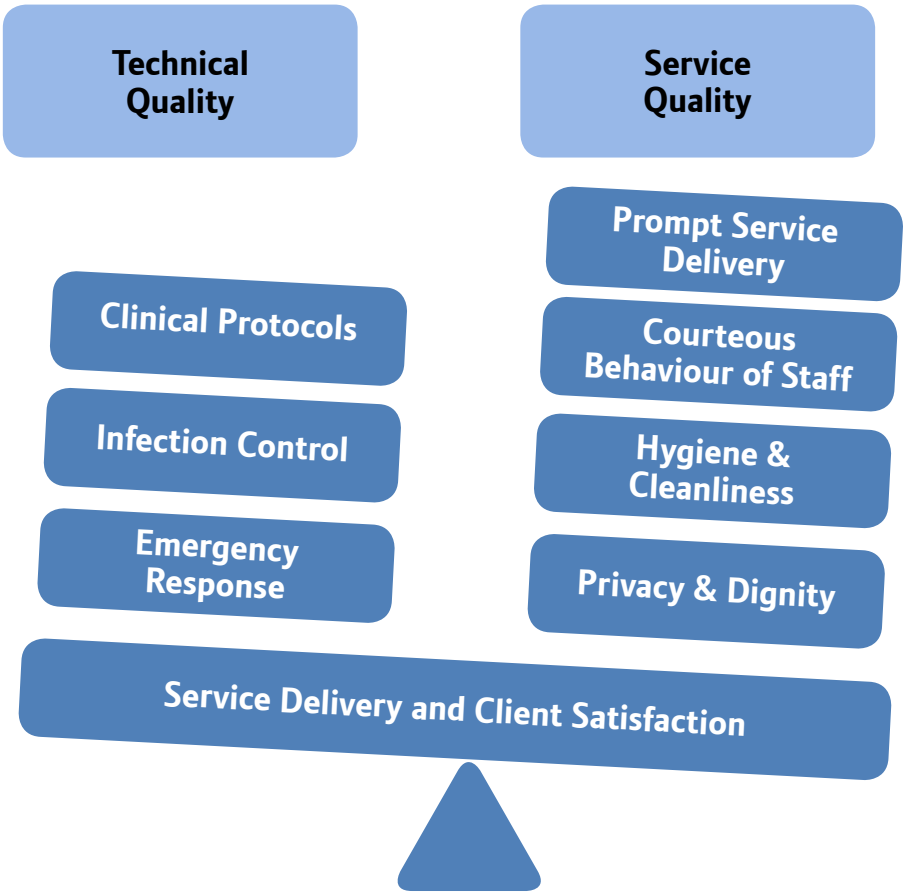
Quality in Health System has two components:

Technical Quality: on which, usually service providers (doctors, nurses & para-medical staff) are more concerned and has a bearing on outcome or end-result of services delivered.

Service Quality: pertains to those aspects of facility based care and services, which patients are often more concerned, and has bearing on patient satisfaction.

Few common issues have been elaborated in Figure 2.1.

Fig 2.1: Sub-Components of Quality



Working definition- WHO defines Quality of Healthcare services in following six subsets:

a. **Patient-Centred:** delivering health care, which takes into account preferences and aspirations of the service users, and is in congruent with their cultures. It implies that patients are accorded dignified and courteous behaviour. Their reasonable belief, practices and rights are respected.

b. **Equitable:** delivering health care which does not vary in quality because of personal characteristics such as gender, caste, socioeconomic status, religion, ethnicity or geographical location.

c. **Accessible:** delivering health care that is timely, geographically reasonable, and provided in a setting, where skills and resources are appropriate to the medical need.

d. **Effective:** delivering health care that is based on the needs, and is in compliance to available evidences. Therefore, observance of treatment guidelines and protocols is important for ensuring the quality of care. The delivered health care results into the improved health outcomes for the individuals in particular, and community in general.

e. **Safe:** delivering health care which minimizes risks and harm to the users.

f. **Efficient:** delivering health care in a manner which maximizes productivity out of the deployed resources. The wastes are avoided.

2.2 Quality as Perceived by Different Stakeholders

Although everyone values quality, but perceives it differently. Patients, Communities (Society), Clinicians, and Administrators have different definitions of quality.

Patient's Requirement: Although patients are deeply concerned, how good clinical care is, but very often, they themselves are not able to judge the technical aspect of the care. Patients are mostly concerned about the issues, other than clinical guidelines & protocols. Usual expectations of patients are given in the Table 2.1.

TABLE 2.1: EXPECTATIONS OF PATIENTS

Care	Cure
1. Clean and inviting atmosphere	1. Correct, speedy, low cost & lasting treatment
2. Courteous behaviour	2. Emergency response
3. Personalised approach	3. No new diseases
4. Psychological well-being	4. No harmful procedure/complication

Users' experiences of health care in a facility, whether personal or shared, have a major impact in their decision of seeking the services at a particular facility. People do not wish to go to a facility where they receive rude treatment.

Society's Definition: At the broader societal level, the definition of quality of care reflects concern of cost effectiveness, equal access and equity in service delivery, transparency and extent of out of pocket expenditure. Society also perceives quality in terms of protection of health rights specialty of marginalized and vulnerable populations.

Healthcare Providers: Clinicians, who provide healthcare services, tend to equate quality of care with technical performance. Often for health care providers, the desired outcomes are related to successful treatment of patients with reduction in morbidity, mortality and disability limitation. For example, doctors' expectation of quality services is that investigation reports are available on time, drugs are available in the dispensary, and patients are getting cured timely.

Governments/Administrators Definitions: An administrator perceives quality in terms of optimal and rational utilization of resources, maximum satisfaction by the users of health facility, delivery of all components under the health programmes, compliance to treatment guidelines & clinical protocols, and improvement in the health status of population.

3

Framework of **QUALITY OF CARE** (QOC)

3.1 QOC

Well frame-work for assessing the quality of care on the well accepted '*Donabedian model*', which classifies QOC in terms of three aspects – structure, process, & outcome.

a. **Structure:** Structural aspect of QOC includes material resources like infrastructure, drugs and equipment; and Human Resources such as availability of adequate number of personnel, who have requisite knowledge and skills. Evaluation of the quality that relies on such structural elements implicitly assumes that well qualified people with well appointed and well organized settings will provide high quality care. However, it is not always the case. Also, it is acknowledged that in the Public Health System, full compliance to infrastructure and HR norms may not be possible. However, after meeting the minimum infrastructure and HR norms for a Public Health Facility, it would be logical to expect a minimum quality in the available services at the Public Health Facility. The proposed system strives to provide QOC within these constraints.

b. **Process:** Care can also be evaluated in terms of processes & sub-processes, required for delivery the care. This refers to what takes place during its delivery – such as how quickly registration of a patient is done, and s/he is attended, courteous behaviour of the service providers, especially of doctors & nurses, conduct of examination with respect to privacy, confidentiality and for patient's right, etc.

c. **Outcome:** The other aspect of quality of care can be assessed in terms of outcome measurements, which denote to what extent goals of the care have been achieved.

All three aspects of the QOC have different connotation to different stakeholders, viz. Patients, Service providers and Health System, as given in Table 3.1.

TABLE 3.1: QOC IN TERM OF INPUTS, PROCESS & OUTCOME

Stakeholders	Inputs	Process	Outcome
Patients' Expectations	■ Barrier Free Access - Prompt & courteous services - No exclusion on the basis of caste and socio-economic status ■ Clean & Inviting environment at the health facility ■ Availability of services ■ Availability of drugs and consumables	■ Minimal waiting time & Prompt referral, if required ■ Good behaviour by service providers ■ Privacy & confidentiality ■ Grievance Redressal ■ Access to Information and involvement in decision making for the care	■ No out of pocket expenditure ■ Availability of services as guaranteed ■ High Patient Satisfaction ■ Treatment and Cure
Service Providers Requirements	■ Adequate and planned infrastructure ■ Serviceable & calibrated Equipment ■ Availability of Quality Drugs ■ Human Resource in numerical adequacy with knowledge and skills ■ Enabling Work Environment	■ Adherence to clinical Protocols ■ Infection Control Practices ■ Training and Skill Development ■ Safe and effective Nursing care	■ Low Mortality, Morbidity, complications, and Referrals, etc. ■ Effectiveness of the care in term of average length of stay, bed occupancy, etc. ■ Adverse drug reactions and Hospital acquired infection ■ Employees' Satisfaction
Health Systems Requirements	■ Allocation of adequate resources ■ Facilities provide full range of services ■ Adequate Technical Support	■ Efficient logistics management ■ Monitoring and Supervision ■ Effective implementation of programmes	■ Optimal utilization of resources ■ Measurable deliverables of programmes ■ Improvement in Health Indicators ■ Enhanced Productivity in terms of volume

3.2 Quality Assurance

American Society for Quality refers to Quality Assurance as "*planned and systematic activities, which are implemented in a quality system, so that quality requirements of a product or service would be fulfilled*". It essentially entails doing a set of activities that include defining quality standards and assessing, monitoring and improving the quality of services against those standards, so that the care provided is as efficient, effective and safe as possible.

Four Principles of Quality Assurance

- Quality Assurance is oriented toward meeting the needs and expectations of the patients.
- Quality assurance focuses on the systems and processes.
- Quality assurance uses data to analyse service delivery processes.
- Quality assurance encourages a team approach to problem solving and quality improvement.

Quality Assurance (QA) in Public Health is a cyclical process involving following major components:

a. Setting up Standards and Measurable elements.

b. Assessment of health facilities against the set standards.

c. Analysing the problems.

d. Preparing and implementing action plan.

3.3 Quality Improvement (QI)

Quality improvement is an interdisciplinary process, which is designed to raise the standards of delivery of diagnostic, therapeutic, rehabilitative and preventive measures in order to maintain, restore or improve health outcomes of individuals and population. It also looks at the care part of facility treatment – courteous behaviour, clean premises, minimal waiting time, patients' right, etc.

Critical steps of Quality Assurance:

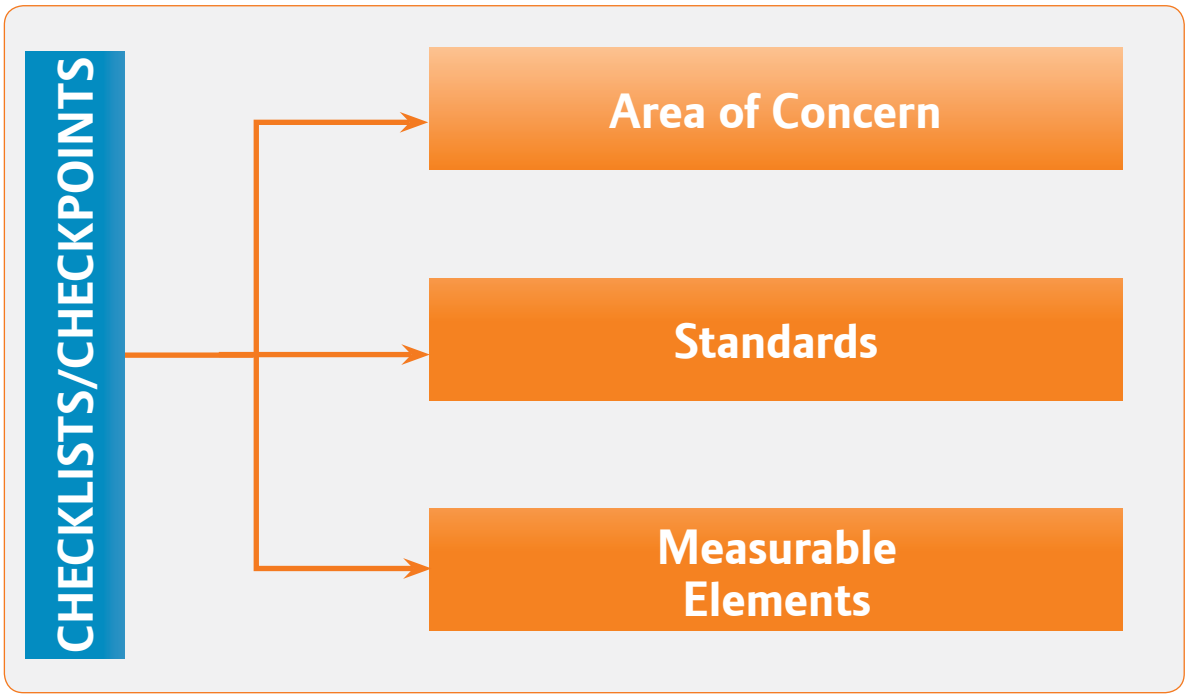
Following steps would be required to be taken for implementing a credible Quality System at Public Health Facilities -

a. **Setting up Quality Standards, Measurable Elements & Check-lists:** To provide consistently high-quality services, the foremost requirement is to set quality standards against which the performance can be measured. These standards must meet the specific requirements of Public health system and encompassing all three aspects of Quality of care i.e. Structure, Process and outcome.

QA was first introduced into modern medicine by a British nurse, Florence Nightingale, who assessed the quality of care in military hospitals. She introduced the first standards in nursing care; these resulted in dramatic reductions of mortality rates in hospitals.

Action planning for the gap assessed against checkpoints needs to be fulfilled within a set time frame and assigned a score during the assessment process. These checkpoints would be compiled in form of departmental check list, so the compliance to all relevant standards for a department of healthcare facility can be checked systematically, objectively and in a user-friendly way. This process should be reviewed periodically for compliance and further improvement. The checkpoints can be of two types, 'essential', one which are non-negotiable and would be required to be adhered by the facility for being quality certified and 'desirable' which are optional and should be fulfilled in due course.

For example, one of the standards for RCH services would be "Facility has established procedures for Antenatal care as per guidelines". For this standard there would be a set of measurable elements and further checkpoints that would objectively assess the compliance to this standard and score antenatal care at the facility accordingly. The assessment would be done with help of assessment tools e.g. Check list for OPD, Laboratory Services, Pharmacy, etc. where all relevant checkpoints pertaining to Antenatal care would be arranged according to standards and measurable elements.



Relationship Between different elements of measurement system

Quality Assurance Standards have been developed at national level which have 70 standards categorized into 8 broad areas of concern i.e. Service provision, Patient Rights, Input, Support Services, Clinical Care, Infection Control, Quality Management and Outcome.

A set of Standards & Measurable Elements for a District Hospital is given in **Section 'D'**. Checklist for measurement of these standard are given in Assessors Guidebook.

b. **Quality Assessment:** This is an activity that measures various elements of service provision against pre-determined standards of care. Such an assessment provides an understanding of the areas where the actual position falls short of the set standards. It includes both periodic reviews in terms of internal scoring of a health facility, followed by assessment by the external assessors, who themselves are not directly responsible for the implementation, so as to avoid a 'conflict of interest situation'.

c. **Identification of gaps and areas of improvement** is an important and integral part of assessment. It is also important to conduct a 'root-cause analysis' of the observed gaps, so that real & sustainable solutions are found. Gaps should be categorised in term security viz: High, moderate, Low.

d. **Action planning:** The most important step following the 'assessment and gap identification' is developing **time bound action plan** for traversing the gaps. Action planning for critical gaps and low hanging fruits should be prioritised.

   It is imperative that for each gap found above, corrective measures are defined along with the person responsible to take action and the time frame for the same. If the observed gaps are many, phased action plan may be developed.

e. **Follow-up Assessment:** After passage of an agreed time-frame, **follow-up assessment** is required to be done to ensure that the plan has been adhered and the gaps have been closed. As the elements related to quality are dynamic in nature, gaps may be found in those areas

also, where none existed in the past /previous assessment (s). Therefore it is important to repeatedly assess a facility for incremental changes for the improvement.

What does not work?	What works?
While external pressures and punitive measures may bring about initial improvement in the desired direction, no change can be sustained till the people responsible for making that change accept it as their own.	At the facility, a motivated team, which understands the need for quality and the standards set for it. It strives to make the needed changes within its capacity, and ensures that it remains that way.

Summary of Assessment Process:

1. Make an Assessment of severity of the Gaps
2. Collate all gaps and allocate severity level
   a. High – Directly impacting quality of care - e. g. closure of Operation Theatre
   b. Moderate – Indirectly impacting quality of care – e. g. Non-segregation of Biomedical Waste
   c. Low – May impact quality of care – e. g. Non-calibration of scale
3. Phasing of Actions – Initially action planning for high priority gaps should be done
4. Allocate resources, define timeline and allocate responsibility
5. Review progress
6. Plan for preventive Action

Points to Remember .....

- Quality Assessment is a cyclical process.
- It is a **continuous** process, and not a one-time effort.
- It is an **incremental** process where improvements are added with each cycle.
- It is primarily an **internal** process, driven by motivated staff of the facility.

SECTION B

THE ORGANISATIONAL STRUCTURES

SECTION | B

THE ORGANISATIONAL STRUCTURES

For strengthening the QA activities, following organisational arrangements need to be set up at various levels with the roles and responsibilities defined for each level.

