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# **National Accreditation Board for Hospitals and Healthcare Providers (NABH)**

## **Accreditation Standards Yoga & Naturopathy Hospital**

2<sup>nd</sup> Edition

Dec 2016

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## NOTICE

### Comments invited on draft accreditation standards for Yoga & Naturopathy Hospitals

National Accreditation Board for Hospitals and Healthcare Providers (NABH), Quality Council of India in consultation with all stake holders including **Central Council for Research in Yoga & Naturopathy (CCRYN)** has prepared draft **Accreditation Standards for Yoga & Naturopathy Hospitals** for accreditation of Yoga & Naturopathy Hospitals.

The comments, suggestions, objections, including deletions/additions if required in the draft document are invited from public at large, including the stakeholders like hospitals and other clinical establishments, industry, consumer groups, etc. the comments may kindly be sent to Dr. Gayatri Vyas Mahindroo, Director, NABH at her email ID [director@nabh.co](mailto:director@nabh.co) within 15 days of publication of this notice on the website. A copy of the same may also be endorsed to Dr. Ishwara N. Acharya, Director General, Central Council for Research in Yoga & Naturopathy (CCRYN) at his email ID [acharyaishwar@gmail.com](mailto:acharyaishwar@gmail.com) , [ccryn.goi@gmail.com](mailto:ccryn.goi@gmail.com) .

**The last date for sending the comments is 10<sup>th</sup> December 2016.**

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2<sup>nd</sup> Edition December 2016

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## INTRODUCTION

The first edition of NABH standard has been in practice for last six years now (2009-16) and is revised and up-graded to 2<sup>nd</sup> edition. The guiding principles for revision of the standards have mainly been the experience of stake holders including assessors, hospitals, members of accreditation and technical committees and industry experts. Before finalization of these, public opinion was also sought. Secretariat of NABH did bulk of job by collating and assimilating the feedback information, linking with relevant chapters and presenting to the technical committee for deliberations. This was again discussed in detail by industry experts. It was finally and extensively reviewed by Committee appointed by Ministry of AYUSH, which went in to thought process and came out with the edition, which is now in your hands.

The accreditation standards are not expected to be prescriptive. They only lay down the requirements and it is up to the healthcare organizations to come out with the systems, processes and modes of measuring performance indicators, which can demonstrate compliance to the requirements as specified in the standard. NABH has tried its best to be as objective and pragmatic as possible.

There can be more than one way, by which a Yoga and Naturopathy healthcare organisation can comply with the requirements of the standards. Three books are being made available for use by the stakeholders ie 2<sup>nd</sup> edition Standards book, a guidebook containing glossary and a compilation of various practices in the form of annexures, including matrix for calculating quality indicators and other relevant material.

Accreditation as we know is basically a framework which helps healthcare organizations to establish objective systems aimed at patient safety and quality of care. Documentation plays an important role in defining such systems. Wherever there are references to documented requirements, it needs to be clearly understood that such documentation needs to be established and understood at all levels, reviewed at regular intervals, and controlled and evidenced for their effective implementation by way of records.

The second edition of these standards has put more focus on clinical care aspects. Structural requirement which used to be a separate book in first edition, have been incorporated in second edition at appropriate places.

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The requirements of the standards shall have to be identified; evidenced by data gathered, analysed and interpreted with the aim of improving the quality system of a hospital. Wherever the word shall/should is used, it is imperative that the organisation implement the same. Where the phrase can/could/preferable is used the organisation would use its discretion and implement it according to the practicability of the proposed guidance.

In general, the organisation will need to establish clear evidence backed by robust systems and data collection to prove that they are complying with the intent of the standards. These systems are as we say, defined, implemented, owned by the staff and finally provide objective evidence of compliance. Some of the key issues are as follows;

1. Patient related: monitoring safety, treatment standards and quality of care. This would mean to effectively meet the expectation of patients and their families and associates.
2. Employee related: monitoring competence, on-going training, awareness of patient requirements and monitoring employee satisfaction.
3. Regulatory related: identifying, complying with and monitoring the effective implementation of legal, statutory and regulatory requirements which affect patient safety.
4. Organisation policies related: defining, promoting awareness of and ensuring implementation of, the policies and procedures laid down by the organisation, amongst staffs, patients and interested parties including visiting medical consultants.
5. NABH Standards related: identification of how the organization meets the NABH standards and the objective elements. Where a part of an element, an element or a standard cannot be applied (for example, related to emergency, surgical procedures, laboratory services, radiological services, etc) in a particular organization, adequate explanation and justification must be provided to NABH and its team of assessors to enable exclusion of applicability. In particular, it must be ensured that the intent of each chapter of standards is understood and applied.

The 2<sup>nd</sup> edition of NABH Accreditation Standards for Yoga & Naturopathy Hospital is divided into 10 chapters, which have been further divided into 87 standards (as compared to 51 in first edition). Put together there are 515 objective elements (as compared to 227 in first edition) incorporated within these standards. The increase in objective elements is to put increased emphasis on patient safety and also to encourage healthcare organizations to pursue continuous quality improvements. Objective elements are required to be complied

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with in order to meet the requirement of a particular Standard. Similarly, standards are required to be complied with, in order to meet the requirement of a particular Chapter. Finally, compliance with all chapters is equally important to establish compliance with the Accreditation Standard.

The Standards shall facilitate health care organizations to deliver safe high quality care.

In the beginning of each chapter, intent is given to highlight the summary of the chapter. The intent statement provides a brief explanation of a chapter's rationale, meaning, and significance. Intent statements may contain detailed expectations of the chapter that are evaluated in the on-site assessment process. For most of the objective elements, interpretation is provided in a separate book just to further elaborate on how that objective element can be met.

We are thankful to chairman & members of Technical Committee who have put great efforts to accomplish this task. These standards are equally applicable to government and private hospitals, and are applicable to whole organisation. Standards are dynamic and would be under constant review process. Comments and suggestions for improvement are appreciated. We seek your support in keeping these standards adequate to the need of the industry.



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## TABLE OF CONTENTS

S.No.	Particular	Page
1.	Access, Assessment and Continuity of Care (AAC)	
2.	Care of Patients (COP)	
3.	Management of Treatment (MOT)	
4.	Patient Rights and Education (PRE)	
5.	Hospital Infection Control (HIC)	
6.	Continuous Quality Improvement (CQI)	
7.	Responsibilities of Management (ROM)	
8.	Facility Management and Safety (FMS)	
9.	Human Resource Management (HRM)	
10.	Information Management System (IMS)	





# Chapter 1

## Access Assessment and Continuity of Care (AAC)

### **Intent of the chapter:**

Patients are well informed of the services that an organization can and cannot provide. This will facilitate in appropriately matching patients with the organization's resources. Only those patients who can be cared for by the organization are admitted to the organization. Out-patients who do not match the organization's resources are similarly referred to organizations that have the matching resources.

Patients that match the organizations resources are admitted using a defined process that includes patient and family education.

Patients cared for by the organization undergo an established initial assessment and periodic and regular reassessments.

Assessments may include laboratory and imaging services. The laboratory and imaging services are provided by competent staff in a safe environment for both patients and staff.

These assessments result in formulation of a definite care plan.

Patient care is multidisciplinary in nature and encourages continuity of care through well defined transfer and discharge protocols. These protocols include transfer of adequate information with the patient.

### Summary of Standards

<b>AAC.1.</b>	The organisation defines and displays the services that it provides.
<b>AAC.2.</b>	The organisation has a well-defined registration and admission process.
<b>AAC.3.</b>	There is an appropriate mechanism for transfer or referral of patients who do not match the organizational resources.
<b>AAC.4.</b>	Patients cared for by the organisation undergo an established initial assessment.
<b>AAC.5.</b>	All patients cared for by the organisation undergo a regular reassessment.
<b>AAC.6.</b>	Laboratory services, if applicable are provided as per the scope of services of the organisation.
<b>AAC.7.</b>	There is an established laboratory quality assurance programme.
<b>AAC.8.</b>	There is an established laboratory-safety programme.
<b>AAC.9.</b>	Imaging services, if applicable are provided as per the scope of services of the organization.
<b>AAC.10.</b>	There is an established quality assurance programme for imaging services.
<b>AAC.11.</b>	There is an established radiation safety programme.
<b>AAC.12.</b>	Patient care is continuous and multidisciplinary in nature.
<b>AAC.13.</b>	The organization has a documented discharge process.
<b>AAC.14.</b>	Organization defines the content of the discharge summary.

