ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

MSDS FOR HOSPITALS

PART A: MANAGEMENT OF HOSPITAL

1. MISSION AND STRATEGIC PLANNING

Standard 1: The hospital's goals, objective and mission statement are followed properly by its management.

Indicator 1: Staff members and the general public can access the mission and vision statement in a format and language that is appropriate for them. Display the mission and vision statements in all departments and include them in staff training programs to ensure alignment with organizational goals.

Assessment Process:

In order to comply with this indicator, the Hospital must have a mission and vision statement, which is displayed at a prominent location, in accessible format[1] as appropriate which shall include promotion of safe and inclusive workplaces, free from all forms of violence and harassment, so that health workers can address the needs of patients diligently. The staff of the hospital is aware of the mission and vision of the hospital. The assessors shall review the mission and vision statements clearly displayed and will also interview random staff members to examine if they are well aware of it.
(Reference: ILO C-190)

Indicator 2: The hospital has a strategic plan in accordance with the mission and vision statements. Furthermore, hospital's policies, annual goals and updates are aligned with the strategic plan.

Assessment Process:

In order to comply with this indicator, the hospital must have a documented strategic plan and the plan must be aligned with the mission and vision statements. All the policies and annual plans of the hospital are in-line with the strategic plan. All the policies and plans of the hospital must be available in documented form.

A. General Management:

Standard 2: defined duties and responsibilities for operating the healthcare establishment, managing its assets, and abiding by relevant rules and regulations.

Indicator 3: The hospital's governing board has clearly defined duties, such as defining and reviewing vision statement, mission goals, establishing a safe and inclusive workplace that ensure decent work[2] and promote gender equality and address violence and harassment for the hospital's staff to be able to provide quality of care and patient safety culture, allocating resources, implementing relevant laws, assessing and managing annual strategic plans. To authorize and oversee the Hospital's in-charge for day-to-day operation duties.

Assessment Process:

In order to comply with this indicator, the Hospital must have notified a Governing Board with complete documentation of its responsibilities, including development of Mission and vision statement, strategic plan is aligned with those statements, review and ensure quality improvement steps, dealing with legislation and regulatory affair, evaluation of annual and long-term plans. The Hospital's board shall authorize and oversee the day-to-day operational duties of the Hospital's in-charge. The board meets on regular basis and the minutes of those meetings along with all the measures taken towards the improvement of system are documented.

Indicator 4: The hospital has a suitably qualified in-charge as per applicable laws (PMDC / HEC) i.e. Chief Executive Officer, Medical Superintendent, Hospital Administrator, Medical Director, Executive Director etc and his/her job description is well-defined.

Assessment Process:

In order to comply with this indicator, the hospital must have a designated in-charge, it could be CEO, MS, Hospital Administrator, MD or ED, who is qualified and experienced for the role. The HR department has maintained a complete HR file of the hospital in-charge having all the credentials, experiences, Job description, role and responsibilities.

Indicator 5: Organogram shows the line of communication is developed, evaluated, and communicated to the appropriate personnel.

Assessment Process:

In order to comply with this indicator, the hospital has developed and/or displayed a current Organogram, depicting the complete hierarchy. Also, the staff members of different departments shall be interviewed to assess whether the Organogram is clearly communicated to the staff or otherwise.

[2] Decent Work : https://www.ilo.org/topics-and-sectors/decent-work

Indicator 6: The hospital has defined and implemented clear protocols for managing both internal and external services to ensure smooth operations, quality care, patient and staff safety, and decent work for its staff. To ensure these, the hospital has defined and implemented clear protocols for managing both internal IPD, OPD, ER, OT, ICU etc and external services like home care services, Diagnostic services franchise any outsourced dept to ensure smooth operations, quality care and patient safety

Assessment Process:

In order to comply with this indicator, the Hospital must have documented and implemented a set of protocols and procedure for every major internal and external services. Documentation, training evidence, staff interviews to assess the communication/orientation on the protocols shall be inspected during the assessment of this indicator.

Indicator 7: A policy of release of information and confidentiality has been established; the hospital has communicated it to the relevant staff and practices the same.

Assessment Process:

In order to comply with this indicator, the Hospital must have defined and implemented a policy for confidentiality and release of information, whether it is regarding the patients or department. The documentation of the policy, training on the policy, and staff interview shall be conducted for assessment of compliance of this indicator.

Indicator 8: The roles, responsibilities, and scope of every clinical service, unit, and department are properly defined and are developed in collaboration with the concerned stakeholders.

Assessment Process:

In order to comply with this indicator, the Hospital must have developed and implemented scope, roles, functions and responsibilities of each clinical service/unit/department. The same should be in documented form, maintained in the administration/HR department and a copy of the same must be disseminated to the relevant section. The staff of every department must be trained on the relevant policies of their department. Documented evidence, staff training documents, and staff interviews shall be reviewed/conducted for assessment of compliance of this indicator.

Indicator 9: The Hospital has appointed in-charge for each service/department, who is qualified and/or experienced.

Assessment Process:

In order to comply with this indicator, the Hospital must have appointed/hired a qualified and experienced in-charge of each of its department. The HR department must have maintained a complete HR file of each manager along with all his/her qualification/credentials, experiences, training, Job descriptions, roles and responsibilities, trainings etc. Documentation, meeting with/interview of the manager of each department shall be conducted in order to assess compliance with this indicator.

Indicator 10: The hospital has signed a contract with every consultant/service provider of hospital that adhere to labour standards to ensure decent work conditions and protect consultant/service provider rights, for providing services to ensure quality of care and patient safety.

Assessment Process:

In order to comply with this indicator, the Hospital must have maintained the record of signed agreement with every consultant practicing in the Hospital, service provider clearly mentioning the ToRs of the agreement to ensure quality of care, patient safety and refraining from any act of violence and harassment not only against patients, but also staff working on different type of contracts. The documented evidence of the same shall be reviewed in order to assess the compliance with this indicator.

Indicator 11: The Hospital develop and publishes duty rosters based on decent working time[3] arrangements for each department in advance and the same is displayed in all relevant sections. Rosters for consultants shall mention first on call and 2nd on call. The work schedules, shift rotation rosters, working time limits, and rest periods should be established in a manner that is commensurate with the health and safety of health and care workers. They must be developed in consultation with employers and workers, ensuring that working time arrangements are family-friendly while simultaneously promoting gender equality.

Assessment Process:

In order to comply with this indicator, the Hospital must have a policy of publishing a duty roster, that is based on decent working time arrangements, developed in consultation with healthcare workers and HCE administration, 24 hours prior to the duties assignment. Also, the rosters must be displayed in the relevant departments. The documented policies, duty rosters being displayed in different departments and staff interviews on the current rosters shall be conducted in order to assess compliance with this indicator.

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[3] As per the ILO's Conventions on Hours of Work (Industry) , 1919 (No. 1)
https://normlex.ilo.org/dyn/nrmlx_en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C001
and Night Work (Women)(Revised), 1948 (No. 89)
https://normlex.ilo.org/dyn/nrmlx_en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312234

Indicator 12: The Hospital has defined a procedure to inform IHRA about significant changes regarding the facilities, the building and/or infrastructure, in the top management, ownership or any other essential personnel and management changes as well as any critical incidents to decide if an interim assessment or earlier assessment is to be done. Also, the record of the same is maintained.

Assessment Process:

In order to comply with this indicator, the Hospital must have developed and implemented a policy to communicated any sort of change regarding the facilities, infrastructure, top management, ownership, any incident/accidents, addition or discontinuation of any service/department, shall be communicated to Islamabad Healthcare Regulatory Authority (IHRA) and the record of any such communication/coordination shall be maintained. The documented policy and record shall be reviewed in order to assess compliance with this indicator.

B. Risk and Quality Management

Standard 3: The hospital controls and manages risks[4], finds ways to keep improving its procedures and services, implements changes, and assess their effectiveness.

Indicator 13: The Hospital has developed and implemented a risk management strategy for providing safe healthcare, which is easily accessible to all staff.

Assessment Process:

In order to comply with this indicator, the Hospital must have developed and implemented a plan for risk assessment and management prepared in consultation with workers of the hospital including healthcare workers, HCE administration, and regularly evaluate and review it for course correction through social dialogue. The documentation of the plan, mechanism for incident reporting and record of corrective measures and risk mitigation steps taken, staff training and its evidence shall be reviewed and the staff shall be interviewed regarding the communication of the risk assessment plan of their respective department.

Indicator 14: A Continuous Quality Improvement (CQI) Committee has been notified by the hospital based on a Plan-Do-Check-Act (PDCA) cycle in line with relevant national and international standards including OSH, and committee meets on monthly basis and minutes and records of its meeting are maintained, implemented and regular follow up is done.

Assessment Process:

In order to comply with this indicator, the Hospital must have notified a Continuous Quality Improvement (CQI) Committee, which promotes a safer, healthier, and more productive healthcare environment, aligned with relevant national and international standards including OSH, benefiting both healthcare workers and patients, the ToRs of the committee are defined and the committee meets on regular basis. The minutes of the meetings (last one year) as per the pre-defined agenda are recorded, maintained and disseminated/communicated to the concerned department. A consolidated report against each meeting and the actions taken (if any) is developed and the record is available.

Indicator 15: The hospital has a list of nationally and internationally recognized sentinel events, accidents, incidents, adverse events and near misses, and all these are documented and reported to the quality department. The quality department then creates and presents report at the CQI Committee meeting for necessary action. The HCE provide training to staff on incident reporting and analysis to prevent recurrence.

Assessment Process:

In order to comply with this indicator, the Hospital must have documented list all of sentinel events including unexpected incidents, near mises and serious adverse patient events that may cause harm to the patients/staff of the hospital. A system is established for the analyses of the root cause, associated factors, reporting to CQI Committee and corrective measures (such as change in policy & operating procedures and training for staff) to prevent or reduce the likelihood of reoccurrence is available. The hospital must have the sentinel events record for last 12 months.

Indicator 16: Performance indicators (KPIs) are available for priority illnesses, important processes, and all services (clinical and non-clinical). Key processes are regularly evaluated for patient satisfaction.

Assessment Process:

In order to comply with this indicator, the Hospital must have defined the Performance indicators (KPIs) for all services, involving the systematic collection and analysis of data across all clinical and non-clinical areas. Regular audits are conducted to track these KPIs such as treatment outcomes, patient safety, resource utilization, patient satisfaction and staff performance. The findings shall be documented in the CQI Committee minutes, along with recommended corrective actions to address any identified gaps.

Indicator 17: The hospital has a clinical departmental audit policy and procedure that is followed, documented and reported to concerned stakeholders. Clinical staff and management are well-aware about the procedure and importance of clinical audit. Ensure that audit reports lead to corrective actions and specify how these actions will be tracked and implemented to improve healthcare service delivery.

Assessment Process:

In order to comply with this indicator, the Hospital must have developed and implemented a policy and procedure outlining the steps for conducting clinical audits by agreeing on audit objectives, scope, and methodology between management and clinical staff. A consolidated report is developed, summarizing findings, identifying areas for improvement, outlining corrective actions and record is available. Clinical staff and management are well-aware about the procedure and importance of clinical audit and record of their training is available. The departmental audit report shall be reviewed to ensure that necessary changes are implemented, and the effectiveness of improvements is monitored. Staff interviews and review of training record will be conducted.

Indicator 18: Mandatory registration of all HCE's under Health Facility Availability Tracker (HFAT) on IHRA's website.

Assessment Process:

In order to comply with this indicator, the hospital must have ensured registration on the HFAT on IHRA's website and established a process for regular updating and verification of facility data, including:

- Mandatory registration of the Healthcare Establishment (HCE) on the HFAT Mobile App
- Entry and updating of key facility information (e.g., services, bed capacity, human resources, equipment, emergency services, etc.)
- Designation of responsible focal person(s) for managing HFAT data entry and updates
- Periodic review and verification of submitted data for accuracy and completeness
- Ensuring timely updates in case of any changes in facility status or services

The hospital must maintain records or evidence of registration and data updates on the HFAT system. The assessment will involve verification of HFAT registration status, review of submitted data, and confirmation of regular updates through system records or reports.

C. Financial Management

Standard 4: Financial resources are properly managed to optimize the services that can be provided and the outcomes that can be obtained.

Indicator 19: The financial head is responsible for developing financial management policies and processes, as well as setting annual budget goals for each department in collaboration with department heads and the hospital's in-charge.

Assessment Process:

In order to comply with this indicator, the Hospital must have designated financial manager with the appropriate qualifications and experience, has developed and implemented clear rules and procedures for managing hospital finances. A documented transparent and collaborative procedure for the annual budget-setting process is in practice by involving the Hospital In-charge

and departmental heads. Record of the budget approval process, financial performance targets and its achievements is available

Indicator 20: The hospital has implemented an internal control audit system, and an external financial audit is carried out every financial year and documented.

Assessment Process:

In order to comply with this indicator, the Hospital must have established and implemented an internal control audit system and consolidated audit reports are available to monitor financial operations, ensuring accuracy, transparency, and compliance with financial policies. Additionally, the external financial audit shall be conducted once every financial year by a qualified third party, and its report is readily available to review the audit findings to ensure that any identified issues are resolved.

Indicator 21: There is an allocated budget for training of staff that is determined to enable the provision of suitable training. Allocate a fixed annual budget for staff training and continuous education programs to enhance skills and maintain high-quality service.

Assessment Process:

In order to comply with this indicator, the Hospital must have allocated a training budget to cover necessary training programs for staff. The training records of the hospital shall be examined to confirm that the allocated funds are being used effectively for relevant training activities, such as workshops, certifications, or skill development programs.

D. Human Resources Management

Standard 5: Employees are hired, trained, assessed, and promoted in compliance with job descriptions, established protocols, and service requirements ensuring these promote gender equality, inclusivity and equal access to opportunity and training for all.

Indicator 22: In order to meet the HCE service objectives, the hospital creates and implements policies and procedures for staff management, including hiring (new hires are hired after verifying their current, valid registration with the appropriate professional accreditation body), selecting, training, evaluating, promoting, and retaining properly qualified employees.

Assessment Process:

In order to comply with this indicator, the Hospital must have developed and implemented policies and procedure for management of staff. Personal files of randomly 15-20 employees shall be examined to confirm that they support the recruitment and maintenance of qualified staff in line with organizational policies.

Indicator 23: Compliance with Fair Wages, Written Contracts, and health Coverage for Health Workers

Assesment Process : This indicator assesses hospitals' adherence to fair employment practices by evaluating the provision of fair wages as per market, legally binding written contracts, and adequate social protection coverage for health workers, in alignment with national and International Labour Standards (ILS).

Hospitals will be evaluated based on document review (contracts, payroll records, benefits policies), worker surveys, and compliance audits.

Indicator 24: The hospital has a policy on staff availability, skill mix and career development opportunities, and each unit's ongoing role and functions of each unit/department are documented.

Assessment Process:

In order to comply with this indicator, the Hospital must have developed and implemented a policy for staff availability, skill mix and career development opportunities, for each of its department. Review of documented records and meeting with/interview of the manager of each department shall be conducted in order to assess compliance with this indicator.

Indicator 25: Fair Workload Distribution and Safe Staffing Levels in Hospitals

Assesement Process:

This indicator assesses whether hospitals ensure equitable workload distribution and maintain safe staffing levels to protect the well-being of health workers and the quality of patient care, in alignment with national regulatory bodies and International Labour Standards (ILS). Clear policies and guidelines exist to ensure fair allocation of tasks among health workers. Mechanisms are in place to prevent excessive working hours and burnout (e.g., shift rotation, rest breaks).Staffing ratios align with national regulations, international best practices, and patient care needs. Hospitals conduct regular assessments to monitor and adjust staffing levels. Contingency plans exist to address staff shortages without compromising health worker well-being.

Met: Hospital has policies and mechanisms ensuring fair workload distribution and meets safe staffing standards.

Partially Met: Some policies exist, but implementation is inconsistent or staffing levels fluctuate.

Not Met: No clear policies or mechanisms in place; staffing shortages and workload imbalances are prevalent.

Indicator 26: The hospital has defined and maintained up-to-date current job descriptions (JDs) and responsibilities for all staff.

Assessment Process:

In order to comply with this indicator, each employee of the hospital must have a written job description that defines his or her responsibilities expectations in line with hospital objectives. The same is made part of the HR file of every employee.

Indicator 27: The hospital has a policy of conduction of proper orientation of every new staff at the time of hiring, on their job descriptions, Hospital's environment, relevant departments/units, services, use of equipment, safety & emergency readiness, quality improvement & patient safety policies, SOPs & Procedures, and hospital rules & regulation.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented an orientation program to ensure that all employees receive comprehensive orientation on their job descriptions (JDs), the hospital's environment, CQI process, hospital's policies and the specific units or services they will be working in. The evidence of orientation sessions and documented participation of employees shall be reviewed as well as interviews of randomly 5-10 employee shall be conducted to ensure that the program is effectively preparing staff for their roles and responsibilities.

Indicator 28: Hospital practitioners and personnel are issued name badges or cards, which are used during duty hours and it prominently displays the practitioner's name, designation, and Specialty or discipline, if applicable.

Assessment Process:

In order to comply with this indicator, the hospital must have a policy in place for issuing name badges/cards to all practitioners and staff and making it mandatory for each staff member to wear it during duty hours. On-site assessment shall be conducted to confirm compliance with the hospital's policy, ensuring that all staff members are properly identified while on duty for both security and communication purposes.

Indicator 29: Annual performance of all employees is assessed in relation to their job description and pre-established goals, in order to identify their training needs, areas for improvement, and strengths.

Assessment Process:

In order to comply with this indicator, the hospital must have a well-documented performance appraisal system and annual record of each employee annual appraisal of the employees' actual performance against agreed targets is available. Personal files of randomly 10-15 employees shall be reviewed to verify that the appraisal system is in use.

Indicator 30: The hospital designates staff who are formally recognized (in writing) as competent/authorized to handle admissions, conduct assessments, administer treatment across various services, manage waiting lists, and make decisions regarding patient discharge.

Assessment Process:

In order to comply with this indicator, the hospital must have a developed and implemented a structured staff competency framework to define the skills, qualifications, and experience required for different roles, such as undertaking admissions, carry out assessments, provide treatment in different services, maintain and manage waiting lists and decide discharge of the patients along with the soft skills necessary to establish a good relationship with patients, support their wellbeing, and ensure effective communication.

The written policy shall be reviewed, on-site observation of staff performing the above-mentioned duties, interviews with staff members shall be conducted to assess compliance with this indicator.

Indicator 31: A qualified nurse, physician, or other healthcare professional oversees student nurses, physicians, or other healthcare trainees as necessary. They are not allowed to practice independently within the hospital.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a clear supervision policy that outlines the roles and responsibilities of qualified professionals in supervising the students, also that any student shall not be allowed to treat any patient without supervision of a qualified person. Review of such policies, documented supervisory records, observation of clinical practices and interviews with both students and their supervising professionals shall be conducted to confirm their understanding of the supervision policy and ensure compliance with this indicator.

Indicator 32: The Hospital carries out a training needs assessment every two years, with the aim of creating training programs for every staff group to satisfy the organization's service requirements as well as the development goals of individual health professionals.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented training needs assessment system with clear training policies that is reviewed every two years, involving input from staff across all levels and including training on soft skills, digital skills, cultural skills, communication skills, workers' rights, leadership skills among others. This will help trainees transit into work life seamlessly. The hospital's training records, policies, and training manuals shall be reviewed by examining reports, surveys, and feedback from staff to monitor the effectiveness of the training provided, ensuring continuous improvement.

Indicator 33: Opportunity of participation in programs for continuous professional development leading to acquisition of recognized quality credentials, provided by well recognized national and international institutes to every employee as per his/her job requirement to deliver safe and quality patient care.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy for continuous professional development program. Policy/SOPs and record of participants and its evaluation report shall be maintained by the hospital

Indicator 34: The Hospital maintains accurate and comprehensive personnel records and credentials (Preferably a digital HR system) including documentation of the training for doctors and all other staff members. These records are treated as confidential and securely stored.

Assessment Process:

In order to comply with this indicator, the HR department of the hospital must have maintained a list of all employees and complete HR file of each employee along with all his/her qualification/credentials, selection criteria, training records, Job descriptions, roles and responsibilities, performance appraisal, disciplinary records, promotions, transfers, retention policy. Additionally, it should have leave and attendance records, overtime approvals, and legal compliance documents such as confidentiality agreements, conflict of interest forms, acknowledgments of company policies. Lastly, exit documentation like resignation letters, exit interview notes, clearance forms, and final settlements should also be included and all these records should be treated as confidential. Personal files of randomly 15-20 employees shall be examined to confirm that they support the recruitment and maintenance of qualified staff in line with organizational needs.

Indicator 35: The hospital has in place a system to measure key indicators such as staff turnover, which is monitored, analyzed, and used to improve human resources.

Assessment Process:

In order to comply with this indicator, the hospital must have a comprehensive HR system and clear policies for staff turnover, and record of implementation of corrective measures is available, such as offering support programs or revising work environments. The above-mentioned policies and records shall be assessed for the same.

Indicator 36: Healthcare workers receive social security benefits as per applicable national law, especially women who may have benefitted from maternity protection and other benefits. This is essential to ensure that working environments are taking into account peculiar gender related challenges and providing conducive environments for women to progress.

Assessment Process:

There is record available on healthcare workers receiving social security benefits as per applicable national law, especially women who may have benefitted from maternity protection and other benefits.

Indicator 37: The Hospital has developed and implemented a policy regarding any attempt and/or actions constituting bribery, fraud, or corruption to result in initiating disciplinary proceedings. The Applying Organization is held accountable for any consequences that may result from its breach of the Code of Ethics as well as any applicable laws and regulations.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented anti-bribery, fraud, and corruption policy along with documented Code of Ethics. The Policies and records of the same shall be reviewed to verify clear documentation outlining the consequences of such actions, including immediate contract termination. The monitoring and auditing system to detect and prevent unethical behavior shall also be observed. A grievance mechanism to address healthcare workers / labour disputes should be included in the such a policy.

2. PATIENT RIGHTS

A. Information for Patients:

Standard 6: Patients have the right to receive all information relevant to their care management enabling them to make informed decisions.

Indicator 38: The hospital has outlined a charter highlighting the patient rights and responsibilities and displayed in the relevant patient area.

Assessment Process:

In order to comply with this indicator, the hospital must have developed Patient Rights and Responsibilities Charter and displayed prominently in patient areas such as waiting rooms, patient rooms, and hospital entrances. A Patients' Charter in a hospital should include components such as the Right to Respect and Dignity, Right to Confidentiality and Privacy, Right to Information, Right to Informed Consent, Right to Access Healthcare Services, Right to Safety, Right to Choose, Right to Second Opinion, Right to Complain and Seek Redressal, and Right to Participate in Decision-Making Regarding Care. It should also outline patients' responsibilities, such as the Responsibility to Provide Accurate Information, Responsibility to Follow Medical Advice, Responsibility to Respect Healthcare workers[5] and Other Patients, Responsibility to Adhere to Hospital Policies, Responsibility to Pay for Services, and Responsibility to Promote Safety by Reporting Concerns (whistle blowing).

The content of the charter shall be assessed to ensure it is comprehensive, easy to understand, and aligned with legal and ethical standards.

Indicator 39: Prevention and Response to Violence, Harassment including gender-based violence as well as dealing with potentially violent patients.

Assessment process:

The hospital has developed and implemented a policy that prohibits all forms of violence and harassment, including gender-based violence, harassment and dealing with potentially violent patients. The development of this policy could also be done by integrating existing policies and mechanisms, such as OSH policies or existing grievance handling procedures, to include specific reference to violence and harassment. Preventive measures have been put in place, and measures are taken to prevent and control any risks leading to violence and harassment. Easy access to reporting and dispute resolution mechanisms and procedures is ensured, and protection against victimization of or retaliation against complainants, victims, witnesses and whistle-blowers is guaranteed.

Indicator 40: There is evidence that patients or their guardians are thoroughly informed about the hospital's facilities, service fees, and available feedback and complaint procedures at the time of registration. Additionally, patients or their attendants are provided with clear information regarding the expected outcomes of the treatment and the estimated treatment costs. Policy of information to patient/attendants regarding care of personal belongings.

Assessment Process:

In order to comply with this indicator, the hospital must have comprehensive informational materials/patient facilitation desk at the point of registration, which include details on hospital facilities, treatment costs, and the feedback as well as available in multiple languages (if necessary). A documented policy should be available and implemented for complaint management system with mechanisms for patients to report issues or concerns easily, either verbally or in writing. A uniform pricing policy is developed and implemented and tariff list for all the services is made available to a patient upon the patient's request. The hospital's registration documents, patient information materials, patient feedback forms, complaint management record and tariff list shall be reviewed. Sample of a file that includes all the elements associated with managing the complaint and demonstrates the progressive follow-up with complainants shall be assessed. Also, patients' interviews shall be conducted to assess compliance with this indicator.

Indicator 41: When a female patient is being examined by an examiner of the opposite gender, a female nurse or chaperone is present. A male patients should also have a chaperone when being examined by opposite gender staff, ensuring gender-sensitive care.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented clear policy that mandates the presence of a female nurse or chaperone whenever a female patient is examined by a male examiner. The written policy shall be assessed and clinical practices shall be verified through on-site observation.

Indicator 42: Adequate information is displayed in various areas of the hospital at key locations through suitable signage.

Assessment Process:

In order to comply with this indicator, the hospital must have clear, visible signage displayed in

prominent locations providing essential information, including directions to key departments, emergency procedures, patient rights, available services, emergency exits, and hospital policies. A walkthrough of the hospital shall be conducted to check for clear and prominent signage in key areas such as entrances, waiting rooms, corridors, patient rooms, and service departments.

Indicator 43: Patient and their families are informed about the status of their health and clinical conditions in appropriate/understandable language, an interpreter is arranged by the Hospital and are involved in the assessment by providing information wherever required.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy for communication protocols, ensuring that all patients and their families receive information about their health in a comprehensible manner. It shall be assessed that written policy and arrangement of interpreters, when necessary, particularly for non-native speakers, patients with hearing impairments, or those with limited understanding of medical terminology.

Indicator 44: The hospital has established a policy that necessitate written consent and defined clear standard operating procedures (SOPs) for taking written consent before those procedures.

Assessment Process:

In order to comply with this indicator, the hospital must have listed those situations/procedures where specific informed consent is necessary and SOPs related to this are implemented. Documented policies shall be reviewed and medical records shall be reviewed to determine the implementation of the same

Indicator 45: Up to date evidence-based information is provided for disease prevention and health promotion in the form of relevant health messages displayed at prominent places. (Booklets and educational materials are available).

Assessment Process:

In order to comply with this indicator, the hospital must have current, evidence-based educational materials available in easily accessible locations covering a range of topics related to disease prevention, health promotion, and wellness. The educational materials such as booklets, brochures, and posters shall be reviewed and a walkthrough of the hospital shall be conducted to observe whether these materials are displayed.

Indicator 46: Each department in the hospital has a waiting room equipped with drinking water. The area is clean, safe, and offers adequate, comfortable seating.

Assessment Process:

In order to comply with this indicator, the hospital must have well-designed waiting areas in each department, equipped with clean, accessible drinking water facilities, comfortable seating,

regularly cleaned and security measures are in place to ensure the safety of patients and visitors. A walkthrough of each department to observe the conditions of the waiting areas and interviews with patients and visitors shall be conducted.