1. **National level:** Central Quality Supervisory Committee (CQSC);
2. **State level:**
    a. State Quality Assurance Committee (SQAC)
    b. State Quality Assurance Unit (SQAU)
    c. QA assessors (Empanelled)
3. **District level:**
    a. District Quality Assurance Committee (DQAC)
    b. District Quality Assurance Unit (DQAU)
4. **District Hospital level:** District Quality Team (DQT)

National Level

The QA team at the national level will consist of representatives from the programme divisions (maternal health, child health, family planning, adolescent health, malaria, TB, leprosy etc.) of the Ministry of Health and Family Welfare, Government of India and National Health Systems Resource Centre. Technical Experts working with various development partners can be co-opted, if required.

The Quality Division at National Health Systems Resource Centre (NHSRC) will be the nodal agency to operationalise the QA protocols in the country. This team will work under the overall guidance and supervision of the Programme Divisions, Ministry of Health & Family Welfare. Director NRHM would

act as the Nodal Officer for the co-ordination between the National Programme Divisions and the NHSRC.

The primary role of the team at the national level will be to provide overall guidance, mentoring and monitoring of QA efforts in the states. It would include:

1. Drawing up the Technical Guidelines and Protocols

The Programme Divisions of the Ministry will draw **v**arious guidelines for Ministry of Health & Family Welfare, Government of India as per the need & requirement for improving technical aspect of service delivery. Such guidelines shall be the part of Quality Assurance programme.

The standards proposed in the QA document are based on various GoI guidelines, IPHS Standards, WHO guidelines, examples of good practices & also standard textbooks & journals. However in view of the wide variations in the conditions of the existing heath facilities and the quality of services available, the standards set in the QA guidelines are the minimum, and the states are expected to meet them. If a state so desires, it can set more rigorous standards of quality after achieving the minimum that are part of these guidelines.

Training: The MoHFW with Quality Division of NHSRC would be responsible for training of State QA Committees & Units. External faculties for the training could also be invited depending upon the need. A pool of National trainers will be created for meeting the training needs of the States.

2. Recruitment of State QA Assessors

States are expected to interview and empanel the QA Assessors, preferably with Hospital Management/ Public Health background. Senior retired personnel of the health department, faculty at medical colleges/institutes running hospital administration courses, experienced public health professionals willing to undertake this task may be empanelled. It needs to be ensured that assessors are of high integrity with no conflict of interest nor there is any commercial interest. The empanelled assessors would be trained in the assessment and scoring methodology. GoI will nominate a representative as the expert in recruitment panel to ensure quality and transparency in recruitment. Names, Professional Qualification and Work experience of empanelled assessors would be shared with NHSRC, who would be maintaining a central registry of External Assessors.

3. Mentoring the State QA Teams

The QA Division of NHSRC will disseminate guidelines and mentor the state QA units under the overall guidance of the national programme divisions and Director NRHM as per requirement in their respective domains. The representatives of GoI (NRHM/RCH/Programme Divisions) are expected to participate in dissemination meetings for technical clarity related on QA framework.

4. Monitoring the QA Activities

The National Programme Divisions will monitor the QA activities in the states, including the trends in key outcome indicators that are targeted for improvement through these QA efforts. They may monitor the QA activities through various means, including but not limited to:

a. Evaluation surveys measuring outcome level data, including client satisfaction status.

b. Visits by the central team members.

c. Quarterly review by NHSRC of the reports sent by the state teams, KPI data etc. followed by feedback to the Programme Divisions of GoI and submission of brief analytical report to NHM division of GoI. The reports will then be forwarded by MoHFW to the States along with the recommendations for improvement.

State Level

Based on the directions of Honourable Supreme court of India, QA Committees (QACs) have been formed by all the states at state and district levels and have been functioning since then. Their initial mandate was to ensure quality in male and female sterilisation services. The Government of India is expanding the scope of these states and district level QA committee beyond family planning to include all services envisaged under the RMNCH+A, disease control programmes and other hospital services.

Keeping in mind the expanded scope of activities that is now brought under the ambit of the QA structures at the state and district levels, these guidelines have been revised as per the structure and function of the QACs and are described below.

State level Quality Assurance Committee (SQAC)

The broad responsibility of this committee will be to oversee the quality assurance activities across the state in accordance with the national & state's guidelines, and also ensure regular and accurate reporting of the various key indicators.

Composition

1. Secretary, Medical and Health (Chairperson).
2. Mission Director – NHM (Vice Chairperson).
3. Director Family Welfare/Director Health Services/Director Public Health Equivalent (Convener): to be nominated by the Chairperson.
4. Additional/Joint Director (FW)/Deputy Director (FW)/Equivalent, designated by the state government as the nodal officer for the Quality Assurance (QA) Cell (Member Secretary).
5. Director, Medical Education.
6. Director/Principal of state training institution e.g. SIHFW/ CTI/ RHFWTC.
7. One Empanelled Gynaecologist (from public institutions).
8. One Empanelled Surgeon (from public institutions).
9. One Anaesthetist (from public institutions).
10. One Paediatrician (from public institutions).
11. One Medical Specialist (from public institutions).
12. One nominated Medical Superintendent (or equivalent) of DH.
13. One each Incharge of PHC, CHC, and Sub-divisional Hospital.
14. State Nursing Adviser (Equivalent).
15. One member from an accredited private sector hospital/ NGO (health care sector).

16. One representative from the legal cell.

17. One representative from medical professional bodies e.g. FOGSI/ IMA/ IAP/IAPSM/ Association of Public Health.

18. Any other member or representatives of public health organisations of eminence as nominated by the state government.

Note: The Quality Assurance Committee as laid down in the "Quality Assurance Manual for Sterilization Services' shall stand subsumed within the QAC mentioned above.

However a five-member "State Family Planning Indemnity Subcommittee" from within the SQAC would redress, dispose and disburse claims/complaints received through the DQAC, to the district health society as per procedure and time frame laid down in the manual on "Family Planning Indemnity Scheme 2013".

The subcommittee would comprise of the following:

1. Mission Director –NRHM (Chairperson).
2. Director Family Welfare/Director Health Services/Director Public Health Equivalent (Convener).
3. Additional/Joint Director (FW)/Deputy Director (FW)/Equivalent (Member Secretary).
4. Empanelled Gynaecologist (from public institutions).
5. Empanelled Surgeon (from public institutions).

Terms of Reference

SQAC is a body for the Policy decision & directions. This is also responsible for all QA initiative, its success & shortcomings. The primary role of the committees at the state level will be to provide overall guidance, mentoring and monitoring of QA efforts in the districts. Some of the ToRs reflected here are operational in nature and shall be implemented by the SQAU, which is the operational and implementation arm of SQAC.

1. Developing the Quality Assurance Policy & Guidelines for the State:

Using national guidelines, the SQACs will develop/adapt QA guidelines specific to their states.

- Composition of the state and district QACs & QAUs.
- Recruitment of consultants for QA at state and district levels.
- Empanelment of state QA assessors who may be retired/serving, part time/ full time as per the state specific need.
- Expanding the scope of QA process as per the states' requirements.

Note: The Recruitment committee should include one nominee from the Ministry of Health & Family Welfare, GoI.

2. Ensuring attainment of the Standards for Quality of Care by Public Health Facilities:

- The committee will develop 'road-map' for achieving the national standards.
- Assessment of need of Technical Assistance (TA) by the facilities and mobilisation of such TA.

3. Mentoring the state/district level units:

- Ensuring that state/district level orientation and other trainings are conducted timely in a meaningful manner.
- The support of the technical team at the national level may be taken to prepare a pool of master-trainers at the state/district.

4. Periodic Review of the progress of QA activities:

- Will conduct review meetings at six monthly interval.
- Review of Quality scores, attained by different categories of Public Health Facilities.
- Take decisions for corrective actions and preventive actions.
- Defining targets and road maps.

5. Review and adjudicate compensation claims: under the National Family Planning Indemnity Scheme for cases of deaths, complications and failures following male and female sterilisation procedures. *(for detailed procedures to be followed please refer to the manual on "Family Planning Indemnity Scheme 2013", Ministry of Health & Family Welfare, Government of India").*

6. Supporting quality improvement process:

- Take visionary decisions for continuous quality improvement and its sustenance.
- Sanction funds for implementation and improvement of quality.
- Reflect fund requirement for Quality Assurance in the annual State PIP along with justification.
- Operationalisation of incentive scheme.

7. Reviewing Key performance indicators of quality:

- The suggested KPIs for District Hospitals are given in the Annexure 'A'. The SQAC may add additional indicators in KPIs list.
- Performance of health facilities as assessed by the KPIs would also be discussed during review meetings of CMO/ CS/ CMHO/DHO.
- RMNCH score card can be used for assessing the performance of the facilities.

8. Reporting:

- The committees' review report should be put on the State's website.
- The reports would also be shared with all district committees and other stakeholders.

Process

a. The state quality assurance committee will meet at least once in six months.

b. The convener will issue meeting notice at least seven working days before the scheduled date of meeting with the approval of the chairperson/ vice chairperson.

c. While every attempt should be made to ensure that the chairperson and/or the vice-chairperson are able to attend the meeting, however, in the absence of the chair, the Convenor shall have the right to convene the meeting and conduct it according to the set agenda. Under such circumstances, the minutes of the meeting should be sent to the chairperson and vice-chairperson for information and ratification.

d. The member secretary will ensure the preparation of the agenda notes for meeting, minutes of the last meeting and Action Taken Report (ATR), which will also be circulated in advance to all committee members, at least seven days before the scheduled date for the meetings.

e. An attendance by at least one-third of the Committee members will constitute the quorum required for a valid meeting.

f. Member secretary will ensure follow-up actions with responsibilities and timelines for the same.

g. The "State Family Planning Indemnity Subcommittee" would meet as often as warranted. At least three members would constitute the quorum of this subcommittee.

State Quality Assurance Unit

SQAU is the working arm under SQAC that will be responsible for undertaking various activities as per ToRs of the unit, and other tasks, as entrusted to them from time to time by the SQAC.

Composition:

1. Additional/Joint Director (FW)/Deputy Director (FW)/Equivalent, designated by the state government as the nodal officer for the Quality Assurance (QA) Unit (Member Secretary - SQAC).
2. State Nodal Officers of Programme Divisions.
3. State Consultant (Quality Assurance).
4. State Consultant (Public health).
5. State Consultant (Quality Monitoring).
6. Administrative-cum-Programme Assistant.

The SQAU is headed by the SQAC's member secretary, who along with the state programme officers provide support to the SQAC for implementation of QA activities in the state. All the positions of this unit should preferably be regular from the state cadre, however in case of non- availability from the state cadre, the posts at Sl. No. 3 to 6 can be hired under NRHM till the posts are filled-in from the state cadre.

The number of full time technical persons (consultants) may be increased once the state decides to expand QA for the Disease Control and other programmes as part of the mandate of the State QAC.

Regional Quality Assurance Units

Large states may have Regional Quality Assurance Units at the division level and will report to SQAU.

Terms of Reference

The terms of reference for the SQAU remain the same as of SQAC, since it is the working arm of SQAC. However, some of the important activities of the SQAU are listed below:

1. Adapt check-lists for RMNCH-A services (as well as for Disease Control Programme implementation) to match the state needs.
2. Develop a plan for the Quality Assurance at each level of health institution in a phased manner.
3. Orient the state level assessors, district level QA units on the quality standards, tools for assessment and improvement plans, and the processes to be followed for QA activities. Assistance of QI Division of NHSRC may be taken for organising the orientation programme.
4. Disseminating the quality assurance guidelines & tools and methodology to be followed at district and sub-district level.
5. Develop a field travel plan for independent and joint (with district teams) visits to the districts by members of the state QAU and programme officers.
6. Following these visits, prepare draft report and recommendations for review.
7. Mentor the program officers and facility in-charges at the districts for implementing quality improvement measures at the facilities.
8. Compile and collate monthly data received from districts on KPI, especially those related to cases of adverse outcomes/complications in maternal, neonatal & child health; maternal, infant & child deaths (all cases), disease control programmes and share it with the SQAC members and discuss at the SQAC meeting.
9. Send the regular reports on sterilisation related indicators (deaths, complications, failures) to the centre after ratification of the same by the Chairperson of the SQAC.
10. Review the implementation of the National Family Planning Indemnity Scheme/ payment of compensation in the state, based on reports received from the districts as well as from the visits undertaken by the QAU members.

Linkages with Program Divisions

- Meetings with various programme officers including SIHFW shall be organised every quarter and if required more frequently for discussion and adaptation of the programme guidelines, orientation of district QA committee (DQAC) and district QA unit (DQAU), sharing the field visit reports on quality assessment and discussing the way forward for improving services.
- The programme officers and SQAU should visit the facility with similar check list and provide supportive supervision. The tour report must be shared with each other.
- SQAU shall be responsible for implementation of all quality related observations.

TORS for the contractual position at State Quality Assurance Unit are given at *Annexure 'B'.*

District Level

District Level Quality Assurance Committee (DQAC)

Composition:

1. District Collector/Dy. Commissioner, Chairperson.
2. Chief Medical Officer/Deputy Director/CDMO/District Health Officer/Equivalent (convener).
3. District Family Welfare Officer/RCHO/ACMO/equivalent (member secretary).
4. Deputy Superintendent/Civil Surgeon/Chief Medical Superintendent of District Hospital (s) or equivalent.
5. In-charge of CHC & PHC (one each, by rotation).
6. Nodal Officers of Programme Divisions at districts.
7. One empanelled gynaecologist (from public institutions).
8. One empanelled surgeon(from public institutions).
9. One Medical Specialist (from public institutions).
10. One anaesthetist (from public institutions).
11. One paediatrician (from public institutions).
12. One representative from the nursing cadre.
13. One representative from the legal cell.
14. One member from an accredited private sector hospital/ NGO (health care sector).
15. One representative from medical professional bodies e.g. FOGSI/IMA/IAP/IAPSM/ Association of Public Health.

However a 5 member "District Family Planning Indemnity Subcommittee" from within the DQAC would process claims received from the clients and complaints/claims lodged against the surgeons and accredited facilities, as per procedure and time frame laid down in the manual on "Family Planning Indemnity Scheme 2013".

The subcommittee would comprise of the following:

1. District Collector, (Chairperson).
2. Chief Medical Officer/District Health Officer/ CDMO/ CMHO (convener).
3. District Family Welfare Officer/RCHO/ ACMO/ equivalent (member secretary).
4. Empanelled Gynaecologist (from public institutions).
5. Empanelled Surgeon (from public institutions).

Terms of Reference:

1. **Dissemination of QA policy and guidelines:**
   - The district QAC will be responsible for disseminating the QA guidelines to all the stakeholders.

2. **Ensuring Standards for Quality of Care:**
    - The committee will ensure that QA standards have been achieved at designated health facilities.

3. **Review, report and process compensation claims** for onward submission to the SQAC under the National Family Planning Indemnity Scheme for cases of deaths, complications and failures following male and female sterilisation procedures. *(for detailed procedures to be followed please refer to the manual on "Family Planning Indemnity Scheme 2013, Ministry of Health & Family Welfare, Government of India").*

4. In case a facility reports a sterilisation related death, the convenor of the DQAC should inform the convenor of the SQAC within 24 hours. Death audit needs to be undertaken by the DQAC and report sent to the state with a copy to the Ministry of Health & Family Welfare, Govt. of India, within one month of the death being reported.

5. **Capacity building of DQAU and DQT:**
    - Ensuring that district level orientation and trainings are accomplished in time for DQAU and also DQT.

6. **Monitoring QA efforts in the district:**
    - The committee needs to ensure that facility assessments and subsequent quality improvement efforts are executed as per plan.

7. **Periodic Review of the progress of QA activities:**
    - Will conduct quarterly review meetings and more if needed.
    - Take decisions for corrective actions.
    - Define targets and road maps.
    - During the district level program review meetings the Key performance indicators (KPI) of quality can be reviewed.
    - RMNCH score card can be used for assessing the performance of the facilities.

8. **Supporting quality improvement process:**
    - Sanction and release of funds for implementation and improvement of quality.
    - Reflect fund requirement in the annual DHAP along with justification.
    - Taking all required actions for incentivization of the facilities on attaining the certified status.

9. **Coordination with the state for:**
    - Dissemination and implementation of guidelines.
    - Facilitator support for the visits of SQAC/SQAU to the districts.
    - Sharing minutes of DQAC meeting and monthly reports.
    - Corrective actions & Preventive actions.

10. **Reporting:**

- The committees' review report to be put on the state NRHM website.
- Share with all district committee members and other stakeholders.
- Share the QA reports with the concerned facility.

Process:

- The district quality assurance committee will meet at least once in a quarter.
- The convener will issue meeting notice at least seven working days before the scheduled date of the meeting with the approval of the chairperson.
- While every attempt should be made to ensure that the chairperson is able to attend the meeting, however, in the absence of the chair, the Convenor shall have the right to convene the meeting. Under such circumstances, the minutes of the meeting should be sent to the chairperson for information and ratification.
- Member secretary will ensure the preparation of agenda notes, and action taken reports, which will be circulated in advance to all committee members preceding the DQAC meetings.
- An attendance by at least one third of the Committee members will constitute the quorum required for a valid meeting.
- Member secretary will ensure follow-up actions with responsibilities and timelines for the same.
- The "District Family Planning Indemnity Subcommittee" would meet as often as warranted.
- At least three members would constitute the quorum of this subcommittee.