## Standards and Objective Elements

### Standard

<b>AAC.1.</b>	<b>The organisation defines and displays the services that it provides.</b>
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### Objective Elements

- a. The services being provided are clearly defined and are in consonance with the needs of the community.
- b. The defined services are prominently displayed.
- c. The staff is oriented to these services.

### Standard

<b>AAC.2.</b>	<b>The organisation has a well-defined registration and admission process.</b>
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### Objective Elements

- a. Documented policies and procedures are used for registering and admitting patients.
- b. The documented policies and procedures address out-patients, in-patients and emergency patients.
- c. A unique identification number is generated at the end of registration.
- d. Patients are accepted only if the organisation can provide the required service.
- e. The documented policies and procedures also address managing patients during non-availability of beds.
- f. The staff is aware of these processes.
- g. Maintenance of separate daily record of bed occupancy with monthly conclusion of occupancy.

### Standard

<b>AAC.3.</b>	<b>There is an appropriate mechanism for transfer or referral of patients who do not match the organizational resources.</b>
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### Objective Elements

- a. Documented policies and procedures guide the transfer of patients to another facility in an appropriate manner.
- b. Documented policies and procedures guide the transfer of stable/unstable patients to another facility in an appropriate manner.
- c. Procedures identify staff responsible during transfer/referral.
- d. The organisation gives a summary of patient's condition and the treatment given.

### Standard

<b>AAC.4.</b>	<b>Patients cared for by the organisation undergo an established initial assessment.</b>
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### Objective Elements

- a. The organisation defines and documents the content of the initial assessment for the out-patients, in-patients and emergency patients.
- b. The organisation determines who can perform the initial assessment.
- c. The organisation defines the time frame within which the initial assessment is completed based on patient needs.
- d. The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition or hospital policy. Initial assessment includes identification of medication that the in-patient is using of the relevant AYUSH system, of any other AYUSH system and of modern medicine.
- e. Initial assessment includes screening for nutritional needs.
- f. Care plan has to be documented and is monitored after the initial assessment.
- g. The care plan also includes preventive aspects of the care where appropriate.
- h. The care plan is countersigned by the doctor in-charge of the patient within 24

hours.

- i. The care plan includes desired results of the treatment, care or service.

### Standard

**AAC.5.**

**All patients cared for by the organisation undergo a regular reassessment.**

### Objective Elements

- a. All Patients are reassessed at appropriate intervals.
- b. Out-patients are informed of their next follow-up, where appropriate.
- c. For in-patients during reassessment the care plan is monitored and modified, where found necessary.
- d. Staff involved in direct clinical care document reassessments.
- e. Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.

### Standard

**AAC.6.**

**Laboratory services, if applicable are provided as per the scope of services of the organisation.**

### Objective Elements

- a. Scope of the laboratory services are commensurate to the services provided by the organization.
- b. Adequately qualified and trained personnel perform and/or supervise the investigations.
- c. Documented policies and procedures guide collection, identification, handling, safe transportation, processing and disposal of specimens.
- d. Laboratory results are available within a defined time frame.
- e. Critical results are intimated immediately to the personnel concerned.
- f. Results are reported in a standardised manner.

- g. Laboratory tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.

**Standard**

<b>AAC.7.</b>	<b>There is an established laboratory quality assurance programme.</b>
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**Objective Elements**

- a. The laboratory quality assurance programme is documented.
- b. The programme addresses verification and/or validation of test methods.
- c. The programme addresses surveillance of test results.
- d. The programme includes periodic calibration and maintenance of all equipment.
- e. The programme includes the documentation of corrective and preventive actions.

**Standard**

<b>AAC.8.</b>	<b>There is an established laboratory-safety programme.</b>
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**Objective Elements**

- a. The laboratory-safety programme is documented.
- b. This programme is aligned with the organisation's safety programme.
- c. Written procedures guide the handling and disposal of biomedical waste.
- d. Laboratory personnel are appropriately trained in safe practices.
- e. Laboratory personnel are provided with appropriate safety equipment/devices.

**Standard**

<b>AAC.9.</b>	<b>Imaging services, if applicable are provided as per the scope of services of the organization.</b>
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**Objective Elements**

- a. Imaging services comply with legal and other requirements.

- b. Scope of the imaging services is commensurate to the services provided by the organisation.
- c. The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.
- d. Adequately qualified and trained personnel perform, supervise and interpret the investigations.
- e. Documented policies and procedures guide identification and safe transportation of patients to imaging services.
- f. Imaging results are available within a defined time frame.
- g. Critical results are intimated immediately to the personnel concerned.
- h. Results are reported in a standardized manner.
- i. Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.

### Standard

<b>AAC.10.</b>	<b>There is an established quality assurance programme for imaging services.</b>
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### Objective Elements

- a. The quality assurance programme for imaging services is documented.
- b. The programme addresses verification and/or validation of imaging methods.
- c. The programme addresses surveillance of imaging results.
- d. The programme includes periodic calibration and maintenance of all equipment.
- e. The programme includes the documentation of corrective and preventive actions.

### Standard

<b>AAC.11.</b>	<b>There is an established radiation safety programme.</b>
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### Objective Elements

- a. The radiation-safety programme is documented.
- b. This programme is integrated with the organization's safety programme.



- c. Handling, usage and disposal of radio-active and bio medical waste are as per statutory requirements.
- d. Imaging personnel are provided with appropriate radiation safety devices.
- e. Radiation-safety devices are periodically tested and results documented.
- f. Imaging personnel are trained in radiation-safety measures.
- g. Imaging signage are prominently displayed in all appropriate locations.

**Standard**

<b>AAC.12.</b>	<b>Patient care is continuous and multidisciplinary in nature.</b>
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**Objective Elements**

- a. During all phases of care, there is a qualified individual designated as responsible for the patient's care.
- b. Care of patients is coordinated in all care settings within the organization.
- c. Information about the patient's care and response to treatment is shared among medical, nursing and other care-providers.
- d. Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.
- e. The patient's record(s) is available to the authorized care-providers to facilitate the exchange of information.
- f. Documented policies and procedures guide the referral of patients to other departments/ specialties.

**Standard**

<b>AAC.13.</b>	<b>The organization has a documented discharge process.</b>
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**Objective Elements**

- a. The patient's discharge process is planned in consultation with the patient and/or family.

- b. Documented policies and procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).
- c. Documented policies and procedures are in place for patients leaving against medical advice (LAMA) and patients being discharged on request.
- d. A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).

### Standard

<b>AAC.14.</b>	<b>Organization defines the content of the discharge summary.</b>
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### Objective Elements

- a. Discharge summary is provided to the patients at the time of discharge.
- b. Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.
- c. Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.
- d. Discharge summary contains information regarding investigation results, any naturopathy procedures performed, yoga practices taught and diet given and other treatments given during the patient stay.
- e. Discharge summary contains follow-up advice, required yoga and naturopathy practices and other instructions in an understandable manner.
- f. Discharge summary incorporates instructions about when and how to obtain urgent care.
- g. In case of death, the summary of the case also includes the cause of death.

## Chapter 2

# Care of Patients (COP)

### Intent of the standards

The organization provides uniform care of patients in different settings. The different settings include care provided in outpatient units, various categories of wards, procedure rooms and operation theatre. When similar care is provided in these different settings, care delivery is uniform. Policies, procedures, applicable laws and regulations guide emergency and ambulance services, cardio-pulmonary resuscitation.

Policies, procedures, applicable laws and regulations also guide care of vulnerable patients (elderly, physically and/or mentally challenged and children), obstetrical patients and pediatric patients.

Pain management , nutrition therapy and rehabilitative services are also addressed with a view to provide comprehensive health care.

The standards aim to guide and encourage patient safety as the overall principle for providing care to patients.