B. Patient Feedback on Services

Standard 7: Patients have the right to file complaints about the care and services they receive, and these complaints are addressed promptly and fairly.

Indicator 47: A documented complaint management system is implemented and made accessible to hospital staff, patients, and attendants. The results of complaint investigations are submitted to the CQI/Complaints Committee each month and are utilized to improve quality. The status of complaints is communicated to patients and attendants. Patient Advice and Liaison Services (PALS) pathway, complaint center for risk Management

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented mechanism for complaint management and have a documented process for collecting, prioritizing, reporting and investigating the complaints. Regular complaints are redressed within 15 days, while complaints relating to sentinel events are redressed within one month of the lodging of complaint and the results of the complaints investigation are submitted on monthly basis to CQI/Complaints Committee and are used for quality improvement. The record of previous complaints shall be reviewed. Sample of a file that includes all the elements associated with managing the complaint and demonstrates the progressive follow-up with complainants shall be assessed, also, patients/staff interviews shall be conducted to verify that the patients/ attendants are informed about the redressal/progress of the complaint.

C. Privacy and Dignity of Patients

Standard 8: During the whole care process, patients' dignity and privacy is maintained.

Indicator 48: Patients have the right to an individual bed and the hospital ensures its compliance.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented the policy for availability of designated bed to each patient. Review of policy and walkthrough of hospital shall be conducted to assess compliance with this indicator.

Indicator 49: Restrooms, consultation rooms, and changing facilities are all set up appropriately to ensure patient's privacy and safety while they are receiving treatment, preferably, similar separate arrangement must be done for healthcare workers in the HCE.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented protocols] to ensure patient and healthcare worker's privacy in all areas. A thorough inspection of patient care areas, including treatment rooms, consultation spaces, washrooms, and changing facilities for patients as well as healthcare workers and patient and staff feedback via interviews shall be conducted to analyze their satisfaction with privacy measures.

PART B: SERVICE DELIVERY

3. CARE CONTINUUM

A. Access to Health Services

Standard 9: Services are continuously available, and the hospital works to reduce physical, economic, social, cultural, organizational, or linguistic barriers to access.

Indicator 50: The hospital ensures easy accessibility of functional wheelchairs and stretchers for all patients at designated points, supported by trained staff assistance.

Assessment Process:

To comply with this indicator, the following SOPs to be followed by the HCE;

1. Functional, clean, and disinfected wheelchairs and stretchers are made available at the gate/reception for patients.
2. All passageways, corridors, stairways, and storage areas are kept clear and well-lit.
3. All entrances, doors, and patient areas are wheelchair accessible.
4. Ramps or operational elevators/lifts with an operator are provided in multi-storey hospital structures.
5. Sufficient supply of wheelchairs and stretchers along with trained staff are available to assist patients.

Assessment will involve physical inspection, review of maintenance records and evidence of training documents.

Indicator 51: The hospital and its departments are well marked and a floor plan is prominently displayed for staff and patient's orientation.

Assessment Process:

In order to comply with this indicator, the hospital must maintain up-to-date site plans, prominently displayed at central locations (accessible to both staff and patients), placed clearly visible signage and make necessary updates when departments or areas change. Physical inspection and review of site plan shall be conducted to verify the same.

Indicator 52: A reception area is available during business hours, staffed by both male and female receptionists to assist patients. The staff in the ward or department, as well as those at the reception, treat all patients and visitors with respect and provide prompt attention. The hospital also has a dedicated welcome counter for senior citizens and individuals with disabilities or special needs.

Assessment Process:

In order to comply with this indicator, the hospital must have well-staffed reception areas during operating hours with both male and/or female receptionists, offer courteous and efficient service, and provide a specialized counter for disabled individuals. Physical inspection, training record of staff and interview with reception staff and patients shall be conducted to evaluate how the reception staff communicates with patients, particularly disabled and elderly individuals.

Indicator 53: The hospital clearly notifies the public of its visiting hours

Assessment Process:

In order to comply with this indicator, the hospital must have clearly defined visiting hours for all departments and ensures these hours displayed prominently on hospital websites, in printed materials, and at key locations within the hospital, such as the reception area. Physical inspection and interviews with the hospital staff shall be conducted to assess that they are well-informed about the visiting hours.

Indicator 54: The hospital provides facilities for family members to sit at the bedside and stay overnight if needed, along with clear and prominently displayed guidelines regarding the number and type of guests and attendants allowed.

Assessment Process:

In order to comply with this indicator, the hospital must have defined and posted visitation rules (e.g., number of visitors, visiting hours, special conditions for certain patient areas) and adequate facilities are available for relatives/visitors to stay with the patient, when necessary while maintaining patient privacy and safety. These rules must be displayed in accessible areas such as the reception, ward entrances, and patient rooms. Physical round of patient areas and interviews with patients/relatives shall be conducted to verify the same.

Indicator 55: Policies and procedures that prioritize patient examination and treatment (triage), waiting time, referrals, bed availability, and special person assistance are documented and followed.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for triage, managing bed availability, patient referrals, managing waiting times and support to special persons. Staff must be trained in these processes to ensure they are

effectively implemented and record of training be maintained. Assessment of color-coding system at triage, review of training record and documented process of patient referrals and staff interviews to check that they are aware of these policies shall be conducted.

Indicator 56: Patients are greeted by the on-call nurse upon admittance to the hospital and given an orientation of the unit, including where the storeroom, restrooms, and other amenities are located. A standardized checklist to ensure comprehensive patient orientation upon admission.

Assessment Process:

In order to comply with this indicator, the hospital must have documented process for introducing the on-duty nurse and providing the necessary orientation to patients that may include a standard checklist or procedure for orientation that staff follow. Review of admission records and interview with staff shall be conducted to verify their knowledge of the orientation process and their responsibilities.

Indicator 57: Elective admissions, along with waiting list management and cancellations, are managed according to patient needs and in accordance with established policies and procedures.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for managing elective admissions, waiting lists, and cancellations. Review of documented policies/waiting lists and interview of hospital staff shall be conducted to verify that they are familiar with the said policies and procedures.

B. Continuity Of Care

Standard 10: Patients have right to continuity of care, which includes collaboration amongst all medical professionals and/or departments that may be engaged in their diagnosis, care, and treatment.

Indicator 58: Each patient receives a unique registration number and the on-duty doctor must examine and fill the relevant forms noting down their symptoms, diagnosis, course of therapy, and services delivered.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a process for registration of each patient with unique identifier and collection of essential personal and medical details, such as symptoms, medical history, diagnosis, treatment, and the services being provided. Patient records shall be reviewed to ensure that the appropriate forms are issued and properly filled out as well as interview of hospital staff, such as receptionists, nurses, and medical practitioners, shall be conducted to verify that they are familiar with the process of patient registration and documentation.

Indicator 59: A qualified individual has been assigned to handle patient assessment, care planning, and care evaluation alongside other services and providers.

Assessment Process:

In order to comply with this indicator, the hospital must have designated a qualified person (such as a care coordinator or senior clinician), to ensure comprehensive, coordinated, and patient-centered care. A sample of patient care plans shall be reviewed to ensure that designated individual care coordinator has performed the assessment, developed a care plan, and evaluated the care provided. Interview of relevant healthcare providers, such as doctors, nurses, and care coordinators shall also conducted.

Indicator 60: There is a 24-hour supply of necessary medications in every treatment area.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented guidelines for stock management of drugs including maintenance of inventory, storage of drugs as per cold chain requirements, and first in first out (FIFO) policy to prevent stockouts or expiry and the staff is trained on these guidelines. Review of guidelines, inspection of storage area, assessment of inventory records/stock register and evidence of relevant staff training shall be conducted.

Indicator 61: Doctors, registered nurses (in their respective field), and suitably trained support personnel are on-site during all working hours in every shift in line with agreed safe staffing levels..

Assessment Process:

In order to comply with this indicator, the hospital must maintain detailed and accurate records of staffing schedules, duty rosters and personnel qualifications. Review of duty rosters and physical inspection of different areas shall be conducted to verify that qualified staff is available every shift of the working hours.

Indicator 62: The hospital has established and implemented a policy requiring emergency staff to call on urgent emergency codes (red, blue, etc.). Notification of code teams with the assigned responsibility. Mock drills are also conducted to guarantee that the appropriate team and equipment are available on time.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy for staff to activate emergency codes with notification of proper emergency response team and regular mock drills to test the effectiveness of these procedures. Record of drill outcomes must be maintained to identify areas for improvement and maintain continuous staff training. Review of relevant policy, record of mock drills and interview with emergency response team to assess the training level of relevant staff shall be conducted.

Indicator 63: The hospital has implemented a suitable protocol for staff handing/taking over a shift to share and receive all relevant patient information, including progress and care details.

Assessment Process:

In order to comply with this indicator, the hospital must have defined and implemented the procedure for handing/taking over of patient information between the shifts and its record is maintained in the patient files/designated register and the staff is trained on these procedures. Review of random 5-10 patient files along with training evidence shall be conducted to assess compliance with this indicator.

Indicator 64: Healthcare professional involved officially in management of concerned patient only, has access to patients' records.

Assessment Process:

In order to comply with this indicator, the hospital must have efficient and secure system in place for managing patient records, whether electronic or paper-based, maintaining confidentiality and accessibility of all healthcare providers to complete and up-to-date patient information. Review the hospital's record management system to assess that patient's record is maintained properly and available to all care providers.

Indicator 65: Discharge or end-of-service planning starts upon admission and includes the patient, their family, and any follow-up care providers.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented discharge planning policy that starts at the point of admission by involving patients and their families in discussions about care needs, expected discharge timelines, and follow-up services. Review of discharge planning policy and interviews with healthcare providers, patients, and family members shall be conducted to ensure that the discharge planning process is communicated effectively.

C. Assessment

Standard 11: Each patient's medical needs are identified using a standardized evaluation process.

Indicator 66: A thorough assessment of the patient's needs, including medical, psychological, social, physical, environmental, educational, spiritual, and cultural aspects, is conducted on a standardized form.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented appropriate care plans and staff is trained to complete comprehensive assessments by filling up

the standardized forms to assess the patient's needs across multiple domains, such as medical, psychological, social, physical, environmental, educational, spiritual, and cultural needs. Documented care plans, patient files and evidence of training shall be examined.

Indicator 67: A member of the medical staff records each patient's medical history and complete examination, including but not limited to vital signs (including oxygen saturation), height, weight, and any significant findings, as soon as possible, but no later than six hours after admission. Ideally, the attending consultant should review and approve all patient evaluations within 24 hours of admission.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policy and procedure for timely documentation of medical history, physical examination and consultant review. Staff must be trained on documentation protocols, and the hospital monitor compliance through regular audits to meet these requirements. Policies and patient records, training evidence of staff and audit reports shall be reviewed to verify that a history and full medical examination are documented within 6 hours of admission and consultant has reviewed and approved the assessments within 24 hours.

Indicator 68: After examining the patient, the doctor clearly documents the assessment findings, records the provisional diagnosis and treatment plan on the OPD card or patient record, and includes the date, signature, and stamp (with the doctor's name on the stamp).

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented clear protocols for doctors to document patient assessments accurately and consistently. Review of protocols and a sample of 5-10 patient records (OPD and in-patient) shall be assessed to verify that the provisional diagnosis, recommended course of action, and relevant details are properly documented, dated, signed, and stamped by the doctor.

Indicator 69: Admission notes are completed prior to any surgery, except in emergency situations. In the case of an emergency, the admission notes are filled out as soon as possible.

Assessment Process:

In order to comply with this indicator, the hospital's documentation policies must specify that admission notes are completed before surgery, with exceptions only in emergency situations and staff is trained on timely documentation of admission notes, even in urgent cases. Documented policy, training evidence and patient's files shall be reviewed to assess compliance.

Indicator 70: Patients are given verbal and written information about next appointments, therapy, and medication after an evaluation.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for provision of written and verbal information to patients about their ongoing care, and staff must be trained to communicate effectively with patients and to document that the information has been given. Review of policies, patients' records, training evidence and interview with the patients shall be conducted to ensure that both written and verbal information about future visits, treatment, and medication is consistently provided.

Indicator 71: The medical team reassess the patients every 8 hours, to determine progress and how they are responding to treatment and to develop further treatment or discharge plan. The outcomes of these reassessments are recorded in the patient's file by the medical team.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented re-assessment protocols, ensuring that both medical and nursing staff adhere to the required intervals for patient evaluation and staff is trained on the same. Review of protocols, training evidence and patient records shall be assessed to monitor compliance.

D. Care Planning, Monitoring and Evaluation

Standard 12: Healthcare providers develop and implement a documented, up-to-date care plan for each patient, and they monitor the treatment provided in accordance with this plan.

Indicator 72: To ensure continuity of care and ongoing appropriate treatment, a documented care plan is created for each patient in collaboration with the patient, caregivers/relatives, and other relevant healthcare professionals. The plan is updated after each reassessment.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and updated patient care plans which are regularly reviewed and adjusted based on patient re-assessments. These care plans are accessible to all healthcare professionals and staff must be trained on creating and updating these plans. Review of care plans in medical record and training evidence shall be conducted for the same.

E. Treatment

Standard 13: The organization provides patients with services that match to their specific needs, take into account best practices, and are coordinated to reduce risks and service interruptions.

Indicator 73: Patient care procedures are guided by clinical guidelines and treatment protocols.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented up-to-date clinical guidelines and treatment protocols, the guidelines are displayed (all guidelines in ER, while critical guidelines in Wards etc), staff must be trained on their use and hospital monitor adherence to these protocols through clinical audits. Documented guidelines/protocols, training evidence and interview of medical staff shall be conducted to ensure that these are being consistently used to guide patient care.

Indicator 74: In order to ascertain that the appropriate medication is given to the relevant patient and that it is recorded in the patient's file or medical record, the hospital has created and put into place protocols and mechanisms.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented protocols and procedures for medication administration and relevant staff must be trained on theses protocols. The following steps must be documented and adhered to in practice:

i. Issuance of unique medical record number to every patient at the time of admission
ii. Identification of the patient via his/her MR number before medications are administered
iii. Verification of the medication and the dosage amount with the prescription
iv. Verification of the routes of administration
v. Verification of the time of administration
vi. Verification of therapeutic duplications
vii. Verification of allergy checks
viii. Verification of drug-drug interactions

Review of policies/protocols, training evidence, assessment of medical records and on-site observation when a nurse or an anesthetist preparing medication shall be conducted to verify the compliance of this indicator.

Indicator 75: The effects of medications, including adverse effects, errors with medications are tracked, examined, and reported. A record of the same is kept on file.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy and procedure to monitor and track medication adverse reactions and errors, ensuring that all incidents are documented in the patient's record. There must be clear reporting mechanism in place for healthcare staff to report adverse effects and medication errors (should be reported to CQI Committee), and staff should be trained on it. Documented record of all such occurrences and corrective actions taken must be available. Review of the policies/procedures, training evidence, patient records and documented reports shall be conducted.

Indicator 76: With the necessary number of nurses on duty round-the-clock in accordance with the required nurse to patient ratio as per PNC rules. There is adequate and sufficient manpower, equipment, and support services available to enable nursing staff to address the care needs of

patients.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented staffing policies to ensure that sufficient nursing staff are available to meet patient care needs (nurse-to-patient ratio), as per the Pakistan Nursing Council (PNC) guidelines. The hospital must ensure that nurses have access to the necessary equipment, supplies, and support services to deliver high-quality care and ensure patient safety. Documented record of regular audits of equipment/supplies and staffing assessment must be maintained. Review of staffing policies, documented audit reports and on-site inspection to verify the availability of appropriate number of nursing staff shall be conducted.

F. Documentation of Care

Standard 14: There is enough information in the patient record to identify the patient, confirm the diagnosis, explain the course and outcomes of the treatment and encourage continuity of care across medical professionals.

Indicator 77: Implement a checklist for maintaining complete and standardized patient records containing identified, readable, signed, dated, and, if required, stamped entries. Following a predetermined list of abbreviations, the hospital uses as few symbols and abbreviations as possible. It should be readable and prevent over writing.

Assessment Process:

In order to comply with this indicator, the hospital must maintain patient records that are legible, dated, signed, and stamped where applicable. All entries should be identifiable to the respective healthcare provider. The hospital must also have an officially approved list of abbreviations, and the use of symbols and abbreviations in patient records should be minimized and in accordance with this list. The assessment will include a review of patient records to ensure adherence to these standards, verification of the existence and implementation of the approved list of abbreviations, and confirmation that staff are aware of and comply with the standardized usage guidelines.

Indicator 78: The hospital treats all information regarding a patient's health, medical condition, diagnosis, prognosis, treatment, and other personal details as strictly confidential, even after the patient's death.

Assessment Process:

In order to comply with this indicator, the hospital must have policies and procedures in place that respect and protect the confidentiality of all patient-related information, including health status, medical condition, diagnosis, prognosis, treatment, and other personal information. This obligation extends beyond the patient's death. The assessment will involve reviewing the hospital's confidentiality policy, evaluating the mechanisms implemented for safeguarding such

information, and verifying that staff are trained to uphold confidentiality standards. Additionally, evidence of measures taken to prevent unauthorized access or disclosure of personal information will be examined.

Indicator 79: The hospital has a policy that confidential information is only disclosed if the patient gives explicit consent or if the law expressly provides for this.

Assessment Process:

In order to comply with this indicator, the hospital must have a documented policy governing the disclosure of confidential patient information. The policy should explicitly state that such information is only disclosed with the patient's explicit consent or when required by law. The assessment will include a review of the hospital's confidentiality policy, verification of the process for obtaining and documenting patient consent for disclosures, and an evaluation of staff awareness and adherence to these protocols. Evidence of compliance with legal requirements for mandatory disclosures will also be reviewed.

Indicator 80: Only with the patient's written consent and/or the Ethics Committee's approval, the patient's record can be utilized for study.

Assessment Process:

In order to comply with this indicator, the hospital's privacy/confidentiality policy must specify that no patient information is used for research without explicit, written consent from the patient and Ethics Committee approval (if available). Standardized consent forms must be available for the same. Staff involved in research should be trained on these procedures and its record is maintained. Review of policy, training evidence and documented record of consents and approvals shall be conducted to ensure compliance

Indicator 81: The patient record is comprehensive enough to enable a patient or attendant to obtain all the information needed for efficient and well-coordinated care.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedure for the record management to ensure that all aspects of patient care are thoroughly documented in the patient record and staff must be trained on maintaining accurate, up-to-date, and comprehensive records. This may include:

- Details of admission, date and time of arrival
- Patient assessment and medical examination
- Sheet containing history pertinent to the condition being treated including details of present and past history and family history.
- Diagnosis by a registered health professional for each entry to the hospital
- Details of the patient care or treatment plan and follow-up plans
- Diagnostic test orders and results of these tests
- Progress notes written by medical, nursing and allied health staff to record all significant events

such as alterations in the patient's condition and responses to treatment and care
- Record of any near misses, incidents or adverse events
- Medication sheet recording each dose given
- Treatment record
- Observation charts, E.g., temperature chart, input and output chart, head injury chart, diabetic chart
- Specialist consultation reports
- Mode of discharge, E.g., left against medical advice or discharged on request
- In case of death, details of circumstances leading to the death of patients

Hospital's policies and procedures, staff training evidence and medical record of patients (random 10-15 files) shall be thoroughly reviewed to ensure that it sufficiently detailed and contain all above information for effective and coordinated care.

Indicator 82: The clinical record of all the surgical patients includes additional anesthetist notes, pre/post operation notes, and a consent document.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies for pre-operative, intra-operative and postoperative care including pre-operative assessment, anesthetist notes, written informed consent, a pre-operative checklist to prevent adverse events like wrong site, wrong patient and wrong surgery and documented operative and post operative notes, recorded prior to the patient being transferred from the recovery area. The informed consent must be signed and properly documented indicating that the patient was informed and consented to the surgery. Review of policies, random sample of surgical patient records (8-10 files) and documented record of consent forms shall be conducted.

Indicator 83: The record of patients where referrals have been made, have a referral letter and referral indications clearly mentioned.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented guidelines and protocols for referral of patients. A formal written referral letter or form must be issued which clearly state the reason for the referral, the referring physician's clinical findings, and the specific request or recommendation for specialist consultation or further evaluation. Designated staff must be properly trained and training record is maintained. Documented guidelines, referred patients' medical record and training evidence shall be conducted to check compliance with this indicator.

Indicator 84: The record clearly shows an "alert" notation for circumstances like potentially dangerous drug reactions, radioactive hazards, infection concerns, and allergic reactions to food or drugs.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a system for documenting patient's alerts which include specific color-coding on patient record or digital notifications within the EHR to flag critical risks like allergies, adverse drug reactions, radioactive hazards and infection risks. Training to all healthcare staff (doctors, nurses, pharmacists) should be provided to ensure they understand how to identify and document alerts in patient records. Review of the alert system including patients record/EHR system, training evidence and interview with medical staff shall be conducted to ensure patient safety.

Indicator 85: Within 72 hours of the patient's discharge, DOR / LAMA, a comprehensive discharge statement, signed by the physician (full name) who approved the discharge, is added to the patient's file and submitted to the records department.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures regarding the completion and submission of discharge summaries to the hospital's record department within 72 hours of discharge and that the doctor must signed, stamped and dated the summary promptly. If the hospital uses EHRs, the system should allow for easy input, signature, and submission of discharge summaries. The hospital must have a standardized template for discharge summaries that includes all the following necessary components:

- Patient identification and demographics.
- The reason for admission
- Significant diagnostic investigation results
- Treatment and surgical procedure (If applicable)
- The patient's response to treatment
- Any discharge medications
- Instructions for post-discharge care, including appointments or further treatments.
- Any complications or issues during the hospital stay.

Healthcare providers (especially doctors) should be trained on the same and it record is maintained. Review of policies and procedures, training evidence and patient's complete clinical record shall be conducted.

Indicator 86: An annual summary report is created and utilized for planning purposes. All diagnoses and treatments are coded in accordance with international standards (ICD).

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented coding guidelines, coding manuals and software systems to integrate it with Electronic Health Records (EHR) systems, for implement coding of all diagnoses and procedures using the ICD standards (such as ICD-10 or ICD-11). The hospital must employ trained and certified coders who are knowledgeable about the ICD system and capable of accurately applying the correct codes to

patient diagnoses and procedures. A comprehensive annual summary report must be prepared and utilized in the planning process (such as for resource allocation, budget planning, staffing, and quality improvement initiatives) and its documented record is maintained. Review of coding guidelines, EHR system, evidence of training/certifications and documented record of annual reports shall be reviewed to check compliance.

Indicator 87: All patient records should be kept on file for a minimum of, Seven Years ideally on a computer system as well as on paper. On the other hand, medical-legal cases as well as birth and death records are preserved forever.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented written record retention policies which define the process for retaining, archiving, or securely destroying records after the retention period expires and specifying that patient records are retained for a minimum of seven years, with birth and death records and medico-legal cases are stored lifetime. The hospital must have both electronic health record (EHR) systems and a physical filing system that can store patient records safely and securely. Staff should receive regular training on data privacy and maintaining confidentiality. Review of policies, EHR and manual filing system, death and birth records and training evidence shall be conducted to ensure compliance with this indicator.

Indicator 88: Patient information is secured against loss, damage, tampering, and unauthorized access. Entries are timed, dated, and signed for accuracy and accountability.

Assessment Process:

In order to comply with this indicator, the hospital must have secure storage for physical patient records (locked cabinets or restricted access rooms) as well as strong cybersecurity measures are implemented for electronic records, including encryption, firewalls, access control systems, and secure backups. All the entries must be timed, dated, signed and strict access control protocols must be developed and implemented with passwords, biometric authentication, or keycards, to verify the identity of those accessing patient information. Physical inspection of record rooms and review of EHR System shall be conducted to ensure that patient information is secured against loss, damage, tampering, and unauthorized access.

Indicator 89: A policy is in place that permits patients and their authorized representatives to access and obtain their complete medical records and diagnostic reports upon discharge.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policy that allows patients and their authorized attendants to access their complete and original medical records and diagnostic reports at the time of discharge, including include a request form for confirming the patient's or attendant's identity and consent for the release of the records. Review of hospital policy, documented record of request forms and feedback system of hospital shall be

conducted.

G. Discharge, Transfer and Referral

Standard 15: Safe and appropriate discharge, transfer or referral of patients is based on the patient's health status and need for continuing care.

Indicator 90: The hospital has established and implemented a policy with criteria to assess a patient's readiness for discharge, transfer, or referral. It ensures reasonable advance notice (preferably 12 hours) is provided to the patient's caregiver and specifies the authorized personnel responsible for these actions.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policy including criteria to determine readiness of the patient for discharge, transfer/referral to another facility along with the procedures for patient and carer notification, ensuring that at least 12 hours of notice is provided when possible. The hospital must define clear roles and responsibilities of authorized person to make these decisions (e.g., attending physician, discharge coordinator, etc.). The discharge, transfer, and referral decisions, as well as the notice to the carer, are properly documented in the patient's medical record and relevant staff must be aware of these procedures. Review of policy, criteria to assess patient's readiness, documented discharge/transfer plan and record and interview with hospital staff shall be conducted.

Indicator 91: Prior to discharge, DOR / LAMA, the patient and/or his/her family are given a signed discharge card or slip that contains pertinent information, including the reason for admission, findings, diagnosis, treatment, medication, condition at discharge, date of discharge, and name of attending practitioner. A copy of the card or slip is kept in the patient's file.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a discharge policy to ensure it specifies the requirements for a discharge card or slip is provided to the patient or their family prior to discharge. This includes ensuring that the policy mandates the inclusion of all relevant information, such as:

- Reason for admission.
- Findings (e.g., diagnostic results, clinical observations).
- Diagnosis.
- Treatment (including surgical procedures or therapies provided).
- Medications prescribed.
- Condition at discharge (including recommendations for follow-up care).
- Date of discharge.
- Name of attending practitioner (including their signature and stamp).

The hospital must have a system in place to ensure that copies of the discharge card/slip are retained in the patient's medical record, whether in physical form or electronically. Review of

policy/procedure and documented discharge cards/slips (random sample of 8-10 patient files) shall be conducted.

Indicator 92: The patient and/or their relevant caregiver or attendant receives guidance on essential post-discharge care skills, including catheter care. Or other necessary patient's home care.

Assessment Process:

In order to comply with this indicator, the hospital must provide written and verbal post-discharge care instructions (specified in discharge policy), providing advice or training on essential skills, so that caregiver become competent enough to manage the patient's needs and reduce the risk of complications after discharge and document the training process. The hospital must have a system in place to follow up with patients or caregivers to ensure the care plan is being followed effectively after discharge. Review of hospital's discharge process, documented evidence of patients/attendants' education or training and interview with staff and patients shall be conducted.

Indicator 93: When patients are transferred to another hospital or doctor, copies of their clinical notes and the discharge slip are provided to ensure continuity of care and facilitate feedback. Qualified staff with training in ACLS should accompany the patient. Necessary resources, such as transport or walking aids, are arranged if required.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for transferring medical information, ensuring that the patient's needs for additional resources are assessed and addressed, and ensure that any equipment or support (like transport or mobility aids) is arranged prior to transfer. Proper documentation and coordination between healthcare teams are essential for maintaining seamless care during the transition. Review of policies and procedures and physical inspection of the facility shall be conducted to ensure that all the needed equipment or support services are available.

