# Accreditation Standards for Dental Institutions/ Hospitals/ Centres


## NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTHCARE PROVIDERS

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## NEED OF THE STANDARDS

Quality is the need of the present time with development of technology and availability of new equipment, Dentistry is becoming more and more effective but along with that unsafe. If as professionals we stick to basic standards we can have safe practices and deliver high quality treatment. Introducing quality management systems are very important and the standards help us to achieve it.

## INTRODUCTION OF NABH

The NABH standards have been laid down keeping the Indian ethos and working environment in mind**. The main focus of the standards is on patient, employee, visitor and environment safety.** These standards are applicable to multidisciplinary Dental hospitals and single specialty hospitals providing secondary, tertiary and quaternary levels of dental care. All the standards are core standards and no optional standards have been laid down. **. The compliance with these standards will indicate that the hospital is patient, staff and environment friendly.** The standards are deceptively simple. On going through the details during the phase of implementation of the standards one would realize that extra efforts and resources are indeed required for ensuring compliance with the standards. It may also be observed, at the time of implementation, that there may be some duplication at a few places. Duplication is a necessity since it will ensure compliance with the said standards and also emphasize the importance of the standards and the objective elements.

We are aware that apart from extra resources needed for implementation, a few guidelines are equally necessary for easy comprehension and correct implementation. The ensuing guidelines, chapter-wise in tabulated form, have been laid down for easy comprehension, better understanding of the standards and the objective elements, removing and clarifying ambiguities uniform application of standards across the organization, and smoother and more efficient implementation. The best way to implement the standards is to have an in-house quality committee/team that will be responsible for making the quality manual based on the NABH standards, the initial implementation of the standards and the subsequent monitoring of the same. While there might be initial expenses for ensuring implementation and monitoring of the standards, in the long term these costs will be recovered by the organization owing to the better and more efficient and effective quality of patient care. Finally it must also be understood that accreditation is an ongoing process. Each time one has to raise the bar and hence the

importance of continual quality improvement. Accreditation is thus a journey and not a destination.

**Dental institution/ hospital/ centre is referred as Dental Facility in this standard.**

# CHAPTER-1 Access, Assessment and Continuity of Care (AAC)

**AAC.1. The organization defines and displays the services that it can provide.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The services being provided are clearly defined and are inconsonance with the needs of the community. | A policy to be framed clearly stating the services the dental facility can provide. |
| 1.2 | The defined services are prominently displayed. | The services so defined should be displayed prominently in an area visible to all patients entering the organization. The display could be in the form of boards, citizen's charter, scrolling messages, etc. Care should be taken to ensure that these are displayed in the language (s) the patient understands. |
| 1.3 | The staff is oriented to these services | All the staff in the dental facility mainly in the reception/registration, OPD, IPD is oriented to these facts through training program regularly or through manuals. |

**AAC.2.The organization has a well documented registration, admission and transfer or referral process.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Processes addresses registering and admitting out patients, inpatients and emergency patients | Dental facility has prepared document (s) detailing the policies and procedures for registration, admission of patient |
| 2.2 | Patients are accepted only if the organization can provide the required service | The staff handling admission and registration needs to be aware of the services that the organization can provide. It is also advisable to have a system wherein the staff is aware as to whom to contact if they need any clarification on the services provided. |
| 2.3 | The policies and procedures also address managing patients during non-availability of beds | The dental facility is aware of the availability of alternate facilities where the patients may be directed in case of non-availability of beds. |
| 2.4 | The staff is aware of these processes | All the staff handling these activities should be oriented to these policies and procedures. Orientation can be provided by documentation/ training. |

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| 2.5 | Processes addresses mechanism for transfer or referral of patient who do not match the organizational resources | The documented policy and procedure should address the methodology of safe transfer of the patient in a life threatening situation to another dental facility. Availability of an appropriate ambulance fitted with life support facilities and accompanied by trained personnel<br>The dental facility gives a case summary mentioning the significant findings and treatment given in case of patients who are being transferred from emergency. For admitted patients a discharge summary has to be given (refer AAC9).The same shall also be given to patients going against medical advice. |