### Summary of Standards

<b>COP.1.</b>	Uniform care of patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.
<b>COP.2.</b>	Emergency services are guided by policies, procedures and applicable laws and regulations.
<b>COP.3.</b>	The ambulance services are commensurate with the scope of the services provided by the organization.
<b>COP.4.</b>	Documented policies and procedures guide the care of vulnerable patients (elderly, physically and/or mentally challenged and children).
<b>COP.5.</b>	Documented policies and procedures guide obstetric (Ante Natal & Post Natal) care.
<b>COP.6.</b>	Policies and procedures guide the care of patients undergoing Naturopathy treatment procedures.
<b>COP.7.</b>	Policies and procedures guide the care of patients undergoing Yoga Therapy treatment procedures.
<b>COP.8.</b>	Documented policies and procedures guide appropriate pain management.
<b>COP.9.</b>	Documented policies and procedures guide appropriate rehabilitative services.
<b>COP.10.</b>	Documented policies and procedures guide all research activities.
<b>COP.11.</b>	Documented policies and procedures guide Therapeutic diet.

## Standards and Objective Elements

### Standard

<b>COP.1.</b>	<b>Uniform care of patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.</b>
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### Objective Elements

- a. Care delivery is uniform when similar care is provided in more than one setting.
- b. Uniform care reflects applicable laws, regulations and guidelines.
- c. Standard guidelines are adopted to guide uniform patient care whenever possible.

### Standard

<b>COP.2.</b>	<b>Emergency services are guided by policies, procedures and applicable laws and regulations.</b>
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### Objective Elements

- a. Policies and procedure for emergency care are documented
- b. Policies also address handling of medico-legal cases.
- c. The patients receive care in consonance with the policies.
- d. Documented policies and procedures guide the triage of patients for initiation of appropriate care.
- e. Staff is familiar with the policies and trained on the procedures for care of emergency patients.
- f. Admission or discharge to home or transfer to another organization is also documented.
- g. In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.

### Standard

**COP.3.**

**The ambulance services inhouse or outsourced are commensurate with the scope of the services provided by the organization.**

### Objective Elements

- a. There is adequate access and space for the ambulance(s).
- b. The ambulance adheres to statutory requirements.
- c. Ambulance(s) is appropriately equipped.
- d. Ambulance(s) is manned by trained personnel.
- e. Ambulance is checked on a daily basis.
- f. Equipment are checked on a daily basis.
- g. Emergency medications are checked daily and prior to dispatch.
- h. The ambulance(s) has a proper communication system.

### Standard

**COP.4.**

**Documented policies and procedures guide the care of vulnerable patients (elderly, physically and/or mentally challenged and children).**

### Objective Elements

- a. Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines.
- b. Care is organized and delivered in accordance with the policies and procedures.
- c. The organisation provides for a safe and secure environment for this vulnerable group.
- d. A documented procedure exists for obtaining informed consent from the appropriate legal representative.
- e. Staff is trained to care for this vulnerable group.

### Standard

<b>COP.5.</b>	<b>Documented policies and procedures guide obstetric (Antenatal and Post Natal) Care.</b>
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### Objective Elements

- a. There is a documented policy and procedure for Obstetric services.
- b. The organization defines and displays whether Obstetric cases can be cared or not.
- c. Documented procedures guide provision of Ante-natal services.
- d. Obstetric patient's assessment also includes maternal nutrition.
- e. Appropriate Ante-natal and Post-natal monitoring is performed and documented.

### Standard

<b>COP.6.</b>	<b>Policies and procedures guide the care of patients undergoing Naturopathy treatment procedures.</b>
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### Objective Elements

- a. The policies and procedures are documented.
- b. An informed consent is obtained by a physician prior to the procedure.
- c. Patients shall have a preprocedure assessment and a provisional diagnosis documented prior to procedures.
- d. Documented policies and procedures exist to prevent adverse events like wrong patient and wrong procedures.
- e. Persons qualified by law are permitted to perform the procedures that they are entitled to perform.
- f. A brief note regarding the procedure is documented.
- g. The physician doing the procedure shall document the post-procedure care plan.
- h. Adequate area, appropriate facilities and equipment/instruments are available in the treatment procedure room.

- i. Patient, personnel and material flow conforms to infection control practices.
- j. Guidelines for various treatment procedures are prepared separately and adhered.
- k. Standard precautions and asepsis is adhered to during the conduct of therapies.
- l. A quality assurance program is followed for the treatment services.
- m. The quality assurance program includes surveillance of the treatment procedure room.

### Standard

<b>COP.7.</b>	<b>Policies and procedures guide the care of patients undergoing Yoga Therapy treatment procedures.</b>
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### Objective Elements

- a. The policies and procedures are documented.
- b. An informed consent is obtained by a physician prior to the procedure.
- c. Patients shall have a preprocedure assessment and a provisional diagnosis documented prior to procedures.
- d. Documented policies and procedures exist to prevent adverse events like wrong patient and wrong procedures.
- e. Persons qualified by law are permitted to perform the procedures that they are entitled to perform.
- f. A brief note regarding the procedure is documented.
- g. The physician doing the procedure shall document the post-procedure care plan.
- h. Adequate area, appropriate facilities and equipment/instruments are available in the treatment procedure room.
- i. Patient, personnel and material flow conforms to infection control practices.
- j. Guidelines for various yoga therapy treatment procedures are prepared separately and adhered.



**Standard**

**Standard**

<b>COP.8.</b>	<b>Documented policies and procedures guide appropriate pain management.</b>
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**Objective Elements**

- a. Documented policies and procedures guide the management of pain.
- b. Patients with pain undergo detailed assessment and periodic re-assessment.
- c. The organization respects and supports the management of pain for all patients.
- d. Patient and family are educated on various pain management techniques, where appropriate.

**Standard**

<b>COP.9.</b>	<b>Documented policies and procedures guide appropriate rehabilitative services.</b>
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**Objective Elements**

- a. Documented policies and procedures guide the provision of rehabilitative services.
- b. The scope of rehabilitative services are commensurate with the organization's requirements.
- c. Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).
- d. Rehabilitative services are provided by a multidisciplinary team.
- e. There is adequate space and equipment to perform these activities.

**Standard**

<b>COP.10.</b>	<b>Documented policies and procedures guide all research activities.</b>
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### Objective Elements

- a. Documented policies and procedures guide all research activities in compliance with national and international guidelines.
- b. The organization has an ethics committee to oversee all research activities.
- c. The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.
- d. Patient's informed consent is obtained before entering them in research protocols.
- e. Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.
- f. Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.

### Standard

<b>COP.11.</b>	<b>Documented policies and procedures guide Therapeutic diet</b>
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### Objective Elements

- a. Documented policies and procedures guide implementation of therapeutic diet after assessment and reassessment of patient needs.
- b. Patients receive food according to their clinical needs.
- c. There is a written order for the diet protocol.
- d. Food is prepared, handled, stored and distributed in a safe manner.

## Chapter 3

# Management of Treatment (MOT)

### Intent of the standards

The organization has a safe and organized treatment/procedure process. The process includes documented policies and procedures that guide the treatment procedures.

Every treatment procedure to be performed should be verified by an appropriate person so as to ensure accuracy of the patient and frequency of procedures.

The process also includes monitoring of patients after treatment and procedures for reporting and analyzing treatment errors & adverse events.

Patients and family members are educated about safe treatment procedures.

### Summary of Standards

<b>MOT.1.</b>	Documentation policies and procedures guide the organisation to deliver safe treatment.
<b>MOT.2.</b>	There is a collection of set forms for acceptable naturopathy treatments.
<b>MOT.3.</b>	Documented policies and procedures guide the safe and rational prescription of treatment.
<b>MOT.4.</b>	There are documented policies and procedures for treatment management.
<b>MOT.5.</b>	Near misses, treatment errors and adverse events are reported and analysed.
<b>MOT.6.</b>	Patients are monitored after the treatment.
<b>MOT.7.</b>	There is a policy and procedure for mental and social well being of the patients and staff.
<b>MOT.8.</b>	There is a policy and procedure for safety, security and privacy for female and male patients.

## Standards and Objective Elements

### Standard

<b>MOT. 1 .</b>	<b>Documentation policies and procedures guide the organization to deliver safe treatment.</b>
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### Objective Elements

- a. There is a documented policy and procedure for treatment section.
- b. These comply with the applicable laws and regulations.
- c. A multidisciplinary committee guides the formulation and implementation of these policies and procedure.