Indicator 94: Prior to the transfer, the patient's status, arrival time, and place of arrival are communicated to the recipient HCE. The recipient HCE then confirms with the sender HCE that the transfer has been done successfully.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented process for communication between transferring and receiving facilities. This includes ensuring timely notifications and confirmation of the bed availability and the required specialized services to ensure continuity of care. The hospital must also have a tracking system to confirm the patient's safe arrival and any necessary post-transfer instructions. A comprehensive record of transferred patients must be maintained. Review of procedure for transfer, documented evidences of prior notification to receiving facility and transfer records shall be conducted.

4. OPERATION THEATRE DEPARTMENT

A. Service Management

Standard 16: Operation Theatres provide safe, hygienic and appropriate services for patients and are coordinated with other services of the hospital to provide continuity of care.

Indicator 95: The operation theatre(s) and/or department are supervised by a senior operating assistant, doctor, or nurse who has the pre requisite qualification and training.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that a designated doctor, nurse or senior operating assistant to hold the responsibility for managing the daily operations, coordinating surgical schedules, and overseeing patient safety in the operation theater and he/she must be suitably qualified and experienced.

Indicator 96: The relevant OT staff is made aware of the list of approved surgical procedures, tools, supplies, and standard operating procedures (SOPs) authorized by the hospital.

Assessment Process:

In order to comply with this indicator, the operation theater must have developed and implemented standard operating procedures (SOPs) for operation theater and an up-to-date list of hospital-approved surgical procedures, equipment and supplies is easily accessible to all relevant staff as per WHO Guidelines. The hospital must ensure that staff receive proper training on these SOPs and its record is maintained. Review of SOPs, training evidence and physical inspection shall be conducted to assess compliance with this indicator.

Indicator 97: Only Qualified, registered, and experienced anesthetists administer anesthesia, in addition to ensuring their availability for all surgical procedures until the patient has completely recovered from anesthesia

Assessment Process:

In order to comply with this indicator, the hospital must have established and implemented a policy ensuring that anesthesia services are provided by a qualified, registered, and experienced anesthetist. The anesthetist must also remain available until the patient has fully recovered from anesthesia. The assessment will involve reviewing the hospital's policy, anesthesia records, the anesthetist's qualifications and credentials, as well as the patients' medical records to verify compliance with this standard.

Indicator 98: The surgeon and anesthetist are always on hand to provide assistance and remain in the recovery area until the last patient has been transferred back to the ward/room. They are supported by designated, trained staff including nursing staff, operating theatre assistants, and

anesthesia technicians. It is recommended that OT support workers have ACLS certification, or at least a minimum, BLS training.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that designated, suitably trained staff members, including nursing staff, operating theatre assistants, and anesthesia technicians, are available to assist both the surgeon and anesthetist during each anesthetic session and they must remain present in the recovery area until the last patient has been discharged back to the ward. The support staff in the operating theatre should be trained in ACLS or, at a minimum, BLS. The assessment will involve reviewing staffing records, training certifications, and the presence of the anesthetist during recovery to confirm adherence to this requirement.

Indicator 99: Surgery, along with support and guidance, is provided by a visiting consultant surgeon or assistant, as per a written contract that defines the terms and scope of their consultation.

Assessment Process:

In order to comply with this indicator, the hospital must have signed a valid MoU or agreement with every visiting consultant surgeon or assistant and its documented record is maintained. A list of all visiting consultant surgeons and/or assistants as well as the documented MoU or agreements will be reviewed in order to assess compliance with this indicator.

Indicator 100: Regular recorded audits of the operating theatre are conducted, and the information gathered is used and reviewed by the relevant management, safety and/or quality improvement committees, and related personnel.

Assessment Process:

In order to comply with this indicator, the hospital must conduct regular, documented audits of the operating theatre. The findings from these audits should be reviewed and discussed with relevant staff, management, and safety or quality improvement committees. The assessment will involve reviewing audit records, meeting minutes, and evidence of follow-up actions taken based on audit results to ensure continuous improvement and adherence to safety and quality standards. The audit must include:

- Admissions and discharges by specialty
- Diagnosis-specific bed utilization
- Procedure-specific operating rates
- Post-operative infections
- Post-operative deaths
- Unplanned return to theatre
- Post-operative pulmonary embolism
- Post-operative Cerebrovascular Accident (CVA)/Stroke
- Post-operative cardiac myocardial infarction
- Unplanned re-admission within 28 days of discharge

- Unplanned transfer to ICU
- Unplanned transfer to another unit
- Unplanned second operation within 6 weeks of surgery
- Unplanned re surgery within 24 hours
- Damaged organs following surgical procedure
- Experienced medical staff in recovery room
- Designated staff in recovery room for female patient especially at night
-

B. Policies, Procedures and Records

Standard 17: Operational policies and procedures clearly describe the key processes of the Operation Theatre and/or department, the responsibility of the staff and expected results, and records provide accurate information for analysis and evaluation.

Indicator 101: The hospital maintains up-to-date~~d~~ written policies for each OT procedure and ensures that it is followed by the staff.

Assessment Process:

In order to comply with this indicator, the hospital must have written, up-to-date policies in place for every procedure conducted in the operating theatre. These policies must align with the guidelines and best practices outlined in WHO surgical safety checklist to ensure patient safety and improve surgical outcomes. These policies should be accessible to and followed by all relevant staff.

i. Signage of OT as a restricted area and identification of persons allowed in the OT
ii. Sterilization and identification of sterilized OT equipment (Register of Steri-guage and steri tape is maintained)
iii. Separation and transport of dirty linen in a unidirectional pathway
iv. Documented pre-operative assessment and instructions
v. Routine equipment checks and preparation
vi. Annual review of functioning equipment in line with the services offered by the OT
vii. Sending for and the transportation of patients from ward to OT
viii. Admission to the operating department
ix. Identification of patients
x. Identification of operation site
xi. Swab and instruments counting before incision and stitching before and after surgery by at least two people, present in the procedure
xii. Time out with all its components
xiii. Recovery room management protocols /guidelines
xiv. Staff protection against exhaust from anesthetic gases
xv. Post-operative care management plan
xvi. Handover procedures for pre-operative and post-operative patients
xvii. Management of infected patients.

xviii. Sending specimens for histopathology
xix. Implementing the WHO Surgical Safety Checklist

Indicator 102: The OT staff prepares a list of scheduled surgeries 24 hours prior to the operations and submits it to the hospital's blood bank for arrangements like cross-matching, if needed.

Assessment Process:

In order to comply with this indicator, the operating theatre staff must prepare a list of planned surgeries at least 24 hours in advance and share it with the hospital's blood bank to facilitate arrangements and cross-matching if required. The assessment will involve reviewing the surgery schedules, communication records with the blood bank, and evidence of timely coordination for blood arrangements when necessary.

Indicator 103: The Hospital has developed and implemented a policy to ensure that any surgery involving general anesthesia or spinal anesthesia must be performed by the consultant, or at the very least, under their supervision.

Assessment Process:

In order to comply with this indicator, the hospital must have a developed and implemented policy ensuring that all procedures or surgeries involving general anesthesia (G.A.) are performed or at least supervised by the consultant. The assessment will involve reviewing the hospital's policy, surgical records, and consultant schedules to verify compliance and proper oversight during such procedures.

Indicator 104: All formal documentation and records related to the OT room are available within the department.

Assessment Process:

In order to comply with this indicator, the department must have to maintain the record of following relevant documentation and review of the record shall be conducted:

- Theatre registers (OT register with detail of every surgery including G.A. and L.A. both, anesthesia register and surgeons' register)
- Prosthesis register
- Electro medical equipment register
- Record of correct swab/instrument count before and after surgery
- Controlled drugs register/log
- Specimens register
- Record of weekly/monthly analyses of surgeries (including the ICD 10 code)
- Next-day schedule for operations
- Maintenance of stock levels of drugs and consumables
- Number and type of emergency procedures
- Duty roster
- Record of surgical safety checklists

- Record of swab or environmental cultures of the operation theatre

Indicator 105: Occupational health and safety regulations and guidelines are displayed at hospital and complied by all employees.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented occupational health and safety rules related to the prevention of workplace hazards and staff must be trained on these rules and instructions. These specific rules must be displayed on the specific areas and may contain following:

- Storage and use of hazardous chemicals
- Use of compressed gases safely
- Laser and radiation safety
- Appropriate shielding and protective clothing, E.g., for image intensification
- Emergency electrical power supply (UPS, inverters, generators and emergency electric lights)
- Spill management with spill kits

Review of health & Safety rules, training evidence, interview with relevant staff and physical inspection of the specific sites shall be conducted.

Indicator 106: A parent may accompany children (patient) during recovery.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy that supports and facilitates parental presence during a child's recovery, particularly in recovery rooms or post-operative care areas. All relevant staff must be aware of and adhere to this policy. The hospital must provide safe, designated spaces for parents, ensuring the child's emotional and physical well-being while maintaining clinical safety standards. Review of hospital policy, interview with staff and on-site inspection of the recovery area shall be conducted.

Indicator 107: Each patient undergoing surgery is identified by a wristband/bracelet or another distinct identification and Red ID bands for fall risk alert, method that is securely attached to them.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented procedures to ensure that every patient have an identification bracelet/band that is clearly visible and securely attached, containing the name, MR number, diagnosis and room/ward number of the patient, reducing the risk of misidentification and ensuring patient safety throughout the surgical process. Review of hospital procedures, observation the pre-surgical/pre-operative patients and interview with surgical and nursing staff shall be conducted to verify compliance.

Indicator 108: There is a separate, fully equipped recovery room next to the operating room that is well-lit and offers quick access to necessary medications and resuscitation supplies.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the recovery room is located near the operating theatre for quick access and is fully equipped, accessible, and staffed by trained professionals, with a clear plan for swift intervention in case of complications. A crash cart/emergency trolly with the following functional equipment (but not limited to) must available and list of the same is maintained:

- Crash Cart with all necessary medicines required for resuscitation
- Airways (Ambu bags) and other intubation material and equipment
- Suction
- Oximeter
- ECG machine
- Tipping/tilting trolleys/beds
- Blood pressure measurement apparatus
- Defibrillator
- Anesthesia machine
- Oxygen concentrator
- Emergency ventilator

Physical inspection and staff interviews shall be conducted to verify that protocols for immediate access to these resources are in place and adhered to.

Indicator 109: The anesthetist is authorized to provide the final clearance for the patient to leave the recovery area. Display of transfer criteria for transfer from PACU to ward.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implanted post-operative protocols, ensuring all criteria for safe discharge are met, and maintaining patient safety. Documented evaluation by anesthetist including stable vital signs, and confirming that the patient has regained appropriate consciousness and function before being discharged from the recovery area, must be available in the patient's record. Review of post-operative protocols and patient's files shall be conducted to check compliance.

Indicator 110: Complete anesthetic record of each surgical patient is available/accessible.

Assessment Process:

In order to comply with this indicator, the hospital must have maintained the complete anesthetic record of each surgical patient containing:

- Date and duration of anesthesia
- Name of surgical operation performed
- The name of the anesthetist, anesthesia assistant and, where relevant, the name of the consultant anesthetist responsible
- Documented pre-operative assessment by the anesthetist
- Drugs and doses given during anesthesia and route of administration
- Patient Monitoring data
- Intravenous fluid therapy
- Post-anesthetic instructions
- Any complications or incidents during anesthesia
- Signatures and Stamp of anesthetist and anesthesia assistant

The staff of the operation theater must be trained on how to document all the above record in registers/electronic system and training evidence is available. Review of operation theater records, training evidence and interview with OT staff shall be conducted in this regard.

C. Facilities and Equipment

Standard 18: Safe and adequate facilities and equipment are provided to meet the needs and volume of patients undergoing procedures in the operating theatre(s).

Indicator 111: The "dirty areas" in the OTs are clearly designated, and theatre staff have access to changing rooms and required PPE's to prevent contamination. Separate restrooms and changing facilities are available for men and women.

Assessment Process:

In order to comply with this indicator, the hospital must have a well-designed and organized uni-directional layout of the OT that separates "dirty" areas from sterile pathways to comply with infection control standards, maintaining a safe and sterile environment for both staff and patients. Separate male and female changing and rest rooms must be provided for staff, that do not overlap with these 'dirty' zones, allowing for hygienic practices and reducing cross-contamination risks, required and sufficient PPE's are provided to the staff. Physical inspection of dirty and sterile areas of the OT and interviews with the staff shall be conducted to verify compliance.

Indicator 112: The staff (OT Incharge) utilizes a separate space for record-keeping and other official activities.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the OT Manager has a dedicated, separate space for maintaining records and conducting of administrative tasks. This space must be located away from the sterile environment of the operating theatre to prevent

contamination. Physical inspection shall be conducted for the same.

Indicator 113: The operating theatre is equipped with all equipment generally used for all OT procedures, also a list of equipment used for special procedures, with sizes for both pediatrics and adults arranged in a proper order. Separate list for HIV hepatitis B&C patients.

Assessment Process:

In order to comply with this indicator, the hospital must maintain a list of inventories of all OT and anesthetic equipment used for all surgical procedures and additionally, maintains a list of equipment used for special surgical procedures, ensuring it is safely stored, regularly inspected/calibrated, and positioned for easy access during procedures, including but not limited to the following:

- Anesthetic machine and ventilator
- Laryngoscopes
- Endotracheal tubes/laryngeal masks
- Airways
- Nasal tubes
- Suction apparatus and connectors
- Oxygen
- Drugs and IVs required for planned anesthesia
- Drugs for emergency situations
- Monitoring equipment including ECG, ETCO2, temperature monitoring, pulse oximeter and blood pressure
- Accessible defibrillator
- Anesthetic gas scavenger system
- Tipping/tilting trolleys/beds
- Multi positioned table with radiolucent tops
- Suction machine
- Instrument cleaning/decontamination facilities
- Temperature and humidity control
- IV Cannulas and CV lines in different sizes
- Blood warmer
- Adequate light sources
- Special equipment for particular age groups, E.g., neonate resuscitation table

Additionally, clear protocols for periodic checking and maintaining equipment must be in place to ensure readiness and safety and its record is maintained. Review of calibration protocols, calibration records, inventory list and physical inspection of OT rooms shall be conducted to check compliance.

5. EMERGENCY SERVICES / CASUALTY DEPARTMENT

A. Service Management

Standard 19: The Emergency Department provides safe, timely and efficient live-saving emergency care and minor treatment and surgery for patients.

Indicator 114: The ER is always staffed by a senior casualty department assistant, doctor, and nurse with the necessary training and expertise, and their roster is displayed. If another qualified staff is assigned to substitute, the arrangement is documented.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the emergency department is always managed by suitably qualified and experienced personnel, with an up-to-date duty roster displayed. If deputizing arrangements are required, they must be documented, specifying the qualifications of the deputy staff through proper shift planning. Review of duty roster and observation of availability of staff as per schedule shall be conducted to check compliance.

Indictor 115: The Emergency department has developed and implemented advance emergency care protocols and is staffed by qualified individuals, duly registered with relevant regulating body, experienced and well trained to an advanced levels to handle the emergency situations. Every employee is trained in Basic Life Support (BLS), however, there must be at least one advanced (cardiac/trauma/pediatric) Life Support (ACLS) provider and a resuscitation team on call according to the schedule.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented advance emergency care protocols and staff of emergency department must have advanced training in BLS, ALS (cardiac, trauma, pediatric), and these qualifications should be documented and regularly updated. A resuscitation team, trained in emergency procedures, must be notified and available on every shift with a specialized emergency doctor being part of it. Review of protocols, training evidence, notification of emergency response team and mock exercise of emergency team shall be conducted to ensure that the team members are trained and ready to respond to emergencies.

Indicator 116: A signed agreement with other healthcare facilities that offer more comprehensive services (related to emergencies in any hospital department) allows for referrals to ensure the provision of necessary emergency services, when required.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented protocols for referral of patient in emergency situations along with signed agreements with other healthcare facilities that offer more comprehensive services. Documented record of referral of patients to those agreed hospitals must be readily available. Review of protocols, documented agreements and referral record shall be conducted to verify the compliance.

Indicator 117: Emergency department data and outcome indicators are systematically collected and compiled for analysis. This includes a recorded review of activity levels, the origin and suitability of referrals, and any adverse events.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a system for collecting and reviewing data on activity volume, referrals, and adverse events, identifying any issues or trends, and using the insights to improve patient care and operational efficiency. Regular reviews by the CQI Committee must be documented, and corrective actions must be taken based on the findings. Data recording system, documented record of outcome indicators data, report of its analysis and evidence of corrective measures taken shall be reviewed.

Indicator 118: Data is recorded for clinical review which includes:

- Number of attendances per day
- Number of patients discharged to home
- Number of admissions to IPD
- Repeat visits (visit within 7 days of first arrival)
- Number of Patients who died in the emergency department

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a system to accurately record and track the number of Emergency department attendances per day, repeat visits within 7 days, and the number of deaths in the said department. The relevant staff must be trained on how to document it and training record is available. These data points must be regularly reviewed and analyzed by CQI committee/mortality committee, and used for continuous clinical review and quality improvement. Review of data management system, training evidence, interview with staff and documented report of CQI/mortality committee shall be conducted to verify that this information is used to improve care and operational practices.

B. **Policies, Procedures and Records**

Standard 20: Operational policies and procedures clearly describe the key processes of the casualty department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluation.

Indicator 119: A disaster plan, clearly defining the emergency department's role, protocols, and the responsibilities of individual staff members in the event of a major crisis, is in place and practiced.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a disaster management plan that clearly defines the procedures, roles and responsibilities of Emergency staff in the event of a major incident or disaster. This plan must be regularly updated, practiced through drills, and staff are well-trained and prepared to respond effectively. Documented record of mock drills and staff training must maintain. Review of disaster management plan, training evidence, record of mock drills and interview with staff shall be conducted.

Indicator 120: The average waiting time for each patient is defined and monitored, ensuring that all patients are seen within fifteen minutes of arrival for an initial assessment and treatment prioritization. Standardized documentation is maintained, covering all aspects of patient registration, discharge, and record-keeping. Implemented policies and procedures for triage protocols.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for triage protocols and management of waiting time for initial assessment and prioritization within 15 minutes of arrival. The patient waiting time must be tracked and monitored regularly through standardized documentation and it must be used for every patient, covering the entire process from registration to discharge, ensuring accuracy and completeness. The hospital must maintain these records and ensure they are readily available for review and quality improvement purposes. Review of policies and procedure and standardized documentation of patient records shall be conducted.

Indicator 121: Policies and Procedures that are locally agreed upon should align with national guidelines for managing various serious acute situations commonly faced / encountered by hospitals.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented locally agreed policies and procedures for handling major acute emergencies, in line with local and national guidelines. These policies must cover all types of emergencies listed below, ensuring that staff are trained and familiar with the protocols for each situation.

- Road traffic accidents
- Major incidents
- Assault
- Domestic violence

- Child protection
- Rape
- Psychiatric emergencies
- Drug abuse
- Suspected criminals
- Suspected victims of crime
- Death in the unit

Documentation of training of staff and care provided during these situations must be properly maintained. Review of policies and procedures, accessibility of these policies to staff, training evidence and a sample of patient records shall be conducted to ensure that the relevant protocols are being followed and documented properly for each of the listed emergencies.

Indicator 122: A signed and updated policy that specifies the types and extent of procedures that can be performed in an emergency, considering the available resources, equipment, and expertise, and a policy that addresses patient referral, selection, and treatment for minor surgeries

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a dated and signed policy that clearly defines the type and extent of minor surgeries allowed in the emergency department, based on available resources and staff skills. This policy must cover the referral process, criteria for patient selection, and the treatment procedures and staff are adequately trained to perform the surgeries safely. The documentation must be maintained for every minor surgery performed to ensure patient safety and quality care. Review of policy, referral and selection criteria, training evidence and patient records shall be examined to check compliance

C. Facilities and Equipment

Standard 21: Safe and adequate facilities and equipment are provided to meet the needs and volume of patients attending the emergency services /casualty department.

Indicator 123:

There is a system in place for routinely evaluating the arrangements and suitability of the medical and surgical supplies, equipment as well as the treatment facilities to determine whether they are adequate for the duties performed in the unit and according to National & International standards including OSH to ensure proper management of emergencies and protection of staff.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a mechanism for regularly reviewing the design and appropriateness of its treatment facilities, as well as the adequacy of medical and surgical supplies as per national/international guidelines and are sufficient for managing emergency cases. The hospital must maintain up-to-date master list of inventories, perform regular equipment checks and maintenance (PPM), and ensure staff

training in using the equipment. Any deficiencies identified in the review must be documented and addressed promptly to ensure optimal emergency care provision. Review of said mechanism, training evidence, on-site inspection of inventory of medical and surgical supplies and equipment maintenance/PPM record shall be conducted.

Indicator 124: The entrance of emergency unit is easily identifiable from outside the hospital.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the casualty entrance is clearly signposted from outside the facility. This includes placing visible, legible signs at strategic locations, ensuring they are appropriately lit and easy to follow.
Visual inspection shall be conducted to check compliance of the same.

Indicator 125: There is enough space available for the ER to safely receive patients at the entrance, including space specifically reserved for the disabled.

Assessment Process:

In order to comply with this indicator, the hospital must provide adequate space at the entrance for patients, including clearly marked designated spaces for disabled individuals near the hospital entrance. Clear signage should direct patients to the entrance of emergency, ensuring ease of access. Visual inspection shall be conducted to check compliance of the same.

Indicator 126: There is a specific area allocated for ambulances at the hospital's emergency department entrance.

Assessment Process:

In order to comply with this indicator, the hospital must have a dedicated, clearly marked space for ambulances at the entrance of the Emergency Department. This space must be large enough for ambulances to park and for medical teams to quickly transfer patients. It should be reserved exclusively for emergency vehicles, with clear signage and unobstructed access. Visual inspection of the area around the emergency department entrance shall be conducted to confirm the presence of a clearly marked, reserved space for ambulances.

Indicator 127: Emergency Code / Paging announcement are placed purposefully throughout the unit to call for assistance.

Assessment Process:

In order to comply with this indicator, the emergency Code / Paging announcement must be strategically placed throughout the emergency department to allow staff to summon help quickly in any situation. This Code / Paging announcement system should be easily accessible, clearly visible, and tested regularly to ensure they are fully functional. Staff must be trained in the use of the Code ⁄ Paging announcement system and record is maintained. Physical inspection, testing for functionality and training evidence shall be reviewed.

Indicator 128: There is appropriate, calibrated, functional equipment for:

- Resuscitation
- Monitoring
- Minor operations
- Sterilization
- X-rays and other imaging (either locally or by referral)

Assessment Process:

In order to comply with this indicator, the hospital must have appropriate, calibrated, and functional equipment for resuscitation, patient monitoring, minor operations, sterilization, and imaging. Documented record of regular maintenance, calibration, and functional testing must be maintained to ensure that all equipment is in optimal working condition. The hospital must ensure that staff are adequately trained to use the equipment and that backup or referral arrangements are in place for imaging needs that cannot be met locally. Review of documented records and staff training evidence and interviews with staff shall be conducted

Indicator 129: Public spaces, clinical rooms, and hallways are free of beds, equipment, and other obstacles.

Assessment Process:

In order to comply with this indicator, the hallways, clinical areas, and public spaces of the emergency department must be kept clear of equipment, beds, or other obstructions at all times, that promote accessibility and the swift movement of patients, staff, and emergency equipment. Regular staff training and awareness must be provided to ensure spaces remain clear and accessible. Physical inspection, training evidence and interviews with staff shall be conducted.

Indicator 130: There are toilet facilities appropriate and available for males, females and those with disabilities.

Assessment Process:

In order to comply with this indicator, the hospital must provide appropriate toilet facilities for males, females, and disabled individuals, ensuring they are clean, well-maintained, and accessible, including sufficient space, grab rails, and other necessary features. Clear signage must be provided to guide individuals to these facilities. Regular cleaning schedules should be followed and documented to maintain hygiene. Physical inspection shall be conducted to check compliance with the same.

Indicator 131: The Hospital provides the facility of public telephone to patients and their attendants.

Assessment Process:

In order to comply with this indicator, the hospital must provide a public telephone that is easily accessible to patients and their relatives. The telephone should be placed in a convenient, clearly marked location within the hospital, ensuring it is in working condition and regularly maintained. Physical inspection shall be conducted to verify the presence and accessibility of a public telephone within the hospital

Indicator 132: There are policies, SOPs in place for the necessary patient investigations in an emergency.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for carrying out necessary investigations during emergencies, specifying all common emergency conditions and clearly outline the required diagnostic procedures. The hospital must ensure that staff are well-trained and aware of the protocols, with a system in place to ensure timely access to investigations and results. The necessary resources, including laboratories and imaging services, must be available and capable of responding to emergency needs. Review of policies, training evidence, staff awareness through interviews and patients record shall be conducted.

6. INTENSIVE CARE UNIT

A. Service Management

Standard 22: The Intensive Care Unit is managed by suitably qualified staff and organized to provide safe and efficient care for seriously ill patients who need to be continuously monitored.

Indicator 133: A qualified professional with relevant training in intensive care is responsible for overall collaboration of the unit and is available for specialist advice. A deputy has been given the responsibility to manage the ICU facilities when the in-charge is not onsite.

Assessment Process:

In order to comply with this indicator, the hospital must designate a qualified professional with appropriate training in intensive care, responsible for the overall coordination of the ICU and is accessible for specialist advice whenever needed, particularly during emergencies or complex cases. In the absence of the in-charge, a qualified deputy must be designated to manage the ICU, ensuring continuous patient care. The training and professional records of manager and deputy must be maintained in HR file of the employees. The hospital must have clear documentation of

this arrangement (staff schedules), ensure staff are familiar with the chain of command. Review of duty roster/staff schedules, on-site inspection and interview with ICU staff shall be conducted to ensure compliance.

Indicator 134: The hospital has appointed a qualified, registered and experienced nurse, who provides the services of nursing care in the unit on daily basis.

Assessment Process:

In order to comply with this indicator, the hospital must designate a qualified, registered, and experienced nurse to be responsible for the day-to-day management of nursing care in the unit and her roles and responsibilities are clearly defined in overseeing nursing care. Physical inspection and interview with the designated nurse shall be conducted for the same.

Indicator 135: Staff levels are determined based on a thorough assessment of patient dependency and patient count, in accordance with national and international guidelines (including PNC, PMDC).

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies for adjusting staff levels based on patient acuity and regularly reviewed staffing schedules to ensure optimal care delivery. The hospital must maintain records of patient dependency assessments and staffing levels must be adequate to meet patient needs, adhering to national and international guidelines (e.g., PNC, PMDC). Review of policy, staff schedules/duty rosters, on-site inspection, documented records of patient dependency assessments and interviews with management shall be conducted.

Indicator 136: Every employee working in the unit is certified in BLS and ACLS, has the necessary training and experience for their relevant job, and participates in ongoing medical education programs organized by the hospital to keep their skills up to date.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that all staff working in the ICU are appropriately qualified for their roles and hold up-to-date BLS/ACLS certifications. Additionally, the hospital must develop and implement continuous medical education (CME) programs to regularly update skills of the staff. Documented records of certifications and CME participation must be maintained. Review of continuous medical education (CME) program, training evidence and interviews with staff shall be conducted.