**AAC.3. Patients cared for by the organization undergo an established initial assessment**

| ***Objective Element*** | | ***Guidance*** |
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| 3.1 | The organization defines the content of the assessments for the out-patients, in-patients and emergency patients. | The hospital shall have a protocol/policy by which a standardized initial assessment of patients is done in the OPD, emergency and IPD. The initial assessment could be standardized across the hospital or it could be modified depending on the need of the department. However, it shall be the same in that particular area. The organization can have different assessment criteria for the first visit and for subsequent visits. In emergency department this shall include recording the vital parameters. |
| 3.2 | The organization determines who can perform the assessments. | The assessment can be done by the treating doctor or junior doctor under supervision of treating doctor or a dental hygienist under supervision of treating doctor. The organization shall determine who can do what assessment and it should be the same across the hospital. |
| 3.3 | The organization defines the time frame within which the initial assessment is completed. | The dental facility has defined and documented the time frame within which the initial assessment is to be completed with respect to emergency/indoor patients. |
| 3.4 | Initial assessment for OPD and Emergency cases is done and documented within a reasonable timeframe | If required treatment is done in the same OPD visit. Waiting time is monitored to make it minimum |
| 3.5 | The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition or hospital policy. | The facility's documented protocol mentions that the initial assessment is to be completed within 24 hours or earlier depending upon the patient's condition. This should also cover history, progress notes, investigation ordered and treatment ordered and all these are to be authenticated by treating doctor. |

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| 3.6 | The initial assessment results in a documented plan of care and includes preventive aspect of the care. | This shall be documented by the treating doctor/dental surgeon or by a member of his team in the case sheet.<br><br>The documented plan of care should cover preventive actions as necessary in the case and should include diet, drugs, etc. |

**AAC.4. patients care is a continuous process and all patient care for by the organization undergo a regular reassessment**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 4.1 | During all phases of care, there is a qualified individual responsible for the patient care who co-ordinates the care in all the setting with-in the organization | The facility to ensure that the care of patients is always given by appropriately qualified dental personnel (resident doctor, surgeon, consultant and/or nurse).<br><br>Care of patients is coordinated among various care providers in a given setting viz OPD, emergency, IP etc. The organization shall ensure that there is effective communication of patient requirements amongst the care providers in all settings. |
| 4.2 | All patients are reassessed at appropriate intervals. | After the initial assessment, the patient is reassessed periodically and this is documented in the case sheet. The frequency may be different for different areas based on the setting and the patient's condition. |
| 4.3 | Staff involved in direct clinical care documents reassessments | Actions taken under reassessment are documented. The staff could be the treating doctor or any member of the team. The nursing staff and trained dental hygienist where available can document patient’s vitals. |
| 4.4 | Patients are reassessed to determine their response to treatment and to plan further treatment or discharge. | Self explanatory |

**AAC.5. Clinical Laboratory services are provided as per the requirements of the patients**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 5.1 | Scope of the laboratory services are commensurate to the services provided by the organization. | The facility should ensure availability of laboratory services commensurate with the health care services offered by it. See also (5.5) below for outsourced lab facilities. |
| 5.2 | Adequately qualified and trained personnel perform and/or supervise the investigations. | The staff employed in the lab should be suitably qualified (appropriate degree) and trained to carry out the tests under supervision of specialist. |
| 5.3 | Policies and procedures guide collection, identification, handling, safe transportation and disposal of specimens. | The facility has documented procedures for collection, identification, handling, safe transportation, processing and disposal of specimens, to ensure safety of the specimen till the tests and retests (if required) are completed. |
| 5.4 | Laboratory results are available within a defined time frame. Critical results are intimated immediately to the concerned personnel | The facility shall define the turnaround time for all tests. The facility should ensure availability of adequate staff, materials and equipment to make the laboratory results available within the defined time frame. |
| 5.5 | Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system. | The facility has documented procedure for outsourcing tests for which it has no facilities. This should include: a) list of tests for outsourcing b) identity of personnel in the outsourced facilities to ensure safe transportation of specimens and completing of tests as per requirements of the patient concerned and receipt of results at facility c) manner of packaging of the specimens and their labeling for identification and this package should contain the test requisition with all details as required for testing. A methodology to check the performance of service rendered by the outsourced laboratory as per the requirements of the facility. |
| 5.6 | Quality assurance for laboratory should be as per accepted practices and also include periodic calibration and maintenance of all the equipments. | The facility has a documented quality assurance program. The laboratory in-charge shall periodically survey tests results. The program includes the documentation of corrected and preventive action. |