### Standard

<b>MOT. 2 .</b>	<b>There is documented policies and procedures for acceptable naturopathy treatments.</b>
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### Objective Elements

- a. A list of naturopathic treatments for the patients and as per the scope of the organizations clinical service is developed.
- b. The list is developed and updated collaboratively by the multidisciplinary committee.
- c. These documented policies and procedures are available for doctors to refer and adhere to.
- d. There is a defined process for acquisition of the equipments and other required items for treatment.

### Standard

<b>MOT. 3 .</b>	<b>Documented policies and procedures guide the safe and rational prescription of treatment.</b>
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### Objective Elements

## Management of Treatment (MOT)

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- a. Documented policies and procedures exist for prescription of treatments.
- b. These incorporate the inclusion of good practice/ guidelines for rational prescription of treatments.
- c. The organization determines the minimum requirements of prescription.
- d. Known allergies are ascertained before prescription.
- e. The organization determines who can ascertain the orders.
- f. Order are written in a uniform location in the medical records.
- g. Treatment orders are clear, legible, dated, timed, named and signed.
- h. Treatment orders contain the name of treatment, area of administration, duration/ frequency of treatment procedure.
- i. Documentation policy and procedure on verbal order is implemented.
- j. The organization defines a list of treatments which involves risk.
- k. Audit of treatment orders/prescription is carried out to check for safe and rational prescription of treatment.
- l. Corrective and/or preventive action is taken based on the analysis, where appropriate.

### Standard

<b>MOT. 4 .</b>	<b>There are documented policies and procedures for treatment management.</b>
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### Objective Elements

- a. Treatments are administered by those who are permitted by law to do so.
- b. Patient is identified before administration.
- c. Duration, time, areas of administration are verified.
- d. Treatment administration is documented.
- e. Documented policies and procedures govern patients self administration of treatments.
- f. Documented policies and procedures govern the use of treatment/ therapy items brought from outside the organization.

**Standard**

<b>MOT. 5 .</b>	<b>Near misses, treatment errors and adverse events are reported and analysed.</b>
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**Objective Elements**

- a. Documented procedure exists to capture near miss, treatment error and adverse drug events.
- b. Near miss, treatment error and adverse event are defined.
- c. These are reported within a specific time frame.
- d. They are collectively analyzed.
- e. Corrective/ preventive actions are taken based on the analysis where appropriate.

**Standard**

<b>MOT. 6 .</b>	<b>Patients are monitored after the treatment.</b>
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**Objective Elements**

- a. The organization defines those situations where close monitoring is required.
- b. Monitoring is done in collaborative manner.
- c. Documented policies and procedures guide the monitoring of the patients after treatment.
- d. Treatment protocols are changed where ever appropriate based on monitoring.

**Standard**

<b>MOT. 7 .</b>	There is a policy and procedure for mental and social well being of the patients and staff.
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**Objective Elements**

- a. There is a policy and procedure for mental and social wellbeing of the patients.
- b. Daily prayer session should be conducted and record of the same shall be maintained, the chanting should be of spiritual significance, not religious.
- c. Pranayama, meditative techniques , health awareness lectures etc should be a part of the program.
- d. There is a scheduled program for patients interactive session. (ex: yoga games, zumba dance, various games and other programs at least once in a week)
- e. Mental and social status of the patients to be recorded before and after hospital stay.
- f. Staffs are also a part of the program.

**Standard**

<b>MOT. 8 .</b>	There is a policy and procedure for safety, security and privacy for female and male patients.
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**Objective Elements**

- a. The organization defines policy and procedure for gender based safety, security and privacy for female and male patients.
- b. To ensure privacy selected therapies must not be offered by a cross gender therapist



## Chapter 4

# Patient Rights and Education (PRE)

### Intent of the standards

The organization defines the patient and family rights and responsibilities. The staff is aware of these and is trained to protect patient rights. Patients are informed of their rights and educated about their responsibilities at the time of admission. The patients are educated about the mechanisms available for addressing grievances.

Patients and family members are educated about the drugless methods adopted in Naturopathy treatment as well as the Yoga and Naturopathy diet pattern and restraints to be exercised during Yoga and Naturopathy treatment.

A documented process for obtaining patient and/or families consent exists for informed decision making about their care as per prevailing law.

Patient and families have a right to information and education about their healthcare needs in a language and manner that is understood by them.

### Summary of Standards

<b>PRE.1.</b>	The organization protects patient and family rights and informs them about their responsibilities during care.
<b>PRE.2.</b>	Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.
<b>PRE.3.</b>	The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process.
<b>PRE.4.</b>	A documented process for obtaining patient and/or family's consent exists for informed decision making about their care.
<b>PRE.5.</b>	Patient and families have a right to information and education about their healthcare needs.
<b>PRE.6.</b>	Patient and families have a right to information on expected costs.
<b>PRE.7.</b>	Organisation has a complaint redressal procedure.

## Standards and Objective Elements

### Standard

<b>PRE.1.</b>	<b>The organization protects patient and family rights informs them about their responsibilities during care</b>
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### Objective Elements

- a. Patient and family rights and responsibilities are documented and displayed.
- b. Patients and families are informed of their rights and responsibilities in a format and language that they can understand.
- c. The organization's leaders protect patient's and family rights.
- d. Staff is aware of their responsibility in protecting patients and family rights.
- e. Violation of patient and family rights is recorded, reviewed and corrective/preventive measures taken.

### Standard

<b>PRE.2.</b>	<b>Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.</b>
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### Objective Elements

- a. Patient and family rights address any special preferences, spiritual and cultural needs.
- b. Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.
- c. Patient and family rights include protection from physical abuse or neglect.
- d. Patient and family rights include treating patient information as confidential.
- e. Patient and family rights include refusal of treatment.
- f. Patient and family rights include informed consent before juice fasting therapy , colonhydrotherapy, Acupuncture, Yogic Kriyas and initiation of any research protocol and any invasive/high risk procedures/treatment.
- g. Patient and family rights include information on how to voice a complaint.

- h. Patient and family rights include information on the expected cost of the treatment.
- i. Patient and family have a right to have an access to his/her clinical records.
- j. Patient and family rights include information on care plan, progress and information on their health care needs.

### Standard

<b>PRE.3.</b>	<b>The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process</b>
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### Objective Elements

- a. The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.
- b. The patient and/or family members are explained about the expected results.
- c. The patient and/or family members are explained about the possible complications.
- d. The care plan is prepared and modified in consultation with patient and/or family members.
- e. The care plan respects and where possible incorporates patient and/or family concerns and requests.
- f. The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.
- g. The patient and/or family members are explained about any change in the patient's condition.

### Standard

<b>PRE.4.</b>	<b>A documented procedure for obtaining patient and/ or family's consent exists for informed decision making about their care.</b>
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### Objective Elements

- a. General consent for treatment is obtained when the patient enters the organisation.

- b. Patient and/or his family members are informed of the scope of such general consent.
- c. Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent.
- d. Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.
- e. The procedure describes who can give consent when patient is incapable of independent decision making.
- f. Informed consent is taken by the person performing the procedure.
- g. Informed consent process adheres to statutory norms.
- h. Staff are aware of the informed consent procedure.

### Standard

<b>PRE.5.</b>	<b>Patient and families have a right to information and education about their Healthcare needs.</b>
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### Objective Elements

- a. When appropriate, patient and/or family are educated about the safe and effective use of prescribed therapies and diet modifications.
- b. Patient and/or family are educated about food-medicine interactions.
- c. Patient and/or family are educated about lifestyle modifications methods and their method of adoption.
- d. Patient and/or family are educated about their specific disease process, complications and prevention strategies.
- e. Patient and/or family are educated about preventing infections.
- f. Patient and/or family are educated in a language and format that they can understand.

**Standard**

<b>PRE.6.</b>	<b>Patient and families have a right to information on expected costs.</b>
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**Objective elements**

- a. There is uniform pricing policy in a given setting (out-patient and inpatient category).
- b. The tariff list is available to patients.
- c. Patients and family are educated about the estimated costs of treatment.
- d. Patients and family are informed about the financial implications when there is a change in the patient condition or treatment setting.