District Quality Assurance Unit

DQAU is the working arm under DQAC that will be responsible for undertaking various activities as per the ToRs of the committee and also entrusted to them from time to time by the DQA Committee.

Composition:

1. District Family Welfare Officer/RCHO/ ACMO/ equivalent (Head of DQAU).
2. One Clinician (Surgical/ Medical/ any other speciality).
3. District Consultant (Quality Assurance).
4. District Consultant (Public Health).
5. District Consultant (Quality Monitoring).
6. Administrative cum Programme Assistant.

The DQAU is headed by the Member Secretary DQAC, who along with the district programme officers provide the support to the DQAC for implementation of QA activities in the district. All the positions of this unit should preferably be regular staff from the government. However, in case of non- availability of the regular cadre staff, posts at sl. no 3 to 6 can be hired under NRHM till the regular cadre become available.

Terms of Reference:

The terms of reference for the QA unit remain the same as of QA Committee, since it is the working arm of DQAC. However, some of the important activities of the DQAU are listed below:

1. Ensure roll out of standard protocols for RMNCH-A services (as well as for Disease Control Programme implementation).
2. Develop a plan for the Quality Assurance at each level of health institution in a phased manner.
3. Disseminating the quality assurance guidelines & tools and methodology to be followed at district and sub district level.
4. Develop a field travel plan for independent and joint (with State teams) visits to the health facilities in the districts by members of the DQAU.
5. Following these visits, prepare the draft report and recommendations.
6. Mentor the facility in-charges at the districts for implementing quality improvement measures at the facilities.
7. Compile and collate monthly data received from facilities on outcome level indicators, especially those related to cases of adverse outcomes/complications in maternal, neonatal & child health; maternal, infant & child deaths (all cases), disease control programmes and share it with the DQAC members and discuss with DQAC meeting.
8. Send the regular reports on sterilisation related indicators (deaths, complications, failures) to the State after ratification of the same by the Chairperson of the DQAC.
9. Review the implementation of the National Family Planning Indemnity Scheme/ payment of compensation in the district, based on reports received from the facilities as well as from the visits undertaken by the DQAU members.

TORS for the contractual position at District Quality Assurance Unit are given at *Annexure 'C.*

District Quality Team (DQT) at District Hospital

The DQT will be functioning exclusively at district hospitals. If any facility below district level implements quality assurance under the supervision of DQAU, special incentives can be given to the team implementing QA activities in the facility.

Composition

The suggested composition of the Quality Team at the District Hospital is as follows:

1. I/C Hospital/Medical Superintendent: Chairperson.
2. I/C Operation Theatre/Anaesthesia I/C, Surgeon.
3. I/C Obstetrics and Gynaecology.
4. I/C Lab services (Microbiologist/ Pathologist) : for enforcing IMEP & BMW protocols.
5. I/C Nursing.
6. I/C Ancillary Services.

7. I/C Transport.
8. I/C Stores.
9. I/C Records.
10. Hospital Manager.

Terms of Reference

1. **Staff orientation:**
   - Formal training needs to be conducted for the staff of DQT with support from the district QAU.
   - DQT should orient the medical, paramedical and support staff team including Group C & D to the service standards set by the state.
2. **Ensuring adherence to quality standards:**
   - Through regular internal assessments, audits, reviews etc the DQT members should ensure that the standards set for a district hospital are being met.
   - Corrective action plans should be initiated for identified gaps.
3. **Regular reporting to district QAC:**
   - The DQT needs to report regularly to the district QAC on outcome level indicators such as sterilisation deaths, complications and failures as well as maternal and infant deaths.
   - The DQT should also report to the district QAC on the internal assessment findings, quality improvement measures undertaken, etc.
4. **Ensure interdepartmental coordination:**
   - The DQT should liaise with various departments within the facility for effective implementation of QA activities.
   - To share the internal assessment findings of DQT and external assessment findings of SQAU/ DQAU with all the staff at the district hospital.
   - DQT will ensure that Departmental nodal officers will take corrective actions as per the road map provided by DQT.

Process:

- Once the DQT is formed, areas for an initial assessment needs to be identified in the first meeting.
- For achieving the standards DQT will undertake the process of filling the check list, scoring the measurable indicators, summing up area wise and services wise gaps.
- Assessment to be carried out and based on its findings follow up actions to be taken.
- Monitoring of the follow up actions has to be done in the subsequent meetings.
- Assessments should be followed by time bound action plans along with person responsible for each action shall be prepared.
- Once the DQT completes the assessment and gives service wise/area wise scoring then will inform and invite District/State assessors for verification and guidance.

- This process will continue till the SQAC assessors certify the attainment of the quality standards at the hospital. Then onwards DQT will ensure maintaining the standards.
- Facility in-charge and Hospital manager should do daily rounds to supervise the QA activities and sustain the motivational level of the staff.
- The DQT should meet once every month.

In case of any death following a sterilisation operation, it should be reported to the convenor of the DQAC within 24 hours. Monthly reports of maternal and infant deaths should also be given to the district QAC. In case there are no deaths, a NIL report should mandatorily be sent. DQAC is responsible for investigating a sterilisation related death and also review of maternal and infant deaths.

TORS for the hospital manager are given at *Annexure 'D'.*

Quality Assessors

Assessment of quality of services in a health facility is a techno-managerial task which requires substantial time, efforts and inputs from the person(s) conducting the assessment. Hence, it is proposed that the state empanels quality assessors who have the technical know-how and are willing to take up such tasks. They should commit for minimum defined duration to ensure continuity of the job. These assessors could be either working experienced professionals or retired senior officials of the department, Medical Colleges faculty and Public Health Professionals, who are willing to spare their time.

TORS for the Quality Assessors are given at *Annexure 'E'.*

SECTION | C

ROAD MAP: THE PROCESS OF IMPLEMENTATION


1
Setting up Organizational Framework
(Merger/Reconstitution of DQAC, SQAU, DQAU, DQAU, DQT etc.)
2
Empanelment of Assessors
3
Adaptation of Standards and Measurement System
(Customization of measurable elements, Checklist and scoring system as per state needs)
4
Training and Capacity Building
(Awareness workshop, Assessor Training, External Assessor Training, Training for Service providers)
5
Facility Level Quality Improvement
Internal Assessment
Key Performance Indicatiors
Rapid Improvement Events
Standard Operating Procedures
Patient Satisfaction Survey
Quality Policy & Objectives
Medical & Death Audits
Calibration & EQUAS
6
Planning of Quality Assurance Activities
Corrective Action and Periodic Review
Implementation of Quality Assurance Mechanisum
Facility Assessment
Action Planning
7
Certification & Accreditation
DQAC recommends to SQAU for State Level Certification
On-Site assessment of & Certification by SQAC
SQAC recommends to Director NRHM for National Accreditation
Visit to facility by Empanelled assessors & NHSRC team for assessment
If score is more than 70% NHRSC recommends Director NRHM for Accreditation
Director NRHM issues the accreditation
8
Sustenance & Incentives
Facilitation and recognition of achievement Financial Incentives
Recertification after every three years

SECTION | C

ROAD MAP:
The Process of Implementation

1. Setting-up Organizational Framework for Quality Assurance

The States may already have some kind of quality assurance organizational structure or a well functioning quality assurance cell for the family planning. These can be restructured or merged with the framework suggested in this guideline. Following framework is recommended to be created by every State for this purpose:

- Constitution of State Quality Assurance Committee (SQAC).
- Constitution of State Quality Assurance Units (SQAU).
- Constitution of District Quality Assurance Committee (DQAC).
- Constitution of District Quality Assurance Units (DQAU).
- Constitution of facility level Quality Teams including District Quality Team at District Hospital.
- Identification and Empanelment of State Quality Assessors as per the guidelines.

Note: For State and District Quality Assurance Units, the members should be deputed, preferably from the regular cadre of the department. If internal resources for the same are not available, new recruitments may be undertaken according to the ToRs given in this guideline (*Annexure 'B', 'C' & 'D'*). Nominee of the Ministry of Health & Family Welfare, GoI should be represented in the recruitment committee.

Proposed budget for setting-up functional state and district quality assurance teams is given in *Annexure 'F'.*

2. Empanelment of Assessors

State is expected to select the state level assessors. Qualifications and ToRs of assessors are given in the Annexure 'E'. Training of Assessors may be arranged in consultation with NHSRC. Name of the participants who successfully complete the assessor training may be entered into national level of register of external assessors.

3. Adaptations of Standards and Measurement System

National Quality Assurance Standards have been developed taking into consideration the existing relevant Quality standards and operational/clinical guidelines through a consultative process with experts and stakeholders and review of best practices globally. Measurement and compliance to these 70 standards (*Section D*) will be mandatory for a District Hospital level facility to get national level Certification including the certification for RMNCH+A Services. Since priorities of each state may vary, the states could undertake following changes in the norms for Certification:

a. States can add more standards, over and above the seventy standards given in the Section D of the guideline. On addition, commensurate measurable elements should also be added along with check list given in the 'Assessor Guidebook' (Volume I & II).

b. A set of eighteen departmental check lists has been provided in the 'Assessor's Guidebook' with these guidelines. Each health facility should be scored on these check list.

c. The starting point could be certification of few areas of a health facility. A state may prefer to go for certification of one or more areas such as RMNCH+A Services/Emergency Department/ Blood Bank/Laboratory/ICU, etc.

d. It is suggested that State may prioritize the certification for delivery points for which the areas to be certified shall be Labour Room, OT, SNCU /NBSU, ANC /PNC wards, Lab services, Blood Bank & OPD clinics.

e. The States are expected to review the check list given in the 'Assessors Guidebook' to decide, whether a checkpoint would be essential or desirable according to their baseline and feasibility for the implementation. In subsequent years some of the desirable components can be made essential to raise the bar.

f. Compliance to all points in the check list and obtaining a credible shall be mandatory for any level of Certification.

g. Compliance to all National Quality Assurance standards is mandatory to attain National Level certification even for the chosen area.

h. After national certification, it will be state's responsibility to visit the facility at least annually and score the facility for ensuring that the standards have been maintained and there is no 'non-conformity' to the standards.

i. The customization of the measurement system may be done by SQAC and SQAU through a consultative process with NHSRC under intimation to MoHFW.

j. Dissemination of the guideline and standards: The State approved standards, ME and check list would be disseminated through state level dissemination workshop(s). The Assessors Guidebook elaborates the standards, their measurable components and departmental check list.

4. Training and Capacity Building

Successful implementation of quality assurance programme requires a cadre of competent assessors, both for undertaking internal assessment by the facility, DQAU and SQAU and also for External Assessment for the National certification. Equally important is to build the capacity of the programme officers, and SQAC members, to enable them to provide directions and support for improving Quality of the Services. Service Providers (doctors, nurses and para-medical staff) would need trainings on softer skills as well as on clinical protocols, Standard Treatment guidelines, Medical/Death audits, etc., which would be essential for improving quality of services.

Following capacity building trainings are suggested:

Sl. No.	Trainings	Target Audience	Duration	Purpose
1.	Awareness Workshop	SQAC members, State level programme officers, RPM units, Civil Surgeons/ CDMO/ DHO/	1 day	To sensitize state level officials for quality assurance program and its steps
2.	Assessor Training	Members of state and district quality assurance units, member of facility level quality assurance teams.	2 days	To acquaint trainees with standards, measurable elements, departmental check lists and scoring system and how to use them
3.	External assessor Training	Assessors who conducts certification /Certification audits (organized at the National level by GoI or its technical resource institutions)	5 days	Detailed discussion about standards and their sub components, scoring methodology, filling up assessment forms and code of conduct
4.	Training for service providers	Facility in charges, hospital and programme managers and other hospital staff	3 days	To understand basic concepts of quality assurance, standards and how to implement them in their facilities
5.	Thematic Training - Apart from trainings on quality assurance the specific training modules for following areas would be developed: ■ Infection Control and Bio Medical Waste Management. ■ Measuring and Improving Patient satisfaction. ■ Medical Records management & Hospital Information System. ■ Quality assurance in Laboratories. ■ Facility Management.			

Budgetary support for the training is given in *Annexure 'G'.*

5. Implementation of Quality Assurance at Facility Level

Quality assurance would be a continual and comprehensive cyclic process. The aim is to cover all the public health facilities. Following set of activities should be undertaken by the facility internally:

a. **Formation of Quality Assurance Team at Facility Level:** In-charge of Health Facility would form an internal quality assurance team, which should have representation from all departments,

nursing staff, laboratory and support staff. The team should meet periodically (more frequently initially) to discuss the status of quality initiative in their area of work. The hospital manager should coordinate conduct of the meeting.

b. **Internal Assessment:** The team would also do an internal assessment at fixed interval preferably quarterly covering all critical departments and action plan would be prepared on observed non conformities. The 'action planning would need allocation of resources for traversing the gaps. Therefore, each identified gap and its 'action-plan' would require following three subset of activities:

   i. Resource Allocation for each gap

   ii. Designating a person, responsible for the action

   iii. Time-frame

c. **Patient Satisfaction Survey:** A quarterly feedback (for OPD – 30 patients, and for IPD – 30 patients in a month, separately) would be taken on a structured format by the hospital manager. This feedback would be analysed to see which are the lowest performing attributes and further actions would be planned accordingly.

d. **Key Performance Indicators:** The Hospital Manager would collate critical data from the departments and calculate some performance indicators and monitor them on monthly basis. A full set of department wise indicators given in the corresponding departmental Check list in 'Area of concern H – Outcome'. Some of these will identified as Key performance Indicators and will be reported to DQAC and SQAC for the monitoring purpose. A set of suggestive Reporting format depicting a Dashboard with KPIs is given in Annexure 'A'.

e. **Quality Policy & Objectives:** Facility would define its *quality policy which is statement of commitment of the facility to provide quality services.* This quality policy would be formulated in consultation with DQAC. Further for implementing this quality policy tangible quality objectives would be established at each facility. In large hospitals, key department may have their own objectives. State may opt to define uniform Quality policy and Objectives at the state level.

f. **Rapid Improvement Events:** Rapid improvement event is quality improvement methodology where one or more areas of hospital are chosen for a more focused quality interventions with specific problem solving tools. Every facility would choose one focused area for Rapid improvement event for every assessment cycle.

g. **Medical & Death Audits:** Under quality assurance programme all facilities should establish procedure for death and medical audit. While death audits should be conducted for all deaths happening at the facility, medical audit & prescription audit would be done on a representative sample drawn from medical records. Emphasis should be laid on maternal and infant death audits and also death/ failure/ complication following sterilization.

h. **Standards Operating Procedures & Work instructions:** For standardising the clinical and management processes at facility level, standards operating procedures should be documented and implemented. Appropriate training to the staff on SOPs and guidelines may be required.

i. **External Quality Assurance of measuring equipment and Laboratories:** This includes calibration of measuring equipments and external quality assurance programme for laboratories.

6. Assessment of Facilities

Apart from Internal assessment that is integral part of facility level quality assurance activities, there would be periodic assessments within the state respectively by DQAU and SQAU.

i. **Schedule of assessment visits plan:** The visit plan should be communicated in advance to the facility in charges. As far as possible, Surprise visits are avoided. DQAC internal meetings and DQAC joint meeting with facility in-charges should be planned well in advance.

ii. **Assessment by DQAU:** DQAU would assess the facility at quarterly interval and share their findings with SQAU. Facility Assessment report would also be shared with SQAC. DQAU would also help the facility in closing the observed gaps. The first assessment and its score will be considered as baseline score and subsequent QA scores will be compared with the baseline to evaluate the improvement.

iii. **Assessment by the SQAU:** Every facility should be assessed at least two times in a year till the certification happens & assess the progress made. As more number of health facilities brought under the QA programme, assistance of empanelled assessors may be taken by the SQAC. After health facilities have made significant improvement and has been consistently getting high score on assessment by SQAU, the facility would be assessed by the National Body, as per procedure given below.

iv. **Assessment Process:** A facility assessment would comprises of following activities presented in the below table:

Assessment	Assessor	Department
Clinical processes	Doctor	Clinical Processes of OPD, IPD, OT, Blood Bank, Emergency, Labour Room , Medical Records, National Health programmes, clinical outcome , Medical & Death Audit
Nursing processes	Nurse / Para Clinical Staff	Nursing procedures at different departments, Laboratories, infection control, Bio Medical Waste management, Pharmacy, ambulances, equipment maintenances
Management support and quality processes	Health Administrator or Managers	Facility Management, Support services, quality processes, Patient feedback , Patient Rights, Statutory requirement, Disaster Management, Hospital data and performance, out sourcing

v. **Traversing the Assessed gaps:** After the gaps have been assessed by the health facility the same will be verified by District QAU and a time line for traversing the gaps along with assigning a nodal person for timely fulfilment of gaps shall be done in concurrence with the facility in-charge. Once this exercise is complete the report along with the defined actions for different levels i.e facility/district/state shall be prepared and shared with SQAU which will then send their assessors for verification and further hand-holding.

vi. **Assessment Protocol:** The Assessors independently assess the different areas of concern of check list of their respective departments/ domains; and fill the sheets as per full, partial or non-compliance. Assessment process would comprise of gathering the information from many sources, such as:

- Staff interview,
- Review of records,
- Direct observation,
- Interviews with the patients and attendant.