Indicator 137: A qualified and intensive care experienced doctor and nurse is available at all times.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that a qualified and experienced ICU doctor and nurse are available at all times, aligned with decent working time arrangements, to provide continuous care for critically ill patients. The hospital must ensure the ongoing availability of these professionals during all shifts, including weekends and holidays, while ensuring decent working time arrangements, including sufficient rest periods, to provide optimal care in the ICU. Physical inspection shall be conducted to verify compliance.

B. Policies and Procedures

Standard 23: Operational policies and procedures which clearly describe the key processes of the ICU, the responsibility of the staff and expected results are followed by staff.

Indicator 138: Specific rules, policies and SOPs including emergency admission to ICU from other departments or HCEs are developed and implemented. Additionally, a list of ICU admission indications in accordance with national and international guidelines is accessible and in use.

i. Theatres
ii. Wards
iii. Other departments
iv. Outside

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for emergency ICU admission from all departments, including operation theatres, wards, other hospital departments, and external healthcare establishments (HCEs). The hospital must have developed and displayed a list of indications for ICU admission aligned with national and international guidelines. The hospital must ensure that these policies are well-communicated and understood by all staff involved in patient transfer to the ICU through trainings. Review of policies and procedures, list of ICU admission indications, training staff, interviews with staff and on-site inspections shall be conducted.

Indicator 139: The hospital has developed and put into effect the management rules and/or procedures for every activity performed in the intensive care unit.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented comprehensive, detailed management policies and procedures for all the activities listed below:

- Airway management
- Conscious Sedation
- Ventilators/respirators

- Central oxygen supply and oxygen cylinders
- CVP readings (central venous pressure)
- Infusion pump management
- Pulse oximeters
- Cardiac monitors
- Arterial lines
- X-ray and other imaging investigations
- Epidural care
- Recovery facilities for all surgical cases where no dedicated recovery unit
- Recovery care of major surgical cases

The hospital must ensure that all ICU staff are well-trained on these procedures and its record is maintained. Review of policies and procedures, training evidence and interview with staff shall be conducted to ensure compliance.

Indicator 140: The hospital has defined and implemented specific emergency protocols for:

i. Apnea/respiratory arrest
ii. Cardiac arrest
iii. Laryngeal spasm/stridor

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented specific emergency protocols for apnea/respiratory arrest, cardiac arrest, and laryngeal spasm/stridor. The hospital must ensure that all relevant staff are trained in these emergency procedures and easily accessible for quick implementation during emergencies. Regular drills and incident reporting mechanism must be in place to ensure optimal care and effective emergency response. Review of protocols, training evidence, documented record of mock drills and interview with staff shall be conducted.

Indicator 141: There is a specific written criteria about who is permitted to carry out emergency clinical procedures. The record of the same is maintained.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented written criteria that define who is authorized to perform critical emergency procedures, as listed below:

i. Intubation
ii. Tracheotomy
iii. Insertion of central lines
iv. Defibrillation
v. Insertion of temporary Pacemaker
vi. Any other procedure, which requires special expertise

This criterion must outline the necessary qualifications, certifications, and experience required for each procedure to ensure that only authorized and qualified personnel perform these procedures, with clear documentation to support the authorization process. Additionally, the hospital must provide regular training, monitoring, and audits to ensure that the criteria are followed and that staff remain updated on best practices and guidelines for these critical interventions. Review of documented criteria, training evidence and patients record shall be conducted.

Indicator 142: The hospital has developed and implemented policies and procedures for:

- Clothing of staff and visitors, including personal protective equipment availability.
- Changing of catheters, humidifiers and ventilator tubing
- Isolation of at-risk or infected patients
- Cleaning and disinfection of the unit

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented written policies and procedures related to specific appropriate attire for staff and visitors, protocols to prevent infections during change of as catheters, ventilator tubing, and humidifiers, isolation of patients with infectious diseases or those at high risk and cleaning schedule that includes frequent disinfection of high-touch surfaces, equipment, and patient areas as well as access to PPE's for healthcare workers and visitors as per requirement. The hospital must ensure that these policies are communicated to all relevant staff, with ongoing training to ensure compliance. Review of policies and procedures, training evidence and physical inspection shall be conducted to verify compliance.

Indicator 143: The ICU has designated visiting hours, defined as per national and international guidelines and no attendants will be permitted in the ICU other than of these specified hours.

Assessment Process:

In order to comply with this indicator, the hospital must have established and clearly defined visiting hours for the ICU, as per National/International Guidelines. These hours must be displayed at the entrance of ICU with directions that no visitor is allowed except the defined hours, for the facilitation of both staff and visitors. Physical inspection shall be conducted to ensure the compliance.

C. Facilities and Equipment

Standard 24: Safe and adequate facilities and equipment are provided to meet the needs and volume of patients in the ICU.

Indicator 144: The unit has sufficient space available for storing disposable and consumable items.

Assessment Process:

In order to comply with this indicator, the hospital must have sufficient space allocated for the storage of disposable and consumable items. This storage must be well-organized, clean, and compliant with infection control standards, items clearly labeled, and storage accessible to staff while ensuring the safety of the space. Physical inspection of the storage area and interviews with staff shall be conducted in this regard.

Indicator 145: The unit is equipped with a working defibrillator and resuscitation trolley/crash cart, and a dedicated staff is in charge of maintaining the equipment and other supplies.

Assessment Process:

In order to comply with this indicator, the hospital must have a functional resuscitation trolley/crash cart and defibrillator in the unit, ready for immediate use during emergencies. List of all the drugs/equipment's available in the trolley must be displayed or maintained. A designated member of staff must be responsible that these devices are regularly checked and maintained according to established protocols, and their contents must be regularly inspected, restocked, and kept organized. The hospital must also ensure that all relevant staff are properly trained in using the resuscitation trolley and defibrillator. Physical inspection of resuscitation trolley/crash cart, review of training evidence, availability of list of drugs & equipment's shall be examined.

Indicator 146: Each bed has a central line facility for:

- Oxygen
- Suction
- Compressed air
- ECG monitoring
- Anti-decubitus mattress

Assessment Process:

In order to comply with this indicator, the hospital must ensure that each bed in the unit is equipped with central line facilities for oxygen, suction, compressed air, and ECG monitoring. These systems must be regularly tested and maintained to ensure functionality. The hospital must also ensure that all relevant staff are trained to use the equipment safely and effectively. Documentation of equipment checks, maintenance, and training should be maintained to ensure ongoing compliance and readiness for patient care. Physical inspection of the above-mentioned devices, training evidence and documented record of maintenance shall be reviewed.

Indicator 147: Facilities in the unit include

- CVP monitoring
- Pulse oximetry
- Blood pressure monitoring (automatic)

- Ambient and patient temperature monitoring
- Arterial blood gases
- Glucometer
- Other facilities as required

Assessment Process:

In order to comply with this indicator, the ICU unit must have all required monitoring and diagnostic equipment as mentioned above and readily available, functional, and regularly maintained. The hospital must keep up-to-date records of calibration, maintenance, and servicing of these devices. Additionally, staff must be trained to use the equipment properly and understand how to interpret the data to ensure timely and effective patient care. Physical inspection of the above-mentioned devices, training evidence and documented record of maintenance shall be reviewed.

7. GYNECOLOGY AND OBSTETRICS SERVICES

A. Service Management

Standard 25: Gynae/Obs. services provide safe, timely and efficient maternity care for patients.

Indicator 148: A qualified and registered gynecologist leads the gynecology/obstetrics department, which is operated by skilled, registered, and experienced healthcare professionals.

Assessment Process:

In order to comply with this indicator, the Gynae/Obstetrics department must be headed by a qualified, registered and experienced Gynecologist. This includes having proper documentation credentials in HR file. The hospital must display the duty roster in a visible location to show the assigned shifts and roles of the staff in the Gyne department. If a deputizing staff member is assigned to the department, the hospital must document and maintain records of these arrangements, including the qualifications and roles of the deputized staff. Physical inspection to check whether the department has a clear, up-to-date roster that shows the names and roles of staff, including the head of the department, review of deputizing procedure and interview of the head shall be conducted.

Indicator 149: Medical and nursing staff who attend births, receive regular training in reproductive, maternal and neonatal child health, and the department maintains a record of this training.

Assessment Process:

In order to comply with this indicator, all the staff in the Gyn / Obs department must receive regular, updated training in reproductive, maternal and neonatal child health. The hospital must

maintain clear and accurate records of all training, including details of participants, dates, and content, to demonstrate compliance with current resuscitation standards. Review of training evidence and interview with the staff shall be conducted to check compliance with this indicator.

Indicator 150: The unit has developed a roster of trained and experienced gynecologist / obstetrician, Medical Officer, Registrar, nurses, and on-call anesthetists accessible all the time.

Assessment Process:

In order to comply with this indicator, the Gyne department must be staffed with qualified, experienced Gynecologist/Obstetrician, Medical Officer, Registrar, Nurses at all hours, with anesthetists available on-call. The hospital must display an up-to-date and accessible duty roster that clearly outlines duties at the following areas:

- OPD Duty Roster
- Indoor Duty Roster
- Emergency Duty Roster
- 24/7 on-call Roster of Consultants
- The roster of on-call Anesthetist must also be displayed in the department (for emergency surgeries).

The doctors on duty must be physically present in the ward during their duty hours.
Review of duty roster, physical inspection and interview with the staff shall be conducted to verify the compliance with this indicator.

Indicator 151: The hospital has developed and implemented an interdepartmental policy for rapid escalation protocols in response to obstetrical emergencies, including staff training and response initiation protocols.

Assessment process: In order to comply with this indicator, the hospital has established and operationalized a comprehensive interdepartmental policy outlining rapid escalation protocols for obstetrical emergencies. This includes structured staff training and clearly defined emergency response procedures to ensure timely and coordinated intervention, with the following SOPs

- The hospital must develop a standardized antenatal and postnatal monitoring chart for all mothers.
- Patients in active labor or presenting with an acute obstetric emergency (Booked/Un booked) shall be referred directly to the Obstetrics and Gynecology Department without prior evaluation in the Emergency Room.
- Staff must be trained in the use of the Modified Early Obstetric Warning Score (MEOWS) system to enable early detection of complications.

To assess compliance, review the hospital's policy, training records, and use of monitoring tools (including MEOWS), interview staff on emergency protocols, and audit patient files to confirm timely interdepartmental response in obstetrical emergencies.

Indicator 152: Departmental clinical audit and review data is collected, examined, and applied to quality-improvement initiatives/activities.

Assessment Process:

In order to comply with this indicator, the hospital must have a system in place for collection, analysis and use of outcome indicators data for clinical audits which must include the following:

- Relevant quality indicator.
- Number of patients in antenatal clinics provided with at least eight antenatal visits, in accordance with WHO guidelines.
- Number of patients with medical or surgical disorders in ante-natal clinics
- Number of patients transferred to higher-level care during pregnancy
- Number of deliveries
- Number of NICU admissions
- Number of high-risk pregnancies identified and managed accordingly
- Number of live births, pre-term births and still births
- Number of newborns receiving essential postnatal care (early breastfeeding, thermal care, and umbilical cord care)
- Perinatal mortality figures
- Maternal mortality figures
- Number of transfers to specialist care during labor
- Birth Registration records
- Number of Caesarean Sections.
- No. of difficult labor cases

This data must be analyzed regularly to identify areas for improvement in patient care. The hospital must use the results from these audits to implement quality improvement activities, making necessary adjustments to care protocols, staffing, or training. All data must be accurately recorded and accessible for review, with clear documentation maintained for transparency and accountability. Review of clinical audit system, documented audit reports and evidence of corrective measures taken in light of results of these audits shall be conducted.

B. Policies, Procedures and Records

Standard 26: Operational policies and procedures clearly describe the key processes of the gynecology and obstetrics department, the responsibility of the staff and expected results. Records provide accurate information for analysis and evaluate

Indicator 153: The hospital has developed and implemented procedures and guidelines for:

- Ante natal care & booking/registration, intrapartum care and Post-natal care in line with WHO guidelines.
- Counselling for parenthood (E.g., family planning, genetic referral)
- Identifying high risk pregnancy, develop a list of high-risk pregnancies and display the list in the department
- Admission to labor
- room/ward
- Emergency Medical assistance required by Nurses and Midwives during labor

- Planning, treatment and mode of delivery
- Plan for managed pain during labor and delivery
- Delivery monitoring process
- Referral within the hospital or to other facilities in case of emergency or need of advanced level healthcare services
- Discharge including discharge summary
- Birth record and certificate
- Labor register
- Immunization for mother and baby
- Infection control
- Disposal of placentas

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented procedures/guidelines covering all the areas listed above, from antenatal to post-natal care. These procedures must be communicated effectively to all staff members, with appropriate training provided to ensure proper adherence. The hospital must maintain clear and accurate records for each aspect of care, such as antenatal and post-natal visits, patient transfers, birth records, and discharge summaries. In addition, the hospital must ensure that procedures are followed to manage high-risk pregnancies, pain during labor, infection control, and the disposal of placentas. Review of procedures/guidelines, training evidence and patient records including antenatal booking forms, patient charts, labor and delivery logs, birth records, discharge summaries, immunization records, infection control measures, and labor registers, shall be conducted to ensure that they are being completed correctly and in a timely manner

Indicator 154: Every patient in the obstetrics and gynecology department is seen and scheduled by a qualified, registered Gynecologist who shall be responsible for the booked patients and can be contacted for advice at any time during the patient's pregnancy.

Assessment Process:

To comply with this indicator, the hospital must establish a structured system to ensure that every patient is booked and cared for by qualified gynecologist from the beginning of pregnancy. Obstetric patients must be clinically assessed and categorized as either low-risk or high-risk. High-risk Gyn / Obs patients must be evaluated and managed by a Consultant Gynecologist responsible for planning their treatment. Low-risk pregnancies may be managed by LHV's and Midwife under appropriate supervision and with clear escalation protocols. The hospital is also required to maintain accurate and updated booking records. Compliance will be assessed through a review of patient records, the consultation appointment system, and interviews with patients to confirm accessibility and continuity of care.

Indicator 155: HCEs must maintain a list of high-risk procedures that are carried out in the hospital and regularly update the same, list must be clearly displayed in visible places across the hospital.

Assessment Process: In order to comply with this indicator, HCEs must ensure that a regularly updated list of high-risk patients, that are managed in the hospital, is clearly visible in prominent areas throughout the facility. A hospital walkthrough will be conducted to check the visibility and presence of the displayed and updated list. The list should be preferably displayed in areas such as ANC clinics, maternity wards, and nursing stations.

Indicator 156: Patients with epidural, during a normal birth, caesarean section, emergency breech/instrumental deliveries, emergency resuscitation, and eclampsia will be managed under care of qualified anesthetist alongside team of gyne/obs.

Assessment Process:

In order to comply with this indicator, the hospital must have anesthetists with the necessary qualifications and experience available at all times to manage anesthesia needs during normal deliveries (e.g., epidurals), Cesarean sections, emergency breech or instrumental deliveries, emergency resuscitation, and eclampsia management. Anesthetists must be part of a well-coordinated on-call system, ensuring that their services can be accessed whenever needed. The hospital must maintain accurate documentation of anesthetist involvement in relevant cases, including the type of anesthesia administered and any complications or interventions required. Regular audits and reviews of anesthesia practices must also be conducted to ensure the quality and safety of care. Review of staff schedules for availability of anesthetist, patient files, anesthesia registers/records and documented audit reports shall be conducted in this regard.

Indicator 157: Records kept after discharge include the combined:

i. Maternity notes (including care plans)
ii. Birth registration(s) (record and certificate)
iii. Labor register
iv. Admission register
v. Neonatal and perinatal morbidity
vi. Neonatal and perinatal mortality
vii. Maternal morbidity and mortality
viii. Sentinel Events, If any
ix. Follow Up esp For Family Planning and mental health

Assessment Process:

In order to comply with this indicator, the hospital must have kept accurate and comprehensive records for all above listed areas after discharge for all patients. These records must be securely stored and easily accessible while adhering to legal requirements for privacy and confidentiality. Regular audits should be conducted to ensure the integrity and completeness of these records. Review of all the records, patient files and audit reports shall be conducted.

Indicator 158: All neonates must be examined by a qualified Pediatrician/ Neonatologist to identify any congenital abnormalities and their management plan. In case of any abnormality detected, the parents must be informed.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies to ensure that all neonates are examined by a qualified pediatrician/ Neonatologist shortly after birth to identify any congenital abnormalities. The pediatrician must document the findings and create a management plan. If any abnormalities are found, the parents must be informed in a clear and timely manner, with all necessary information about the condition and the proposed management plan. The hospital must also ensure appropriate follow-up care, referrals to specialists if needed, and proper documentation of all examinations and communications with the parents. Review of hospital's policies, neonatal records, care plans, documented communication with parents and process for follow-up care or referral shall be conducted to verify the same.

C. Facilities and Equipment

Standard 27: Facilities and equipment are safe and adequate in design and number for the purpose and quantity of patients attending/in the Gynecology / Obstetrics department.

Indicator 159: The delivery room has each of equipment needed for safe deliveries that is operational and well maintained.

Assessment Process:

In order to comply with this indicator, the delivery room must be properly equipped and maintained with all the necessary required equipment for safe delivery as per WHO guidelines and effective deliveries, including but not limited to the following:

- Fetoscope
- CTG machine
- Ultrasound machine
- Delivery tables which can be turned to the Trendelenburg position
- An anesthetics machine with emergency oxygen supplies
- Endotracheal tubes, laryngoscope
- An incubator, with temperature adjustable for infants in need
- Separate oxygen supply to the incubator
- Resuscitation equipment and drugs for infants and for adults
- Intravenous crystalloid and plasma expanders
- Weighing machine for the baby

The hospital must maintain up-to-date service records for each piece of equipment, ensuring it is regularly inspected and repaired as necessary. Staff must be trained to use all equipment correctly, with all items readily accessible for emergencies. Regular audits must be conducted to ensure the equipment is in optimal working condition. Physical inspection of delivery room, review of inventory and maintenance records and training evidence shall be conducted.

Indicator 160: There is a separate room available (ideally soundproof) for patients who are seriously ill or require critical care, such as those with eclampsia.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that a separate, preferably soundproof room is available for patients who are seriously ill and require intensive care, such as those with eclampsia. This room must be properly equipped with the necessary medical devices for continuous monitoring and staffed by qualified medical professionals who can provide critical care. The hospital must maintain a list of cases/situations who will be quickly admitted to that room. Physical inspection of room, review of list of situations and inventory records shall be examined.

Indicator 161: The area for labor provides for:

i. Space for the patient and a female companion
ii. Alternative birthing methods
iii. Ambulation throughout labor
iv. Washing and toilet facilities for the comfort of the patient

Assessment Process:

In order to comply with this indicator, the labor area must have sufficient space for both the patient and a female companion, ensuring privacy and comfort. The labor room must provide facility for alternative birthing methods, with the necessary equipment available for methods such as water birth or upright positions, and staff must be trained to assist with these options. Additionally, the hospital must provide clean, private, and accessible washing and toilet facilities within or near the labor area to enhance the comfort and dignity of the patient during labor. Physical inspection and interview with staff shall be conducted

Indicator 162: There is enough space for mothers and babies to be together in the postnatal ward.

Assessment Process:

In order to comply with this indicator, the hospital must have post-natal ward with sufficient space and facilities for babies to room-in with their mothers, The hospital should also provide appropriate facilities for baby care, such as a crib, changing table, and necessary supplies. Physical inspection and interview with patients/mothers shall be conducted to verify compliance with this indicator.

Indicator 163: Nursery facility that is suitable in size, have the right supplies and equipment, and have a consistent temperature and humidity level.

Assessment Process:

In order to comply with this indicator, the hospital have nursery facility with appropriate temperature and humidity control to maintain a safe environment for newborns. The facility must be spacious enough to accommodate the babies and necessary equipment comfortably. Additionally, the nursery must be maintained with hygienically and as per IPC standards. Physical inspection for checking of functioning thermostats, humidity monitors, and any heating or cooling systems, and observation of cleaning and sterilization procedures shall be conducted.

Indicator 164: The organization has adequate NICU facility & technically competent staff to manage high- risk cases & provide appropriate neonatal care for such cases.

Assessment Process: In order to comply with this indicator there must be a dedicated Neonatal Intensive Care Unit (NICU) with restricted access and adequate infection control measures.

The NICU must be close to labor room and staffed 24/7 by qualified neonatologists/pediatrician (trained in neonatology), ACLS and PALS certified personal is available in each shift, and neonatal care nurses, as per duty rosters and care requirements.

Neonatal resuscitation training shall be mandatory for all healthcare staff.

The following essential equipment and supplies must be functional and available within the NICU:

- Neonatal resuscitation drugs
- Properly functioning ventilators and CPAP (Continuous Positive Airway Pressure) machines for respiratory support.
- Neonatal monitors for continuous observation of vital signs.
- Availability of temperature-controlled incubators, radiant warmers, and phototherapy units.
- Ambu bag
- Infusion pumps
- Neo-natal face mask
- Neo-natal laryngoscope
- Feeding tubes
- A selection of Neo-natal Endo tracheal tubes
- Oxygen supply
- Suction machine

Indicator 165: The hospital has designated lactation consultant or trained nursing staff to provide breastfeeding support to mothers.

Assessment Process: In order to comply with this indicator every hospital must have a designated lactation consultant or trained nursing staff to provide breastfeeding support. Nursery is well-stocked with supplies for baby care and equipped with resources for educating mothers on new born care. This includes providing the necessary tools and materials for teaching mothers how to breastfeed, change, bathe, and generally care for their newborns.

8. DIALYSIS UNIT

A. Service management

Standard 28: The Dialysis Centre is appropriately located, clearly marked, and ensures accessible, safe, and hygienic services, with effective coordination with other hospital departments to support continuity of care.

Indicator 166: The dialysis unit is easily identifiable and accessible.

Assessment Process:

In order to comply with this indicator, the dialysis unit of the HCE shall be strategically located in proximity to, or have easy access to the following relevant hospital departments to facilitate timely utilization of essential services, as and when necessary:

a. Emergency Room, Intensive Care Unit (ICU) and HDU
b. Pharmacy
c. Blood bank
d. Diagnostic Services
e. CSSD
f. Biomedical Department

- Ramps**,** stairs, or lifts should be available, as needed, to ensure easy access to the facility both from outside and within the Healthcare Establishment (HCE).
- A clearly visible, well-lit signboard identifying the Dialysis Unit should be installed in a prominent location.
- The Unit must be designed and maintained to ensure a safe, clean, and hygienic environment for patients, attendants, staff, and visitors.
- Directional signage should be clearly placed to help guide patients and their families to the Dialysis Unit.
- Warning signs should be displayed near the entrance to limit visitor access and maintain safety protocols.
- Operating hours of the dialysis services must be clearly shown at a visible location for public awareness.
- Physical inspection shall be conducted to check compliance with the same.

Indicator 167: The Dialysis Unit is equipped with the necessary infrastructure, providing adequate space.

Assessment Process

In order to comply with this indicator, the layout of the Dialysis Unit includes the following essential areas to ensure safe & efficient operations:

a) The waiting area should be equipped with sufficient seating to accommodate both patients and visitors.
b) The nursing station must be located in a way that allows for proper surveillance of

patients undergoing hemodialysis.

c) A designated area shall be provided for CAPD training for the patient and their family members.
d) The center must have separate, clean public toilets for males and females.
e) Dialysis Room/(s).
f) All plumbing in the water treatment room must be installed to prevent backflow or cross-contamination between potable and non-potable water systems, by ensuring that Reverse Osmosis (RO) system is in place.
g) A work area shall be provided, equipped with a work counter, handwashing sink, and storage cabinets.
h) The Dialysis Centre shall be equipped with adequate ventilation and air conditioning facilities, particularly in areas where patients are handled.
i) Storage space for supplies, consumables and backup equipment.
j) Clinical Waste Collection arrangements.

Indicator 168: Professionals with relevant registered qualification and experience are appointed at the Dialysis Centre.

Assessment Process:

Compliance with this standard requires that all medical professionals and staff appointed at the Dialysis Centre are qualified and possess relevant experience. The overall in-charge of the dialysis facility must be a qualified Nephrologist or Pediatric Nephrologist**,** with duly registered with PM&DC. In the absence of a Nephrologist, a Urologist, Physician, or Surgeon with qualifications registered with PM&DC can be appointed on temporary basis only**.**

To ensure compliance with this indicator, review personnel files and the duty roster to confirm that all staff members are qualified, possess relevant qualification & experience, and are assigned roles consistent with their credentials.

Indicator 169: Accurate and comprehensive medical records are maintained for all patients in the Dialysis Unit.

Assessment Process:

Comprehensive data is maintained for every patient undergoing dialysis (preferably Electronic medical record). Access to both current and past medical records is limited to authorized healthcare providers, who are also responsible for making entries. Intra-dialysis records are diligently maintained as part of the patient documentation. These (Medical) records, whether for active or discharged patients, are periodically reviewed by authorized personnel to ensure timeliness, legibility, and accuracy.

B. Safety

Standard 29: The Dialysis Unit ensures the safety of all individuals by protecting them from potential hazards.

Indicator 170: Strict implementation of protocols for prevention and isolation of Hepatitis B & C.

Assessment Process:

In order to comply with the above indicator, written Standard Operating Procedures (SOPs) must be in place and strictly followed by all staff. These SOPs may be adapted to suit the specific needs of the dialysis facility, provided that no essential details, as outlined below, are omitted during implementation.

1. All patients undergo ELISA testing for Hepatitis B and C prior to their initial hemodialysis session.
2. Patients are re-tested for Hepatitis B and C upon returning from another hemodialysis center.
3. Individuals who test positive for Hepatitis B or C are treated as infectious and are dialyzed separately, using dedicated machines, instruments, and equipment.
4. Staff members caring for Hepatitis B or C positive patients follow strict protective protocols.
5. Every hospital must arrange mandatory Staff vaccination.

Indicator 171: SOPs for the management of co-infected patients with Hepatitis B & C are followed.

Assessment Process:

To comply with this indicator, all hospitals must have written Standard Operating Procedures (SOPs) in place, which must be strictly followed by the staff. These SOPs may be tailored to the specific needs of the dialysis facility, provided that all essential elements outlined below are retained.

1. Patients co-infected with both Hepatitis B and C are preferably managed in isolation.
2. The dialyzer must be used only once (except for the same patient).

Indicator 172: HIV Prevention and Isolation SOPs are implemented and followed in line with the defined policy.

Assessment Process: In order to comply with this indicator, the hospital must have developed and implemented SOPs for HIV prevention and isolation, which the staff follows strictly and proper documentation maintained.

1) All patients undergo anti-HIV antibody testing prior to their first hemodialysis session.
2) Patients are re-tested for anti-HIV antibodies upon returning from another hemodialysis facility.
3) For HIV-negative patients, serologic testing is repeated annually.
4) HIV-positive patients are dialyzed in a designated isolation room or a clearly marked area within the same room, using dedicated machines, equipment, instruments, and single-use items.
5) The dialyzer is strictly used only once (except for the same patient)

PART C: AUXILARY SERVICES

9. LABORATORY SERVICES

A. Service Management

Standard 30: The medical testing laboratory is managed and organized to provide efficient and effective laboratory care to patients and support services to clinicians.

Indicator 173: A certified and registered pathologist, qualified and registered laboratory scientist manages the medical testing laboratory. There is enough and qualified staff (including but not limited to a skilled medical technologist or technicians) available on hand to carry out the job descriptions for the specified service.