**AAC.6. There is an established laboratory safety program.**

| *Objective Element* | | *Guidance* |
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| 6.1 | The laboratory safety program is documented. | A well documented lab safety manual is available in the lab. This takes care of the safety of the workforce as well as the equipment available in the lab. |
| 6.2 | This program is integrated with the organization's safety program | Lab safety program is incorporated in the safety program of the hospital. |
| 6.3 | Written policies and procedures guide the handling and disposal of infectious and hazardous materials. | The lab staff should follow standard precautions .The disposal of waste is according to biomedical handling and management rules, 1998. |
| 6.4 | Laboratory personnel are appropriately trained in safe practice are provided with appropriate safety equipment/devices | All the lab staff undergoes training regarding safe practices in the lab. Adequate safety devices are available in the lab e.g. fire extinguishers, dressing materials, standard precautions, disinfectants, etc |

**AAC.7. Imaging services are provided as per the requirements of the patients**

| *Objective Element* | | *Guidance* |
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| 7.1 | Imaging services comply with legal and other requirements | The facility is aware of the legal and other requirements of imaging services and the same are documented for information and compliance by all concerned in the facility. The facility maintains and updates its compliance status of legal and other requirements in a regular manner. |
| 7.2 | Scope of the imaging services are commensurate to the services provided by the organization. | Self explanatory |
| 7.3 | Adequately qualified and trained personnel perform and/or supervise the investigations. | As per AERB guidelines |
| 7.4 | Policies and procedures guide identification and safe transportation of patients to imaging services. | The facility has documented policies and procedures for informing the patients about the imaging activities, their identification and safe transportation to the imaging services. This should also address transfer of unstable patients to imaging services. |

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| 7.5 | Imaging results are available within a defined time frame. Critical results are intimated immediately to the concerned personnel | The organization shall document turnaround time of imaging results.<br><br>Critical results are intimated immediately to the concerned personnel |
| 7.6 | Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system. | The facility has documented procedure for outsourcing tests for which it has no facilities. This should include: a) list of tests for outsourcing b) identity of personnel in the outsourced facilities to ensure safe transportation of specimens and completing of imaging tests, c) the manner of identification of patients and the test requisition with all details as required for testing and d) a methodology to check the selection and performance of service rendered by the outsourced imaging facility as per the requirements of the facility. |
| 7.7 | Quality assurance for radiology services should be as per accepted practices and also include periodic calibration and maintenance of all equipments | Refer to AERB guidelines.<br><br>Documents for verification and validation of imaging methods shall be available.<br><br>HOD shall periodically survey the imaging results.<br>Calibration and maintenance of all equipment shall be carried out by competent persons. |
| 7.8 | Imaging personnel are trained in radiation safety and are provided with appropriate safety equipment devices | Refer to AERB guidelines<br>The safety program of the imaging department has reference in the hospital safety manual.<br>Protective devices e.g. lead aprons should be exposed to X-ray for verification of cracks and damages. |
| 7.9 | Imaging signage are prominently displayed in all appropriate locations | Self explanatory |

**AAC.8. The organization has a documented process for generating and maintains OPD records of patient care**

| *Objective Element* | | *Guidance* |
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| 8.1 | Policy and procedures are in place to maintain OPD records of patient care | Facility devise OPD dental records which has patient card and institutional OPD folder. Patient card contains OPD registration number, diagnosis, procedure done, treatment prescribed, advice given and appointment. Institutional OPD folder contains history, examination, diagnosis investigations, procedures done, treatment prescribed and appointment. |
| 8.2 | The record contains the diagnosis and plan of treatment | |
| 8.3 | The record contains investigations ordered and the results thereof. | |
| 8.4 | The record contains the treatment received and procedures conducted on the patient | |
| 8.5 | Patients take home OPD Card/slip contains procedural summary, medications, instruction and follow up appointment.<br>Organization defines the time frame for which these records are retained | The organization decides the contents of the Procedural Summary |