**Standard**

<b>PRE.7.</b>	<b>Organisation has a complaint redressal procedure.</b>
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**Objective elements**

- a. The organisation has a documented complaint redressal procedure.
- b. Patient and/or family members are made aware of the procedure for lodging complaints.
- c. All complaints are analysed.
- d. Corrective and/or preventive action(s) are taken based on the analysis where appropriate.

## **Chapter 5**

# **Hospital Infection Control (HIC)**

### **Intent of the standards**

The standards guide the provision of an effective infection control program in the organization. The program is documented and aims at reducing/eliminating infection risks to patients, visitors and providers of care.

The organization measures and takes action to prevent or reduce the risk of Hospital Associated Infection (HAI) in patients and employees.

The organization provides proper facilities and adequate resources to support the Infection Control Program.

The program includes an action plan to control outbreaks of infection, disinfection/sterilization activities, Bio-medical Waste (BMW) management, training of staff and employee health.

### Summary of Standards

<b>HIC.1.</b>	The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention & Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.
<b>HIC.2.</b>	The organization implements the policies and procedures laid down in the Infection Control Manual.
<b>HIC.3.</b>	The organization performs surveillance activities to capture and monitor infection prevention and control data.
<b>HIC.4.</b>	The organization takes actions to prevent or reduce the risk of Hospital Associated Infections (HAI) in patients and employees.
<b>HIC.5.</b>	The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).
<b>HIC.6.</b>	Biomedical waste (BMW) is handled in an appropriate and safe manner.
<b>HIC.7.</b>	The infection control programme is supported by the organization's management and includes training of staff.
<b>HIC.8.</b>	There are documented policies and procedures for disinfection activities in the organization.



## Standards and Objective Elements

### Standard

<b>HIC.1.</b>	<b>The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention &amp; Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care</b>
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### Objective Elements

- a. The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections.
- b. The infection prevention and control programme is a continuous process and updated at least once in a year.
- c. The hospital has a multi-disciplinary infection control committee which coordinates all infection prevention and control activities
- d. The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities.
- e. The hospital has designated infection control officer as part of the infection control team.

### Standard

<b>HIC.2.</b>	<b>The organization implements the policies and procedures laid down in the Infection Control Manual.</b>
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### Objective Elements

- a. The organization identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas.
- b. The organization adheres to standard precautions at all times.
- c. The organization adheres to hand-hygiene guidelines.
- d. The organization adheres to cleaning, disinfection and sterilization practices.
- e. Laundry and linen management processes are also included

- f. Kitchen sanitation and food handling issues are included in the manual.
- g. Engineering controls to prevent infections are included.
- h. The organisation adheres to housekeeping procedures.
- i. Mortuary practices and procedures are included as appropriate to the organization.

### Standard

<b>HIC.3.</b>	<b>The organization performs surveillance activities to capture and monitor infection prevention and control data.</b>
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### Objective Elements

- a. Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.
- b. Collection of surveillance data is an ongoing process.
- c. Verification of data is done on regular basis by the infection control team.
- d. Scope of surveillance activities incorporates tracking and analyzing of infection risks, rates and trends.
- e. Surveillance activities include monitoring the effectiveness of housekeeping services.
- f. Surveillance activities include monitoring the compliance with hand-hygiene guidelines.
- g. Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.
- h. In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.

### Standard

**HIC.4.**

**The organization takes actions to prevent or reduce the risk of Hospital Associated Infections (HAI) in patients and employees.**

**Objective Elements**

- a. The organization takes action to prevent urinary tract infections.
- b. The organization takes action to prevent respiratory tract infections.
- c. The organization takes action to prevent HAI.
- d. The organization takes action to prevent skin infections.
- e. Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned.

**Standard**

**HIC.5.**

**The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).**

**Objective Elements**

- a. Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.
- b. Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.

**Standard**

**HIC.6.**

**Biomedical waste (BMW) is handled in an appropriate and safe manner.**

**Objective Elements**

- a. The organization adheres to statutory provisions with regard to biomedical waste.
- b. Proper segregation and collection of biomedical waste from all patient-care areas of the hospital is implemented and monitored.
- c. The organization ensures that biomedical waste is stored and transported to the

site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.

- d. Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorized contractor(s).
- e. Appropriate personal protective measures are used by all categories of staff handling biomedical waste.

### Standard

<b>HIC.7.</b>	<b>The infection control programme is supported by the organization's management and includes training of staff.</b>
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### Objective Elements

- a. Hospital management makes available resources required for the infection control programme.
- b. The hospital earmarks adequate funds from its annual budget in this regard.
- c. The organisation conducts induction training for all staff.
- d. The organisation conducts appropriate "in-service" training sessions for all staff at least once in a year.

### Standard

<b>HIC.8.</b>	<b>There are documented policies and procedures for disinfection activities in the organization.</b>
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### Objective Elements

- a. There is adequate space available for **disinfection** activities
- b. Documented procedure guides the cleaning, packing, **disinfection** and/or storing and issue of items.
- c. Regular validation tests for sterilisation are carried out and documented.
  - d. There is an established recall procedure when breakdown in the disinfection system is identified.

## Chapter 6

# Continuous Quality Improvement (CQI)

### **Intent of the standards**

The standards encourage an environment of continuous quality improvement. The quality program should be documented and involve all areas of the organization and all staff members. The organization should collect data on structures, processes and outcomes, especially in areas of high risk situations. The collected data should be collated, analyzed and used for further improvements. The improvements should be sustained. Infection control and patient safety plans should also be integrated into the organization's quality plan.

The organization should define its sentinel events and intensively investigate when such events occur.

The quality programme should be supported by the management.

### Summary of Standards

<b>CQI.1.</b>	There is a structured quality improvement and continuous monitoring programme in the organization.
<b>CQI.2.</b>	There is a structured patient-safety programme in the organisation.
<b>CQI.3.</b>	The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.
<b>CQI.4.</b>	The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.
<b>CQI.5.</b>	The quality improvement programme is supported by the management.
<b>CQI.6.</b>	There is an established system for clinical audit.
<b>CQI.7.</b>	Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.
<b>CQI.8.</b>	Sentinel events are intensively analyzed.

## Standards and Objective Elements

### Standard

<b>CQI.1.</b>	<b>There is a structured quality improvement and continuous monitoring programme in the organization.</b>
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### Objective Elements

- a. The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.
- b. The quality improvement programme is documented.
- c. There is a designated individual for coordinating and implementing the quality improvement programme.
- d. The quality improvement programme is comprehensive and covers all the major elements related to quality improvement and risk management.
- e. The designated programme is communicated and coordinated amongst all the employees of the organization through proper training mechanism.
- f. The quality improvement programme is reviewed at predefined intervals and opportunities for improvement are identified.
- g. The quality improvement programme is a continuous process and updated at least once in a year.
- h. Audits are conducted at regular intervals as a means of continuous monitoring.

### Standard

<b>CQI.2.</b>	<b>There is a structured patient-safety programme in the organisation.</b>
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### Objective Elements

- a. The patient-safety programme is developed, implemented and maintained by a multi-disciplinary committee.
- b. The patient-safety programme is documented.
- c. The patient-safety programme is comprehensive and covers all the major elements related to patient safety and risk management.

- d. The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.
- e. There is a designated individual for coordinating and implementing the patient-safety programme.
- f. The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.
- g. The patient-safety programme identifies opportunities for improvement based on review at pre-defined intervals.
- h. The patient-safety programme is a continuous process and updated at least once in a year.
- i. The organization adopts and implements national/international patient-safety goals/solutions. \* Ref to Annexure on Patient Safety Goal for Naturopathy And Yoga Hospitals.
- j. The organization uses at least two identifiers to identify patients across the organization.

### Standard

<b>CQI.3.</b>	<b>The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.</b>
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### Objective Elements

- a. Monitoring includes appropriate patient assessment.
- b. Monitoring includes safety and quality control programmes of the diagnostics services.
- c. Monitoring includes availability and content of medical records.
- d. Monitoring includes infection control activities.
- e. Monitoring includes naturopathy treatment procedures, yoga therapy practices and dietary practices.
- f. Monitoring includes clinical research.



- g. Monitoring includes data collection to support further improvements.
- h. Monitoring includes data collection to support evaluation of these improvements.