Assessment Process:

In order to comply with this indicator, the medical testing laboratory must be managed by a qualified and registered pathologist or qualified laboratory scientist with appropriate experience in the field. The laboratory must be staffed with sufficient, well-trained, and qualified medical technologists, technicians, or other laboratory staff to fulfill the defined service requirements. The hospital must define the roles and responsibilities of staff through job descriptions, which must be the part of HR file. Regular audits and reviews must be conducted to ensure the laboratory operates according to established protocols and regulatory standards. Physical inspection, review of job descriptions and interview with the staff shall be conducted to assess their awareness with these job descriptions.

Indicator 174: In order to contribute to decisions that impact laboratory operations, departmental staff members attend departmental meetings. The HOD nominates laboratory employees to serve on the hospital quality committee, the health and safety committee, and other pertinent bodies.

Assessment Process:

In order to comply with this indicator, the department must have developed and implemented policies for laboratory staff actively participate in relevant advisory or consultative bodies, enabling them to contribute to decisions that affect laboratory services, policies, and operational practices. The hospital must encourage and facilitate staff involvement in health and safety committees, hospital quality improvement committees, and other relevant groups to ensure a collaborative approach to improving patient care and safety. Staff participation must be documented through meeting minutes and records, with a clear process for input into decisions. Review of policies, evidence of staff participation in different meetings, review of staff attendance, and interviews with staff shall be conducted.

Indicator 175: The Laboratory develops a pamphlet, lists the services provided, their costs, the kinds of samples/specimen needed, and the estimated time needed to report for testing and it is readily available.

Assessment Process:

In order to comply with this indicator, a pamphlet (outlining the services offered by the laboratory) must be available to patients, either in print or digitally, outlining the services offered by the laboratory. This pamphlet should include a comprehensive list of tests and services, the types of specimens required for each, the prices for the tests, and the approximate reporting time for results. The information should be clear, accurate, and easy to understand to help patients make informed decisions. The hospital must regularly update the pamphlet to reflect any changes in services, pricing, or procedures, and ensure that it is easily accessible to patients either in the hospital or through online platforms. Review of pamphlets shall be conducted to assess whether the pamphlet clearly outlines all the required information.

Indicator 176: The hospital has a strict policy that the laboratory staff must report any infection found in in-patient samples that could endanger hospital employees or patients, in writing to the assigned hospital Infection Control Committee.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented protocols for the timely and documented communication to designated infection control committee about any infections identified in in-patient samples that may pose a risk to the hospital's staff or patients. The laboratory staff must be trained in prompt reporting of these infections. The infection control committee should act upon this information to implement necessary precautions, containment strategies, and corrective actions and record of the same must be maintained. Regular reviews and audits should be conducted to ensure compliance with infection control protocols and timely reporting. Review of hospital protocols, training evidence, laboratory records (to ensure that infectious results are flagged appropriately and communicated in a timely manner), meeting minutes of infection control committee and documented action plans (in response to any infections reported by the laboratory) shall be conducted.

Indicator 177: In accordance with the most recent National and International recommendations as well as regulatory requirements, the hospital has created and implemented policies and procedures for the collection, handling, transportation, storage, control, reporting, and disposal of samples and tests.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures that cover the entire process of sample management, from collection to disposal, in full compliance with legal requirements, national and international standards and properly documented. The staff must be trained on these policies and regular audits and monitoring must be conducted to maintain high standards of compliance. This includes maintaining proper systems for tracking samples, ensuring appropriate storage conditions, and guaranteeing safe disposal of materials in accordance with environmental and health regulations.

Review of policies and procedures, physical inspection for the observation of collection, storage, transportation and disposal practices, staff training evidence and interview with staff shall be conducted.

Indicator 178: The department conduct and planned systematic activities to monitor and evaluate its services and progress.

Assessment Process:

In order to comply with this indicator, the laboratory department must have developed and implemented a system for monitoring and evaluating its services. This plan should include regular audits, the use of key performance indicators, and the collection and analysis of relevant data to assess service quality. The hospital must implement a structured feedback mechanism from both patients and staff to gather insights for improvement. Regular reviews and audits must be conducted to ensure continuous improvement and to maintain high-quality laboratory services. Review of monitoring and evaluation system, feedback records from patients and staff and audits reports shall be conducted to check compliance with this indicator.

B. Samples and Tests

Standard 31: Laboratory samples and tests are managed to maximize accuracy of testing and minimize risks to patients and staff.

Indicator 179: A printed standardized requisition form is available and must be properly completed by the requesting physician when ordering laboratory tests.

Assessment Process:

In order to comply with this indicator, the hospital must have a printed, standardized, comprehensive, and easy to fill out requisition form, readily available for physicians to fill completely when ordering laboratory tests. It must capture all relevant patient and test information as required, including following:

i. Patient information
ii. Patient location within hospital
iii. Sample collection time
iv. Investigations required/advised
v. Type of sample
vi. Probable diagnosis
vii. Requesting physician name
viii. Name of person collecting the sample

The hospital must be developed and implemented protocols to ensure that the requisition form is completed accurately and legibly before sample collection. Proper training must be provided to physicians and laboratory staff to ensure compliance with the form-filling process, reducing the risk of errors. Regular audits should be conducted to ensure that the requisition process is followed correctly. Review of protocols, standardized requisition forms, training evidence and audit reports shall be conducted.

Indicator 180: Collected samples are labeled with the patient's name and registration or MR number.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for accurate labeling at the point of collection with the patient's name and registration/MR number to ensure samples are traceable to the correct patient at all stages of testing. The labeling process must be standardized, consistent, and secure to prevent misidentification or mix-ups. Review of hospital's policies and procedures and on-site observation of sample labeling process shall be conducted.

Indicator 181: Distinct labels are used for high-risk samples.

Assessment Process:

In order to comply with this indicator, the hospital's sample labelling policy must specify identifying and labeling of high-risk samples such as those involving infectious agents or hazardous materials, with clear guidelines on how these samples should be handled, stored, and transported to prevent cross-contamination or exposure. These labels must include appropriate warnings, such as "High-Risk" or "Infectious," and are easily distinguishable from regular labels. Staff must be trained on handling and labeling of these samples. Review of hospital's policies and procedures, staff training evidence, on-site observation of high-risk sample labeling process and interview with lab staff shall be conducted.

Indicator 182: Steps are taken to ensure the safe transport of specimens and samples.

Assessment Process:

In order to comply with this indicator, the hospital department must have developed and implemented documented procedures for the safe transportation of specimens, including risk assessments, use of appropriate transport containers, and staff involved in whole process must be trained on how to transport hazardous or high-risk samples. Review of hospital's sample transportation procedures, staff training evidence and on-site inspection of transportation process including packaging, containers and transport vehicles or pathways that reduce the risk of exposure to staff and patients shall be conducted.

Indicator 183: There is a dedicated area for receipt and verification of samples or specimens. Once the following sample information have been entered or recorded in the laboratory's register, samples are securely and precisely delivered to the appropriate parts of the laboratory:

i. Patient name, location
ii. Identification of sample source(s)
iii. Full name of the investigation(s)
iv. Number of investigations
v. Investigation results

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented procedures for sample reception, verification, proper documentation in the laboratory register, accurate handling, storage, and distribution to prevent errors and to ensure traceability. The laboratory's register must include the patient's name, location, sample source identification, the name(s) of the investigations, the number of investigations, and any results. Staff must be trained on these procedures and its record is maintained. Review of hospital's procedures, laboratory register, staff training evidence and on-site observation of sample reception and verification process shall be conducted.

Indicator 184: When test results are reported, they are also entered into the laboratory records, which the relevant staff may easily access. Additionally, a hard copy of the results is available at reception of laboratory to enable picking up by OPD, wards staff or patients/attendants.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a reporting system that ensures test results are properly recorded in the laboratory register, with results made readily accessible to authorized staff. Hard copies of the results must be securely available at laboratory reception for collection by patients, staff, or attendants. The hospital must have a clear process for retrieving test reports in a timely and secure manner. Review of reporting system, laboratory register, random 5-10 hard copies of previous reports, and on-site inspection of laboratory reception shall be conducted

Indicator 185: The hospital has created and implemented signed and dated, Standard operating procedures (SOPs) for different tests. Staff members may inform patients verbally and in writing (when needed) of the steps involved in test preparation.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented signed and dated SOPs for each test and related patient preparation, covering the following:

1. Patient preparation for tests
2. Completion of test request forms
3. Reporting of test results
4. Dealing with out-of-hours test requests
5. Investigating transfusion reactions
6. Actions to be taken in case of infection emergency
7. Emergency and urgent requests
8. Storage of specimens and blood on the wards and in other departments
9. Dispatch of samples to other laboratories
10. Posting of samples
11. Acceptable parameters for response to test requests and reporting times
12. Sample collection
13. Handling
14. Labelling

15. Transportation
16. Retention
17. Storage
18. Disposal of samples, including blood and body fluids

The hospital must ensure that these SOPs are readily accessible to staff and that staff are adequately trained to follow them. The hospital must have developed and implemented procedures for communicating with patients (verbally and in writing) via written materials like brochures, consent forms, and instructional posters. Additionally, the hospital must monitor compliance with these procedures and regularly review and update the SOPs as necessary. Review of hospital's SOPs to verify that SOPs comprehensively cover all aspects of patient preparation, staff training evidence, instructional materials and interview with staff shall be conducted to assess compliance with this indicator.

Indicator 186: A qualified and experienced laboratory expert is available to give expert advice on:

1. The samples required
2. Any query about interpretation of results by medical team
3. Further recommended tests

Assessment Process:

In order to comply with this indicator, the laboratory services must be staffed with qualified professionals who can provide expert advice on the samples required for tests, how to interpret results, and any further tests that may be recommended and documented record of this communication is properly maintained. Additionally, the hospital must have resources to assist staff in making informed decisions regarding sample collection and test interpretation. Reviewing of communication records between laboratory staff and expert and interview with staff shall be conducted.

Indicator 187: There is an agreement between the hospital and an outside laboratory that covers every aspect of tests, including deadlines for results reporting, and staff members follow it. A specified SOP is followed in the lab to communicate the results for a set of crucial values.

Assessment Process:

In order to comply with this indicator, the hospital must have established a written agreement/MOU with any external laboratory, outlining clear terms for test procedures, reporting times, and responsibilities for both parties. This agreement must specify timelines for the delivery of results and address the process for communicating critical values. The hospital must ensure that staff are familiar with the agreement and consistently follow the protocols established within it. Furthermore, the laboratory must have developed and implemented a SOP for the immediate reporting of critical values, ensuring that these results are communicated quickly to medical personnel/ordering doctor to support urgent decision-making and a list of critical values is developed and displayed in the lab. Review of MOU, list of critical values, SOPs for reporting of critical values and interview with staff shall be conducted.

C. Safety

Standard 32: All persons are protected from potential hazards in the laboratory.

Indicator 188: There is a system in place to limit authorized personnel's access to the laboratory.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented clear policies that define who is permitted access in the laboratory, with designated personnel responsible for security measures to ensure that access to the laboratory is restricted to authorized personnel only. This may involve Radio Frequency Identification (RFID) control systems, locked doors, or other physical barriers to prevent unauthorized entry. The hospital must also ensure that staff are trained to follow these policies. Review of policies, training evidence of staff and on-site assessment of physical security measures shall be conducted.

Indicator 189: The laboratory department has developed health and safety policies, and current necessary hazard and safety action notices are displayed in the relevant sections as well as accessible and followed by the staff.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented health and safety policies, including hazard notices and safety action bulletins, including but not limited to:

- Safety regulations
- Fire precautions
- Infectious diseases including AIDS/HIV and hepatitis.

The hospital must display these notices prominently in all relevant areas for staff to see, and readily available in both physical and digital formats, ensuring staff are informed of all health and safety protocols. Staff must be trained on these policies have uninterrupted access to PPE's and regularly reminded of safety measures to minimize risk in the workplace. Review of health and safety policies, display of hazard notices and safety action bulletins, staff training evidence and interview with staff shall be conducted.

Indicator 190: Hazardous materials are handled safely with the use of the proper equipment. Clear instructions on how to properly dispose of radioactive, hazardous, and clinical waste are posted and followed. Hazardous and infectious waste are disposed of in distinct containers with clear labels. Material Safety Data sheets (MSDS) are kept up to date.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented clear protocols on safe handling and safe disposal of hazardous material as well as clinical, toxic, and radioactive waste and should be prominently displayed. The plan should include measures on greening processes that impact the environment negatively including disposal of waste but also

how the hospital will train the workers and equip with the skills and competencies to adapt to safer and greener work that saves them from hazards and help them with just transitions. Appropriate equipment for the same must be provided to ensure that staff have access to protective gear and tools (PPEs) that minimize the risk of exposure. Separate, clearly labeled containers must be used for hazardous and infectious waste, ensuring proper segregation. The hospital must maintain and make accessible up-to-date Material Safety Data Sheets (MSDS) for all hazardous substances to guide safe handling and disposal practices. Regular staff training must be conducted to ensure compliance with these safety protocols. Review of protocols, staff training evidence, assessment of safety equipment and procedures for disposal of waste and review of Material Safety Data Sheets (MSDS) shall be conducted.

Indicator 191: There is an eye wash station in the laboratory and facility of emergency showers in HCE for the employees in case of an emergency.

Assessment Process:

In order to comply with this indicator, the laboratory must have eye wash stations and are easily accessible areas where staff are at risk of exposure to hazardous materials. These stations must be properly maintained, with clean water and functioning equipment. Clear signage is in place to direct staff to the eye wash stations and emergency shower, and staff must be trained on how to use them in case of an emergency. Regular checks and maintenance must be conducted to ensure the eye wash stations and showers are operational and ready for immediate use. Physical inspection, review of staff training evidence and maintenance records shall be conducted to verify the same.

D. Facilities and Equipment

Standard 33: Safe and adequate facilities and equipment are provided to meet the needs and volume of patients served by the laboratory.

Indicator 192: Office and laboratory areas are adequately ventilated, well-lit, with adequate staff facilities and enough laboratory equipment, for employees to do their duties safely.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that laboratory and office spaces are properly lit, ventilated, and large enough to accommodate staff and equipment safely. The hospital must provide staff with sufficient laboratory equipment, enabling them to work safely and efficiently. Staff must have facilities including the following:

- Locker space
  Toilet and washing/shower facilities
- Special showering facilities in case of spill of chemicals or gases
- Staff rest room
- Overnight accommodation for on call staff
- Eating and break areas.

All facilities should be regularly maintained, accessible, and compliant with health and safety regulations. Physical inspection of laboratory, review of maintenance records and interview with staff shall be conducted to confirm that all facilities are clean, properly maintained, and accessible.

Indicator 193: There are sufficient storage facilities for specimens and reagents, ensuring favorable conditions required for storage of each specimen and reagent. The staff can easily search, access and safely handling it.

Assessment Process:

In order to comply with this indicator, the hospital must provide sufficient and well-organized storage facilities for specimens and reagents, ensuring that they are being provided their favorable conditions and are easily accessible for staff. Storage areas must be clearly labeled and designed to accommodate safe handling and efficient retrieval. The hospital should implement a tracking system to ensure specimens are easily identifiable and can be traced throughout the laboratory process. Regular audits should be conducted to maintain organization and compliance with safety standards. Physical inspection and review of sample tracking system shall be conducted.

Indicator 194: Refrigerated storage facilities are used for specified samples, specimens, and blood samples. Functioning emergency electrical supply / back-up for refrigerators is available and there is a procedure in place to regularly assess its readiness. Temperatures are regularly monitored and recorded and action is taken where a temperature varies from an acceptable range.

Assessment Process:

In order to comply with this indicator, the hospital must have refrigerated storage facilities for specified samples and specimens, with functioning emergency electrical supply systems in place to maintain refrigeration during power interruptions. The hospital must have a defined procedure to regularly assess the readiness of backup power systems. Temperatures of refrigerated storage must be regularly monitored and temperature logs maintained, with the documented record of corrective actions taken, whenever the temperature falls outside an acceptable range. Physical inspection, temperature logs and evidence of corrective measures taken shall be reviewed to assess the compliance.

Indicator 195: Laboratory equipment is managed through established schedules for inspection, calibration, and maintenance. Records of these activities are systematically maintained within the laboratory.

Assessment Process:

In order to comply with this indicator, the hospital must have defined and implemented documented schedules for regular inspection, calibration and maintenance of all laboratory equipment. These schedules must align with industry standards and equipment manufacturer recommendations. The hospital must maintain accurate records of all inspection, calibration, and maintenance activities within the laboratory, ensuring that data is readily accessible for staff and auditors. Additionally, staff must be trained to follow these procedures to ensure the proper

functioning of equipment and the accuracy of test results. Review of maintenance schedules, staff training evidence and documented records of inspection and calibration of equipment shall be conducted.

10. BLOOD BANK

A. Service Management

Standard 34: The hospital blood bank unit is structured and managed to ensure the safe, efficient provision of blood and blood products, while effectively supporting clinical departments and patient care.

Indicator 196: The blood bank must be registered with the Islamabad Blood Transfusion Authority (IBTA).

Assessment Process:

To comply with this indicator, the hospital's blood bank must hold a valid registration with the Islamabad Blood Transfusion Authority (IBTA).

The assessment process will include verification of the original and active registration certificate issued by IBTA, along with supporting documentation such as, correspondence with the authority, and any renewal confirmations etc. To ensures that the blood bank operates within the legal framework and meets the licensing requirements set forth by the regulatory body.

Indicator 197: The hospital blood bank unit must be overseen by a qualified professional having requisite postgraduate qualification (hematologist/pathologist) duly recognized by PM&DC, with training in transfusion medicine. All functional areas within the blood bank should be staffed by competent and trained personnel, including but not limited to laboratory technologists or technicians.

Assessment Process:

In order to comply with this indicator, the hospital blood bank unit must be overseen by a qualified professional along with sufficient number of skilled and certified support staff to effectively meet service requirements.

The hospital is responsible for clearly defining the roles and responsibilities of all blood bank staff through documented job descriptions, which must be maintained in each staff member's HR file. Regular audits and performance reviews must be conducted to ensure that the blood bank operates in line with approved protocols and national regulatory standards.

To assess compliance, a physical inspection of the blood bank unit, a review of job descriptions, and interviews with staff should be conducted to confirm their understanding of assigned responsibilities and adherence to established procedures.

Indicator 198: A Policy is established covering all aspects and use of blood or blood products & transfusion services and are duly governed by applicable laws and regulations.

Assessment Process:

In order to comply with this indicator, the procedures manual must cover all activities in the blood bank. The document broadly outlines the processes being carried out in the blood center. The processes include and is not limited to;

(a) Collection of blood and blood products
(b) Processing and storage
(c) Donor screening such as virology screening.
(d) Blood transfusion prescription signed by a medical officer
(e) Serologic testing (grouping, x-match, antibody screening)
(f) Blood administration and monitoring
(g) Adverse effects of transfusion and workup
(h) Disposal of blood and blood related products
(i) Staffing and procurement for blood bank and transfusion services
(j) Record keeping for traceability of processes/actions at all steps in the blood chain
(k) Calibration, maintenance, and monitoring of equipment in the facility.
(l) Audit of transfusion practices by hospital transfusion committee

The blood service provision will be checked only as per scope of services being portrayed and rendered. All documents must be in conformance with standards prescribed by the Authority.

Indicator 199: The blood bank unit located within a hospital facility should establish liaison with all departments of hospital especially those requiring blood more frequently.

Assessment process: To ensure compliance with the above indicator;

1. The hospital must provide ready access to the blood bank for key clinical areas such as the Emergency Unit, Operating Unit, and Critical Care Units.
2. The hospital should implement policies that ensure the quality, safety, and consistent availability of blood and its components, in line with the national blood policy and relevant legislative requirements.
3. Tertiary care hospitals are required to maintain a fully operational Blood Center or Hospital Blood Bank on a 24/7 basis, as mandated by applicable regulations, to ensure timely and uninterrupted transfusion services.

Indicator 200: Staff members are trained to implement policies.

Assessment Process: To ensure compliance with the above indicator verify that staff members of the blood bank unit are familiar with the policies and procedures governing the operation of blood transfusion services. Examine training records / attendance / feedback to confirm that personnel have been trained on these documented protocols, and conduct interview of the staff to assess their understanding and adherence to the compliance requirements.

B. Safety

Standard 35: All persons are protected from potential hazards in the Blood Bank Unit.

Indicator 201: There is a system in place to limit authorized personnel's access to the Blood Bank Unit.

Assessment Process: To comply with this indicator, the hospital must establish and implement clear policies restricting access to the blood bank and allowing authorized personnel only, with preferred installation of Radio Frequency Identification (RFID) technology. Designated staff should be responsible for enforcing security measures, such as access control systems or locked entry points. Staff must be trained on these protocols. Compliance will be verified through policy review, training records, and on-site assessment of physical security.

Indicator 202: The hospital has established and implements standardized donor eligibility criteria for blood transfusion services in accordance with National and International safety guidelines.

Assessment Process:

In order to comply with this indicator, the hospital shall establish and implement standardized donor eligibility criteria for blood transfusion services, fully aligned with national and international safety guidelines to ensure donor and recipient safety. The following criteria must be consistently applied during donor selection:

- Donors having a history of jaundice, blood transfusion, major surgery & invasive dental treatment within the previous one year must be deferred for another one year.
- Permanent deferral for individuals with a history of or currently suffering from Hepatitis B or C, HIV, syphilis, cardiovascular, CNS, malignant, renal, respiratory diseases, and insulin-dependent diabetes mellitus.
- Exclusion of pregnant or lactating women unless donation is justified by neonatal need.
- Deferral of individuals undergoing active medical investigations or awaiting specialist opinions until a medical clearance is obtained.
- Donors who have used anti-platelet medications like aspirin or non-steroidal anti-inflammatory drugs (NSAIDs) within the past 5 days should be deferred from donating platelets intended for transfusion.
- Donor eligibility based on age should be minimum 18 years, maximum 60 years for first-time donors, with no upper limit for regular donors.
- Enforcement of minimum donation intervals: 3 months for males and 4 months for females.

C. Facilities and Equipment

Standard 36: Safe and adequate facilities and equipment are provided to meet the needs and volume of patients served by the blood bank.

Indicator 203: Blood Bank Unit is adequately ventilated, well-lit, with adequate staff facilities and enough equipment, for employees to do their duties safely as per requirement of the relevant regulatory bodies, i.e. PMDC, PNMC, ILO, AHPC etc.

Assessment Process:

In order to comply with this indicator, the blood bank must consist of the following Functional Areas:

- Donor waiting area.
- Reception.
- Access to public toilets.
- Patient screening room for medical examination of patients prior to donor procedures
- Blood collection; the collection area shall have a staff work bench, chairs and couches for donors and hand washing facilities.
- Rest and recovery area for patients following blood donation procedures with provision for patient refreshments prior to the patient departure.
- A staff member trained in Basic Life Support (BLS) must be present to monitor the blood donation process and provide immediate first aid in the event of any post-donation medical emergency.
- Blood Storage area including refrigerators and freezers.
- Support areas, including clean-up, sterilizing, storage areas for reagents and supplies used in the process, general supplies and disposal facilities for contaminated waste.
- Secure Records storage, which may be collocated with Reception.
- Access to Staff Room and Change Rooms with lockers and Toilets.
- A staff member trained in Basic Life Support (BLS) must be present to monitor the blood donation process and provide immediate first aid in the event of any post-donation medical emergency.

11. RADIOLOGY

A. Service Management

Standard 37: Radiology services are structured and managed to ensure the delivery of safe, efficient patient care while effectively supporting clinical specialties.

Indicator 204: The clinical oversight and patient safety within the radiology department are overseen by a qualified radiologist. Radiology services are delivered by a designated, registered radiologist or radiographer, who is assigned explicit responsibility for managing all non-clinical aspects of the department.

Assessment Process:

In order to comply with this indicator, the radiology department must be under the clinical direction of a qualified, registered radiologist who is responsible for patient safety and the overall clinical operation of the department. The administration of radiology services must be overseen by a qualified radiologist or radiographer with clearly defined responsibilities for managing all non-clinical aspects of the department. The hospital must establish and document clear job descriptions for both clinical and non-clinical staff to ensure the department functions efficiently and meets safety, quality, and regulatory standards. Physical inspection, review of job descriptions and interview with department's staff shall be conducted.

Indicator 205: Radiation protection measures are overseen by the radiologist and monitored by the Hospital in-charge in compliance with Pakistan Nuclear Regulatory Authority (PNRA) guidelines. A valid PNRA license is present and prominently displayed within the radiology department, along with documented evidence of regular inspections conducted by the PNRA.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that radiation protection in the radiology department is effectively supervised by the radiologist, with consistent monitoring by hospital In-charge, as per PNRA guidelines. The hospital must hold a valid PNRA license, which should be displayed in the radiology department. It is essential for the hospital to comply with all PNRA regulations, ensuring that radiation safety measures are in place to protect both staff and patients and staff must be trained on these safety measures. The hospital must also keep records of regular PNRA inspections, ensuring that inspections are conducted as required and that any recommendations or corrective actions are properly implemented. Physical inspection, Review of PNRA license, staff training evidence, documented monitoring records and previous inspections record by PNRA shall be conducted.

Indicator 206: Employees adhere to documented policies and procedures for every aspect of radiology services, such as

- Patient registration and reception.
- Preparation of the patient for imaging
- Documentation and dispatch
- Processing and analyzing the film or scan
- Reporting on the film or scan

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for all aspects of radiology services, including the all above mentioned areas. Regular staff training must be provided to ensure that all policies and procedures are followed consistently. Review of policies and procedures, staff training evidence, physical inspection and interview with staff shall be conducted to ensure compliance.

Indicator 207: The department has the most recent reference manuals, radiation safety reports, and radiation rules and standards.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented an up-to-date reference manual, radiation regulations, and safety guidelines which are readily available within the radiology department. The hospital must also maintain current radiation safety reports that document safety measures, incidents, and compliance with regulations. These materials must be easily accessible to all staff members, who should be trained to refer to them regularly in the course of their duties to ensure compliance with radiation safety protocols. Review of reference

manuals, radiation regulations and guidelines, radiation safety reports and staff training evidence shall be conducted.

Indicator 208: To monitor the quality of its services, the Radiology Department uses an internal quality control program, participates in the hospital's health and safety committee, and implements the outcomes of its quality control program.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a quality control program that monitors the effectiveness of its radiology services. This program should include:

- Equipment utilization review
- Performance checks on equipment, including processors
- A record of maintenance checks for all items of equipment
- Film and scan reject rates
- Clinical audit
- Turnaround time is available for the reporting of films and scans.

Clinical audits must be conducted under this quality control program to evaluate the quality of radiological services and corrective measures must be taken for continuous improvement. The radiology department must participate in hospital's health and safety committee and these quality control activities must be integrated with the hospital's overall health and safety goals and quality improvement system. Review of quality control program, documented reports of clinical audits, evidence of participation in hospital's health and safety committee and actions taken shall be conducted.

B. Service Provision

Standard 38: Patients are systematically registered, receive radiological services in line with written requests and have their radiology investigations reported promptly and accurately.