**AAC.9. The organization has a documented discharge process and contents of discharge summary**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 9.1 | Process addresses discharge of all patients including medico-legal patients leaving against medical advice | Self explanatory |
| 9.2 | A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice) | The facility hands over the discharge papers to the patient/attendant in all cases and copy retained. In LAMA cases, the declaration of the patient/attendant is to be recorded on proper format |

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| 9.3 | Discharge summary contains the reasons for admission, significant findings and diagnosis, investigation results, procedure performed treatment given and the patient's condition at the time of discharge. | Self explanatory |
| 9.4 | Discharge summary contains follow-up advice medications follow up instructions in an understandable manner | Self explanatory |
| 9.5 | Discharge summary incorporates instructions about when and how to obtain urgent care | Self explanatory |
| 9.6 | In case of death the summary of the case also includes the cause of death | |

# Chapter 2. Care of Patients

**COP.1. Uniform care of patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | Care delivery is uniform when similar care is provided in more than one setting | The organization shall ensure that patients with the same health problems and care needs receive the same quality of healthcare throughout the organization irrespective of the category of ward. |
| 1.2 | Uniform care is guided by policies and procedures which reflect applicable laws and regulations | Self explanatory |
| 1.3 | The care and treatment orders are signed, named, timed and dated by the concerned doctor and countersigned by consultant I/C of case | The treatment of patient could be initiated by a junior dental surgeon or student trainee but same should be countersigned and authorized by the treating consultant of the case within 24 hours. |
| 1.4 | Evidence based dentistry and acceptable clinical practice guidelines are adopted to guide patient care whenever possible | The organization could develop clinical protocols based on these and the same could be followed in management of patients. |

**COP.2. Emergency services are guided by policies, procedures, applicable laws and regulations**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Documented procedure addresses care of patient arriving in emergency including the medico-legal cases | These could include SOPs/protocols to provide either general emergency care or management of specific conditions The policy shall be in line with statutory requirements |
| 2.2 | Policies and procedures guide the triage of patients for initiation of appropriate care | |
| 2.3 | Staff is familiar with the policies and trained on the procedures for care of emergency patients | All the staff working in the dental casualty where functioning should be oriented to the policies and practices through training/documents. Staff should preferably be trained/well versed in ACLS and BCLS |
| 2.4 | Admission or discharge to home or transfer to another organization is also documented | All the staff working in the dental casualty where functioning should be oriented to the policies and practices through training/documents. Staff should preferably be trained/well versed in ACLS and BCLS. |

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| 2.5 | The ambulance is appropriately equipped and manned by trained personnel | Ambulance should have at least equipment for basic life support and manned by a trained driver. |
| 2.6 | In the ambulance, there is a check-list of all equipments and emergency medications on regular basis | |

**COP.3. Policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 3.1 | Documented procedures guide the uniform use of resuscitation throughout the organization | The organization shall document the procedure for the same. This shall be in consonance with accepted practices. |
| 3.2 | Staff providing direct patient care is trained and periodically updated in cardio-pulmonary resuscitation | These aspects shall be covered by hands-on training. If the organization has a CPR team (e.g. code blue team) it shall ensure that they are all trained in ALS and are present in all shifts. |
| 3.3 | The events during a cardio-pulmonary resuscitation are recorded | In the actual event of a CPR or a mock drill of the same, all the activities along with the personnel attended should be recorded. |

**COP.4 Policies and procedures define rational use of blood and blood products**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 4.1 | Documented policies and procedures are used to guide rational use of blood and blood products | This shall address the conditions where blood and blood products can be used. |
| 4.2 | Informed consent is obtained for transfusion of blood and blood products | Self explanatory. Also refer to PRE3.4 and 3.5. |
| 4.3 | Procedure addresses documenting and reporting of Transfusion reaction. | The organization shall ensure that any transfusion reaction is reported. These are then analyzed (by individual/committee as decided by the organization) and appropriate corrective/preventive action is taken. The organization shall maintain a record of transfusion reactions. |