### Standard

<b>CQI.4.</b>	<b>The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.</b>
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### Objective Elements

- a. Monitoring includes procurement as essential to meet patient needs.
- b. Monitoring includes reporting of activities as required by laws and regulations.
- c. Monitoring includes risk management.
- d. Monitoring includes utilization of space, manpower and equipment.
- e. Monitoring includes patient satisfaction which also incorporates waiting time for services.
- f. Monitoring includes employee satisfaction.
- g. Monitoring includes adverse events and near misses.
- h. Monitoring includes availability and content of medical records.
- i. Monitoring includes data collection to support further improvements.
- j. Monitoring includes data collection to support evaluation of these improvements.

### Standard

<b>CQI.5.</b>	<b>The quality improvement programme is supported by the management.</b>
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### Objective Elements

- a. Hospital management makes available adequate resources required for quality improvement programme.
- b. Hospital earmarks adequate funds from its annual budget in this regard.
- c. The management identifies organizational performance improvement targets.

- d. Appropriate statistical and management tools are applied whenever required.

**Standard**

<b>CQI.6.</b>	<b>There is an established system for clinical audit.</b>
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**Objective Elements**

- a. Medical and nursing staff / technical staff participates in this system.
- b. The parameters to be audited are defined by the organization.
- c. Patient and staff anonymity is maintained.
- d. All audits are documented.
- e. Remedial measures are implemented.

**Standard**

<b>CQI.7.</b>	<b>Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.</b>
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**Objective Elements**

- a. The organization has an incident reporting system.
- b. The organization has a process to collect feedback and receive complaints.
- c. The organization has established processes for analysis of incidents, feedbacks and complaints.
- d. Corrective and preventive actions are taken based on the findings of such analysis.
- e. Feedback about care and service is communicated to staff.

**Standard**

<b>CQI.8.</b>	<b>Sentinel events are intensively analyzed.</b>
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**Objective Elements**

- a. The organisation has defined sentinel events.
- b. The organization has established processes for intense analysis of such events.

Continuous Quality Improvement (CQI)

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- c. Sentinel events are intensively analyzed when they occur.
- d. Corrective and Preventive Actions are taken based on the findings of such analysis.

## Chapter 7

# Responsibilities of Management (ROM)

### **Intent of the standards**

The standards encourage the governance of the organization in a professional and ethical manner. The organization complies with the laid down and applicable legislations and regulations. The responsibilities of the leaders at all levels are defined. The services provided by each department are documented.

Leaders ensure that patient safety and risk management issues are an integral part of patient care and hospital management.

### Summary of Standards

<b>ROM.1.</b>	The responsibilities of the management are defined.
<b>ROM.2.</b>	The organization complies with the laid-down and applicable legislations and regulations.
<b>ROM.3.</b>	The services provided by each department are documented.
<b>ROM.4.</b>	The organization is managed by the leaders in an ethical manner.
<b>ROM.5.</b>	The organisation displays professionalism in management of affairs.
<b>ROM.6.</b>	Management ensure that patient safety aspects and risk management issues are an integral part of patient care and hospital management.

## Standards and Objective Elements

### Standard

<b>ROM.1.</b>	<b>The responsibilities of the management are defined.</b>
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### Objective Elements

- a. Those responsible for governance lay down the organization's vision and mission statement.
- b. Those responsible for governance approve the strategic and operational plans and organization's budget.
- c. Those responsible for governance approve the organization's budget and allocate the resources required to meet the organization's mission.
- d. Those responsible for governance monitor and measure the performance of the organization against the stated mission.
- e. Those responsible for governance establish the organization's organogram.
- f. Those responsible for governance appoint the senior leaders in the organization.
- g. Those responsible for governance support safety initiatives and quality-improvement plans.
- h. Those responsible for governance support research activities
- i. Those responsible for governance address the organization's social responsibility.

### Standard

<b>ROM.2.</b>	<b>The organisation complies with the laid-down and applicable legislations and regulations.</b>
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### Objective Elements

- a. The management is conversant with the laws and regulations and knows their applicability to the organisation.
- b. The management ensures implementation of these requirements.
- c. Management regularly updates any amendments in the prevailing laws of the land.
- d. There is a mechanism to regularly update licenses/registrations/certifications.

**Standard**

<b>ROM.3.</b>	<b>The services provided by each department are documented.</b>
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**Objective Elements**

- a. Scope of services of each department is defined.
- b. Administrative policies and procedures for each department are maintained.
- c. Each organizational program, service, site or department has effective leadership.
- d. Departmental leaders are involved in quality improvement.

**Standard**

<b>ROM.4.</b>	<b>The organization is managed by the leaders in an ethical manner.</b>
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**Objective Elements**

- a. The leaders make public the mission statement of the organization.
- b. The leaders establish the organization's ethical management.
- c. The organisation's established ethical management shall be documented.
- d. The organization discloses its ownership.
- e. The organization honestly portrays the services which it can and cannot provide.
- f. The organization honestly portrays its affiliations and accreditations.
- g. The organization accurately bills for it's services based upon a standard billing tariff.

**Standard**

<b>ROM.5.</b>	<b>The organisation displays professionalism in management of affairs.</b>
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**Objective elements**

- a. The person heading the organisation has requisite and appropriate administrative qualifications.

## Responsibilities of Management (ROM)

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- b. The person heading the organisation has requisite and appropriate administrative experience.
- c. The organisation prepares the strategic and operational plans including long-term and short-term goals commensurate to the organisation's vision, mission and values in consultation with the various stakeholders.
- d. The organisation coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.
- e. The organisation plans and budgets for its activities annually.
- f. The functioning of committees is reviewed for their effectiveness.
- g. The organisation documents employee rights and responsibilities.
- h. The organisation has a formal documented agreement for all outsourced services.
- i. The organisation monitors the quality of the outsourced services.

### Standard

<b>ROM.6.</b>	<b>Management ensure that patient safety aspects and risk management issues are an integral part of patient care and hospital management.</b>
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### Objective elements

- a. Management ensures proactive risk management across the organisation.
- b. Management provides resources for proactive risk assessment and risk reduction activities.
- c. Management ensures implementation of systems for internal and external reporting of system and process failures.
- d. Management ensures that appropriate corrective and preventive actions are taken to address safety-related incidents.



## Chapter 8

# Facility Management and Safety (FMS)

### Intent of the standards

The standards guide the provision of a safe and secure environment for patients, their families, staff and visitors. To ensure this, the organization complies with the relevant rules and regulations, laws and byelaws and requisite facility inspection requirements.

The organization plans for emergencies within the facilities and the community.

The organization plans for eliminating smoking within the facility. ~~and safe management of hazardous materials.~~

The organization provides for safe water, electricity and temperature control where ever required.

The organization has a program for clinical and support service equipment management.

### Summary of Standards

<b>FMS.1.</b>	The organisation has a system in place to provide a safe and secure environment.
<b>FMS.2.</b>	The organisation's environment and facilities operate to ensure safety of patients, their families, staff and visitors.
<b>FMS.3.</b>	The organisation has a programme for engineering support services.
<b>FMS.4.</b>	The organisation has a programme for bio-medical equipment management.
<b>FMS.5.</b>	The organisation has plans for fire and non-fire emergencies within the facilities.
<b>FMS.6.</b>	The organisation has herbal plantation.
<b>FMS.7.</b>	The organisation's environment and facilities operate in a planned manner to ensure safety of patients, their families, staff and visitors and promotes environment friendly measures.

## Standards and Objective Elements

### Standard

<b>FMS.1.</b>	<b>The organisation has a system in place to provide a safe and secure environment.</b>
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### Objective Elements

- a. Safety committee coordinates development, implementation and monitoring of the safety plan and policies.
- b. Patient-safety devices are installed across the organisation and inspected periodically.
- c. The organisation is a non-smoking area.
- d. Facility inspection rounds to ensure safety are conducted at least twice in a year in patient-care areas and at least once in a year in non-patient-care areas.
- e. Inspection reports are documented and corrective and preventive measures are undertaken.
- f. There is a safety education programme for staff.