Indicator 209: Forms for laboratory requests follow a standard structure and include all required data.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that all laboratory request forms follow a standard format and must contain the following essential information:

- Patient's name
- Medical Record number
- Date of birth (if not available, age)
- Examination requested
- Previous examinations
- Clinical diagnosis/indications/relevant history

- Information relating to the pregnancy rule in women of childbearing age
- Identity of requesting physician
- History of allergy
- For medico legal cases mark of identification of the patient and name of police official bringing the patient
- Use of metformin

Review of laboratory request forms and previous records shall be conducted to ensure they adhere to a standard format and contain all necessary information.

Indicator 210: Diagnostic imaging is only carried out in response to a fully completed and signed written request from a licensed and certified healthcare professional.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy that diagnostic imaging procedures are only performed when there is a signed written request from a qualified medical practitioner. The request must include all relevant patient information, the type of imaging requested, and clinical details to justify the examination. The staff are trained to verify the qualifications of practitioners submitting requests. Review of hospital policy, imaging request forms and staff training evidence shall be conducted.

Indicator 211: There is a written policy and procedures in place for handling requests made during emergencies or after hours. Staff members are always available for mobile radiography and other imaging needs, with proper working time management.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy and formal arrangements to manage out-of-hours or emergency diagnostic imaging requests. This policy must outline the process for submitting, reviewing, and approving emergency imaging requests when the regular imaging staff is unavailable. The hospital must ensure that on-call staff, including those for mobile radiography and other imaging services, are available at all times to respond to emergency situations. Clear documentation must be maintained to track emergency requests. Review of policy and formal arrangements and previous records shall be conducted to check the availability and responsiveness of on-call staff and ensure that emergency imaging requests are handled promptly.

Indicator 212: The conditions under which pregnant women may have radiological testing are outlined in a written policy that was approved by the radiologist. There are conspicuous signs alerting women of reproductive age to the risks of radiation exposure during pregnancy.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a written policy, agreed upon by the radiologist, that governs the conditions under which pregnant women may be subjected to radiological examinations and staff must be trained on it. The hospital must display prominent warning signs in the radiology department, informing women of childbearing age about the potential dangers of radiation exposure during pregnancy. Review of

policies, staff training evidence and on-site inspection for assessment of display of waring/danger signs shall be conducted to ensure.

Indicator 213: A certified and registered radiologist reads every film, and the hospital receives the written findings from the radiologists within a certain period of time following the examination.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy that all films are read by a qualified radiologist, and that written radiologist reports are generated for each examination and radiologist must be aware of it. These reports must be received by the hospital within a clearly defined time frame. The hospital must have a system in place for tracking the submission of reports and ensuring that radiologists adhere to these time frames. Review of policy, previous radiologist reports and interview with the radiologist shall be conducted.

Indicator 214: The severity of the issue determines the required reporting times; for example, standard reports must be sent within 24 hours, but emergency patient films or scans must be submitted within an hour.

Assessment Process:

In order to comply with this indicator, the hospital's radiological reporting policy must be developed and implemented that specify clear reporting times for radiological examinations based on the urgency of the situation. Emergency films or scans must be reported within one hour, ensuring that critical care decisions can be made promptly and routine reports should be completed and reported within 24 hours. The staff must be trained to prioritize urgent cases appropriately. Regular audits of reporting times should be conducted to ensure that the hospital consistently meets these standards. Review of policy for clear reporting times, previous records of radiological reports and staff training evidence shall be conducted.

Indicator 215: A written, signed reporting of the radiograph is made only by a qualified radiologist whereas, interpretation only by a registered clinician whose skills are relevant to the radiography, if a radiologist is unable to report on the film in a timely manner. For example, an orthopedic surgeon may interpret bone/joint radiography, a neurologist or neurosurgeon may interpret brain/spine radiography, or a chest physician may interpret chest radiography.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy to ensure that, written, signed reporting of the radiograph is made only by a qualified radiologist whereas, if a radiologist is unable to report on a film within the required time frame, the relevant clinician with expertise may interpret the radiograph. The hospital must ensure maintaining quality care even when a radiologist is unavailable. Review of policy and documented record of previous such reports shall be conducted to ensure compliance.

Indicator 216: The referring physician is informed of any significant or surprising findings.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy which states that critical or unexpected findings from radiological examinations are discussed directly with the referring doctor as soon as possible. This communication should be timely, with documentation of the discussion maintained to ensure that appropriate actions are taken to address any urgent findings. Staff must be trained on reporting of these critical results. Review of policy, documented record of reporting critical values and staff training evidence shall be conducted.

Indicator 217: In the wards and other departments, radiology reports or copies of the reports are kept in the patient's medical file.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented guidelines to ensure that radiology reports or copies of the reports are placed in the patients' medical files in the wards and other relevant departments. Relevant staff must be trained on these guidelines. Review of guidelines, Patient records and training evidence of staff shall be conducted to verify the same.

C. Safety

Standard 39: Radiological services are provided in accordance with current radiation rules and regulations, risks are minimized and the safety of patients and staff are protected.

Indicator 218: All ionizing radiation examinations are carried out by qualified professionals. Employees deliver services in compliance with current laws and regulations regarding ionizing radiation.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a system for examinations involving ionizing radiation and these must be performed by personnel who are properly trained and qualified to handle such procedures safely. Staff must be familiar with and follow current ionizing radiation regulations and statutory requirements, ensuring compliance with safety standards set by relevant authorities. The hospital must provide regular training and updates to staff on radiation safety practices. Review of system, evidence of staff training and interview with staff shall be conducted to ensure compliance.

Indicator 219: There must be a crash cart with emergency supplies and medications in the unit or located nearby to ensure timely access in case of an emergency. All resuscitation equipment is operational, easily accessible, and checked regularly for proper functioning. Every employee in radiology services takes refresher courses on evidence-based practice, resuscitation, and current radiology trends.

Assessment Process:

In order to comply with this indicator, the radiology department must have a functional resuscitation trolley/crash cart in the unit, ready for immediate use during emergencies. List of all the drugs/equipment's available in the trolley must be displayed or maintained. A designated member of staff must be responsible that these devices are regularly checked and maintained according to established protocols, and their contents must be regularly inspected, restocked, and kept organized. The hospital must also ensure that all relevant staff are properly trained in using the resuscitation trolley and defibrillator. Physical inspection of resuscitation trolley/crash cart, review of training evidence, availability of list of drugs & equipment's shall be examined.

Indicator 220: In areas where biohazards or radiography equipment are present, protective apparel is supplied and worn. It is the duty of the supervising radiologist to monitor adherence to national guidelines for following:

- Radiation monitoring devices are worn by employees who handle radiological equipment.
- These devices are inspected and maintained in compliance with legal requirements.
- Records of these exams are retained for the duration of the service employees' employment.
- Specify staff safety measures and training as per national guidelines.

Assessment Process:

In order to comply with this indicator, the hospital must provide protective clothing, such as lead aprons, and ensure that staff working with radiological equipment or in areas with biohazards wear radiation monitoring devices. These devices must be regularly assessed and maintained in compliance with statutory regulations, ensuring that staff are not exposed to harmful levels of radiation. Staff must be provided regular training and latest information on protection and radiation safety measures. The hospital must maintain records of radiation exposure tests for the entire duration of a staff member's employment, ensuring these records are kept for the working lifetime of the staff. The radiologist in charge is responsible for monitoring compliance with national safety guidelines, ensuring that staff are protected and that all necessary measures are in place to maintain a safe working environment. Physical inspection, maintenance record of radiation monitoring devices (such as dosimeters), records of radiation exposure tests and interview the Incharge shall be conducted.

D. Facilities and Equipment

Standard 40: Facilities and equipment are provided and maintained to maximize patient comfort and safety.

Indicator 221: Patients have access to a separate spot for registration. Waiting area with sufficient seats for both men and women, as well as separate restrooms for men and women and disabled.

Assessment Process:

In order to comply with this indicator, the hospital must have a dedicated registration area exclusively for patients, ensuring it is easily accessible and designed to facilitate smooth

registration processes. The hospital must also provide separate waiting areas, with adequate seating, for males and females to ensure privacy and cultural sensitivity. Additionally, the hospital must provide clean, well-maintained, and fully functional and separate (male and female) toilets and washing facilities near the waiting areas. The assessment process will include a review of the physical setup, maintenance records of the facilities, and interviews with both staff and patients to verify their awareness and satisfaction with these provisions. Direct observation of the areas will also be conducted to confirm compliance with the indicator.

Indicator 222: Before any diagnostic equipment is bought and installed, the relevant hospital advisory committee (or its equivalent) and a senior radiologist is consulted, to make sure the equipment satisfies contract requirements and validates mechanical, electrical, and radiation safety. For reference, the department maintains the test records.

Assessment Process:

In order to comply with this indicator, the hospital must have an established advisory committee or an equivalent body that includes representation from radiology staff. This committee must be actively involved in the decision-making process for the purchase and installation of diagnostic equipment. The hospital must ensure that the committee is consulted to confirm that the equipment aligns with contract specifications and meets all necessary standards for mechanical, electrical, and radiation safety. Additionally, tests to verify compliance with these safety requirements must be conducted, and comprehensive records of these tests should be maintained within the relevant department for future reference. The assessment process will involve a review of the advisory committee's terms of reference, meeting minutes, and decisions related to the procurement of diagnostic equipment. Records of safety tests and staff awareness will also be verified to ensure adherence to this indicator.

Indicator 223: The workload of each diagnostic equipment and employee is specified, and this information is utilized to figure out the department's resource requirements and to ensure decent working conditions aligned with national and international labor standards.

Assessment Process:

In order to comply with this indicator, the hospital must have a system in place to define and monitor the workload of each piece of diagnostic equipment and the staff operating it. The workload analysis must include metrics such as the number and types of diagnostic tests performed, the operational hours of the equipment, and the staff's working hours, capacity and duties. This data must be regularly reviewed and used to assess the adequacy of resources, including staffing levels, maintenance schedules, and procurement of additional equipment if required. The assessment process will include a review of workload records, resource planning documents, and evidence of periodic evaluations. Staff interviews will be conducted to confirm awareness of workload management, and operational data will be examined to ensure that resource allocations align with the department's needs.

Indicator 224: In order to ensure that all radiological equipment is stable, operational, and placed in appropriately lead-protected rooms, the hospital has developed and placed into effect a procedure and policy.

Assessment Process:

In order to comply with this indicator, the hospital must have established and implemented policies and procedures to ensure that all radiology equipment is installed in lead-protected rooms that meet safety standards. The policies must outline the steps to verify the structural integrity and lead protection of the rooms before installation. The hospital must also have a system to regularly assess the stability and functionality of radiology equipment, ensuring compliance with safety and operational standards. Records of these assessments, including installation checklists and maintenance logs, must be maintained and readily available for review. The assessment process will involve examining the relevant policies and procedures, reviewing maintenance and safety records, and conducting site visits to verify the proper installation and protective measures in radiology rooms. Staff awareness and adherence to these policies will also be evaluated through interviews.

Indicator 225: To keep equipment in good operating order, a scheduled preventive maintenance schedule that complies with manufacturer guidelines is implemented. Every installed piece of equipment has an appropriate maintenance contract in place. The PPM (Planned Preventative Maintenance) record is kept up to date.

Assessment Process:

In order to comply with this indicator, the hospital must have a planned preventative maintenance (PPM) program for all diagnostic equipment, aligned with the manufacturer's guidelines. This program should ensure regular inspections, servicing, and timely interventions to maintain equipment in optimal working condition. Additionally, a proper maintenance contract must be established for each installed piece of equipment, specifying the scope of services and responsibilities of the maintenance provider. Records of all PPM activities, including dates, findings, and actions taken, must be systematically maintained for accountability and future reference. The assessment process will include a review of the PPM schedule, maintenance contracts, and records of maintenance activities. Radiation safety reports will be verified, and staff awareness of the maintenance and safety protocols will be evaluated through interviews and documentation checks.

12. PHARMACY SERVICES

A. Services Management

Standard 41: The pharmaceutical service is managed and organized to provide efficient and effective pharmaceutical services through rational use of drugs within the hospital.

Indicator 226: A licensed pharmacist who is currently registered with the Pakistan Pharmacy Council oversees the pharmaceutical service. When the in-charge pharmacist is not available, a deputy is assigned with certain tasks and obligations.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that its pharmaceutical services are managed by a qualified pharmacist who holds a graduate degree and is registered with the Pakistan Pharmacy Council. In the pharmacist's absence, a suitably qualified deputy with clearly defined duties and responsibilities must be designated to ensure uninterrupted management of pharmaceutical services. The hospital must maintain records verifying the qualifications and registration of both the pharmacist and the deputy, along with documentation of the delegation of responsibilities. The assessment process will include a review of personnel files, job descriptions, and any policies or procedures related to the delegation of authority. Staff interviews will also be conducted to confirm awareness and adherence to these requirements.

Indicator 227: The job descriptions and the specified pharmacy services can be fulfilled by a sufficient number of suitably competent employees.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the pharmacy department is staffed with an adequate number of appropriately qualified personnel to effectively deliver the defined pharmacy services. The qualifications of the staff must align with their respective job descriptions, and the staffing levels should be sufficient to manage the workload, including routine tasks and peak demands. The hospital must maintain updated job descriptions for all pharmacy roles and evidence of staff qualifications and training. The assessment process will include a review of staffing records, job descriptions, and duty rosters to verify adequacy and alignment with service requirements. Interviews with pharmacy staff will also be conducted to assess their awareness of their responsibilities and satisfaction with the staffing arrangements.

Indicator 228: To provide pharmaceutical services during non-working hours, a certified pharmacist or designated deputy is on duty or available via phone.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that a qualified pharmacist or a designated deputy is available on duty or on call outside normal working hours to provide pharmaceutical services aligned with good work time arrangement. This arrangement ensures that patients have access to essential pharmaceutical care, including medication dispensing and consultation, during evenings, weekends, and holidays. The hospital must have documented schedules or on-call rosters confirming the availability of the pharmacist or deputy, along with records of their contact details and responsibilities during off-hours. The assessment process will involve reviewing on-call schedules, duty rosters, and documentation verifying the qualifications of the pharmacist or designated deputy. Interviews with pharmacy staff will be conducted to confirm the effectiveness and reliability of the on-call system.

Indicator 229: In accordance with legal requirements, the hospital established and implemented written rules and procedures for ordering, buying, managing, storing, dispensing, and disposing of all medications inside the facility.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented comprehensive written policies and procedures that govern the entire lifecycle of medicines within the facility. These policies should cover the processes for ordering, purchasing, controlling, storing, dispensing, and disposing of all medicines, ensuring that each step adheres to relevant legal requirements and best practices. The policies must also address safeguards for maintaining the quality and integrity of medicines, including proper storage conditions and accountability in dispensing. The hospital must ensure that staff members involved in these processes are well-trained and familiar with the policies. The assessment process will involve reviewing the written policies and procedures, verifying their alignment with legal requirements, and conducting interviews with staff to assess their understanding and compliance. Additionally, records of medicine orders, stock control, dispensing activities, and disposal methods will be examined to ensure adherence to the established procedures.

Indicator 230: Staff members take part in the hospital's quality improvement system, and the department uses an internal quality control program to keep an eye on the caliber of its services.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the pharmacy department actively monitors the quality of its services through an internal quality control program. This program should include regular evaluations of pharmaceutical practices, patient safety, and service efficiency, ensuring continuous improvement. Additionally, the pharmacy staff must be integrated into the hospital's broader quality improvement system, participating in activities such as audits, feedback sessions, and training initiatives aimed at enhancing the overall quality of care and patient safety. The assessment process will include a review of the internal quality control program, evidence of staff participation in the quality improvement system, and records of audits or evaluations conducted.

Indicator 231: To guarantee the safe, efficient, and cost-effective use of medications, the pharmacy service offers a routine prescription monitoring service locally.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that the pharmacy service provides a regular prescription monitoring service. This includes:

- Identifying inappropriate medication
- Monitoring adverse reactions
- Monitoring dispensing errors

- Checking adequacy of labelling of drugs and information on package inserts
- Physical examination of drugs to assess their quality and expiry dates
- A mechanism to encourage prescription of cost-effective, economical and quality drugs

The pharmacy team must evaluate prescriptions, while also ensuring that cost-effective treatment options are considered. The hospital must have a structured system in place for documenting prescription reviews and follow-up actions. The assessment process will involve reviewing prescription monitoring records, policies, and any reports related to prescription audits.

B. Selection, Ordering and Purchasing of Medication

Standard 42: Selection and procurement of medication is appropriate to the scope of service, patient needs, and cost-effectiveness.

Indicator 232: The hospital formulary is created collaboratively, taking into account patient needs, hospital services, cost-effectiveness, and evidence-based standards. It also complies with current provincial and national regulations, such as the WHO essential drug list and the National Essential Drugs List (NEDL).

Assessment Process:

In order to comply with this indicator, the hospital must ensure that its formulary is developed through a collaborative process involving key stakeholders, such as healthcare providers, pharmacists, and administrators. The formulary must be designed to reflect the needs of patients, the services provided by the hospital, and the principles of cost-effectiveness and evidence-based medicine. It must also align with established provincial and national guidelines, such as the National Essential Drugs List (NEDL) and the World Health Organization (WHO) Essential Drug List. The hospital must regularly review and update the formulary to ensure it remains relevant and compliant with current medical standards and guidelines. The assessment process will include a review of the formulary development process, documentation of collaboration, and evidence that the formulary is in compliance with national and international standards.

Indicator 233: A pharmacy purchasing committee has been notified by the hospital, and the pharmacist is one of its members. Policies and procedures for the Purchase Committee have been created and put into effect by the hospital.

Assessment Process:

In order to comply with this indicator, the hospital must have established a purchase committee, and relevant policies outlining its roles, responsibilities, and decision-making processes, with a qualified pharmacist serving as a member of the committee. This committee must be responsible for overseeing the procurement of medicines and pharmaceutical supplies, including tendering, evaluation of tenders, selection, ordering and reception and physical examination of delivered drugs. The purchase committee also ensures that:

- Evaluation of tenders and selection of the provider occurs through a transparent process based on specific criteria including quality and cost.
- The quality, quantity and expiry date of purchased medicines are checked upon receipt.

- Samples of delivered drugs sent to the Drugs Testing Laboratory for quality check, in case of purchase of sub-standard drugs by the Hospital.

The assessment process will involve reviewing the composition of the purchase committee, including the pharmacist's role, as well as the policies and procedures governing the committee's activities.

Indicator 234: The following requirements must be fulfilled by the hospital before purchases:

- DRAP drug registration, raw material certificates, GMP certificates, ISO quality certificates, and so on.
- All bought devices, including pacemakers, implants, and stents shall be DRAP approved.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that all medicines purchased meet the required criteria, including registration with the Drug Regulatory Authority of Pakistan (DRAP). Additionally, the hospital must verify that the drugs have the necessary supporting documentation, such as certificates for raw materials, Good Manufacturing Practice (GMP) certification, and quality certificates like ISO or equivalent. For medical devices, including stents, pacemakers, and implants, the hospital must ensure that these items are approved by DRAP prior to purchase. The hospital must maintain records of the registration, certifications, and approvals for all medicines and devices acquired. The assessment process will involve reviewing procurement records, verification of drug and device certifications, and ensuring compliance with DRAP regulations. Interviews with the procurement team and pharmacy staff will also be conducted to confirm their understanding and adherence to these requirements.

Indicator 235: Every unit has access to the list of drugs that are readily available at the hospital pharmacy.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that a comprehensive and up-to-date list of all medications available in the pharmacy is readily accessible to all hospital units. This list should be maintained in a format that is easily retrievable by healthcare providers and staff, ensuring that they can quickly check the availability of medications when prescribing or administering treatments. The hospital must also have a system in place to update the medication list regularly to reflect changes in stock, new medications, or discontinued items. The assessment process will involve reviewing the accessibility of the medication list, verifying its completeness and accuracy, and confirming that all relevant hospital units have access to it.

Indicator 236: There is a defined procedure for obtaining necessary pharmaceuticals that are not typically kept at the hospital pharmacy. The appropriate department keeps a record of the same.

Assessment Process:

In order to comply with this indicator, the hospital must have a documented process in place for obtaining medications that are not routinely stocked or available in the pharmacy. This process should clearly outline the steps for requesting, sourcing, and procuring such medications, ensuring that these procedures are efficient and meet patient care needs. Additionally, the hospital must maintain records of all such requests and acquisitions, ensuring that they are properly documented within the relevant department for accountability and future reference. The assessment process will involve reviewing the documented procedure for obtaining non-stock medications, verifying that the process is followed, and examining records of previous requests and acquisitions.

C. Storage and Stock Management

Standard 43: Stock is stored and managed to ensure that medications are current, kept safe and are continuously available to meet the needs of clinical staff and patients.

Indicator 237: The hospital makes sure that medications are kept in ideal storage settings that satisfy all standards for preserving their efficacy, safety, and quality.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that medicines are stored in conditions that protect them from light, dampness, and temperature extremes, and that storage areas are free from vermin and insects. The storage areas must be well-ventilated, and there should be designated containers or cupboards for flammable or hazardous materials. Medicines that require refrigeration must be stored in a suitable facility. Emergency medications must be stored in sealed, tamper-evident containers and be readily accessible in all patient areas. Controlled drugs must be securely stored in a separate cupboard, fixed to the wall or floor, in compliance with relevant regulations. The assessment will involve inspecting the storage conditions of medicines across different areas, reviewing temperature and humidity logs, and checking the security measures for controlled drugs.

Indicator 238: The department uses a formal stock control system, which is developed and implemented for the hospital.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a formal stock control system, which includes:

- A defined stock list with agreed Period Automatic Replacement (PAR) levels for all wards and departments.
- Stocks of controlled and high alert medicines are ordered by authorized personnel with

mandating steps for their safe usage.

- Medicines required in an emergency are available and replaced promptly after use.
- All expired or recalled medicines, including unwanted medicines returned by patients and unused controlled medicines, are safely disposed of in accordance with a written procedure.

The hospital must maintain and update the stock list regularly and staff must be trained and authorized to order controlled and high-alert medicines, and documented evidence of the same is available. The assessment will involve inspecting the existence and accuracy of a defined stock list, reviewing of procedure for ordering controlled and high-alert medicines, emergency medicine stock management process, safe disposal of expired, recalled, or unwanted medicines and staff training evidence on all these procedures.

Indicator 239: Regarding medication recalls and danger warnings, a formal policy and procedures are established and put into effect. All recalled or expired medications, as well as any unused controlled substances, are disposed of securely following a documented protocol.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a written policy and procedures on hazard warnings and medicine recalls, including specific procedures for handling such situations. The hospital must have documented guidelines for safely disposing of expired, recalled, and unused controlled medicines, ensuring compliance with health and safety standards. Staff must be adequately trained on these procedures, and the hospital should maintain proper documentation of all actions taken in response to recalls and disposals, ensuring accountability and transparency. The assessment process will involve reviewing of written policy and procedure for handling hazard warnings and medicine recalls, documentation and records of expired, recalled, or unwanted medicines and staff training evidence. The hospital designated disposal areas shall also be inspected to ensure that hazardous medicines, particularly controlled substances, are disposed of securely to prevent diversion or misuse.

Indicator 240: Order forms, copies of delivery notes, store receipts, issue vouchers, and a book of records (controlled or prescription medicine book) are all kept on the premises in accordance with national applicable legislation through a formal, documented system.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented written procedures for the retention and management of all relevant documents, including order forms, delivery notes, store receipts, issue vouchers, and controlled/prescription drug books. All documents must be securely stored and easily accessible for audits, inspections, and traceability purposes, with access restricted to authorized personnel. All records related to the procurement, receipt, and distribution of medicines must be accurate, updated, and reflect a clear audit trail. The assessment will involve reviewing of written procedure for the retention of important

documents, examination of controlled drugs book/prescription drugs book, inspecting premises for safe storage of all mentioned documents and assessing previous audit reports.

Indicator 241: For medications that need to be kept in cold storage, lockable medical refrigerators with thermometers recording maximum and minimum temperature are available and operational. Regular monitoring and recording of temperatures are done, and when a temperature deviates from an acceptable range, appropriate action is taken.

Assessment Process:

In order to comply with this indicator, the hospital must have lockable refrigerators dedicated solely to storing temperature-sensitive medicines, with maximum and minimum thermometers used to regularly monitor and record the temperature of the refrigerators. The hospital must have a clear procedure in place to take corrective action if temperatures vary outside the acceptable range. Staff must be trained on the importance of proper medicine storage and the correct procedure for responding to temperature variations. Regular audits or checks should be conducted to ensure compliance with these practices. This assessment will involve inspecting designated lockable medicine refrigerators and maximum and minimum thermometers or automated temperature monitoring systems to track temperature variations. Temperature logs (recorded at least once or twice a day), documented evidence of corrective actions taken and staff training evidence shall also review.

Indicator 242: Availability of Crash Cart with medications needed for Emergency response.

Assessment Process:

In order to comply with this indicator, the hospital's pharmacy must ensure the availability and maintenance of a crash cart stocked with essential emergency medications required for immediate response to critical situations, including but not limited to cardiac arrest, anaphylaxis, and seizure management. The hospital's approved list of emergency medicines must be available. Staff members must be regularly trained on the use of emergency medicines and the crash cart. The hospital must maintain records of routine inspections, ensuring that the crash cart is always prepared and up-to-date with the required medicines and supplies for managing cardiac arrest. The assessment process will involve physical inspection of crash cart stocked with required emergency medicines for managing cardiac arrest, reviewing hospital's approved list of emergency medicine, assessing records of routine inspections or audits of the crash cart's contents and staff training evidence.

D. Prescribing, Administration and Dispensing of Medicines

Standard 44: Prescribing, dispensing and administration of medications are safe, efficient and effective and promote best possible treatment outcome.

Indicator 243: Only authorized prescribers are permitted to write prescriptions, and a pharmacist or someone working under their supervision must dispense medications in compliance with a valid prescription from a licensed registered medical professional.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a system for prescription and dispensing of medicines, to ensure that only authorized and qualified medical practitioners are allowed to issue prescriptions and medicines must be dispensed only by, or under the supervision of, a pharmacist in accordance with a valid prescription from a registered medical practitioner. The hospital must maintain accurate and up-to-date records of prescriptions and dispensed medications for audit purposes. All relevant staff, including prescribers and pharmacy personnel, must be trained on the procedures for issuing and dispensing prescriptions to ensure compliance with legal and safety standards. The assessment will involve reviewing the hospital's policies and procedures for documenting prescriptions, dispensing details, and ensuring that records are securely stored for future reference and regulatory compliance. Training record for both medical practitioners (prescribers) and pharmacy staff shall be reviewed to ensure that they understand their roles and responsibilities.

Indicator 244: Every prescription is readable and has the prescribing physician's signature and stamp.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented clear guidelines for prescriptions of medicines, specifying that all prescriptions are clearly legible, signed, and stamped by the prescribing doctor, with no errors or confusion that could lead to medication mistakes, including the following:

1. Patient's name and additional identifier
2. Age, Sex and weight (where applicable)
3. Diagnosis
4. Name of Medication, dose, route, frequency and duration
5. Clear identification of prescriber

The hospital must maintain the record of all prescriptions either by electronic prescribing systems or manually to minimize errors related to legibility and ensure completeness of required information. The hospital should regularly audit prescriptions to ensure compliance with these standards and provide training to prescribers to reinforce best practices. The assessment process will involve reviewing hospital's guidelines, examining prescription records to verify above mentioned points and assessing the training evidence of prescribers.