Detailed process and protocols of assessments and scoring are given in Vol 2 assessor' guidebook .

7. National Certification

a. **Empanelment of External assessors:** States are expected to select the state level assessors. Qualifications and ToRs of State assessors are given in the Annexure 'E'. Training of External Assessors may be arranged in consultation with NHSRC. Name of the participants who successfully complete the assessor training may be entered into national level of register of external assessors.

b. **Certification Process:**

   i. Once the gaps are traversed, the DQAC may inform the SQAU for State level certification.

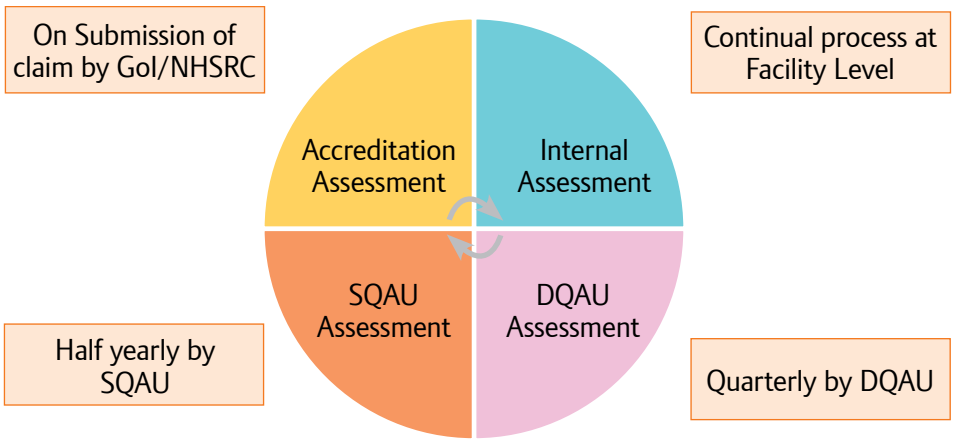
   ii. On satisfactory cross check by SQAU, the SQAC would approach Director, NHM for the Ministry of Health & Family Welfare, GOI Certification (Annexure 'I').

   iii. NHSRC will conduct assessment through QA assessors and after examining the assessors report. Appropriate recommendation would be sent to Director, NRHM who, is proposed to be designated authority for issuing the National QA Certification, till any such body is created by the GoI.

   iv. The State level assessors of one State will be utilized for assessment of another State by MoHFW/ NHSRC. Once a facility receives certificate its validity will be for 3 years (Annexure 'J').

c. After three years facility would undergo National re-Certification audit. The process will begin 3 months before the expiry of Certification for which application will be given to SQAC for recertification. Till the SQAC organises the re-Certification process & sends request to National level, the facility will deemed to be accredited. Once the National assessors visit the facility, their recommendation will need to be implemented before fresh certification is issued from National level.

Cost of External Assessment is given in Annexure 'H'.



Assessments in Quality Assurance Programs

8. Post Assessment Activities:

a. **Action Planning:** After the assessment, the team members should facilitate a closing meeting with facility in-charges along with departmental heads, and share the scores and gaps report. The root cause and possible solutions should also be discussed and then time bound action plan is prepared accordingly.

b. **Corrective action and periodic review:** The facility in charge is expected to take actions for timely closure of the gaps and nominate officials for completing the actions. The progress of gap closure with hospital performance (Key Performance Indicators) would be reviewed in monthly review meeting at district level by DQAC.

c. DQAC should subsequently report the progress of gap closure and KPIs to SQAC in a consolidated report. During the SQAC review meetings, these reports should be discussed; and feedback/ instructions should be given to DQAC. SQAC will also share the report/ KPIs with NHSRC/MoHFW, GoI on quarterly basis.

9. Sustenance and Incentives

Quality culture could be build up with consistent efforts and investments. It is not something which is inherent and cannot be changed. One of the key initiative for building Quality culture is through 'rewards and recognition' and continuing handholding support from the state & district administration. The facilities, which get National Certification for the quality and have retained such status during subsequent assessments, must be incentivised. The proposal for incentives can be re-visited at the time, when large numbers of facilities are accredited.

Incentives could be classified into following three categories:

i. Institutional incentives - Monetary and Non-monetary.

ii. Team incentives - Monetary and Non-monetary.

iii. Individual incentives - Monetary and Non-monetary.

A. Financial Incentives:

Financial incentives could be rewards for individuals and quality team, who have been the 'change-agents' at the facility level and District Quality Unit, and were instrumental in launch of Quality Assurance programme and certification of the Health Facility. A percentage of incentive money could be used for improving infrastructure and amenities for the staff and patients.

1. Incentive money can be given to the health facility that succeeds in getting the National Certification. The amount should be proportionate to the size of the facility (No. of Beds). An amount of Rs. 5000/- per functional bed may be fixed. In that case, a 100-bedded hospital would receive Rs. 5.0 lakh as incentive money on attainment of the certified status. This money can be used for following purposes:

   a. 25% of fund could be spent on financial incentives for the staff, who have been active participants of quality assurance programme.

   b. Remaining 75% of such fund could be spent in improving working condition at the health facility. However, such fund would not be spent on those activities for which support from the state's regular budget is available. Few activities could be:

      i. Welfare activities like organising recreation event (e.g. annual retreat, cultural function, etc.).

      ii. Strengthening of staff canteen/ rest room (e.g. Purchase of microwave for heating of food by duty staff).

iii. Library with books, journals, periodical for doctors, nurses and paramedical staff.

iv. Improvement in amenities in duty rooms.

v. Health insurance for contractual employees and for those employees, who are not covered by any other scheme.

vi. In organising functions for recognition of staff, who were instrumental in promoting and sustaining quality assurance programme at the health facility.

The facility's *Rogi Kalyan Samiti* (RKS) may take a decision on the usage of incentive fund.

2. During subsequent two years, the state would assess the facility, and check-points would be given a numerical score each year. On successful verification of its quality status, the state would provide an incentive of the same amount, which the facility had received on attainment of the initial certification.

3. On quality certification of health facility, there is expected to be considerable increase in the case load, thereby creating additional demand on the services. Thus, the health facility may require additional funds for increasing human resources, additional infrastructure such as expansion of waiting area, hiring of laboratory technicians, construction/repair of staff quarters, etc. Such requirements should be examined on case to case basis and would be backed by adequate hospital performance data and KPI. The State should allot additional funds for expansion of such services at the designated facility.

B. Non- Financial Incentives

There could be many approaches for Non-financial incentives. Creating a sense of pride in being a part of the quality team would go a long way in sustaining such efforts.

1. Facility getting external certification & national Certification should be facilitated at a state level function. The certificate should be displayed at the facility. In addition, facility in charge & Quality team could be given certificates of appreciation.

2. Achievements are published in local media, and government publication.

3. Staff of the quality certified hospital should be encouraged for higher education/training in reputed institutions. The course fee may be borne by the state. They should also be deputed to attend CMEs programmes/workshops on the public expense.

4. While undergoing appraisal, due consideration & weightage should be given to those personnel, who worked actively in attaining the certified status and thereafter maintaining the quality status.

5. GoI will provide logo for quality accredited facility. Such logo can be displayed at the facility and can also be used on hospital stationary.

6. A national level Quality Excellence award can **also** be given by GoI to best performing facility (scoring the highest marks) in each category – DH (Large & small), SDH, CHC, PHC, etc.), which is separate from the certification and given to exceptionally well performing health facility in the country (say a Score of 95% or more).

There should also be provision that any facility which is quality certified, which loses its quality certificate in a subsequent year would require thorough investigation and 'root-cause' analysis at the highest level in the state, and corrective and preventive actions are taken. If a number of facilities lose their certification, the Quality Assurance Committee at district and state levels must fix responsibility for whose action or non-action led to loss of certification and corrective actions be initiated on priority.

SECTION D

STANDARDS & MEASURABLE ELEMENTS

SECTION | D

STANDARDS & Measurable Elements

Area of Concerns & Standards[1]

Area of Concern - A: Service Provision	
Standard A1	The facility provides Curative Services
Standard A2	The facility provides RMNCHA Services
Standard A3	The facility Provides diagnostic Services
Standard A4	The facility provides services as mandated in national Health Programmes/State Scheme.
Standard A5	The facility provides support services
Standard A6	Health services provided at the facility are appropriate to community needs.
Area of Concern - B: Patient Rights	
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities.
Standard B2	Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barriers on account of physical economic, cultural or social reasons.
Standard B3	The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.
Standard B4	The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making.
Standard B5	The facility ensures that there are no financial barriers to access, and that there is financial protection given from the cost of hospital services.

1 These Standards have been prepared for a District Hospital Level facility.

Area of Concern - C: Inputs	
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.
Standard C2	The facility ensures the physical safety of the infrastructure.
Standard C3	The facility has established Programme for fire safety and other disaster.
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.
Standard C5	The facility provides drugs and consumables required for assured services.
Standard C6	The facility has equipment & instruments required for assured list of services.
Area of Concern - D: Support Services	
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors.
Standard D4	The facility has established Programme for maintenance and upkeep of the facility.
Standard D5	The facility ensures 24 X 7 water and power backup as per requirement of service delivery, and support services norms.
Standard D6	Dietary services are available as per service provision and nutritional requirement of the patients.
Standard D7	The facility ensures clean linen to the patients.
Standard D8	The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.
Standard D9	Hospital has defined and established procedures for Financial Management.
Standard D10	The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government.
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.
Standard D12	The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations.
Area of Concern - E: Clinical Services	
Standard E1	The facility has defined procedures for registration, consultation and admission of patients.
Standard E2	The facility has defined and established procedures for clinical assessment and reassessment of the patients.
Standard E3	The facility has defined and established procedures for continuity of care of patient and referral.
Standard E4	The facility has defined and established procedures for nursing care.
Standard E5	The facility has a procedure to identify high risk and vulnerable patients.
Standard E6	The facility follows standard treatment guidelines defined by state/Central government for prescribing the generic drugs & their rational use.
Standard E7	The facility has defined procedures for safe drug administration.
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage.

Standard E9	The facility has defined and established procedures for discharge of patient.
Standard E10	The facility has defined and established procedures for intensive care.
Standard E11	The facility has defined and established procedures for Emergency Services and Disaster Management.
Standard E12	The facility has defined and established procedures of diagnostic services.
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.
Standard E14	The facility has established procedures for Anaesthetic Services.
Standard E15	The facility has defined and established procedures of Operation theatre services.
Standard E16	The facility has defined and established procedures for end of life care and death.
Maternal & Child Health Services	
Standard E17	The facility has established procedures for Antenatal care as per guidelines.
Standard E18	The facility has established procedures for Intranatal care as per guidelines .
Standard E19	The facility has established procedures for postnatal care as per guidelines .
Standard E20	The facility has established procedures for care of new born, infant and child as per guidelines.
Standard E21	The facility has established procedures for abortion and family planning as per government guidelines and law.
Standard E22	The facility provides Adolescent Reproductive and Sexual Health services as per guidelines.
National Health Programmes	
Standard E23	The facility provides National health Programme as per operational/Clinical Guidelines.
Area of Concern - F: Infection Control	
Standard F1	The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection.
Standard F2	The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis.
Standard F3	The facility ensures standard practices and materials for Personal protection.
Standard F4	The facility has standard procedures for processing of equipment and instruments.
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention.
Standard F6	The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.
Area of Concern - G: Quality Management	
Standard G1	The facility has established organizational framework for quality improvement.
Standard G2	The facility has established system for patient and employee satisfaction.
Standard G3	The facility has established internal and external quality assurance Programmes wherever it is critical to quality.
Standard G4	The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.
Standard G5	The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages

Standard G6	The facility has established system of periodic review as internal assessment, medical & death audit and prescription audit.
Standard G7	The facility has defined and established Quality Policy & Quality Objectives.
Standard G8	The facility seeks continually improvement by practicing Quality method and tools.
Area of Concern -H: Outcome Indicator	
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/ National benchmarks.
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark.
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/ National benchmark.
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/ National benchmark.

Measurable Elements

Area of Concern - A: Service Provision	
Standard A1	**The facility provides Curative Services**
ME A1.1	The facility provides General Medicine services
ME A1.2	The facility provides General Surgery services
ME A1.3	The facility provides Obstetrics & Gynaecology Services
ME A1.4	The facility provides Paediatric Services
ME A1.5	The facility provides Ophthalmology Services
ME A1.6	The facility provides ENT Services
ME A1.7	The facility provides Orthopaedics Services
ME A1.8	The facility provides Skin & VD Services
ME A1.9	The facility provides Psychiatry Services
ME A1.10	The facility provides Dental Treatment Services
ME A1.11	The facility provides AYUSH Services
ME A1.12	The facility provides Physiotherapy Services
ME A1.13	The facility provides services for OPD procedures
ME A1.14	Services are available for the time period as mandated
ME A1.15	The facility provides services for Super specialties, as mandated
ME A1.16	The facility provides Accident & Emergency Services
ME A1.17	The facility provides Intensive care Services
ME A1.18	The facility provides Blood bank & transfusion services
Standard A2	**The facility provides RMNCHA Services**
ME A2.1	The facility provides Reproductive health Services
ME A2.2	The facility provides Maternal health Services
ME A2.3	The facility provides Newbornhealth Services
ME A2.4	The facility provides Child health Services
ME A2.5	The facility provides Adolescent health Services
Standard A3	**The facility Provides diagnostic Services**
ME A3.1	The facility provides Radiology Services
ME A3.2	The facility Provides Laboratory Services
ME A3.3	The facility provides other diagnostic services, as mandated
Standard A4	**The facility provides services as mandated in national Health Programmes/ State Scheme**
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines
ME A4.2	The facility provides services under Revised National TB Control Programme as per guidelines
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines

ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines
ME A4.5	The facility provides services under National Programme for control of Blindness as per guidelines
ME A4.6	The facility provides services under Mental Health Programme as per guidelines
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines
ME A4.9	The facility Provides services under Integrated Disease Surveillance Programme as per Guidelines
ME A4.10	The facility provide services under National health Programme for deafness
ME A4.11	The facility provides services as per State specific health programmes
Standard A5	**The facility provides support services**
ME A5.1	The facility provides dietary services
ME A5.2	The facility provides laundry services
ME A5.3	The facility provides security services
ME A5.4	The facility provides housekeeping services
ME A5.5	The facility ensures maintenance services
ME A5.6	The facility provides pharmacy services
ME A5.7	The facility has services of medical record department
ME A5.8	The facility provides mortuary services
Standard A6	**Health services provided at the facility are appropriate to community needs**
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.
ME A6.2	There is process for consulting community/ or their representatives when planning or revising scope of services of the facility.

Area of Concern - B: Patient Rights	
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities.**
ME B1.1	The facility has uniform and user-friendly signage system.
ME B1.2	The facility displays the services and entitlements available in its departments.
ME B1.3	The facility has established citizen charter, which is followed at all levels.
ME B1.4	User charges are displayed and communicated to patients effectively.
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC/BCC approaches.
ME B1.6	Information is available in local language and easy to understand.
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel.
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barriers on account of physical economic, cultural or social reasons.**
ME B2.1	Services are provided in manner that are sensitive to gender.
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services.
ME B2.3	Access to facility is provided without any physical barrier & friendly to people with disability.
ME B2.4	There is no discrimination on basis of social & economic status of patients.
ME B2.5	There is affirmative action to ensure that vulnerable sections can access services.
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**
ME B3.1	Adequate visual privacy is provided at every point of care.
ME B3.2	Confidentiality of patients records and clinical information is maintained.
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services.
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups.
Standard B4	**The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making.**
ME B4.1	There is established procedures for taking informed consent before treatment and procedures.
ME B4.2	Patient is informed about his/her rights and responsibilities.
ME B4.3	Staff are aware of Patients rights responsibilities.
ME B4.4	Information about the treatment is shared with patients or attendants, regularly.
ME B4.5	The facility has defined and established grievance redressal system in place.
Standard B5	**The facility ensures that there is no financial barrier to access, and that there is financial protection given from the cost of hospital services.**
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes.

ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards.
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility.
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles.
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients.
ME B5.6	The facility ensure implementation of health insurance schemes as per National / state scheme.

Area of Concern - C: Inputs	
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.**
ME C1.1	Departments have adequate space as per patient or work load.
ME C1.2	Patient amenities are provide as per patient load.
ME C1.3	Departments have layout and demarcated areas as per functions.
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law.
ME C1.5	The facility has infrastructure for intramural and extramural communication.
ME C1.6	Service counters are available as per patient load.
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital).
Standard C2	**The facility ensures the physical safety of the infrastructure.**
ME C2.1	The facility ensures the seismic safety of the infrastructure.
ME C2.2	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/ board.
ME C2.3	The facility ensures safety of electrical establishment.
ME C2.4	Physical condition of buildings are safe for providing patient care.
Standard C3	**The facility has established Programme for fire safety and other disaster.**
ME C3.1	The facility has plan for prevention of fire.
ME C3.2	The facility has adequate fire fighting Equipment.
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation.
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.**
ME C4.1	The facility has adequate specialist doctors as per service provision.
ME C4.2	The facility has adequate general duty doctors as per service provision and work load.
ME C4.3	The facility has adequate nursing staff as per service provision and work load.
ME C4.4	The facility has adequate technicians/paramedics as per requirement.
ME C4.5	The facility has adequate support/general staff.
ME C4.6	The staff has been provided required training/skill sets.
ME C4.7	The Staff is skilled as per job description.
Standard C5	**The facility provides drugs and consumables required for assured services.**
ME C5.1	The departments have availability of adequate drugs at point of use.
ME C5.2	The departments have adequate consumables at point of use.
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed.
Standard C6	**The facility has equipment & instruments required for assured list of services.**
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients.
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility.

ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility.
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients.
ME C6.5	Availability of Equipment for Storage.
ME C6.6	Availability of functional equipment and instruments for support services.
ME C6.7	Departments have patient furniture and fixtures as per load and service provision.

Area of Concern - D: Support Services	
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**
ME D1.1	The facility has established system for maintenance of critical Equipment.
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment.
ME D1.3	Operating and maintenance instructions are available with the users of equipment.
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.**
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables.
ME D2.2	The facility has establish procedure for procurement of drugs.
ME D2.3	The facility ensures proper storage of drugs and consumables.
ME D2.4	The facility ensures management of expiry and near expiry drugs.
ME D2.5	The facility has established procedure for inventory management techniques.
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas.
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature.
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs.
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**
ME D3.1	The facility provides adequate illumination level at patient care areas.
ME D3.2	The facility has provision of restriction of visitors in patient areas.
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers.
ME D3.4	The facility has security system in place at patient care areas.
ME D3.5	The facility has established measure for safety and security of female staff.
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility.**
ME D4.1	Exterior of the facility building is maintained appropriately.
ME D4.2	Patient care areas are clean and hygienic.
ME D4.3	Hospital infrastructure is adequately maintained.
ME D4.4	Hospital maintains the open area and landscaping of them.
ME D4.5	The facility has policy of removal of condemned junk material.
ME D4.6	The facility has established procedures for pest, rodent and animal control.
Standard D5	**The facility ensures 24 × 7 water and power backup as per requirement of service delivery, and support services norms.**
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas.
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load.
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply.
Standard D6	**Dietary services are available as per service provision and nutritional requirement of the patients.**
ME D6.1	The facility has provision of nutritional assessment of the patients.

ME D6.2	The facility provides diets according to nutritional requirements of the patients.
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients.
Standard D7	**The facility ensures clean linen to the patients.**
ME D7.1	The facility has adequate sets of linen.
ME D7.2	The facility has established procedures for changing of linen in patient care areas
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen.
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**
ME D8.1	The facility has established procures for management of activities of Rogi Kalyan Samiti.
ME D8.2	The facility has established procedures for community based monitoring of its services.
Standard D9	**Hospital has defined and established procedures for Financial Management.**
ME D9.1	The facility ensures the proper utilization of fund provided to it.
ME D9.2	The facility ensures proper planning and requisition of resources based on its need.
Standard D10	**The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government.**
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities.
ME D10.2	Updated copies of relevant laws, regulations and government orders are available at the facility.
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement.
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**
ME D11.1	The facility has established job description as per govt guidelines.
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments.
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department.
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations.**
ME D12.1	There is established system for contract management for out sourced services.
ME D12.2	There is a system of periodic review of quality of out-sourced services.

Area of Concern - E: Clinical Services	
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**
ME E1.1	The facility has established procedure for registration of patients.
ME E1.2	The facility has a established procedure for OPD consultation.
ME E1.3	There is established procedure for admission of patients.
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility.
Standard E2	**The facility has defined and established procedures for clinical assessment and reassessment of the patients.**
ME E2.1	There is established procedure for initial assessment of patients.
ME E2.2	There is established procedure for follow-up/ reassessment of Patients.
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral.**
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer.
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.
ME E3.3	A person is identified for care during all steps of care.
ME E3.4	The facility is connected to medical colleges through telemedicine services.
Standard E4	**The facility has defined and established procedures for nursing care.**
ME E4.1	Procedure for identification of patients is established at the facility.
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility.
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens.
ME E4.4	Nursing records are maintained.
ME E4.5	There is procedure for periodic monitoring of patients.
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**
ME E5.1	The facility identifies vulnerable patients and ensure their safe care.
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need.
Standard E6	**The facility follows standard treatment guidelines defined by state/Central government for prescribing the generic drugs & their rational use.**
ME E6.1	The facility ensured that drugs are prescribed in generic name only.
ME E6.2	There is procedure of rational use of drugs.
Standard E7	**The facility has defined procedures for safe drug administration.**
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check).
ME E7.2	Medication orders are written legibly and adequately.
ME E7.3	There is a procedure to check drug before administration/dispensing.
ME E7.4	There is a system to ensure right medicine is given to right patient.
ME E7.5	Patient is counselled for self drug administration.

Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage.**
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated.
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.
ME E8.3	Care provided to each patient is recorded in the patient records.
ME E8.4	Procedures performed are written on patients records.
ME E8.5	Adequate form and formats are available at point of use.
ME E8.6	Register/records are maintained as per guidelines.
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records.
Standard E9	**The facility has defined and established procedures for discharge of patient.**
ME E9.1	Discharge is done after assessing patient readiness.
ME E9.2	Case summary and follow-up instructions are provided at the discharge.
ME E9.3	Counselling services are provided as during discharges wherever required.
ME E9.4	The facility has established procedure for patients leaving the facility against medical advice, absconding, etc.
Standard E10	**The facility has defined and established procedures for intensive care.**
ME E10.1	The facility has established procedure for shifting the patient to step-down/ward based on explicit assessment criteria.
ME E10.2	The facility has defined and established procedure for intensive care.
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubation, and care of patients on ventilation and subsequently on its removal.
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management.**
ME E11.1	There is procedure for Receiving and triage of patients.
ME E11.2	Emergency protocols are defined and implemented.
ME E11.3	The facility has disaster management plan in place.
ME E11.4	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement.
ME E11.5	There is procedure for handling medico legal cases.
Standard E12	**The facility has defined and established procedures of diagnostic services.**
ME E12.1	There are established procedures for Pre-testing Activities.
ME E12.2	There are established procedures for testing Activities.
ME E12.3	There are established procedures for Post-testing Activities.
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**
ME E13.1	Blood bank has defined and implemented donor selection criteria.
ME E13.2	There is established procedure for the collection of blood.
ME E13.3	There is established procedure for the testing of blood.
ME E13.4	There is established procedure for preparation of blood component.
ME E13.5	There is establish procedure for labelling and identification of blood and its product.
ME E13.6	There is established procedure for storage of blood.
ME E13.7	There is established the compatibility testing.
ME E13.8	There is established procedure for issuing blood.
ME E13.9	There is established procedure for transfusion of blood.

ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication.
Standard E14	**The facility has established procedures for Anaesthetic Services.**
ME E14.1	The facility has established procedures for Pre-anaesthetic Check up and maintenance of records.
ME E14.2	The facility has established procedures for monitoring during anaesthesia and maintenance of records.
ME E14.3	The facility has established procedures for Post-anaesthesia care.
Standard E15	**The facility has defined and established procedures of Operation theatre services.**
ME E15.1	The facility has established procedures OT Scheduling.
ME E15.2	The facility has established procedures for Preoperative care.
ME E15.3	The facility has established procedures for Surgical Safety.
ME E15.4	The facility has established procedures for Post operative care.
Standard E16	**The facility has defined and established procedures for end of life care and death.**
ME E16.1	Death of admitted patient is adequately recorded and communicated.
ME E16.2	The facility has standard procedures for handling the death in the hospital.
ME E16.3	The facility has standard operating procedure for end of life support.
ME E16.4	The facility has standard procedures for conducting post-mortem, its recording and meeting its obligation under the law.
Maternal & Child Health Services	
Standard E17	**The facility has established procedures for Antenatal care as per guidelines.**
ME E17.1	There is an established procedure for Registration and follow up of pregnant women.
ME E17.2	There is an established procedure for History taking, Physical examination, and counselling of each antenatal woman, visiting the facility.
ME E17.3	The facility ensures availability of diagnostic and drugs during antenatal care of pregnant women.
ME E17.4	There is an established procedure for identification of High risk pregnancy and appropriate treatment/referral as per scope of services.
ME E17.5	There is an established procedure for identification and management of moderate and severe anaemia.
ME E17.6	Counselling of pregnant women is done as per standard protocol and gestational age.
Standard E18	**The facility has established procedures for Intranatal care as per guidelines.**
ME E18.1	Established procedures and standard protocols for management of different stages of labour including AMTSL (Active Management of third Stage of labour) are followed at the facility.
ME E18.2	There is an established procedure for assisted and C-section deliveries per scope of services.
ME E18.3	There is established procedure for management/Referral of Obstetrics Emergencies as per scope of services.
ME E18.4	There is an established procedure for new born resuscitation and newborn care.
Standard E19	**The facility has established procedures for postnatal care as per guidelines.**
ME E19.1	Post partum Care is provided to the mothers.

ME E19.2	The facility ensures adequate stay of mother and newborn in a safe environment as per standard Protocols.
ME E19.3	There is an established procedure for Post partum counselling of mother.
ME E19.4	The facility has established procedures for stabilization/treatment/referral of post natal complications.
ME E19.5	There is established procedure for discharge and follow up of mother and newborn.
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines .**
ME E20.1	The facility provides immunization services as per guidelines.
ME E20.2	Triage, Assessment & Management of newbornshaving emergency signs are done as per guidelines.
ME E20.3	Management of Low birth weightnewborns is done as per guidelines.
ME E20.4	Management of neonatal asphyxia, jaundice and sepsis is done as per guidelines.
ME E20.5	Management of children presentingwith fever, cough/ breathlessness is done as per guidelines.
ME E20.6	Management of children with severeAcute Malnutrition is done as per guidelines.
ME E20.7	Management of children presentingdiarrhoea is done per guidelines.
Standard E21	**The facility has established procedures for abortion and family planning as per government guidelines and law.**
ME E21.1	Family planning counselling services provided as per guidelines.
ME E21.2	The facility provides spacing method of family planning as per guideline.
ME E21.3	The facility provides limiting method of family planning as per guideline.
ME E21.4	The facility provide counselling services for abortion as per guideline.
ME E21.5	The facility provide abortion services for 1st trimester as per guideline.
ME E21.6	The facility provide abortion services for 2nd trimester as per guideline.
Standard E22	**The facility provides Adolescent Reproductive and Sexual Health services as per guidelines.**
ME E22.1	The facility provides Promotive ARSH Services.
ME E22.2	The facility provides Preventive ARSH Services.
ME E22.3	The facility Provides Curative ARSH Services.
ME E22.4	The facility Provides Referral Services for ARSH.
National Health Programmes	
Standard E23	**The facility provides National health Programme as per operational/ Clinical Guidelines.**
ME E23.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines.
ME E23.2	The facility provides services under Revised National TB Control Programme as per guidelines .
ME E23.3	The facility provides services under National Leprosy Eradication Programme as per guidelines.
ME E23.4	The facility provides services under National AIDS Control Programme as per guidelines.

ME E23.5	The facility provides services under National Programme for control of Blindness as per guidelines .
ME E23.6	The facility provides services under Mental Health Programme as per guidelines .
ME E23.7	The facility provides services under National Programme for the health care of the elderly as per guidelines .
ME E23.8	The facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines .
ME E23.9	The facility provide service for Integrated disease surveillance Programme.
ME E23.10	The facility provide services under National Programme for prevention and control of deafness.

Area of Concern - F: Infection Control	
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection.**
ME F1.1	The facility has functional infection control committee.
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas.
ME F1.3	The facility measures hospital associated infection rates.
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff.
ME F1.5	The facility has established procedures for regular monitoring of infection control practices.
ME F1.6	The facility has defined and established antibiotic policy.
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis.**
ME F2.1	Hand washing facilities are provided at point of use.
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices.
ME F2.3	The facility ensures standard practices and materials for antisepsis.
Standard F3	**The facility ensures standard practices and materials for Personal protection.**
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements.
ME F3.2	The facility staff adheres to standard personal protection practices.
Standard F4	**The facility has standard procedures for processing of equipment and instruments.**
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas.
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment.
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention.**
ME F5.1	Layout of the department is conducive for the infection control practices.
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas.
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas.
ME F5.4	The facility ensures segregation infectious patients.
ME F5.5	The facility ensures air quality of high risk area.
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines.
ME F6.2	The facility ensures management of sharps as per guidelines.
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines.

Area of Concern - G : Quality Management	
Standard G1	**The facility has established organizational framework for quality improvement.**
ME G1.1	The facility has a quality team in place.
ME G1.2	The facility reviews quality of its services at periodic intervals.
Standard G2	**The facility has established system for patient and employee satisfaction.**
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals.
ME G2.2	The facility analyses the patient feedback, and root-cause analysis.
ME G2.3	The facility prepares the action plans for the areas, contributing to low satisfaction of patients.
Standard G3	**The facility has established internal and external quality assurance Programmes wherever it is critical to quality.**
ME G3.1	The facility has established internal quality assurance programme in key departments.
ME G3.2	The facility has established external assurance programmes at relevant departments.
ME G3.3	The facility has established system for use of check lists in different departments and services.
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**
ME G4.1	Departmental standard operating procedures are available.
ME G4.2	Standard Operating Procedures adequately describes process and procedures.
ME G4.3	Staff is trained and aware of the procedures written in SOPs.
ME G4.4	Work instructions are displayed at Point of use.
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages.**
ME G5.1	The facility maps its critical processes.
ME G5.2	The facility identifies non value adding activities/waste/redundant activities.
ME G5.3	The facility takes corrective action to improve the processes.
Standard G6	**The facility has established system of periodic review as internal assessment , medical & death audit and prescription audit.**
ME G6.1	The facility conducts periodic internal assessment.
ME G6.2	The facility conducts the periodic prescription/medical/death audits.
ME G6.3	The facility ensures non compliances are enumerated and recorded adequately.
ME G6.4	Action plan is made on the gaps found in the assessment/audit process.
ME G6.5	Corrective and preventive actions are taken to address issues, observed in the assessment & audit.
Standard G7	**The facility has defined and established Quality Policy & Quality Objectives.**
ME G7.1	The facility defines its quality policy .
ME G7.2	The facility periodically defines its quality objectives and key departments have their own objectives.
ME G7.3	Quality policy and objectives are disseminated and staff is aware of that.
ME G7.4	Progress towards quality objectives is monitored periodically.
Standard G8	**The facility seeks continually improvement by practicing Quality method and tools.**
ME G8.1	The facility uses method for quality improvement in services.
ME G8.2	The facility uses tools for quality improvement in services.

Area of Concern - H: Outcomes	
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National Benchmarks.**
ME H1.1	Facility measures productivity Indicators on monthly basis.
ME H1.2	The Facility measures equity indicators periodically.
ME H1.3	Facility ensures compliance of key productivity indicators with National/State Benchmarks.
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/ National Benchmark.**
ME H2.1	Facility measures efficiency Indicators on monthly basis.
ME H2.2	Facility ensures compliance of key efficiency indicators with National/State Benchmarks.
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National Benchmark.**
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis.
ME H3.2	Facility ensures compliance of key Clinical Care & Safety with National/State Benchmarks.
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National Benchmark.**
ME H4.1	Facility measures Service Quality Indicators on monthly basis.
ME H4.2	Facility ensures compliance of key Service Quality with National/State Benchmarks.