### Standard

<b>FMS.2.</b>	<b>The organisation's environment and facilities operate to ensure safety of patients, their families, staff and visitors.</b>
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### Objective Elements

- a. Facilities are appropriate to the scope of services of the organisation.
- b. Up-to-date drawings are maintained which detail the site layout, floor plans and fire-escape routes.
- c. There is internal and external sign postings in the organisation in a language understood by the patient, families and community.
- d. The provision of space shall be in accordance with the available literature on good practices (Indian or international standards) and directives from government agencies.

- e. Potable water and electricity are available round the clock.
- f. Alternate sources for electricity and water are provided as backup for any failure/shortage.
- g. The organisation regularly tests these alternate sources.
- h. There are designated individuals responsible for the maintenance of all the facilities.
- i. There is a documented operational and maintenance (preventive and breakdown) plan.
- j. Maintenance staff is contactable round the clock for emergency repairs.
- k. Response times are monitored from reporting to inspection and implementation of corrective actions.

### Standard

<b>FMS.3.</b>	<b>The organisation has a programme for engineering support services.</b>
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### Objective Elements

- a. The organisation plans for equipment in accordance with its services and strategic plan.
- b. Equipment are selected, updated or upgraded by a collaborative process.
- c. Equipment are inventoried and proper logs are maintained as required.
- d. Qualified and trained personnel operate and maintain equipment and utility systems.
- e. There is a documented operational and maintenance (preventive and breakdown) plan.
- f. There is a maintenance plan for water management.
- g. There is a maintenance plan for electrical systems.
- h. There is a maintenance plan for heating, ventilation and air-conditioning.
- i. There is a documented procedure for equipment replacement and disposal.

**Standard**

<b>FMS.4.</b>	<b>The organisation has a programme for bio-medical equipment management.</b>
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**Objective Elements**

- a. The organisation plans for equipment in accordance with its services and strategic plan.
- b. Equipment are selected, updated or upgraded by a collaborative process.
- c. All equipment are inventoried and proper logs are maintained as required.
- d. Qualified and trained personnel operate and maintain the medical equipment.
- e. Equipment are periodically inspected and calibrated for their proper functioning.
- f. There is a documented operational and maintenance (preventive and breakdown) plan.
- g. There is a documented procedure for equipment replacement and disposal.

**Standard**

<b>FMS.5.</b>	<b>The organisation has plans for fire and non-fire emergencies within the facilities</b>
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**Objective Elements**

- a. The organisation has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.
- b. The organisation has a documented safe-exit plan in case of fire and non-fire emergencies.
- c. Staff is trained for its role in case of such emergencies.
- d. Mock drills are held at least twice a year.
- e. There is a maintenance plan for fire-related equipment.

### Standard

<b>FMS.6.</b>	<b>The organisation has herbal plantation</b>
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### Objective Elements

- a. The organisation has herbal plantation within the organisation.
- b. The herbs planted are in accordance to their botanical identification and as per their use in naturopathy treatments.

### Standard

<b>FMS.7.</b>	<b>The organisation's environment and facilities operate in a planned manner to ensure safety of patients, their families, staff and visitors and promotes environment friendly measures.</b>
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- a. The organisation takes initiatives towards an energy efficient and environmental friendly hospital.\*

**Interpretation:** This includes using the concepts of reduce, recycle and reuse in promoting the basic concepts of green hospital. eg: energy efficient lighting in a phased manner, rain water harvesting, increase usage of solar power, recycling where possible.

### Standard

- a. Use natural and locally available materials for construction to provide natural insulation from external heat and cold

## **Chapter 9**

# **Human Resource Management (HRM)**

### **Intent of the standards**

The most important resource of a hospital and health care system is the human resource. Human resources are an asset for effective and efficient functioning of a hospital. Without an equally effective human resource management system, all other inputs like technology, infrastructure and finances come to naught. Human resource management is concerned with the “people” dimension in management.

The goal of human resource management is to acquire, provide, retain and maintain competent people in right numbers to meet the needs of the patients and community served by the organization. This is based on the organization’s mission, objectives, goals and scope of services.

Effective Human Resource Management involves the following processes and activities:

- a. Acquisition of Human Resources which involves human resource planning, recruiting and socialization of the new employees.
- b. Training and development relates to the performance in the present and future anticipated jobs. The employees are provided with opportunities to advance personally as well as professionally.
- c. Motivation relates to job design, performance appraisal and discipline.
- d. Maintenance relates to safety and health of the employees.

The term “staff/ employee” refers to all salaried personnel working in the organization as well as contractual personnel. It does not refer to “fee for service” medical professionals.

The term “Therapist ” refers to Class XII/PUC with training for 1 month from National Institute of Naturopathy or Class X with 3 years’ relevant experience either in Naturopathy therapy or Yoga classes or personnel having educational qualification less

than class X provided he/she is certified by the Head of the Organisation for their competence & skill.



### Summary of Standards

<b>HRM.1.</b>	The organization has a documented system of human resource planning.
<b>HRM.2.</b>	The organisation has a documented procedure for recruiting staff and orienting them to the organisation's environment.
<b>HRM.3.</b>	There is an ongoing programme for professional training and development of the staff.
<b>HRM.4.</b>	Staff, students and volunteers are adequately trained on specific job duties or responsibilities related to safety.
<b>HRM.5.</b>	An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.
<b>HRM.6.</b>	The organization has a well-documented disciplinary procedure.
<b>HRM.7.</b>	A grievance handling mechanism exists in the organization.
<b>HRM.8.</b>	The organization addresses the health needs of the employees.
<b>HRM.9.</b>	There is a documented personal record for each staff member.
<b>HRM.10.</b>	There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.
<b>HRM.11.</b>	There is a process for credentialing and privileging of nursing professionals / support staff permitted to provide patient care without supervision.
<b>HRM.12.</b>	There is a process for collecting, verifying and evaluating the credentials (education, training and experience) of therapist.

## Standards and Objective Elements

### Standard

<b>HRM.1.</b>	<b>The organization has a documented system of human resource planning.</b>
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### Objective Elements

- a. Human resource planning supports the organisation's current and future ability to meet the care, treatment and service needs of the patient.
- b. The organisation maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.
- c. The required job specifications and job description are well defined for each category of staff.
- d. The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.

### Standard

<b>HRM.2.</b>	<b>The organisation has a documented procedure for recruiting staff and orienting them to the organisation's environment.</b>
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### Objective Elements

- a. There is a documented procedure for recruitment.
- b. Recruitment is based on pre-defined criteria.
- c. Every staff member entering the organisation is provided induction training.
- d. The induction training includes orientation to the organisation's vision, mission and values.
- e. The induction training includes awareness on employee rights and responsibilities.
- f. The induction training includes awareness on patient's rights and responsibilities.
- g. The induction training includes orientation to the service standards of the organisation.
- h. Every staff member is made aware of organisation's wide documented policies

and procedures as well as relevant department/unit/service/programme's documented policies and procedures.

### Standard

<b>HRM.3.</b>	<b>There is an ongoing programme for professional training and development of the staff.</b>
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### Objective Elements

- a. A documented training and development policy exists for the staff.
- b. The organisation maintains the training record.
- c. Staff should be given appropriate orientation/training to respective system of medicine.
- d. Training also occurs when job responsibilities change/new equipment is introduced.
- e. Feedback mechanisms for assessment of training and development programme exist.

### Standard

<b>HRM.4.</b>	<b>Staff, students and volunteers are adequately trained on specific job duties or responsibilities related to safety.</b>
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### Objective Elements

- a. All staff is trained on the risks within the organisation environment.
- b. Staff can demonstrate and take actions to report, eliminate/minimize risks.
- c. Staff are made aware of procedures to follow in the event of an incident.
- d. Reporting procedures for common problems, failures and user errors exist.
- e. Staff is trained on occupational safety aspects.

**Standard**

<b>HRM.5.</b>	<b>An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.</b>
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**Objective Elements**

- a. A documented performance appraisal system exists in the organization.
- b. The employees are made aware of the system of appraisal at the time of induction.
- c. Performance is evaluated based on the pre-determined criteria
- d. The appraisal system is used as a tool for further development.
- e. Performance appraisal is carried out at pre defined intervals and is documented.