**COP.5. Policies and procedures guide the dental laboratory services**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 5.1 | The scope of the dental laboratory services are commensurate to the services provided by the hospital | Dental facility should ensure availability dental lab facilities commensurate with the services offered by it. See (5.7) also for the outsourced Lab facilities. |
| 5.2 | Adequately qualified and trained personnel perform and supervise the work | |
| 5.3 | Policies and Procedures guide the identification, disinfection handling, processing, safe transportation of the models and prosthesis as well as safe disposal of the waste | The impressions and models need to be disinfected properly<br>The model should be accompanied by a properly completed authorization form duly signed by treating dental surgeon/ dental specialist. |
| 5.4 | All models and prosthesis are available within a defined time frame. | |
| 5.5 | Quality assurance for dental lab should be as per accepted practices and also includes periodic calibration and maintenance of all equipments | |
| 5.6 | Corrections and alterations are attended to through a structured and time based programme. | |
| 5.7 | Lab jobs not available in the organisation are out sourced to organisations based on their quality assurance programme | |
| 5.8 | Lab has a documented safety programme which is integrated with the organisations safety program. All personnel are trained in lab safety and are provided safety equipment and devices | A well documented dental Lab safety manual is available which take care of all staff as well all equipment available in the Lab. This could be as per Occupational health & Safety Management System-OSHAS 1800. |

**COP.6. Policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged)**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 6.1 | Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines | Self explanatory. |
| 6.2 | Care is organized and delivered in accordance with the policies and procedures | Facility develops SOP's for delivery of care. |
| 6.3 | The organization provides for a safe and secure environment for this vulnerable group | The organization shall provide proper environment taking into account the requirement of the vulnerable group |

**COP.7. Policies and procedures guide the care of pediatric dental patients**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 7.1 | The organization defines and displays the scope of its pediatric dental services | |
| 7.2 | Those who care for children have age-specific competency | These shall not just be for doctors but shall include hygienist and nursing staff also. The competency shall be based on qualification, experience and training. |
| 7.3 | Provisions are made for special care of children | Adequate amenities for the care of children to be available in the hospital. |
| 7.4 | The children's family members are educated about oral hygiene and safe parenting and this is documented in the medical record | Self explanatory |

**COP.8. Policies and procedures guide the administration of anesthesia**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 9.1 | There is a documented policy and procedure for the administration of local and regional anesthesia. | Facility shall document on the indications, the type of anesthesia and procedure for the same. Authorization for administration of local & regional anesthesia in dental clinics is defined |

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| 9.2 | An immediate preoperative reevaluation is documented. | This shall be done by an anesthesiologist just before the patient is wheeled in to the respective OT. |
| 9.3 | Informed consent for administration of anesthesia is obtained by the anesthetist | Self explanatory. |
| 9.4 | During anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and potency and level of anesthesia | Self explanatory |
| 9.5 | Each patient's post-anesthesia status is monitored and documented | This shall be done in the recovery area/OT and at least include monitoring of vitals till the patient recovers completely from anesthesia and shall be done by an anesthesiologist. If the patient's condition is unstable and he/she requires ICU care the same shall be monitored there. |
| 9.6 | A qualified individual applies defined criteria to transfer the patient from the recovery area | This shall be done by a designated individual as decided by the facility and shall be in consonance with best clinical practices. |
| 9.7 | All adverse anesthesia events are recorded and monitored | Self explanatory |

**COP.10. Policies and procedures guide the care of patients undergoing surgical procedures**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 10.1 | The policies and procedures are documented | This shall include the list of surgical procedures as well as competency level for performing these procedures. |
| 10.2 | Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery | All patients undergoing surgery are assessed preoperatively and a provisional diagnosis is made which is documented. This shall be applicable for both routine and emergency cases |
| 10.3 | An informed consent is obtained by a surgeon prior to the procedure | Self explanatory |