Indicator 245: The hospital has established and put into effect a policy that allows medical, nursing, and pharmacy personnel to verbally request medications in case of emergency, subject to the condition that necessary approvals are sought from treating physician within next 2 hours.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a written policy for verbal ordering of medicines in emergencies, clearly outlining the circumstances under which verbal orders are permissible and the procedures to follow. The policy must be agreed upon by medical, nursing, and pharmacy staff to ensure consistent implementation across the hospital and its documented evidence is available. Safety protocols, such as repeat-back or read-back procedures, should be followed to minimize the risk of medication errors. Verbal orders should be documented and verified promptly. The hospital should regularly audit the use of verbal orders to ensure they are being issued appropriately and in line with the policy, and corrective actions should be taken when necessary. The assessment will involve reviewing hospital's verbal ordering policy, meeting minutes or communication records that demonstrate that the policy has been agreed upon by all relevant departments: medical, nursing, and pharmacy, patient's file for documentation of verbal orders and audit reports.

Indicator 246: A written and verbal policy is in place to advise patients about the prescription medication, including its cost, advantages, side effects, correct usage, and the dangers of disobeying instructions.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a documented policy ensuring that patients receive both written and verbal information about the prescribed medication, including:

i. The costs
ii. The potential benefits and adverse effects
iii. How to use medicine safely and properly
iv. Risks of ignoring instructions

The hospital must regularly review whether the policy is being followed and if patients are receiving adequate information about their prescribed medicines. Feedback forms should be used to make improvements where necessary. The assessment process will involve reviewing hospital's policy, method of communication involving both written materials (e.g., medication leaflets, instruction sheets) and verbal communication by healthcare providers (e.g., doctors, nurses, or pharmacists). Assessing Patient feedback, auditing prescription documentation and interview with the patients shall also be conducted in this regard.

Indicator 247: Every drug given and administered for a specific patient is listed on an authorized hospital prescription/medication chart that is a part of the patient's file.

Assessment Process:

In order to comply with this indicator, the hospital must have an approved prescription/medication chart that is used for documenting all prescribed medications and their administration, including details such as:

- The name of the medication
- Dose of the medication
- Route of administration (e.g., oral, intravenous)
- Frequency and duration of treatment
- Date and time of prescription
- Date and time of administration
- Signature or identification of the healthcare professional who administered the medication

The completed medication chart must be integrated into the patient's medical record and easily accessible for review by all healthcare providers involved in the patient's care. The chart should be legible and easy to read, preventing any confusion or medication errors. If using electronic systems, the system should be user-friendly and reliable. The hospital must ensure that all healthcare providers involved in prescribing, administering, and documenting medications are properly trained on the use of the medication chart. Regular audits should be conducted to ensure the proper use and accuracy of medication charts. The assessment process will involve reviewing prescription/medication charts to verify that all required details are mentioned and integrated into the patient's medical file. Staff training evidence and audit reports for tracking and resolving any issues, such as missing information or inconsistent documentation shall be examined.

Indicator 248: The pharmacy maintains a register, which records:

i. Patient name and registration number
ii. Date
iii. Diagnosis
iv. Medicines prescribed
v. Medicine dispensed
vi. Name of the pharmacist

Assessment Process:

In order to comply with this indicator, the pharmacy must have maintained a dedicated register that records the patient's name, registration number, diagnosis, medicines prescribed, medicines dispensed, and the pharmacist's name involved in dispensing the medication. All entries in the register must be accurate, legible, and complete. The information recorded must align with the prescriptions provided by the doctors and the medicines dispensed by the pharmacy. The pharmacist's name must be recorded for each dispensing entry to maintain accountability and traceability. Regular audits should be conducted to ensure the accuracy of the register and address any discrepancies or issues in the dispensing process. The assessment will include reviewing pharmacy register to verify that each entry containing the required information in a structured format and meet standards for confidentiality and data security to protect patient information.

Indicator 249: The hospital has developed and implemented the following rules and procedures, which are signed and dated:

- Which medications can be given over-the-counter (without a prescription) and under what conditions?
- Stewardship of Antibiotics
- The administration of cytotoxins, narcotics, IV medications, and psychotropic substances
- Getting medications that the hospital pharmacy does not carry
- Taking care of individuals' own medications

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented dated and signed policies covering the safe dispensing and administration of medicines, including OTC drugs, antibiotics, controlled substances, and handling of patients' own medicines. These policies must adhere to national regulations, patient safety guidelines, and best practices in pharmaceutical care. The hospital must provide ongoing training to staff to ensure that they understand and follow these policies effectively and regular audits should be conducted to assess compliance with these policies. The assessment process will involve reviewing all above mentioned policies, training evidence of staff and audit reports.

Indicator 250: Medical practitioners follow policies for antibiotic stewardship which include:

i. Restricting the use of broad-spectrum agents to minimize the development of resistant viruses and bacteria
ii. Using prophylactic antibiotics only where their efficacy has been established.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented, dated, and signed policy that includes restrictions on broad-spectrum antibiotics and guidelines for the use of prophylactic antibiotics. The hospital must ensure that broad-spectrum antibiotics are prescribed only, when necessary, with clear criteria for their use and approval processes in place. All healthcare professionals should be trained on the principles of antibiotic stewardship and be kept up to date with current guidelines and practices. The hospital must assess the effectiveness of its antibiotic stewardship program, ensuring continuous improvement based on feedback, audit results, and resistance patterns. The assessment process will involve review of written antibiotic stewardship policy, approval mechanism for restricting or requiring special approval for the use of broad-spectrum antibiotics, staff training g evidence and audit reports of hospital for monitoring and corrective measures.

PART D: INFECTION CONTROL, HYGIENE AND WASTE MANAGEMENT

13. INFECTION CONTROL

Standard 45: The organization designs and implements a coordinated program to reduce the

risks of nosocomial infections in patients, visitors/attendants, contractors and staff.

Indicator 251: Based on established practice guidelines, current scientific knowledge and national and international guidelines the hospital establishes an infection control program to prevent or lower the occurrence of nosocomial infections. This program is developed and overseen by a multidisciplinary team known as the "infection control committee".

Assessment Process:

In order to comply with this indicator, the hospital must have established a comprehensive, evidence-based infection control program that follows current guidelines and national/international guidelines (e.g., CDC, WHO, and local health authorities), for preventing and reducing healthcare-associated infections. The program should be documented, dated, and signed, indicating that it has been approved by senior hospital management and infection control specialists and address all aspects of infection prevention and control. The hospital must notify a multidisciplinary infection control committee to oversee the program and monitor infection control activities. The committee should meet regularly to review infection data, monitor trends, discuss issues related to infection control and documented meeting minutes are disseminated for awareness of all the relevant staff. The hospital must provide training and education to staff on these infection control practices and a system for regular monitoring and evaluating the effectiveness of the infection control program should in place. The assessment process will involve review of documented infection control program, notification and meeting minutes of multidisciplinary committee/IPC committee, staff training evidence and monitoring reports.

Indicator 252: The infection control program covers every department of the hospital and outlines the goals, annual activities, surveillance techniques, resources, and procedures related to infection risks. These include surgical wound infections, respiratory tract infections, and urinary tract infections.

Assessment Process:

In order to comply with this indicator, the following steps should be undertaken:

1. Examine the hospital's infection control (IC) program document to verify the inclusion of:
   - Clearly defined goals and objectives
   - Annual activity plan
   - Surveillance techniques for monitoring infection trends
   - Defined roles and responsibilities of IC staff
   - Resource allocation for IC activities
   - Policies and procedures targeting surgical wound infections, respiratory tract infections, and urinary tract infections
2. Verify through documentation and interviews that the IC program is implemented across all hospital departments, including clinical, diagnostic, and support services.
3. Review surveillance data for infection rates and trends.

4. Check for the use of standardized surveillance methods (e.g., CDC/NHSN definitions).
5. Ensure a mechanism exists for identifying, tracking, and analyzing healthcare-associated infections (HAIs).
6. Review records of any past outbreaks and assess the timeliness and effectiveness of the response.
7. Confirm the availability of protocols for outbreak investigation and containment.
8. Conduct interviews with the Infection Control Officer (ICO), infection control team, and representatives from different departments to assess awareness and adherence to the IC program.
9. Observe actual practices within clinical areas (e.g., hand hygiene, PPE use, environmental cleaning) to determine alignment with IC protocols.
10. Confirm that infection surveillance data is documented, analyzed, and reported regularly to relevant hospital committees (e.g., Infection Control Committee, Quality and Safety Committee).

Indicator 253: An infection control committee with members from all pertinent departments and disciplines, including medical, nursing, microbiology/pathology, kitchen, and laundry personnel, is tasked with overseeing the infection control program. The committee holds regular meetings, and minutes of such meetings are kept on file.

Assessment Process:

In order to comply with this indicator, the hospital must have established an infection control committee with representatives from all relevant departments, each with clearly defined roles and responsibilities. Regular meetings must be scheduled, and minutes be thoroughly documented to reflect discussions, decisions, and actions taken. The hospital should also ensure that there are processes in place for follow-up on infection control issues discussed in meetings, with clear accountability for the implementation of any actions. Regular reviews and updates to infection control protocols must be made to ensure the program remains effective in reducing the risk of infections. The assessment process will involve review of composition and functionality of the infection control committee, the frequency and documentation of committee meetings, ensuring that meeting minutes are properly recorded and accessible.

Indicator 254: The following duties are included in the infection control committee's explicit stated Terms of Reference:

- Coordination of infection control measures;
- Development and execution of an epidemic strategy with frequent exercises
- The creation, execution, and oversight of the infection control program; the endorsement of infection control guidelines and protocols
- Acceptance of surveillance operations
- Examining and evaluating infection risks and infection control data

- Addressing recognized infection control concerns with appropriate measures, such as education
- Assessing the success of the measures used; controlling waste management
- Monitoring several resistant organisms and organisms linked to the use of antibiotics;
- Supervising the supply of sterile materials

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented infection control committee's Terms of Reference which include all the listed responsibilities. These responsibilities must be incorporated into the routine practices of the hospital, with specific individuals assigned to oversee each area. The assessment process will involve review of the written Terms of Reference (TOR) of the infection control committee, presence of an epidemic plan, evidence of regular drills, and a documented record of monitoring of infection control programs. Physical inspection of waste management practices and procedures related to sterile supply management shall also conducted. Evidence of training initiatives shall also be reviewed to assess the hospital's commitment to continuous improvement.

Indicator 255: Evidence of routine infection control audits are obtained.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that infection control audits are conducted regularly as part of its continuous quality improvement process. These audits should be comprehensive, covering critical aspects such as hand hygiene, sterilization procedures, waste management, and surveillance of infections. The findings of each audit must be documented and reviewed by the infection control committee to identify areas for improvement. The hospital must implement corrective actions based on audit results and track their effectiveness over time. The assessment process will involve examining the audit reports to confirm that they cover key areas such as infection control practices, adherence to policies, and the effectiveness of preventive measures and evidence of corrective actions that are implemented and followed up.

Indicator 256: To reduce infections, cultures are routinely taken from high-risk hospital locations in accordance with National and International infection control recommendations. The corresponding records are kept in the appropriate departments.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that cultures are consistently obtained from high-risk areas, such as intensive care units (ICU), operating theaters, and wards with immunocompromised patients, in accordance with infection control guidelines. The hospital must maintain proper documentation and records of culture results within the relevant departments, ensuring they are easily accessible for review. These records should be routinely analyzed to identify any patterns or potential outbreaks, leading to timely interventions. The

hospital should also keep record of corrective actions taken based on culture results, to minimize the risk of infections. Regular training and updates on proper culture collection techniques should be provided to staff to ensure compliance. The assessment process will involve reviewing the hospital's infection control protocols to ensure that high-risk areas are clearly defined and cultures are taken at appropriate intervals. Examination of culture records from relevant departments, evidence of corrective measures and documented record of staff training shall be conducted.

Indicator 257: Relevant support employees get the proper orientation and training in the fundamentals of infection control that are pertinent to their jobs.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented induction and training program for support staff (including cleaning, laundry, and kitchen staff), ensuring that they understand fundamental infection control concepts that are relevant to their roles, including:

- Basic concept of microbes
- Proper handwashing
- Segregation of waste and hazards associated with waste (biohazard waste and chemicals of concern[6])

The hospital must ensure that training is not just a one-time event but an ongoing process, with refresher courses and regular assessments of staff knowledge and skills. The hospital should also provide practical guidance on how staff can apply infection control measures in their day-to-day duties. Additionally, the hospital should ensure there is supervision and periodic audits to verify that support staff are consistently following infection control protocols. The assessment process will involve review of induction and training program, staff training evidence, audit reports and interview with support staff.

- If the Hospital does not have developed and implemented induction and training program for support staff and record of the same is not maintained, then rate as **"Not Met".**

Indicator 258: The hospital developed and put into effect waste management and infection control policies and procedures that cover every important aspect of IPC activities.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented infection control and waste management policies including, but are not limited to, the following areas:

[6] In line with the ILO's Convention on Chemicals, 1990 (No. 170)
https://normlex.ilo.org/dyn/nrmlx_en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312315

- Use of standard precautions including handwashing techniques
- Sterilization and decontamination of equipment
- Food hygiene
- Laundry and linen management
- Identification and management of organization-acquired infections
- Management of outbreaks of infection
- High risk and communicable diseases
- Operation of the mortuary, where applicable
- Collection, storage and disposal of infectious waste, body fluids, tissues, blood and blood products
- Disposal of sharps and needles
- Cleaning of all hospital surfaces, supplies and equipment, E.g., floor, walls, ceilings, beds and basins
- Management and cleaning of spillage
- Vaccination of staff
- the isolation of patients specific to the reason for isolation
- Identifying and treating patients with MRSA

WHO's "5 Moments of Hand Hygiene"

- Before patient contact
- Before aseptic procedures
- After exposure to body fluids
- After patient contact
- After contact with patient surroundings

These policies must be regularly reviewed and updated to reflect current guidelines and evidence-based practices. The hospital must ensure that all staff members are trained on these policies and that the procedures are embedded into daily practices. The hospital should also implement routine audits and inspections to confirm that infection control and waste management procedures are consistently followed throughout the facility. The assessment process will involve review of all the listed policies, staff training evidence, documented audit reports. Onsite inspection for observing staff practices and interviews with staff across various departments shall be conducted to gauge their understanding of these policies and their ability to apply them in practice.

Indicator 259: The hospital has enough stock of essential Personal Protective Equipment (PPEs) and are correctly used in sections where there is a risk of infection.

Assessment Process:

In order to comply with this indicator, the hospital must have maintained an adequate and up-to-date stock of essential PPEs to meet the needs of all departments where there is a risk of infection. The hospital should establish a clear process for monitoring and managing PPE inventory, ensuring that there is always enough stock available for staff, especially during times of high demand (e.g., outbreaks). Staff should be trained on the correct techniques for donning,

doffing, and disposing of PPE to prevent contamination. Audits should be conducted to ensure compliance with PPE usage protocols, and any issues should be promptly addressed to maintain high standards of infection control. The assessment process will involve physical inspection to verify that the hospital has an adequate and readily available stock of essential Personal Protective Equipment (PPE). Review of inventory records, staff training evidence and documented audit reports shall also be conducted.

Indicator 260: The hospital shall have an adequate number of isolation rooms for infected patients, designed and maintained in accordance with national and international IPC guidelines.

Assessment process: In order to comply with this indicator hospital must ensure the availability of an adequate number of isolation rooms to accommodate cases requiring source isolation, particularly those with multidrug-resistant organisms (MDROs) or other infectious diseases. Patient with suspected or confirmed transmissible infections must be managed in single-occupancy rooms, preferably equipped with attached toilet and shower facilities.

For infections that are transmitted via the airborne route, patients should be placed in negative pressure isolation rooms as indicated. These rooms should include:

- An anteroom
- Attached toilet and shower facilities
- Controlled temperature and humidity, allowing for doors to remain closed and eliminating the need to open windows
- Exhaust air systems that safely vent air outside the building, ensuring that extracted air does not re-enter the facility through the fresh air intake

In facilities where negative pressure rooms are not available, alternative strategies to reduce airborne transmission—especially of Mycobacterium tuberculosis (M. tuberculosis)—should be adopted. These include the use of:

- Natural ventilation
- Mixed-mode or mechanical ventilation systems
- Installation of HEPA filters.

A. STERILE SUPPLIES

Standard 46: Equipment and supplies are sterilized to minimize risk of infection in patients and staff.

Indicator 261: The processes of cleaning, processing, sterile storage, and distribution are physically separated by a designated sterilization department or area. Airflow is also present to avoid cross-contamination and to keep materials contained inside each location where instruments are cleaned.

Assessment Process:

In order to comply with this indicator, the hospital must have established a designated sterilization department or area that adheres to infection control guidelines and ensures the separation of cleaning, processing, and storage functions. The hospital must ensure that airflow systems are properly maintained ensuring that it is designed to maintain a positive pressure in areas where instruments are cleaned and negative pressure in sterile storage areas to prevent the movement of contaminants, with controlled air pressure to avoid contamination between different areas. Staff working in the sterilization department should be trained on infection control protocols and proper handling of sterile instruments. The hospital should regularly monitor and maintain sterilization equipment and ventilation systems to ensure they operate effectively. The assessment process will involve on-site inspection to evaluate the physical layout and infrastructure of the sterilization department, airflow system, workflow within the sterilization area to ensure that staff follow appropriate procedures to maintain the integrity of sterilized instruments and equipment. Review of maintenance records for the ventilation and sterilization equipment and staff training evidence shall also be conducted.

Indicator 262: The hospital has one or more operational sterilizers and an autoclave with a drying cycle, which is sufficient for the hospital's workflow and doesn't interfere with any department's daily operations.

Assessment Process:

In order to comply with this indicator, the hospital must have a sufficient number of functional sterilizers or autoclaves, each equipped with a drying cycle, to meet the demands of various departments without causing delays. The sterilization equipment should be regularly maintained and calibrated to ensure it operates efficiently and effectively. The staff should be trained to use the equipment properly and document the sterilization process for quality assurance purposes. Routine maintenance and performance checks should be conducted to ensure the sterilizers remain in good working condition and do not affect the hospital's operations. Additionally, contingency plans should be in place to address any potential equipment failures to avoid disruption to hospital functions. The assessment process will involve physical inspection to verify that the hospital has functional sterilizers or autoclaves with drying cycles and review of records of sterilization, including routine checks, calibration and contingency plan.

Indicator 263: Staff members who are responsible for overseeing the supply of sterile materials, decontamination, inspection, function testing, assembly, packing, terminal processing, and storage are identified, their responsibilities are explained to them in detail, and they get training on every aspect of their jobs.

Assessment Process:

In order to comply with this indicator, the hospital must have defined clear roles of all staff involved in the management of sterile supplies, ensuring that responsibilities for decontamination, inspection, testing, assembly, packaging, terminal processing, and storage.

These roles should be communicated effectively to all relevant staff, ensuring they understand the scope of their responsibilities and how their work fits into the overall infection control process. The hospital must provide specialized training for staff, covering each aspect of their role in the sterile supply chain. Regular competency assessments and audits should be conducted to verify that staff are performing their duties correctly. The assessment process will involve review of documented roles and responsibilities, training evidence, interview with the relevant staff and physical inspection.

Indicator 264: There is recorded proof of regular compliance with the current established rules and procedures (based on national/international criteria) addressing the functions of sterilization.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and maintained policies and procedures that adhere to national or international infection control guidelines, covering all aspects of sterilization and the handling of sterile supplies, including the following:

- Receiving, cleaning and disinfection of used items
- Preparation and processing of sterile packs
- Storage of sterile supplies and expiry dates
- Decontamination of instruments prior to sending for repair, maintenance or servicing
- Handling of instruments following an infected case
- Handling of equipment identified as “bio-hazard"
- Product labelling, batch numbering and identification
- Restricted personnel access to the clean production area
- Cleaning procedures, manual methods
- Housekeeping procedures
- Infestation control
- Personal hygiene
- Microbiological and environmental monitoring
- Criteria for testing and replacing air filters
- Recall procedures

Staff should be trained on these specific protocols and routine audits and checks should be performed to ensure ongoing compliance with these policies. The assessment will involve review of all the listed policies, staff training evidence and physical inspection to observe operational practices in the sterilization department, housekeeping practices, personal hygiene standards, etc. Evidence of recall procedures shall also be reviewed, ensuring they are in place and followed in case of identified issues with sterile products.

Indicator 265: As recommended by the manufacturer, temperature-sensitive tapes and gauges are used to determine the sterilization state of sterilized items. Each sterilized bag has an expiration date listed in accordance with National and International guidelines. And before using the sterile pack, a record of the same is kept in the appropriate department.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that all sterilized items are properly assessed for sterilization status using temperature-sensitive tapes, gauges, and indicators, as recommended by the manufacturer. These indicators must be regularly checked to confirm they provide accurate readings and comply with infection control standards. The hospital should ensure that all sterilized pouches or containers are clearly labeled with the sterilization date and expiry date, in accordance with relevant guidelines, to ensure safe use of sterile supplies. Records of sterilization, including the results of the sterilization cycle, indicators, and expiry dates, should be meticulously maintained in the relevant department to ensure traceability and accountability. Staff should be trained in proper sterilization procedures and documentation practices. The assessment process will involve onsite inspection to check that the hospital uses temperature-sensitive tapes and gauges and observation of sterilized pouches to ensure each one is properly labeled with the sterilization date and expiry date. Review of sterilization records and staff training evidence shall also be conducted.

Indicator 266: Records and an inventory system are accessible for:

- Acceptance of load processes
- Records of sterilization plant history
- The CSSD Department has sterile items available. Sterile goods are sent to departments and wards.
- Autoclaves and sterilizers (history and maintenance)
- Calibration and servicing
-

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a comprehensive inventory and record-keeping system that covers all aspects of sterilization and sterilized goods management. This includes maintaining detailed records for acceptance of loads, sterilization cycles, servicing histories, and the availability of sterilized goods in the CSSD Department. The hospital should ensure that sterilizers and autoclaves are regularly serviced and calibrated, with servicing records clearly documented to maintain the functionality and safety of the equipment. The inventory system should be regularly audited to ensure that records are complete, accurate, and compliant with infection control standards. Staff should be trained in maintaining these records and following proper procedures for sterilization, handling, and issuing sterile goods. The assessment process will involve review of the hospital's inventory and record-keeping system to ensure that all necessary documentation is in place and up to date.

Indicator 267: To avoid contamination and/or damage, all trays, packs, and containers are kept under storage settings that maintain the integrity of their packing. Every pack is identified by the article's name, the contents of the pack, the packer's initials, the date, and the initials of the sterilizer.

Assessment Process:

In order to comply with this indicator, the hospital must have secure, clean, and temperature-controlled storage areas to preserve the integrity of trays, packs, or containers. Proper shelving and organization are crucial to prevent cross-contamination. All the trays/packs/containers must be properly labeled that include all relevant information for traceability, including the name, contents, packing date, packer's initials, and sterilization details. Hospitals must conduct regular internal audits and inspections of storage conditions, labeling, and sterilization records to ensure best practices for patient safety. The assessment process will include inspecting storage areas, packaging of trays, packs, and containers to ensure traceability, accountability, and that proper sterilization procedures have been followed. Records for sterilization procedures and documented audit reports shall be reviewed.

Indicator 268: Every instrument tray, container, or pack has a completed checklist that is used for packing, using the instruments in the OT, and returning the instruments for re-sterilization.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented SOPs to monitor instrument handling for the entire process of packing, using, and returning instruments. The SOPs should outline who is responsible for completing checklists at each stage. Staff must be trained on completing these checklists and tracking instruments. Hospitals must ensure that either a manual or electronic record is in place to manage these checklists. Ongoing audits and quality control must be conducted for compliance with safety and infection control protocols. The assessment process will involve review of SOPs, record of previously filled checklists, staff training evidence and documented audit reports.

Indicator 269: Functional eye wash stations are available.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that eye wash stations are installed in all relevant areas, such as sterilization rooms, laundry, and areas where dirty equipment is handled, as per safety standards. These eye wash stations must be easily accessible and not obstructed by equipment, storage, or other barriers. Routine maintenance checks must be conducted to ensure eye wash stations are functional, with adequate water flow and proper pressure. The assessment process will involve on-site inspection of eye wash stations and review of documented maintenance records.

B. CLEANLINESS AND SANITATION

Standard 47: All hospital facilities, equipment and supplies are kept clean and safe for patients, visitors/attendants and staff.

Indicator 270: The following documented policies and procedures are available that staff members adhere to:

- Cleaning and disinfecting all furniture, equipment, floors, walls, storage spaces, and other surfaces and locations, as well as scheduling
- Cleaning of specialized areas, such as the intensive care unit, OT, labor room, emergency room, dressing room, laboratory, and so on, as well as the timetables for the same
- Waste should be separated into contagious and non-infectious categories and color-coded accordingly.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for cleaning/disinfection of all areas, including equipment, furniture, floors, walls, storage areas, and other surfaces and waste segregation along with color coding. Cleaning schedules must be defined that specify daily, weekly, and monthly tasks for different areas and surfaces and its record must be maintained. Staff must be trained on the correct methods and protocols for cleaning and disinfecting various surfaces and equipment to prevent cross-contamination. A monitoring system must be ensuring adherence to cleaning and disinfection schedules, including periodic audits to check for compliance and effectiveness. The assessment process will involve review of policies and procedures, cleaning schedules, staff training evidence and audit reports. Interview with housekeeping staff shall also conducted to assess their understanding and practices.

Indicator 271: The hospital's grounds are clear of trash and other debris. There are enough covered, hygienic trash cans (according to the designated color codes with pictures of waste materials and elaborated in both English and Urdu language, available for patients, guests, and employees, and they are regularly emptied.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a routine cleaning schedule for all hospital areas (including corridors, waiting areas, patient rooms, bathrooms, and outdoor spaces) to ensure that no litter accumulates. Specific cleaning staff or housekeeping teams must be designated for maintaining cleanliness in different areas, ensuring that litter is promptly disposed of. Sufficient covered dustbins (color-coded dustbins for different types of waste) must be placed in all areas of the hospital, including patient rooms, waiting areas, corridors, cafeterias, bathrooms, and outdoor areas. Dustbins should be conveniently located and easily accessible for patients, visitors, attendants, and staff. All hospital staff must be trained on proper waste disposal practices, the importance of keeping premises litter-free, and the correct use of color-coded dustbins. Regular inspections of hospital premises should be conducted to monitor cleanliness. The assessment process will involve review of cleaning schedules, daily cleaning logs, staff training evidence and regular monitoring reports. Physical inspection of the hospital or healthcare facility shall also be conducted for checking that the conditions match the documentation and policies.

Indicator 272: The hospital has developed and put into effect cleaning and sanitation policies and procedures, as well as processes for disposing of sharps and separating contagious and non-infectious waste. In addition to receiving training on these regulations, the required personnel are also given enough cleaning supplies and equipment.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for cleaning, sanitation and segregation of infectious and non-infectious waste. Relevant staff must receive regular training on the policies, focusing on cleaning procedures, proper waste segregation, and safe handling of sharps and infectious materials. The hospital must ensure that staff have access to the appropriate cleaning materials, waste disposal bins, and personal protective equipment (PPE) required for safe and effective cleaning and waste management. The hospital must implement a system for monitoring adherence to policies, conduct regular internal audits, and take corrective actions. The assessment process will involve review of hospital's policies and procedures, staff training evidence and audit reports. A walkthrough of hospital premises shall be conducted to check if cleaning procedures are being followed in practice, including the proper disposal of waste in designated bins and ensuring that sharps are disposed of in approved containers.