**Standard**

<b>HRM. 6.</b>	<b>The organization has a well-documented disciplinary policies and procedure.</b>
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**Objective Elements**

- a. Documented policies and procedures exist.
- b. The disciplinary policy and procedure is based on the principles of natural justice.
- c. The policy and procedure is known to all categories of employees of the organization.
- d. The disciplinary procedure is in consonance with the prevailing laws.
- e. There is a provision for appeals in all disciplinary cases.

**Standard**

<b>HRM.7.</b>	<b>A grievance handling mechanism exists in the organization.</b>
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**Objective Elements**

- a. Documented policies and procedures exist.
- b. The policies and procedures are known to all categories of staff of the

organisation.

- c. The redress procedure addresses the grievance.
- d. Actions are taken to redress the grievance.

### Standard

<b>HRM.8.</b>	<b>The organization addresses the health needs of the employees.</b>
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### Objective Elements

- a. A pre-employment medical examination is conducted on all the employees.
- b. Health problems of the employees are taken care of in accordance with the organization's policy.
- c. Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.
- d. Occupational health hazards are adequately addressed.

### Standard

<b>HRM.9.</b>	<b>There is a documented personal record for each staff member.</b>
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### Objective Elements

- a. Personal files are maintained in respect of all staff.
- b. The personal files contain personal information regarding the staff qualification, disciplinary background and health status.
- c. All records of in-service training and education are contained in the personal files.
- d. Personal files contain results of all evaluations.

### Standard

<b>HRM.10.</b>	<b>There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.</b>
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### Objective Elements

- a. Medical professionals permitted by law, regulation and the hospital to provide patient care without supervision are identified.
- b. The education, registration, training and experience of the identified medical professionals is documented and updated periodically.
- c. All such information pertaining to the medical professionals is appropriately verified when possible.
- d. Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.
- e. The requisite services to be provided by the medical professionals are known to them as well as the various departments/units of the organisation.
- f. Medical professionals admit and care for patients as per their privileging.

### Standard

<b>HRM.11.</b>	<b>There is a process for credentialing and privileging of nursing professionals / support staff, permitted to provide patient care without supervision.</b>
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### Objective Elements

- a. Nursing staff / support staff permitted by law, regulation and the organisation to provide patient care without supervision are identified.
- b. The education, registration, training and experience of nursing staff is documented and updated periodically.
- c. All such information pertaining to the nursing staff is appropriately verified when possible.

- d. Nursing staff / support staff are granted privileges in consonance with their qualification, training, experience and registration.
- e. The requisite services to be provided by the nursing staff are known to them as well as the various departments/units of the organisation.
- f. Nursing / support staff professionals care for patients as per their privileging.

**Standard**

<b>HRM.12.</b>	<b>There is a process for collecting, verifying and evaluating the credentials (education, training and experience) of therapist.</b>
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**Objective Element**

- a. The education, training and experience of therapist are documented and updated periodically.
- b. All such information is appropriately verified when possible.
- c. Therapist are granted privileges in consonance with their qualification, training, experience and registration.
- d. Therapist care for patients as per their privileging.

## **Chapter 10**

# **Information Management System (IMS)**

### **Intent of Standards**

Information is an important resource for effective and efficient delivery of health care.

Provision of health care and its continued improvement is dependent to a large extent on the information generated, stored and utilized appropriately by the organizations.

The goal of information management in a organisation is to ensure that the required inputs are available to the right personnel. This is provided in an authenticated, secure and accurate manner at the right time and place. This helps to achieve the ultimate organizational goal of a satisfied and improved provider and recipient of health care.

An effective information management system is based on the information needs of the organization. The system is able to capture, transmit, store, analyze, utilize and retrieve information as and when required for improving clinical outcomes as well as individual and overall organizational performance.

Although a digital based information system improves efficiency, the basic principles of a good information management system apply equally to a manual/paper based system.



### Summary of Standards

<b>IMS.1.</b>	Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.
<b>IMS.2.</b>	The organization has processes in place for effective management of data.
<b>IMS.3.</b>	The organization has a complete and accurate medical record for every patient.
<b>IMS.4.</b>	The medical record reflects continuity of care.
<b>IMS.5.</b>	Documented policies and procedures are in place for maintaining confidentiality, integrity and security of information.
<b>IMS.6.</b>	Documented policies and procedures exist for retention time of records, data and information.
<b>IMS.7.</b>	The organization regularly carries out review of medical records.

## Standards and Objective Elements

### Standard

<b>IMS.1.</b>	<b>Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.</b>
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### Objective Elements

- a. The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization.
- b. Policies and procedures to meet the information needs are documented.
- c. These policies and procedures are in compliance with the prevailing laws and regulations.
- d. All information management and technology acquisitions are in accordance with the documented policies and procedures.
- e. The organization contributes to external databases in accordance with the law and regulations.

### Standard

<b>IMS.2.</b>	<b>The organization has processes in place for effective management of data.</b>
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### Objective Elements

- a. Formats for data collection are standardized.
- b. Necessary resources are available for analyzing data.
- c. Documented procedures are laid down for timely and accurate dissemination of data.
- d. Documented procedures exist for storing and retrieving data.
- e. Appropriate clinical and managerial staff participates in selecting, integrating and using data.

### Standard

<b>IMS.3.</b>	<b>The organization has a complete and accurate medical record for every patient.</b>
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### Objective Elements

- a. Every medical record has a unique identifier.
- b. Organisation policy identifies those authorized to make entries in medical record.
- c. Every medical record entry is dated and timed.
- d. The author of the entry can be identified.
- e. The contents of medical record are identified and documented.
- f. The record provides an up-to-date and chronological account of patient care.
- g. Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.

### Standard

<b>IMS.4.</b>	<b>The medical record reflects continuity of care.</b>
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### Objective Elements

- a. The medical record contains information regarding reasons for admission, diagnosis and care plan.
- b. The medical record contains the results of tests carried out and the care provided.
- c. All procedures performed are incorporated in the medical record.
- d. When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.
- e. The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel.
- f. In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.
- g. Care providers have access to current and past medical record.

**Standard**

<b>IMS.5.</b>	<b>Documented policies and procedures are in place for maintaining confidentiality, integrity and security of information.</b>
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**Objective Elements**

- a. Documented policies and procedures exist for maintaining confidentiality, security and integrity of information.
- b. Documented policies and procedures are in consonance with the applicable laws.
- c. The policies and procedures incorporate safeguarding of data/record against loss, destruction and tampering.
- d. The hospital has an effective process of monitoring compliance of the laid down policy.
- e. The organisation uses developments in appropriate technology for improving confidentiality, integrity and security.
- f. Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.
- g. A documented procedure exists on how to respond to patients/physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.

**Standard**

<b>IMS.6.</b>	<b>Documented policies and procedures exist for retention time of records, data and information.</b>
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**Objective Elements**

- a. Documented policies and procedures are in place on retaining the patient's clinical records, data and information.
- b. The documented policies and procedures are in consonance with the local and national laws and regulations.
- c. The retention process provides expected confidentiality and security.

- d. The destruction of medical records, data and information is in accordance with the laid down policy.

### Standard

<b>IMS. 7.</b>	<b>The organization regularly carries out review of medical records.</b>
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### Objective Elements

- a. The medical records are reviewed periodically.
- b. The review uses a representative sample based on statistical principles.
- c. The review is conducted by identified care providers.
- d. The review focuses on the timeliness, legibility and completeness of the medical records.
- e. The review process includes records of both active and discharged patients.
- f. The review points out and documents any deficiencies in records.
- g. Appropriate corrective and preventive measures undertaken are documented.

## ANNEXURE

### Patient safety goals for naturopathy hospital

SI	Goal	How to achieve
1	Identify patient correctly	Use atleast any two ways to identify patient. Ex: uhid, name, date of birth etc
2	Improve effective communication	On 3 aspects Between doctor and patient Between doctor and therapist Between therapist and patient
3	Improve the safety in treatment during high alert conditions	Double sign required (therapist/ supervisor/ doctor) Condition ex: 1. Steam bath for hypertensive patient 2. Massage for pregnant lady
4	Ensure 4r: right treatment, right patient, right duration , right site	Cross check the prescription with patients card
5	Reduce the risk of hospital acquired infections.	Maintain infection control measures
6	Ensure active pain management	Hospital should ensure active pain management protocol and procedures. Prevent patient fall