ANNEXURES

ANNEXURE 'A'

Reporting Format

Monthly Quality Assurance Report				
Name of the Facility			District	
Month			Last DQAC Visit	
Last Internal Assessment				
A: Gap Closure Status				
	No. of Gaps	**Closed**	**In Process**	**Not Initiated**
A1	Facility Level			
A2	District Level			
A3	State Level			
A4	Total			
A6	Brief Description of Resources required	1		
		2		
		3		
		4		
		5		
B: Departmental Score Cards				
	Department	**Baseline**	**Previous Month**	**This Month**
B1	Accident & Emergency			
B2	Outdoor Department			
B3	Labour Room			
B4	Maternity ward			
B5	Paediatric ward			
B6	Indoor Department			
B7	Nutritional Rehabilitation centre			
B8	Sick new born care unit			
B9	Intensive Care Unit			

B10	Operation Theatre			
	Department	**Baseline**	**Previous Month**	**This Month**
B11	Post Partum Unit			
B12	Blood Bank			
B13	Laboratory			
B14	Radiology			
B15	Pharmacy			
B16	Auxiliary Services			
B17	General Administration			
B18	Mortuary			
	Overall Score			

C: Thematic Score Cards				
	Area of Concern	**Baseline**	**Previous Month**	**This Month**
C 1	Service Provision			
C2	Patient Right			
C3	Inputs			
C4	Support Services			
C5	Clinical Services			
C6	Infection Control			
C7	Quality Management			
C8	Outcome			
	Overall Score			

D: Key Performance Indicators (KPI)					
	Indicator	**Unit**	**Current Month**	**Previous Month**	**Previous Year's (same month)**
	Productivity				
D1	Bed Occupancy Rate				
D2	Lab test done per thousand Patients (indoor & OPD)				
D3	Percentage of cases of high risk pregnancy/ obstetric complications out of total registered pregnancies at the facility				
D4	Percentage of surgeries done at night out of total surgeries				

	Indicator	Unit	Current Month	Previous month	Previous Year's (same month)
D5	Percentage of surgeries done during day out of total surgeries				
D6	Percentage of C- Section out of Total deliveries				
	Efficiency				
D7	No. of Deaths in Emergency/Total No. of emergency attended				
D8	Percentage of out referrals out of Total Admission				
D9	No. of major surgeries per surgeon (in a month)				
D10	OPD per Doctor				
D11	External Quality score for lab tests (Median value)				
D12	Percentage of Stock outs of Vital drugs (list of essential commodities under RMNCH+A)				
	Clinical Care/Safety				
D13	No. of Maternal Deaths out of total admission during ANC, INC, PNC				
D14	No. of Neonatal Deaths out of total live births and neonatal admission				
D15	Percentage of cases for which Maternal Death Review done				
D16	Average Length of Stay				
D17	Percentage of Surgical Site Infection out of total surgeries				
D18	Percentage of Mortality out of total SNCU admissions				
D19	Number of Sterilization Failures				
D20	Number of Sterilization Complications				
D21	No. of Deaths after Sterilization				

	Indicator	Unit	Current Month	Previous month	Previous Year's (same month)
D22	No. of unit issued on replacement X 100/ Total no of unit issued				
D23	Percentage of delivery having partograph recorded				
D24	Percentage of IIIrd and IVth generation antibiotics being prescribed (Sampling methods)				
	Service Quality				
D25	Percentage of LAMA out of Total Admission				
D26	Patient Satisfaction Score for IPD*				
D27	Patient Satisfaction Score for OPD*				
D28	Registration to Drug Time (average)				
D29	Percentage of JSY payments done before discharge				
D30	Percentage of women provided drop-back facility after delivery				

*Patient Satisfaction forms and methodology are given in Appendix A

APPENDIX 'A'

Patient Satisfaction forms & Steps for its Implementation
OPD Patient Feedback

Dear Client,

You have spent your valuable time in the hospital in connection with your / relative's/ friend's treatment. You are requested to share your opinion about the quality of services, which you experienced, while visiting the hospital. The information provided by you would be kept confidential and would only be used for improving the services.

Please tick the appropriate box and drop the questionnaire in the Suggestion box

Sl. No.	Attributes	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1	Availability of sufficient information in Hospital (Directional & location signages, Registration counter, Laboratory, Radiology Department, Dispensary, etc)					
2	Waiting time at the registration counter					
3	Behaviour and attitude of Hospital Staff					
4	Amenities in waiting area (chairs, fans, drinking water and cleanliness of bathrooms & toilets)					
5	Attitude & communication of Doctors					
6	Time spent on consulting, examination and counselling					
7	Availability of Lab and radiology investigation facilities within the hospital					
8	Promptness at Medicine distribution counter					
9	Availability of prescribed drugs at the hospital dispensary					
10	Your overall satisfaction during the visit to the hospital					

1. What improvement would you like to see in the hospital

2. What made you come to this hospital for treatment?

3. Would you like to return to this hospital next time for treatment

4. Your valuable suggestions

Date _____ Clinic_____ Age _____Sex_____

Inpatient Feedback

Dear Client

You have spent your valuable time in the hospital in connection with your / relative's/ friend's treatment. You are requested to share your opinion about the quality of services, which you experienced, while staying in the hospital. The information provided by you would be kept confidential, and would only be used for improving the services.

Please tick the appropriate box and drop the questionnaire in the Suggestion box

Sl. No.	Attributes	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
	Availability of sufficient information at Registration/ Admission counter (Directional & location signages, Registration counter, Laboratory, Radiology Department, Dispensary, etc)					
	Waiting time at the Registration/Admission counter					
	Behaviour and attitude of hospital staff at the registration/ admission counter					
	Your feedback on discharge process					
	Cleanliness of the ward					
	Cleanliness of Bathrooms & toilets					
	Cleanliness of Bed sheets, pillow-covers, etc					
	Cleanliness of surroundings and campus drains					
	Regularity of Doctor's attention					
	Attitude & communication of Doctors					
	Time spent for examination of patient and counselling					
	Promptness in response by Nurses in the ward					
	Round the clock availability of Nurses in the ward					
	Attitude and communication of Nurses					
	Availability, attitude & promptness of Ward boys/girls					
	All prescribed drugs were made available from Hospital Supply					
	Your Perception of Doctor's knowledge					
	Diagnostics Services were provided within the hospital					
	Timeliness of supply of the diet and its quality					
	Your overall satisfaction during the treatment as an in-patient					

1. What improvement would you like to see in the hospital

2. What made you come to this hospital for treatment?

3. Would you like to return to this hospital next time for treatment

4. Your valuable suggestions

Date _____ Ward_____ Age _____Sex_____ Date of Admission

Methodology

Patient/Client satisfaction surveys are the integral part of Quality Improvement program at facility level. It gives the valuable information about patient perception and experience about the quality services, which of course will guide service providers to further improve the processes and service delivery. Apart from taking patient feedback a Patient Satisfaction improvement program includes analysing feedback given by patients, root cause analysis to identify the causes of low satisfaction, preparing action plan and taking corrective actions to complete the continual improvement cycle (Plan-Do-Check -Act). Following is a brief description of different steps for patient satisfaction program.

1. Plan:

a. **Periodicity**: Plan for frequency of Patient Satisfaction Survey. Large secondary care hospitals like districts hospitals can have survey on monthly basis. Smaller facilities like PHC and CHC may take patient satisfaction on quarterly basis.

b. **Stationary:** Translate patient satisfaction survey in local language and ensure that formats are available in adequate no. at OPD clinics/registration counter/May I Help you desk and Nursing station in ward. The above-mentioned formats can be used for conducting outpatients and In-patients satisfaction survey.

c. **Responsibility:** Designate who will be taking and collecting feedback**.** Hospital Manager / Quality Manager may be responsibility to coordinate the program

d. **Sample Size:** For getting valid results sample size should be adequate. Following table gives simple guidance how much should be the Sample size based on patient load in previous quarter. It should not be less than 30 for being statically valid.

Population (OPD Attendance/ IPD Admissions)	Sample Size (Number of patients to be surveyed)			
	Margin of Error -10% Confidence Level -90%	Margin of Error -10% Confidence Level -95%	Margin of Error - 5% Confidence Level -90%	Margin of Error -5% Confidence Level -95%
10	9	9	10	10
20	16	17	19	20
50	29	34	43	45
100	41	50	74	80
200	51	66	116	132
300	56	73	143	169
500	60	81	176	218
1000	64	88	214	278
3000	67	94	249	341
5000	67	95	257	257
10000	68	96	264	370
15000	68	96	266	375
20000	68	96	268	377
30000	68	96	269	380
50000	68	96	270	382
100000	68	96	270	383

2. Do:

Patient feedback should be taken as per decided plan and sample size. While taking feedback it should be taken care of that all departments are equally covered specially the services having high case load like ANC clinic, Maternity ward etc. Feedback should also represent patient those can not give feedback by their own like illiterates, disabled and children's through affirmative measures like verbal feedback from illiterate patients and feedback from parents for new-born and children. Exit feedback should be preferred from who have already availed the services e.g. Like at Pharmacy counter for OPD and at the time of discharge in IPD . Filled forms should be collected and submitted to coordinator.

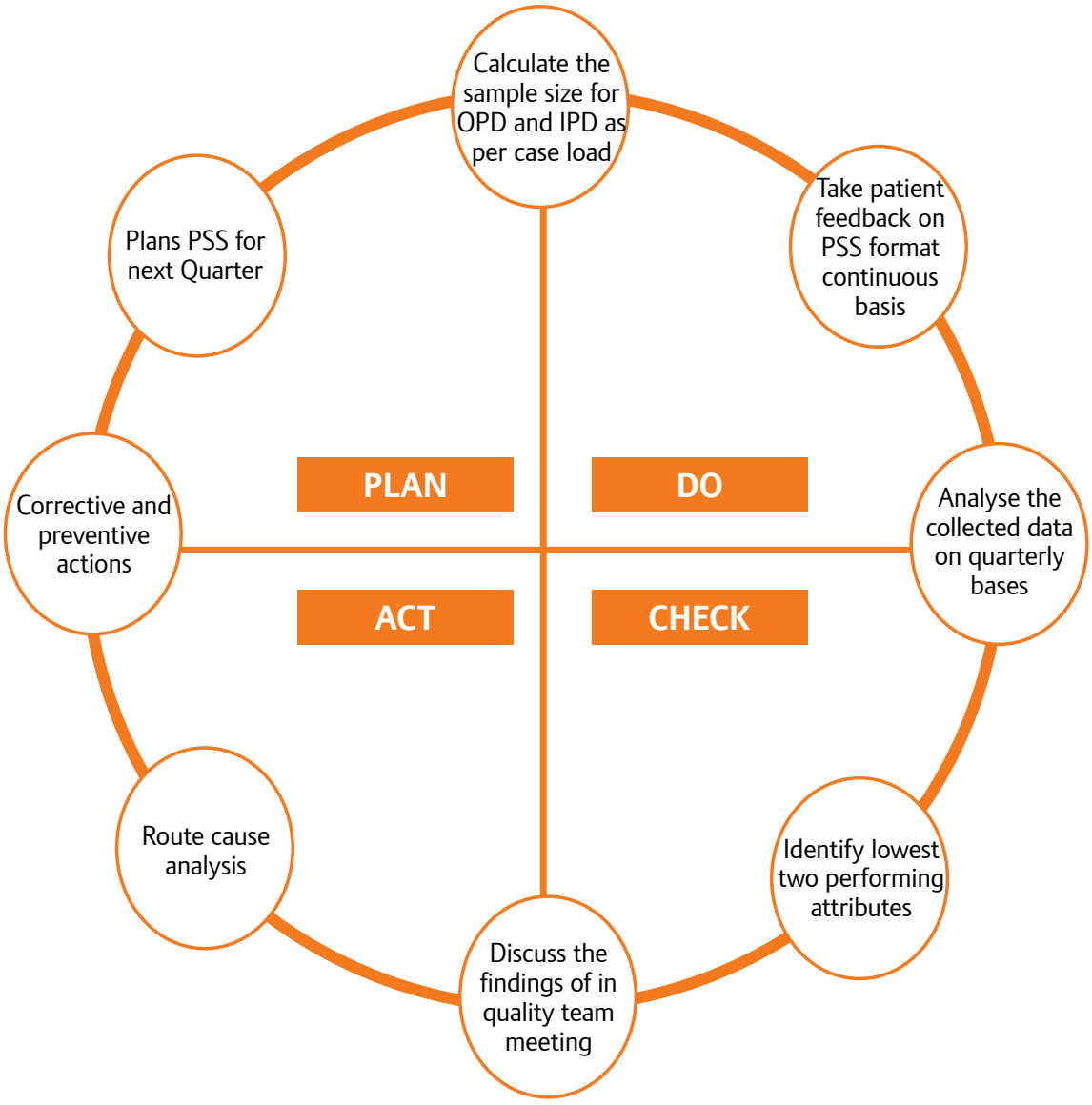
3. Check:

Feedback collected should be collated and analysed. Analysis should generate overall as well as area/ attribute wise score. Lowest performing two attributes should be identified and root cause analysis should be done for them.

4. Act:

Action plan should be prepared on causes identified during root cause analysis including corrective and preventive action to be taken, time line and person responsible for taking action. Compliance to action should be reviewed monthly.

Following illustration shows the process and steps of Patient Satisfaction Improvement Program:



ANNEXURE 'B'

Terms of Reference: State consultant (Quality Assurance)

Selection Criteria:

MBBS/Dental/AYUSH/Nursing graduate with masters in Hospital administration/ Health Management (MHA-Full time or equivalent) with 5 years experience in public Health/Hospital administration, out of which, at least 3 years work in the field of quality. Training and experience of implementing a recognised quality system like NABH/ISO 9001:2008/Six Sigma/Lean/Kaizen would be preferred.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy across the state.
2. To assist, support and conduct assessment and scoring of Public Health facilities.
3. Grading of healthcare facilities on the basis of score.
4. Facilitating selection of facilities that may go for Certification and supporting them in the process.
5. Estimating state's requirements (in terms of Structure, Process and outputs) for improving quality of healthcare services.
6. Review the status of QA activities in districts.
7. Providing support to Districts in taking appropriate and time-bound actions on closure of the gaps, identified during the initial self assessment.
8. Conducting workshops and training for district personnel on QA and Certification of healthcare facilities.
9. Providing necessary support to DQAC/DQAU in the area of Quality Assurance and Certification.
10. Ensuring conduct of meetings regularly & taking follow-up actions and presenting 'Action Taken Report (ATR)' in the SQAC meetings.

11. To provide technical assistance to achieve compliance to statutory requirements such as Atomic Energy Act & AERB Guidelines, Blood bank License, PC PNDT act, Biomedical (Management & handling) rules, etc.
12. To review the Patient's and employee's satisfaction from different districts submitted by DQAU, subsequently develop an action plan to address the concerns of patients, which led to poor satisfaction.
13. Advise on the further development of QA and Certification across health facilities in the state.
14. Monitoring of recording/reporting system through field visits and submit the visit reports with appropriate suggestions/actions for improvement.
15. To assist the State Nodal Officer for quality assurance in discharging his duties.
16. To attend to any other duties/responsibilities assigned by the authorities and the reporting officer.
17. To facilitate state level assessment.
18. Liaison with the Central body for Certification of State's Public Health Facilities and facilitate the assessment process.

Terms of Reference: State consultant (Public Health)

Selection Criteria

MBBS/BDS/AYUSH/Nursing graduates with Masters in Public Health (MPH), Community Medicine (MD), MBA-(Health Management) with 5 years experience in public Health/Hospital administration, out of which, at least one year work in the field of Public Health Quality. Training and experience of implementing a recognised quality system like NABH/ISO 9001:2008/Six Sigma/Lean/Kaizen would be preferred.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy especially related to National Health Programs.
2. Coordination with State's Programme Officers for implementation of National Health Programmes at Facility level under ambit of Quality Assurance Activities.
3. Providing technical support in implementing the technical protocols & clinical standards.
4. Estimating state's requirements of resources for Quality Assurance programme and coordinate with the Directorate and SPMU for allocation of resources for the gap closure, found during the assessment process.
5. To assist, support and conduct Assessment and scoring of Public Health facilities.
6. Grading of healthcare facilities on the basis of score.
7. Certification Review the status of QA activities at different facilities.
8. Review of financial requirement of facilities.
9. Facilitate need assessment for training, prepare training curriculum and plan training activities in collaboration with training institutes.

10. Conducting workshops and training for the district personnel on QA and Certification of healthcare facilities.
11. Ensure that the planned outputs related to Quality Improvement Programme are achieved as per the annual work plan of the State.
12. Analyze financial and physical progress report and take corrective measures for improving.
13. Identify the cause of any unreasonable delay in the achievement of milestones, or in the release of funds and propose corrective action.
14. Providing necessary support to DQAC/DQAU in the area of Public health.
15. Advise on the further development of QMS across health facilities in the state.
16. Monitoring of recording/reporting system through field visits and submit the visit report with appropriate suggestions/actions for improvement.
17. To attend to any other duties/responsibilities assigned by the authorities and the reporting officer.

Terms of Reference: State Consultant (Quality Monitoring)

Selection Criteria

Post graduate degree/advance qualification in Statistics. Specialization in Biostatistics/Masters in Health Informatics (MBA health informatics)/Masters in epidemiology (MPH epidemiology) with two years experience in Public Health would be an added advantage.

Roles and Responsibilities:

1. To create a single source repository of health care data at the state level.
2. Collection, compilation and regular updation of data from various sources - Census, HMIS, Periodical surveys (NSSO, NFHS, SRS, AHS, etc.), and reports etc.
3. To develop a system of monthly reporting of Key Performance Indicators (KPI) from all the facilities to the State level.
4. Collection/collation/Analysis and Review of KPIs and presenting analysis findings to programme officers, directorate and SQAC.
5. To regularly update SQAC of emerging and changing trends.
6. Capacity building and mentoring of District Consultant (statistics/demographics/HMIS).
7. To conduct trainings on how to use data for informed decision making and planning.
8. Monitoring of recording/reporting system through field visits and submit the visit reports with appropriate suggestions/actions for improvement.
9. To provide necessary statistical support to technical consultants of SQAC and DQAC. To provide necessary information to the relevant consultant.
10. Submission of reports to Govt of India/NHSRC as per GoI guidelines/instructions.
11. To attend to any other duties/responsibilities assigned by the SQAC.

Terms of Reference: Administrative cum Programme Assistant (SQAU)

Selection Criteria

Recognised Graduate Degree with fluency in MS Office package with two years experience of managing office and providing support to Health Programme/NRHM. Knowledge of Accountancy would be an added advantage. Candidates having drafting skills would be preferred.

Roles and Responsibilities:

1. To provide support to SQAC in its administration.
2. To coordinate all activities of SQAU.
3. Preparation of agenda notes of SQAC meetings, and ensuring its circulation to SQAC members.
4. Preparation of the minutes of meetings and initiating correspondence for follow-up action.
5. Liaison with DQAC and DQAU.
6. Facilitatory support for the field visits including logistics arrangement.
7. Liaisoning with the External Assessors and maintenance of their register at state level.
8. Submission of Utilisation certificates in respect of funds received.
9. Upkeep of files, registers and books of accounts.