Indicator 273: To ensure compliance with health and safety laws, laundry employees are trained and adhere to linen and laundry policies and procedures.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies for linen and laundry work, including but not restricted to the following:

- Collection, transportation and storage with clear separation of clean and dirty linen from the individual departments
- Sorting of linen into soiled, infected and foul linen
- Removal of blood stains/washing
- Disinfection/autoclaving
- Washing/hydro extraction
- Drying
- Repairs of linen if required
- Pressing
- Distribution to individual departments
- Storage in individual departments
- Record keeping for receipt and distribution of clean linen

Laundry staff must be regularly trained on these policies and appropriate equipment must be available for washing, drying, and disinfecting linens, such as washing machines, hydro extractors, autoclaves, and pressing equipment. The hospital must maintain complete record of receipt, washing, and distribution of linen. Regular audits must be conducted to ensure that

laundry staff are following the policies and procedures. The assessment process will involve review of hospital's linen and laundry policies, training records, records for linen receipt, distribution, and storage and audit reports. A walk-through of the laundry facilities shall also be conducted to assess if staff are following the defined procedures, including the correct separation of soiled, infected, and foul linen.

C. WASTE MANAGEMENT

Standard 48: Clinical and other infectious or injurious waste is handled, stored and disposed of to minimize harm and risk of infection/injury to patients, visitors, contractors, staff and the community.

Indicator 274: Waste management policies and procedures are in place that define roles, collection schedules, and equipment availability. The waste disposal plan includes written guidelines for the regulation, identification, segregation, labeling, containment, storage, transportation, treatment, and final disposal of both infectious, non-infectious and hazardous waste categories, in accordance with relevant national laws. Where applicable, these guidelines cover:

- Pathology waste
- Cytotoxic and chemical liquid waste
- Heavy metals, radio-active or any other form of high-risk waste

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented waste management policies and waste disposal plan that cover all areas of waste handling, from collection to disposal. These policies should specify the responsibilities of staff, the timelines for waste collection, and the necessary equipment required for waste management. The hospital must ensure that these policies adhere to national or provincial laws, especially regarding the handling of high-risk waste such as pathology, cytotoxic, and chemical liquid waste.

The hospital must also provide the necessary equipment, such as color-coded bins and secure containers, to ensure proper waste segregation and containment. The containers should be clearly labeled to identify the type of waste being stored, and designated areas for the safe storage of high-risk waste should be established. The hospital must maintain records of waste collection, transport, and disposal. Regular staff training must also be carried out. The assessment process will involve review of hospital's waste management policies, waste disposal plan, staff training evidence and documented record of waste segregation, storage, transport, treatment and subsequent disposal. A physical inspection shall be conducted to assess whether waste is being properly segregated in designated containers and availability of adequate equipment for waste storage, handling, and transportation.

Indicator 275: Policies, Plans and SOPs regarding waste management are developed and all the relevant processes are led by the Infection Control Committee and infection control staff supervise the process, who are skilled and experienced with assigned responsibility.

Assessment Process:

In order to comply with this indicator, the hospital must have appointed a qualified, registered and experienced personnel(s) for developing and updating waste management plan and policies. The Infection Control Committee must oversee the process to ensure alignment with infection control practices, with regular updates to the policies. The hospital must maintain clear documentation outlining the roles of those involved in waste management and infection control. Regular staff training should be conducted to ensure that all personnel are familiar with the policies and procedures. The assessment process will involve review of the hospital's waste management policies to ensure they are developed and regularly updated by qualified and experienced personnel. Feedback from infection control personnels shall be taken through interviews.

Indicator 276: The Local Authority has verified that incinerator facilities, where present, comply with environmental health and health and safety standards.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that its incineration facilities, if provided, are certified by the Local Authority (e.g. Environmental Protection Agency) as compliant with all applicable health, safety, and environmental regulations. The hospital should maintain up-to-date certification and keep documentation of inspections and approvals readily available for review. The hospital must ensure the proper operation and maintenance of incineration facilities to meet necessary emissions control requirements along with regular monitoring and record-keeping. The assessment process will involve physical inspection of incinerator, review of certification, records or logs of incinerator operation, maintenance, and inspections.

Indicator 277: When the hospital outsources waste disposal, a formal Memorandum of Understanding (MoU) is established with the waste management provider, and a record of the waste transfer is maintained.

Assessment Process:

In order to comply with this indicator, the hospital must have established a formal, written MoU with the waste management company, if the in-house incineration facility is not available. This MoU should specify the roles, responsibilities, and compliance requirements for both parties in handling, transporting, and disposing of waste. The hospital must maintain detailed records of all waste handovers, including the type, amount, and handling details of the waste being transferred. This documentation should be readily accessible for auditing. The assessment process involves review of MoU with waste management company and assessment of waste handover records.

Indicator 278: In accordance with applicable national regulations, clear guidelines for waste segregation and storage are prominently displayed in the areas where waste is generated. This includes the use of clearly marked and color-coded bins for waste segregation.

Assessment Process:

In order to comply with this indicator, the hospital must have developed, implemented and displayed guidelines for waste segregation and storage and posted them in all areas where waste is generated. The hospital must provide clearly labeled and color-coded bins for each category of waste, ensuring that staff can easily identify and use them. The bins should be well-maintained, clean, and positioned in convenient locations. Staff should be trained on waste segregation procedures to ensure safe and compliant waste disposal. The assessment will involve review of guidelines, staff training evidence and on-site observation of verify that the bins used for waste segregation are clearly labeled and color-coded in accordance with the relevant national or provincial laws.

Indicator 279: Waste is stored in an appropriate area (the yellow room) that poses no hazards prior to collection and disposal.

Assessment Process:

In order to comply with this indicator, the hospital must have stored the infectious waste in a designated, secure location, such as a "yellow room," prior to collection and disposal. This room should be clearly marked, safe, and free from hazards, ensuring that waste does not pose a risk to health or safety. The hospital must maintain the storage area in a clean and organized condition, with proper containers for different types of waste. The room should be ventilated and comply with safety regulations, with regular inspections to ensure it remains hazard-free. Waste must be promptly collected and removed to prevent any accumulation that could lead to contamination or health risks. The assessment process will involve inspection of waste storage area and interview with the relevant staff for compliance.

Indicator 280: The hospital keeps record of the amount of waste generated in each category, analyses the data, and uses the results for statistical and quality-improvement purposes.

Assessment Process:

In order to comply with this indicator, the hospital must have maintained accurate and up-to-date records on the quantity of waste generated in each category. These records should be regularly analyzed to identify trends, monitor waste management efficiency, and support decision-making. The hospital should use the data to guide quality improvement activities, such as identifying opportunities for waste reduction, improving waste segregation practices, or enhancing waste

disposal methods. Statistical analysis of waste generation data should be incorporated into the hospital's broader waste management and quality improvement plans to ensure ongoing compliance and environmental responsibility. The assessment process will involve review of waste generation records, documented evidence of data analysis and its usage in quality improvement plans.

D. FOOD AND NUTRITION SERVICES

Indicator 281: The hospital's food handling policies and procedures have been established and implemented, with relevant staff members received training on it.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for handling food items, including but not limited to the following:

- Access to the kitchen is restricted for unauthorized personnels.
- All staff handling food have health checks prior to appointment and at regular intervals during their employment and records are kept.
- Dress Code is defined for those working in the kitchen including wearing of head cover for hair, clean uniforms and appropriate footwear.
- Cleaning of all areas and surfaces on which food is stored and prepared.
- Food storage, E.g., all food is stored separately from non-foods, cooked food is stored separately from uncooked/raw food and the covering and labelling of food
- Use and cleaning of equipment for food preparation, handling and transport, E.g., separate cutting boards are used for raw and cooked foods
- Testing and monitoring of safe temperatures for cooked food
- Testing and monitoring of refrigerator temperatures for safe food storage

All kitchen staff must undergo regular health checks to ensure that they are fit to handle food safety. Records of these checks should be kept up to date. The hospital must provide continuous training on food safety protocols, including hygiene practices, food handling, and sanitation. The hospital must implement a system for monitoring and recording temperatures of cooked food and refrigerators to ensure safe food handling. The assessment process will involve review of hospital's food handling policies and procedures and records related to food safety, such as temperature logs, health check records, and cleaning schedules. Physical inspection of the kitchen and food preparation areas shall be conducted to assess if staff are adhering to the procedures, such as restricted access for unauthorized personnel and maintaining proper hygiene and cleanliness.

Indicator 282: The food shelves and kitchen are well-ventilated. All windows in areas used for food preparation and storage are fitted with suitable fly screens, and insectocutors—ultraviolet electric insect removers are strategically /effectively placed in key areas prone to flying insects.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that kitchen and food storage areas are equipped with effective ventilation systems, including windows, exhaust fans, and air conditioning to promote airflow and reduce humidity. All windows in food preparation and storage areas must be fitted with high-quality fly screens and insectocutors to prevent the entry of insects. Records of all inspections, cleaning, and repairs must be maintained for accountability and to track the effectiveness of pest control measures. The assessment process will involve physical inspection of kitchen and food storage area and review of inspection and repairing records.

Indicator 283: Kitchen waste is quickly cleared from food preparation areas and placed in covered, secure containers for proper disposal.

Assessment Process:

In order to comply with this indicator, the hospital must ensure that all kitchen waste is placed in covered, secure containers in food preparation areas to prevent contamination. Waste should be removed immediately after it is generated, ensuring no accumulation in food prep zones. The hospital must also ensure proper segregation of kitchen waste, with appropriate disposal practices in place. Additionally, staff must be trained on waste management procedures to ensure compliance with hygiene and safety standards. The assessment process will involve on-site inspection of food preparation areas, review of the hospital's waste management policies and staff training evidence.

PART E: SAFE AND APPROPRIATE ENVIRONMENT

14. HEALTH AND SAFETY

Standard 49: Promotion of health and safety and the avoidance of risk to human life as well as to the property of the Hospital are integrated within the organization and among all levels of staff.

Indicator 284: The hospital has implemented occupational health and safety rules and procedures aligned with international labor standards on OSH. The Health & Safety Committee, in addition to being well-informed, plays a role in developing the facility's risk management plan. The Committee promotes two-way communication between management and staff regarding health and safety issues. It regularly brings together management and employees from different departments. The agenda includes follow-up from previous meetings, and the minutes of each meeting are recorded and kept on file for easy access by staff.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented comprehensive health and safety policies and procedures that address occupational health and safety concerns for all staff, including:

- Contamination incidents
- Sharps and needle-stick injuries
- Drug dependence
- HIV/AIDS
- Hepatitis B and C
- Lifting and manual handling of patients and equipment
- Basic life support
- Control of waterborne diseases
- Storing and handling of inflammable liquid
- Personal protective equipment and clothing
- Review of pressure vessels and systems
- Body fluid spillage
- First aid procedures at work
- Violence and aggression towards staff
- Outbreak and prevention of fire
- Other internal accidental events such as explosion
- Safe use of electrical equipment
- Safe disposal of clinical waste
- Safe handling of gas cylinders
- Safety precautions necessary when storing, handling and using liquefied gases, E.g., nitrogen and oxygen
- Control and prevention of spillage of hazardous substances, like mercury and glutaraldehyde
- Cytotoxic drugs
- introduction of new technology
- Disaster management plan and drills
- Safe economic practices.

A Health & Safety Committee must be established, comprising representatives from both management and staff across departments. This committee should be actively involved in the development of the Facility Risk Management Plan and meet regularly to discuss and address health and safety issues. The hospital must ensure that meetings of the Health & Safety Committee are documented with clear agendas, and that minutes are recorded and made available to all staff. The committee should facilitate open communication, enabling staff to raise health and safety concerns, and follow up on action items from previous meetings. Proper record-keeping and transparent communication are essential to maintaining a safe working environment and fostering continuous improvement in health and safety practices. The assessment process will involve reviewing the hospital's health and safety policies and procedures, Health & Safety Committee notification, meeting minutes and evidence of corrective actions taken on the recommendation of said committee.

Indicator 285: HCP periodically assesses the staff for communicable diseases and documents in staff file. This includes Hepatitis B, C, HIV, TB, and recommended immunizations (Hep B, Influenza, etc.).

Assessment Process:
The assessment team shall verify that the HCP has established procedures for periodic health screening of staff for communicable diseases and for maintaining recommended immunizations. On-site review of staff files will be conducted to confirm documentation of assessments, test results, and immunization status.

The team shall assess whether screenings and immunizations are performed according to national guidelines and schedules, and whether follow-up actions are taken for any identified health concerns. Staff interviews may be conducted to confirm awareness and participation in health monitoring programs.

Indicator 286: The hospital arranged training on health and safety protocols for all new employees, which is relevant to their roles, within a month of starting. Additionally, all staff undergo continuous health and safety training, with records kept current.

Assessment Process:

In order to comply with this indicator, all new employees of the hospital must be trained in health and safety procedures specific to their duties within one month of starting their roles. The training should cover all relevant procedures and be tailored to the employee's responsibilities. The hospital must establish a continuing health and safety training program for all staff, ensuring that employees regularly receive updates and refreshers on health and safety practices. Records of all training sessions must be maintained and include details such as training dates, content, and employee attendance, ensuring that all staff members are regularly updated on health and safety protocols. The assessment process will involve review of training records, evidence of participation of staff and interview with newly established staff to get feedback from them.

Indicator 287: All of the emergency phone numbers related to health and safety are included in each department. A system is in place, which:

- Regularly identify and record actual and potential hazards in a hazard register (at least annually)
- Assess identified hazards to determine which are significant
- Eliminate, isolate or minimize the impact of the significant hazards
- Submit the record to the Health and Safety Committee for review

Assessment Process:

In order to comply with this indicator, the hospital must have maintained an up-to-date hazard register that records all actual and potential hazards, updated at least annually. This should include details on the nature of the hazard, its location, and its potential impact. The hospital must have a systematic process to assess hazards, categorize them by significance, and prioritize actions and must implement actions to eliminate, isolate, or minimize the risks associated with significant hazards. The Health and Safety Committee comprising workers of all cadres of the respective hospital and the HCE administration and hinges on social dialogue to review the hazard records regularly. Emergency telephone numbers and contact information related to health and safety must be displayed prominently in each department for easy access in case of an emergency. The assessment process will involve review of hazard register, Health and Safety Committee's documented recommendations on identified hazards and evidence of corrective measures taken.

Indicator 288: The Health and Safety guidelines, along with any current health and safety notices, including hazard warnings, are distributed to the relevant staff and displayed in designated public areas.

Assessment Process:

In order to comply with this indicator, the hospital must display health and safety notices in relevant areas where staff and visitors are likely to see them. Key locations include hallways, staff rooms, near hazardous zones, and patient care areas. The hospital must ensure that all staff are aware of the notices and regular training and communication about safety procedures must be conducted. The assessment will involve physical inspection of facility to verify that that the displayed notices are up-to-date, accurate, and relevant and interviews with staff shall be conducted.

Indicator 289: The Hospital has developed and implemented a pest control policy and procedure, outlining steps to prevent, detect, and eliminate pests.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a written policy outlining procedures for pest control, covering prevention, detection, and removal of pests. The hospital must have regular pest detection procedures in place, including routine inspections of high-risk areas (kitchens, waste areas, patient rooms), and trained staff or pest control experts to identify early signs of pest activity. The hospital must maintain detailed records of pest control activities, including inspection reports, treatments used, and corrective actions taken. The assessment will involve physical inspection, review of hospital's policy and assessment of relevant records.

Indicator 290: The hospital has a disaster plan that is reviewed and updated every two years, involving all departments and services. The plan outlines responsibilities, communication protocols with other organizations, required resources, and the staff members who need to be notified in the event of a disaster. The plan is practiced in collaboration with local authorities and emergency services.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a disaster management plan that covers all departments and services, with clear procedures for managing disasters of various types (e.g., fire, natural disaster, mass casualty events). The plan should be reviewed and updated every two years. The disaster plan must outline specific roles and responsibilities for staff members in case of a disaster. This includes who takes charge, how departments will coordinate, and what actions each staff member should take during a disaster. The hospital must establish formal linkages with external institutions, including local emergency services (police, fire, medical), local authorities, and neighboring hospitals. The disaster plan must specify the resources required to effectively manage the disaster. This includes medical

supplies, backup systems (e.g., power generators), evacuation plans, and sufficient staff members. The hospital must regularly carry out disaster rehearsals and these drills should test the effectiveness of the plan, the speed of response, and the readiness of staff to act. The assessment will involve review of disaster plan, documentation of mock drills and feedback from relevant staff.

15. FIRE SAFETY AND EMERGENCY PREPAREDNESS

Standard 50: The organization minimizes the risks of fire and protects patients, visitors and staff in case of fire and is prepared for disasters and emergencies.

Indicator 291: There is a fire safety plan that covers risk reduction and prevention, early identification, suppression, reduction, and safe fire escape.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a comprehensive fire safety plan that includes clear procedures for fire prevention, early detection, suppression, abatement, and ensuring safe exit routes in case of fire. The hospital must implement preventive measures to minimize fire risks, such as regular inspection and maintenance of electrical systems, safe storage of flammable materials, and fire-resistant building materials. The hospital must ensure fire safety training for all staff, including procedures for using fire extinguishers, evacuating patients, and responding in case of a fire. The hospital must maintain up-to-date records of fire safety inspections, testing of equipment, training sessions, and fire drills. The assessment process will include review of fire safety plan, Staff training evidence/drill records, documented record of assesses the fire prevention strategies, such as fire-resistant materials, proper storage of flammable substances, and regular electrical safety inspections. Interviews with staff shall also be conducted.

Indicator 292: To ensure safe evacuation during a fire or emergency, access and exit routes are kept free of obstructions at all times.

- Patient room doors and exit doors do not have interior locks.
- Areas where smoking is prohibited, restricted, or allowed are clearly marked and monitored.
- The entire hospital is equipped with a functional fire alarm system, and hydrants are available on the premises.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for all above listed requirements. The hospital must maintain clear

access and exit routes at all times. Emergency exit paths should be free of obstructions and wide enough to allow for the rapid evacuation of staff, patients, and visitors in case of a fire or other emergency. Exit doors and patient room doors should be designed to remain unlocked from the inside, allowing quick access during emergencies. Smoking areas must be clearly marked with appropriate signage indicating where smoking is permitted and where it is prohibited or restricted. The hospital must have a fully operational fire alarm system throughout the building and hydrants must be available and easy to access in the event of a fire. The assessment will involve physical inspection to check all listed requirements, interview with the relevant staff and review of all related documentation

Indicator 293: An annual fire safety inspection at the hospital, conducted in accordance with national guidelines, identifies fire risks and develops strategies to reduce these risks and prevent fires.

Assessment Process:

In order to comply with this indicator, the hospital must have conducted annual fire safety inspections to identify fire hazards and assess the effectiveness of existing fire prevention measures. A list of all potential fire risks should be documented and prioritized. After each fire safety inspection, the hospital must address any identified risks and implement corrective measures to eliminate or reduce the risks. The assessment will involve review of fire safety inspections, including findings, recommendations, actions taken, and follow-up inspections.

Indicator 294: A trained Hospital Safety representative regularly tests and documents the alarm systems, fire extinguishers, and other fire prevention and control equipment. Any recommendations arising from these tests and inspections are promptly addressed, and records are maintained.

Assessment Process:

In order to comply with this indicator, the hospital must have designated a person responsible for safety who ensures the regular testing and maintenance of all fire prevention systems, including alarms, fire extinguishers, and emergency equipment. This person should be trained in fire safety regulations and procedures. The hospital must have a routine testing schedule for fire safety equipment and corrective actions must be taken to address any issues or deficiencies identified during inspections or tests. The assessment will involve review of detailed records of all testing inspections, evidence of corrective actions taken and interview with the designated person

Indicator 295: Chemicals that are potentially dangerous (explosive, flammable, or highly combustible materials) are recognized, kept safely, and designated storage places are marked with Material Safety Data Sheets (MSDS).

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies for safe handling of potentially explosive, flammable or highly combustible material, specifying that all explosive, flammable, or highly combustible materials must be clearly labeled with appropriate warning signs to alert staff and visitors to the risks. These materials must be stored in designated secure storage areas that are equipped with proper ventilation and safety features, such as fire-resistant cabinets or explosion-proof storage rooms. Access to storage areas containing hazardous materials should be restricted to trained and authorized personnel. The hospital must provide adequate fire extinguishers, spill kits, and first aid supplies in areas where flammable, explosive, or highly combustible materials are stored. In case of chemicals their storage should take into account changing climate and heat levels which may impact the chemistry of various substances making them hazardous for workers exposure. The hospital must maintain up-to-date Material Safety Data Sheets (MSDS) for each hazardous material, which must be available to all staff and written safety protocols must be in place for dealing with any accidents involving hazardous materials. The assessment will involve physical inspection to verify that hazardous materials are labeled with clear warning signs, securely stored in designated areas and locked or restricted to prevent unauthorized access. Review of policies and procedures, staff training evidence and Material Safety Data Sheets (MSDS) shall also be conducted.

16. SAFE AND APPROPRIATE EQUIPMENT

Standard 51: There are clear and documented responsibilities, policies and procedures for procurement, use, maintenance, repair and disposal of equipment to minimize the potential for harm.

Indicator 296: A team is notified to develop a procurement policy and strategy for procuring safe and appropriate equipment and to ensure that all purchased equipment and supplies are of the same type and brand to simplify maintenance and repairs.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a procurement policy that outlines the criteria for purchasing new equipment and supplies. The policy should ensure that equipment is compatible with other equipment used in the hospital to facilitate maintenance and repairs. The hospital must have a designated procurement team responsible for the entire process of equipment procurement. The team should:

- Assess the need for new equipment based on hospital requirements.
- Consult with departments to ensure that equipment meets their specifications.
- Procure equipment following appropriate procedures.
- Assess how equipment is being used and whether it is serving its intended purpose.
- Condemn outdated or unsafe equipment when necessary.
- Conduct regular audits of equipment to ensure proper functioning and compliance.

The hospital must have procedures in place to condemn equipment that is no longer safe or functional. The condemnation process should include clear documentation and follow appropriate disposal and replacement protocols. The assessment will include review of policies and procedures, documented equipment audits, procedures for condemnation and interviews with procurement team.

Indicator 297: A copy of the equipment supply orders is kept in the hospital's records and is stored in accordance with the hospital's policies or, for public hospitals, the Government Financial Rules (GFR).

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies and procedures for placement of supply orders of equipment and these must be done according to established hospital rules or Government Financial Rules (GFR) if applicable, especially in public hospitals. A copy of each supply order for equipment must be kept in the hospital's records. The order should be clearly documented and include details such as equipment specifications, quantities, pricing, and the name of the vendor. The hospital must have an established process for financial approval of equipment procurement. The hospital must maintain a proper audit trail for all procurement activities. Documentation should include requests for equipment, approval forms, purchase orders, and invoices as well as accurate inventory records that match the equipment ordered. The assessment will include review of policies and procedures, examination of supply order records, audit reports and inventory records.

Indicator 298: Annual maintenance service agreements are established with suppliers for high-value equipment.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented policies to ensure that all equipment used within the facility is certified to comply with health and safety regulations. This includes obtaining certifications from suppliers or independent regulatory bodies that confirm the equipment meets required safety standards. The hospital must have annual maintenance contracts (AMCs) in place for costly or critical equipment and detailed records of all maintenance activities, including service dates, repairs mIade, and any upgrades must be maintained. The hospital must conduct regular safety inspections of equipment to ensure that it continues to meet health and safety standards. The assessment will involve reviewing policies, certificates of compliance or safety standards certifications, annual maintenance contracts and documented maintenance records.

Indicator 299: Records are maintained for equipment purchases, failures, defects, maintenance, repairs, and disposal. In addition, documentation of relevant staff training on equipment

operation and minor maintenance is also kept.

Assessment Process:

In order to comply with this indicator, the hospital must have maintained detailed records for all equipment, which include:

- Procurement information (suppliers, costs, specifications)
- Defects and failures (documenting any equipment issues)
- Maintenance and repairs (service records, dates, and types of actions taken)
- Disposal records (for equipment that is no longer in service or safe for use)

The hospital must keep a log of all maintenance and repair activities. This includes documentation of regular inspections, preventative maintenance, and any corrective actions taken to repair or replace equipment. Training records for staff who operate and perform minor maintenance on equipment must be maintained and updated equipment inventory that includes all procurement, service, and disposal records should be available. The assessment will include review of all the listed records, staff training evidence and inventory of equipment's.

Indicator 300: A record of the maintenance and testing of electrical equipment, such as emergency lights and generators, which require regular testing, is kept for a period of seven years.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a schedule for routine testing and maintained a detailed list of all electrical equipment that requires routine testing, including critical equipment such as generators, emergency lighting, and other safety or operational systems. These records should include:

- Dates of maintenance and testing
- Test results
- Actions taken to address any issues or deficiencies
- These records must be maintained for a minimum of seven years for auditing and compliance purposes.

The hospital must document any corrective actions taken as a result of testing failures or issues with electrical equipment and relevant staff must be properly trained. The assessment will involve review of all list of electrical equipment's, their maintenance records and staff training evidence.

Indicator 301: The store in-charge regularly conducts equipment audits in accordance with the equipment's history sheet, maintenance contract, and/or operating manual.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a system for equipment audit and must ensure that each piece of equipment has an operational

manual and maintenance contract in place. The hospital must maintain history sheets for all equipment. These should include a complete record of the equipment's lifecycle, detailing:

- Installation date
- Maintenance and repairs
- Issues or failures encountered
- Scheduled service dates and completed checks.

The hospital must conduct regular and routine equipment audits and must take corrective actions based on the findings of the routine audits. The assessment will involve review of relevant documents related to equipment's operational manual, maintenance contracts, history sheets and audit reports.

Indicator 302: All departments and staff are aware of the form used to request equipment repairs. Essential equipment is logged in a tracking system, and the frequency of equipment malfunctions and issues is recorded.

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a form that all staff can use to request equipment repairs and report defects. This form should be standardized, easy to fill out, and include key information such as:

- Equipment details (e.g., name, model, serial number)
- Description of the defect or failure
- Date and time of occurrence
- Priority level of the request (if applicable)

The hospital must maintain a logbook for all critical equipment and a detailed record of all incidents involving equipment defects and failures must be maintained. The hospital must ensure that all staff are trained and made aware of the reporting procedure for defective equipment. The assessment will include review of request forms, equipment logbook and staff training evidence.

Indicator 303: There is a designated committee responsible for the condemnation and disposal of obsolete technology. Additionally, a process has been established that includes criteria for classifying equipment as "condemned" or "obsolete."

Assessment Process:

In order to comply with this indicator, the hospital must have developed and implemented a policy and procedure that clearly defines the criteria for condemning and disposing of obsolete or non-functional equipment, such as:

- Non-functional and beyond economical repair
- Non-functional and obsolete
- Functional but obsolete
- Functional but hazardous
- Functional but no-longer required

The hospital must keep detailed records of all condemned and obsolete equipment and should regularly audit its equipment inventory to identify items that are nearing the end of their useful life or may need to be condemned. The assessment will involve review of policies and procedures, condemnation records and documented audit reports.

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