ANNEXURE 'C'

Terms of Reference: District consultant (Quality Assurance)

Selection Criteria

MBBS/Dental/AYUSH/Nursing graduate with masters in Hospital administration/ Health Management (MHA-Full time or equivalent) with 2 years experience in Public Health/Hospital administration. Training and experience of implementing a recognised quality system like NABH/ISO 9001:2008/Six Sigma/ Lean/Kaizen would be preferred. Previous work experience in the field of health quality would be an added advantage.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy across the district.
2. To assist the District Quality Assurance Officer in discharging his duties.
3. To assist, support and conduct Assessment and scoring of Public Health facilities in the district.
4. Grading of healthcare facilities on the basis of score in the district.
5. Ensuring that DQAC meets regularly and follow-up actions have been taken.
6. Selecting facilities that may go for Certification and supporting them in the process.
7. Estimating district's requirements (in terms of Structure, Process and outputs) for improving quality of healthcare services.
8. Review the status of QA activities at different facilities in the district.
9. To provide support to facilities in the district in taking appropriate and time-bound actions on closure of the gaps, identified during assessments.
10. Conducting workshops and training at district and facility level on QA and Certification of healthcare facilities.

11. To provide technical assistance to health facilities in achieving compliance to statutory requirements such as Atomic Energy Act & AERB Guidelines, Blood bank, PC PNDT act, BMW Rules, etc. in the district.
12. To review the Patient's and employee's satisfaction from different facilities, subsequently develop an action plan to address the concerns of patients, which led to poor satisfaction.
13. Advise on the further development of QA and Certification across health facilities in the district.
14. To attend to any other duties/responsibilities assigned by the DQAC and SQAC.
15. Monitoring of recording/reporting system through field visits and submit the visit reports with appropriate suggestions/actions for improvement.

Terms of Reference: District consultant (Public Health)

Qualification Criteria

MBBS/Dental/AYUSH/Nursing graduate with degree/diploma in Health Management with 02 years relevant work experience. Training in Health quality like NABH/ISO 9001:2000/Six Sigma/Lean/Kaizen by a reputed organization will be preferable.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy especially related to National Health Programs.
2. Coordination with the state programme officers and SQAU QA related activities at Health facilities in the district.
3. Providing technical support in assessing the technical protocol.
4. Estimating district's requirements for QA program and improving quality of healthcare delivery.
5. Providing District inputs for District PIP and to SQAU on the QA programmes in the State.
6. To assist, support and conduct Assessment and scoring of Public Health facilities in the district.
7. Assist and support grading of health facilities on the basis of scores.
8. Facilitating selection of facilities that may go for Certification and supporting them in the process.
9. Ensuring that DQAC meets regularly and follow-up action is taken.
10. Review the status of QA activities at different facilities.
11. Conducting workshops and training at facilities and district level on QA and Certification of healthcare facilities.
12. Facilitate need assessment for training, prepare training curriculum and plan training activities in collaboration with training institutes.
13. Analyze financial and physical progress report and provide supervisory support.
14. Identify the cause of any unreasonable delay in the achievement of milestones, or in the release of funds and propose corrective action.

15. Monitoring of recording/reporting system through field visits and submit the visit reports with appropriate suggestions/actions for improvement.
16. To attend to any other duties/responsibilities as assigned DQAC.

Terms of Reference: District Consultant (Quality Monitoring)

Selection Criteria

Degree in Statistics with good academic record from a reputed University. Specialization in Biostatistics would be an added advantage. Previous work experience of Health/ hospital would be preferred.

Roles and Responsibilities:

1. Collection and compilation of data from various sources- Census, Surveys, and reports, etc. at District level and reporting to SQAC/ SQAU.
2. To develop a system of monthly reporting of Quality indicators from all the facilities in the district and reporting it to the State.
3. Collection/collation/Analysis and Review of Key performance indicators and health care data and dissemination of findings to DQAC and facilities.
4. To regularly update SQAC of emerging and changing trends.
5. To conduct trainings on how to use data for informed decision making and planning. How to implement Statistical techniques e.g. Statistical Process Control, measure of variance, reducing defects and errors for quality improvement.
6. Monitoring of recording/reporting system through field visits and submit the visit reports with appropriate suggestions/actions for improvement.
7. To provide necessary statistical support to SQAC and DQAC.
8. To attend to any other duties/responsibilities assigned by DQAC and SQAU.

Terms of Reference: Administrative cum Programme Assistant (DQAU)

Selection Criteria

Recognised Graduate Degree with fluency in MS Office package with one year experience of managing office and providing support to Health Programme / NRHM. Knowledge of Accountancy would be an added advantage. Candidates having drafting skills would be preferred.

Roles and Responsibilities:

1. To provide support to DQAC in its administration.
2. To coordinate all activities of DQAU.
3. Preparation of agenda notes of DQAC meetings, and ensuring its circulation to DQAC members.

4. Preparation of the minutes of meetings and initiating correspondence for follow-up action.
5. Liaison with SQAC and SQAU.
6. Submission of reports to SQAU.
7. Facilitatory support for the field visits including logistics arrangement.
8. Submission of Utilisation certificates in respect of funds received.
9. Upkeep of files, registers and books of accounts.

ANNEXURE 'D'

Terms of Reference: Hospital Manager

Selection Criteria

MBBS/Dental/AYUSH/Nursing/Life Science/Social Science graduate with masters in Hospital administration/ Health Management with one year experience in public Health/Hospital administration. Candidates with experience in Healthcare Quality/formal quality of a quality system would be preferred. Fluency in English, computer literacy, knowledge of government legislations and policies are essential. Candidate must have good communication skills both written and verbal.

Roles and responsibilities

This position carries responsibility for administration (smooth and quality services) of all non-direct patient care services and departments in a District Hospital. Manage non-clinical services (like infection prevention, security, diet etc.), staff and facilitate Rogi Kalyan Samiti meetings and actions. Specific duties and responsibilities will include:

1. Ensuring good quality non-clinical services like infection prevention, security, diet etc.
2. Ensuring clean surroundings, OPD areas, Wards, labour room, OT and Patient amenities.
3. Periodical assessment of hospitals on quality check list and arrive at a score for the facility.
4. Identification of gaps, develop action plan under the guidance of incharge of the hospital and monitor compliance.
5. Facilitate conduct of meeting of *Rogi Kalyan Samiti*. It would include ensuring preparation of agenda notes, action taken report and minutes of the meeting.

6. Management of out-sourced services such diet, security, laundry, BMW management.
7. Ensuring that the hospital meets all regulatory compliances such as BMW, Blood Bank/storage license, AERB regulations, etc.
8. Hospital manager is to take a round of the hospital daily and look at the functioning of departments, equipment and ambulance. Facilitation of activities for gap closure, corrective and preventive action.
9. Keep a record of non functional equipments and time line for its repair along with AMC for all equipments.
10. Supervising punctuality, day-to-day working, supervision of other staff members, work output and channel the work input to improve overall efficiency and keep unit's morale up.
11. Planning and work-out modalities towards upliftment, preventive maintenance of equipment and vehicles and modernization of the hospital.
12. Analyze utilization of various hospital services and equipments etc.
13. Periodic information and Assessment on utilization of untied grants, AMGs, RKS grant etc and timely submission of SOEs and UCs.
14. Analyze financial outlays and its effective utilization.
15. Prepare yearly plan for expenditure after assessment.
16. Carrying out exit interviews, satisfaction surveys (external and internal customer), time motion studies etc. to keep hospital services up to quality standards.
17. To institute an effective grievance redressal system both for the employees and the patients.
18. Computerization of District Hospital functions.
19. Strengthen District Hospital MIS, KPI and report actions taken.
20. Prepare monthly/quarterly and yearly report of hospital progress.
21. Perform other duties and work assigned by the hospital incharge.

ANNEXURE 'E'

Terms of Reference: Quality Assessors

State can empanel Assessors from the pool of Experienced Doctors, Nurses, and Hospital/Health Administrators, who have been actively involved in the Patient care and/or Hospital administration and/or related academics (like Community Medicine/ Community Health Administration/ Hospital Administration).

Qualification: MBBS/BDS/AYUSH/B Sc (Nursing) Degree/Full Time MHA or equivalent.

Experience: Post degree at least 10 years experience of direct care of patient/Programme Administration/Health Administration/Health Consultancy/Relevant Teaching experience.

Qualified Assessors of NABH/NABL/ISO 9001:2008/Six Sigma/Lean/Kaizen would be preferred.

Age: 40 years and above with fitness to travel extensively, sometimes in difficult conditions.

Purpose of Empanelment

The State and Central Govt has launched Quality Assurance Programme. The empanelled Assessors are expected to undertake visits to Health Facilities on behalf of State Quality Assurance Committee (SQAC) or Ministry of Health & Family Welfare GoI/NHSRC. They would be working in a team, size of which would depend upon the type of facility and quantum of work. The team would make an assessment of Health facilities. The assessment would be based on the Standards and Measurable elements, as notified by MoHFW/State Govt. Such assessment would be undertaken on check-lists for respective departments.

Hence it is expected that the incumbent would have following additional attributes, over and above the qualification and experience:

1. The assessors should possess excellent observation and analytical skills.
2. Should have good judgment in assessing performance against set standards & criteria.

3. High degree of communication skills; listening, verbal and written. Ability to write clear and comprehensive assessment report.
4. The candidate would be required to travel within the state and outside the state for approx. 60% of their time.
5. The selected candidate would be required to successfully undergo the assessors training, which would be arranged SQAC in consultation with NHSRC.
6. The assessors should be proficient in MS Office and Internet/ email.
7. The assessor is expected to be objective and impartial. He would be required to be self-dependent, efficient, self-organized yet flexible, ability to prioritize work, attention to detail, logical thinking, ability to follow standardized procedures.
8. Social skills: acceptable interactions with all categories of hospital staff and ability to attune to relevant internal and external context.

Roles & Responsibilities:

1. The assessors would be responsible for ensuring that all relevant standards and criteria are assessed adequately during the survey and producing the final assessment report to accurately reflect the findings within the agreed timelines.
2. They are expected to conduct opening and closing meeting in the facility. After completion of the assessment, they are required to prepare assessment report and submit to the Health Facility, District Quality Assurance Committee and SQAC.
3. Role of assessors would also be provide supportive supervision at the facilities.
4. The assessors would facilitate development of 'gap-closure' plan at the facility level through a consultative process.

ANNEXURE 'F'

Budget

Operational Cost: State Quality Assurance Unit (SQAU)						
Sl. No.	**Head**	**Recurring (R)/ Fixed (F)**	**Salary per month**	**No.**	**Months**	**Total (in INR)**
1	State Consultant (Quality Assurance)	R	50000	1	12	600000
2	State Consultant (Public Health)	R	50000	1	12	600000
3	State Consultant (Quality Monitoring)	R	40000	1	12	480000
4	Programme cum Administrative Assistant	R	15000	1	12	180000
5	Establishment of Quality Unit at State level - (in first year only) Furniture, fixtures, interiors etc.	F	100000			100000
6	Air Conditioners	F	100000			100000
7	2 Computer, 2 Laptop with 1 printer, 1 scanner, 1 FAX and 1 Photocopier	F	250000			250000
8	Cost of Electricity, Telephone, Internet, printing, stationery etc.	R	15000		12	180000
9	Contingency & Misc.	R	5000		12	60000

Sl. No.	Head	Recurring (R)/ Fixed (F)	Salary per month	No.	Months	Total (in INR)
10	Review Meetings at State (Quarterly)	R	10000	0	4	40000
	Total (for first year) both Fixed and Recurring					**2590000**

Sqau: Monitoring & Supportive Supervision						
Sl. No.	**Head**	**Recurring (R) / Fixed (F)**	**Unit Cost**	**No. of mandays in field in a month**	**Frequency**	**Total (in INR)**
1	Travel support (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	R	2500	10	12	300000
2	DA including Accommodation	R	2000	10	12	240000
	Total (for one year)					**540000**

Operational Cost: District Quality Assurance Unit						
Sl. No.	**Head**	**Recurring (R)/Fixed (F)**	**Salary per month**	**No.**	**Months**	**Total (in INR)**
1	District Consultant (Quality Assurance)	R	40000	1	12	480000
2	District Consultant (Public Health)	R	40000	1	12	480000
3	District Consultant (Quality Monitoring)	R	30000	1	12	360000
4	Programme cum Administrative Assistant	R	12000	1	12	144000
5	Establishment of Quality Unit at District level - (in first year only) Furniture, Fixtures, interiors etc.	F	50000			50000
6	Air Conditioners	F	50000			50000
7	2 Computer, 2 Laptop with 1 Printer, 1 scanner, 1 FAX and 1 Photocopier	F	250000			250000

Sl. No.	Head	Recurring (R) / Fixed (F)	Salary per month	No.	Months	Total (in INR)
8	Cost of Electricity, Telephone, Internet, Printing, Stationery etc.	R	12000		12	144000
9	Contingency & Misc.	R	2000		12	24000
10	Review Meeting	R	2000		12	24000
	Total (for first year) both fixed and recurring					**2006000**

District Quality Assessment cum Mentoring Visits Activities

Sl. No.	Head	Recurring (R) / Fixed (F)	Unit Cost	Number of Participants	Days	Total
1	Travel support (to and fro)/Hiring of vehicle (Reimbursement as per actual)	R	1000	2	60	120000
2	DA	R	200	2	60	24000
	Total for One year					**144000**

District Hospital Quality Manager

Sl. No.	Head	Recurring (R) / Fixed (F)	Unit Cost	Number	Months	Total
1	Quality Manager	R	35000	1	12	420000
2	Misc. - Internet, conduct of Meeting, Internal Assessment, etc.	R	2000	1	12	24000
	Total					**444000**

State Quality Assessment cum Mentoring Visits Activities

Head	Unit cost	Number of Participant	Days	Amount (in INR)
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	2500	2	3	15000
Honorarium for assessors	2000	2	3	12000
Boarding & Lodging	4000	2	4	32000
Sub Total				**59000**
Contingency	10000			10000
Total (for one District Hospital)				**69000**

ANNEXURE 'G'

Trainings

Awareness Workshop (One day)					
Sl. No.	**Head**	**Unit Cost**	**No. of Participants**	**No. of Trainings in a year**	**Amount (in INR)**
1	Hiring of Venue	10000		1	10000
2	Tea & Lunch	250	40	1	10000
3	Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees)	250	40	1	10000
4	Local Mobility Support	2000		2	4000
5	Honorarium (Guest Faculty)	1000	2	1	2000
6	Travel Cost (for Outstation Participants)	3000	10	1	30000
7	Travel Cost for 1 external faculty(economy class air-fare as per actuals)	20000	1		20000
8	Boarding & Lodging for one external Faculty	4000		2	8000
9	**Sub total**				**94000**
10	Contingency	10000			10000
	Total (One Trg)				**104000**

Orientation Training for Assessors(SQAU & DQAU) (Two days)					
Sl. No.	**Head**	**Unit cost**	**Number of Participant**	**Days**	**Total**
1	Hiring of Venue	10000		2	20000
2	Travel Cost of Participants	2000	40		80000
3	DA to Participants	500	40	2	40000
4	Tea & Lunch	250	40	2	20000
5	Travel of one external trainer (to and fro by economy class air fare as per actuals)	20000	1		20000
6	Per diem for Faculty / Honorarium for External trainers	1000	1	2	2000
7	Boarding & Lodging for Trainers	4000	4	3	48000
8	Local Mobility support	2000		3	6000
9	Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, etc. (Rate x Days of training x no. of trainees)	250	40	2	256000
10	**Sub Total**				**256000**
11	Contingency	10000			10000
	Total (for one training)				**266000**
	State Level Training of Service Providers (Three days)				
Sl. No.	**Head**	**Unit cost**	**Number of Participant**	**Days**	**Total (in INR)**
1	Hiring of Venue	10000		3	30000
2	Travel Cost of Participants	2000	40		80000
3	DA to Participants	500	40	3	60000
4	Lunch/Refreshment	250	40	3	30000
5	Travel of one external trainer (to and fro by economy class air fare as per actuals)	20000	1		20000
6	Per diem for Faculty/ Honorarium for External trainer	1000	1	3	3000
7	Boarding & Lodging for Trainers	4000	4	4	64000
8	Local Mobility support	2000		4	8000
9	Incidental Exp. like study material, course material, Photo copying, job aids, flip charts, etc. (Rate x Days of training x no. of trainees)	250	40	3	30000
10	**Sub Total**				**325000**
11	Contingency	10000			10000
	Total (for one training)				**335000**

National Level External Assessors Training (Five days)					
	Head	**Unit cost**	**Number of Participant**	**Days**	**Total (in INR)**
1	Hiring of Venue	15000		5	75000
2	Travel Cost of Participants (to and fro by economy class air fare as per actuals)	20000	30		600000
3	DA	1000	30	5	150000
4	Lunch/Refreshment	500	40	5	100000
5	Travel of two external trainers (to and fro by economy class air fare as per actuals)	20000	2	0	40000
6	Per diem/Honorarium for External trainers	2000	2	5	20000
7	Boarding & Lodging for Trainers /Participants	3000	32	5	480000
8	Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees)	250	30	5	37500
10	Local Transport	2000	2	6	24000
11	**Sub Total**				**1526500**
12	Contingency	20000			20000
	Total (for training of 1 batch of approx. 30 External Assessors)				**1546500**

ANNEXURE 'H'

Cost of External Assessment

Cost of External Certification By GoI (For one DH)				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors(economy class air-fare as per actuals)	20000	2		40000
Honorarium for External assessors	2000	2	3	12000
Boarding & Lodging	4000	2	4	32000
Local Transport	2000	1	4	8000
Sub Total				**92000**
Contingency	10000			10000
Total (for one District Hospital)				**102000**
Cost of State Certification (For one DH)				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	2500	2	3	15000
Honorarium for External assessors	2000	2	3	12000
Boarding & Lodging	4000	2	4	32000
Sub Total				**59000**
Contingency	10000			10000
Total (for one District Hospital)				**69000**

ANNEXURE 'I'

Application for External Certification for Quality of Services

From
State Quality Assurance Committee

No. Date: -

To,
Joint Secretary (Policy)
Ministry of Health & Family Welfare
Government of India
Nirman Bhawan, Maulana Azad Road
New Delhi - 110011

REQUEST FOR ASSESSMENT OF HEALTH FACILITY FOR QUALITY CERTIFICATION

Sir

We are happy to inform that Quality Assurance Programme at following Health facility in the State/UT has made substantial progress and the health facility has scored ------- (percentage of marks obtained in SQAC Assessment) -

Name of Health Facility
Full Address

Hence, we request you to issue instructions for assessment of the health facility for the MoHFW GoI Quality Assurance certification. Detail information on the health facility is given in the attached **appendix I.**

Thanking you.

Yours sincerely

(----------)

Chairperson
SQAC

APPENDIX 'I'

Hospital Data Sheet (to be enclosed with the application for External Quality Certification)

1. Name of Health Facility	
2. Full Address	
3. Contact Details -	
a. SQAU	i. Nodal Officer - ii. Email – iii. Tel – iv. Score of the facility on SQAU Assessment -
e. DQAU	i. Nodal Officer - ii. Email – iii. Tel – iv. Score of the facility on DQAU Assessment -
e. Facility	i. Incharge – ii. Email – iii. Tel – iv. Score of the facility on internal assessment
1. Nearest Railway Station	
2. Nearest Airport	
3. Details of Hospital	
a. Number of Beds	i. Sanctioned beds - ii. Functional beds -
a. Distribution of Beds	i. Medical – ii. Surgical – iii. Gynae. – iv. Maternity – v. Paediatrics - vi. Orthopaedics – vii. Ophthalmology – viii. ENT – ix. ICU – x. SNCU – xi. Others (Please add) –
1. Maternal Services	a. Number of deliveries in a month b. Number of Caesarean Section in a month
3. OPD Services	a. OPD Services available in the hospital – General/Medical/ Surgical/Paediatrics/Gynae./ANC/Orthopaedics/Eye/ ENT/Dermatology/VD/Psychiatric/ARSH/FamilyPlg./ Immunisation/ICTC/Any other ----- b. Average OPD attendance in a month
1. Laboratory Services –	Average Number of tests conducted per month
2. Radiological Services –	a. No. of X-ray machines b. No. of Ultrasound Machine c. CT Scan d. Any other

ANNEXURE 'J'

CENTRAL QUALITY SUPERVISORY COMMITTEE
Ministry of Health & Family Welfare
Government of India

Certificate No ---

CERTIFICATE OF QUALITY OF SERVICES

(Name of Hospital----------)

Place----------)

Has been assessed and has been found to comply with 'National Quality Standards for Public Health' for following areas of the hospital –

This certificate has been issued on ---------- at New Delhi

Valid until:

Head Quality Improvement Division NHSRC New Delhi	Director NRHM Ministry of Health & FW Government of India New Delhi	Deputy Commissioner (I/C MH) Ministry of Health & FW Government of India New Delhi

GLOSSARY

Certification	A formal process by which an Independent and recognized body, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Certification standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. Certification is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.
Action plan	Specific actions that respond to short- and longer-term strategic objectives.
Analysis	An examination of facts and data to provide a basis for effective decision (s).
Approach	It includes the appropriateness of the methods to the Item requirements and to the organization's operating environment, as well as how effectively the methods are used.
Capacity building	Planned development of (or increase in) knowledge, management, skills, and other capabilities of an individual/organization through acquisition, incentives, technology, and/or training.
Certification	A process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. Certification usually applies only to organizations, while certification may apply to individuals, as well as to organizations. When applied to individual practitioners, certification usually implies that the individual has received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure.
Client satisfaction	Customer's perception of the degree to which the customers' requirements have been fulfilled.
Continual Improvement	A recurring activity to increase the ability to fulfil requirements. In continual improvement you improve a bit, sustain the development over a period of time and then go to the next stage, sustain and again improve and so on.

Corrective action	Action to eliminate the cause of a detected non-conformity or other undesirable situation.
Customer	The actual and potential users of organization's services or programs (referred to as "health care services" in the Health Care Criteria).
Cycle time	The time required to fulfil commitments or to complete tasks.
Defect	The non-fulfilment of a requirement, related to an intended or specified use.
Document	Information and its supporting medium.
Effectiveness	Extent to which planned activities are realized and planned results achieved.
Efficiency	Relationship between the results achieved and the resources used.
Empowerment	Giving people the authority and responsibility to make decisions and take appropriate actions.
Goals	Future condition or performance level that one intends to attain.
Governance	The system of management and controls exercised in the stewardship of the organization.
Health care services	Services delivered by the organization that involves professional clinical/medical judgment, including those delivered to patients and those delivered to the community.
Internal audit	Audit carried by in house authorities to evaluate the compliance of implemented Quality Management Set up.
Key	The major or most important elements or factors, those that are critical to achieving intended outcome.
Indicators	Numerical information that quantifies input, output, and performance dimensions of processes, programs, projects, services, and the overall organization outcomes.
Key Performance Indicator (KPI)	Metric or measure used to quantify and evaluate progress made relative to the objectives wished to achieve.
Laboratory	Facility for inspection, test or calibration that may include, but is not limited to, chemical, metallurgical, dimensional, physical, electrical, reliability testing.
Licensure	Process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession. Licensure ensures that an organization or individual meets minimum standards to protect public health and safety.
Measurement System	A system of measuring all components of Quality i.e. Standards, Measuring Elements, Check points and score card. (*applicable in the context of current document only*).

Mission	The overall function of an organization. It may define patients, stakeholders, or markets served; distinctive or core competencies; or technologies used.
Partners	Key organizations or individuals who are working in concert with the main or leading organization to achieve a common goal or to improve performance.
Patient	The person receiving health care services including preventive, promotional, acute, chronic, rehabilitative care and all other services in the continuum of care.
Performance	Outputs and outcomes obtained from processes, health care services, and patients and stakeholders that permit evaluation and comparison relative to goals, standards, past results, and other organizations.
Preventive action	Action to eliminate the cause of a potential non-conformity or other undesirable potential situation.
Process	Set of activities with the purpose of producing a health care service for patients and stakeholders within or outside the organization. In the Baldrige Scoring System, process achievement level is assessed.
Productivity	The term "productivity" refers to measures of the efficiency of resource use.
Purpose	The fundamental reason of existence of an organization.
Quality	Degree to which a set of inherent characteristics fulfils the requirements.
Quality assurance	Part of quality Management, focussed in providing confidence that quality requirements will be fulfilled.
Quality Improvement	Part of Quality Management, focussed on increasing the ability to fulfil quality requirements.
Quality management	Co-ordinated activities to direct and control an organization with regard quality.
Quality objective	Something sought or aimed for, related to quality.
Quality policy	Overall intentions and direction of an organization related to quality, as formally expressed by top management.
Record	Document stating results achieved or providing evidence of activities performed.
Results	The outputs and outcomes achieved by an organization and evaluated on the basis of current performance; performance relative to appropriate comparisons; the rate, breadth, and importance of performance improvements; and the relationship of results measures to key organizational performance requirements.
Stakeholders	Are the marketplace benefits that exert a decisive influence on an organization's likelihood of future success.

Standard	A document established by consensus and approved by a recognized body that provides for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context.
SOP (Standard Operating Procedure)	Written procedure prescribed for repetitive use as a practice, in accordance with agreed upon specifications aimed at obtaining a desired outcome. The purpose of a SOP is to carry out the operations correctly and always in the same manner.
Sustainability	It's the organization's ability to address current organizational needs and to have the agility and strategic management to prepare successfully for future organizational, market, and operating environment.
Systematic	The approaches that are well ordered, repeatable, and use data and information making learning possible.
Top management	Person or group of people who directs and an organization, at the highest level.
Trends	The numerical information that shows the direction and rate of change for an organization's results. Trends provide a time sequence of organizational performance. Examples of trends called for by the Health Care Criteria include data related to health care outcomes and other health care service performance; patient, stakeholder, and workforce satisfaction and dissatisfaction results.
Value	The perceived worth of a product, process, asset, or function relative to cost and to possible alternatives.

BIBLIOGRAPHY

1 An Introduction to Quality Assurance in Health Care, Avedis Donabedian.

2 District Health facility Guidelines for Development and Operations, WHO Regional Publication, Western Pacific Series 22, World Health Organization Regional Office for Western Pacific, 1998.

3 Evaluation and Quality Improvement Program (EQuIP) standards, 4th Edition, Australian Council on Healthcare Standards.

4 Facility based New born Care operational Guide, Guideline for Planning and implementation, Ministry of health and Family Welfare, Govt. of India.

5 Guideline for enhancing optima Infant and Young Child feeding practices, Ministry of Health And Family welfare, Govt. of India.

6 Guideline for implementing Sevottam, Dept. of Administration reform and Public Grievance, Ministry of Personal and Public Grievance and Pension, Govt of India.

7 Guideline for Janani- Shishu Suraksha Karyakaram (JSSK), Maternal Health Division, Ministry of Health and Family welfare, Govt. of India.

8 Implementation Guide on RCH-II, Adolescent and reproductive Sexual health Strategy, for State and District Program Manager, Ministry of Health and Family Welfare, Govt. of India.

9 Indian Public Health Standards (IPHS), Guidelines for District Hospitals (101 to 500 Bedded), Revised 2011, Directorate General of Health Services, Ministry of Health & Family Welfare, Govt. of India.

10 International Covenant on Social, Economic and Cultural Rights (ICESCR), 1976.

11 IS 10905, Part -2, Recommendations for basic requirements of general hospital buildings: Part 2 Medical services department buildings, 1984.

12 IS 10905, Part -3, Recommendations for Basic Requirements of General Hospital Buildings - Part 3 : Engineering Services Department Buildings, 1984.

13 IS 10905, Part-1,Recommendations for basic requirements of general hospital buildings: Part 1 Administrative and hospital services department buildings, 1984.

14 IS 12433, Part -1, Basic requirements for hospital planning: Part 1 up to 30 bedded hospitals, 1988.

15 IS 12433, Part -2, Basic Requirements for Hospital Planning - Part 2 : UP to 100 Bedded Hospital, 2001.

16 IS 13808 : Part 1 , Quality management for hospital services (Up to 30-bedded hospitals) Guidelines : Part 1 Out-Patient Department (OPD) and Emergency Services, 1993.

17 IS 13808 : Part 2, Quality Management Procedures for Diagnostic and Blood Transfusion Services - Guidelines - Part 2 : Up to 30-Bedded Hospitals, 1993.

18 IS 13808 : Part 3, Quality management for hospital services (up to 30 bedded hospitals) - Guidelines: Part 3 Wards, nursing services and operation theatre, 1993.

19 IS 15195, Performance Guidelines for Quality Assurance in Hospital Services up to 30-Bedded Hospitals, 2002.

20 IS 15461, Performance Guidelines for Quality Assurance in Hospital Services up to 100-Bedded Hospitals, 2004.

21 IS 4347 , Code of practice for Hospital lighting, 1967.

22 ISO 15189, Medical Laboratories- Particular requirements for quality and competence, Second edition.

23 ISO 9001, Quality Management System requirement, Fourth Edition.

24 Janani Suraksha Yojana, Govt of India, Ministry of Health and Family Welfare, Maternal Health Division.

25 Joint Commission International Certification Standard for Hospital, 4th Edition.

26 National Certification Board for Hospital and Healthcare Provider, 3rd Edition.

27 National Guideline for Improvement of Quality and Safety of Healthcare Institutions (for Line Ministry and Provincial Hospital, First Edition.

28 Operational Guidelines on Maternal and Newborn Health, Ministry of Health and Family welfare, Govt. of India.

29 Principles of Hospital Administration, Second Edition, John R. Mc Gibony, M.D.

30 Promoting Rational Drug Use under NRHM, National Health System Resource Centre, 2009.

31 Quality Assurance Services of Sterilization Services, Research Studies & Standard division, Ministry of Health and family welfare, Govt. of India.

32 Standards for Blood Bank and Blood Transfusion Facilities, National AIDS Control Organization, Ministry of Health and Family Welfare, Govt. of India.

33 Standards for Female and Male Sterilization Services, Research Studies & Standard division, Ministry of Health and family welfare, Govt. of India.

LIST OF **ABBREVIATIONS**

1	ACMO	Assistant Chief Medical Officer
2	AERB	Atomic Energy Regulatory Board
3	AIDS	Acquired Immuno-deficiency Syndrome
4	AIIMS	All India Institute of Medical Sciences
5	AMTSL	Active Management of Third Stage of Labour
6	ARSH	Adolescent Reproductive and Sexual Health
7	AYUSH	Ayurveda, Yoga, Unani, Siddha, & Homeopathy
8	BCC	Behavioural Change Communication
9	BDS	Bachelor of Dental Sciences
10	BMW	Biomedical Waste Management
11	CHC	Community Health Centre
12	CMHO	Chief Medical & Health Officer
13	CMO	Chief Medical officer
14	CQSC	Central Quality Supervisory Committee
15	CS	Civil Surgeon
16	CTI	Collaborating Training Institute
17	DC CH	Deputy Commissioner Child Health
18	DC FP	Deputy Commissioner Family Planning
19	DC MH	Deputy Commissioner Maternal Health
20	DH	District Hospital
21	DHAP	District Health Action Plan
22	DHO	District Health Officer
23	DQAC	District Quality Assurance Committee
24	DQAU	District Quality Assurance Unit
25	DQT	District Quality Team
26	ENT	Ear Nose & Throat
27	FOGSI	The Federation of Obstetric and Gynaecological Societies of India
28	FW	Family Welfare
29	GoI	Government of India
30	HMIS	Hospital Management Information System
31	HR	Human Resource
32	I/C	In charge
33	IAP	Indian Academy of Paediatrics
34	IAPSM	Indian Association of Preventive and Social Medicine
35	IEC	Information, Education & Communication
36	IMA	Indian Medical Association
37	IMEP	Infection Management and Environment Plan
38	IPD	In Patient Department
39	IPHS	Indian Public Health Standard
40	ISO	International Organisation for Standardisation
41	JCI	Joint Commission International

42	KPI	Key Performance Indicators
43	MBA	Masters in Business Administration
44	MBBS	Bachelor in Medicine & Bachelor in Surgery
45	MCH	Maternal & Child Health
46	ME	Measureable Elements
47	MHA	Masters in Hospital Administration
48	MOHFW	Ministry of Health and Family Welfare
49	MPH	Masters in Public Health
50	NABH	National Certification Board for Hospitals & Health Care Providers
51	NGO	Non Government Organization
52	NHSRC	National Health Systems Resource Centre
53	NPCDCS	National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke
54	NRHM	National Rural Health Mission
55	NUHM	National Urban Health Mission
56	OPD	Out Patient Department
57	OT	Operation Theatre
58	PC PNDT	Pre Conception and Prenatal Diagnostic Test
59	PDCA	Plan Do Check Act
60	PHA	Public Health Administration
61	PHC	Primary Health Centre
62	PIP	Programme Implementation Plan
63	QA	Quality Assurance
64	QAC	Quality Assurance Committee
65	QAU	Quality Assurance Unit
66	QI	Quality Improvement
67	QMS	Quality Management System
68	QOC	Quality of Care
69	RCH	Reproductive and Child Health
70	RCHO	Reproductive Child Health Officer
71	RHFWTC	Regional Health & Family Planning Training Centre
72	RMNCH+A	Reproductive, Maternal, Neonatal, Child Health and Adolescent
73	SIHFW	State Institute of Health & Family Welfare
74	SOP	Standard Operating Procedure
75	SPIP	State Programme Implementation Plan
76	SPMU	State Programme Management Unit
77	SQAC	State Quality Assurance Committee
78	SQAU	State Quality Assurance Unit
79	TB	Tuberculosis
80	ToRs	Terms of Reference
81	UNFPA	United Nations Population Fund
82	UNICEF	United Nations International Children's Emergency Fund
83	USAID	United States Agency for International Development
84	UT	Union Territory
85	VD	Venereal Diseases
86	WHO	World Health Organization

National Rural Health Mission
Ministry of Health and Family Welfare
Government of India