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| 10.4 | Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery | Policies should be available for preventing adverse events like wrong patients, wrong site, and wrong teeth by a suitable mechanism. |
| 10.5 | Persons qualified by law are permitted to perform the procedures that they are entitled to perform | The facility identifies the individuals who have the required qualification (s), training and experience to perform procedures in consonance with the law. |
| 10.6 | A brief operative note and postoperative plan of care is documented prior to transfer out of patient from recovery area/ detention area | This note provides information about the procedure performed, post operative diagnosis and the status of the patient before shifting and shall be documented by the surgeon/member of the surgical team. |
| 10.7 | The operating surgeon documents the post-operative plan of care | Self explanatory |
| 10.8 | A quality assurance program is followed for the surgical services and all procedures on the dental chair | This shall be an integral part of the facility's overall quality assurance program. It shall focus on post operative complications e.g. bleeding, rational use of antibiotics, etc. |
| 10.9 | The quality assurance program includes surveillance of the operation theatre environment and dental clinic | Surveillance activities include monitoring the quality of air provided, rate of air exchange , cleaning and disinfection processes, etc. |
| 10.1 | The plan also includes monitoring of surgical site infection rates | Self explanatory |

**COP.11 Policies and procedures guide appropriate pain management**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 11.1 | Documented policies and procedures guide the management of pain | The facility shall define the group of patients for whom this is applicable. A good reference point for defining these patients could be those having pain as the predominant debilitating symptom. |
| 11.2 | The organization respects and supports the appropriate assessment and management of pain for all patients | Self explanatory |

**COP.12. Policies and procedures guide all research activities**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 12.1 | Documented policies and procedures guide all research activities in compliance with national and international guidelines | Self explanatory |
| 12.2 | The organization has an ethics committee to oversee all research activities | An ethics committee should be framed in the hospital to monitor activities undertaken by various providers. Any research undertaken in the hospital falls under its ambit. |
| 12.3 | The committee has the powers to discontinue a research trial when risks outweigh the potential benefits | Self explanatory |
| 12.4 | Patient's informed consent is obtained before entering them in research protocols | Self explanatory |
| 12.5 | Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal | Self explanatory |
| 12.6 | Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services | Self explanatory |

# Chapter 3. Management of Medication (MOM)

**MOM.1. Policies and procedures guide the organization of pharmacy services, usage of medication and usage of dental materials**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | There is a documented policy and procedure for pharmacy services, medication and dental materials usage | The policies and procedures shall address the issues related to procurement, storage, formulary, prescription, dispensing, administration, monitoring and use of medications and dental materials. |
| 1.2 | These comply with the applicable laws and regulations | Self explanatory. |
| 1.3 | 1.3 a multi disciplinary committee guides the formulation and implementation of these policies and procedure | There shall be representative of major clinical departments, administration and shall include a pharmacist |
| 1.4 | A list of medication and dental materials appropriate for the patients and organization's resources is developed | The hospital formulary shall be prepared and be preferably updated at regular intervals. |
| 1.5 | There is a defined process for acquisition of these medications and dental materials | The process should preferably address the issues of vendor selection, vendor evaluation, and generation of purchase order and receipt of goods as per rules. |
| 1.6 | Documented policies and procedures exist for storage of medication and dental materials | These should address issues pertaining to temperature (refrigeration), light, ventilation, preventing entry of pests/rodents and worms.<br><br>The organization shall also ensure that the storage requirements of the drug and dental materials as specified by the manufacturer are adhered to. If the recommendations are conflicting in nature, the organization shall follow the manufacturer's recommendation. This shall be applicable to all areas where medications are stored including dental clinics, OT and wards. |
| 1.7 | Beyond expiry date medications and dental materials are not stored/ used | Self explanatory. |
| 1.8 | Sound-alike and look-alike medication/ dental materials are stored separately | Many drugs in ampoules, vials or tablets may look-alike or sound-alike. They should be segregated and stored separately. |
| 1.9 | Emergency medications are available all the time and replenished in a timely manner when used | Adequate amount of emergency medicines should be stocked at all times. Re-order level at definite quantity should be done. |

**MOM.2 Policies and procedures guide the prescription of medications**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | The organization determines who can write orders | This shall be done by the treating dental surgeon/specialist. |
| 2.2 | Orders are written in a uniform location in the medical records | All the orders for medicines are recorded on a uniform location of the case sheet. Electronic orders when typed shall again follow the same principles. |
| 2.3 | Medication orders are clear, legible, dated, named and signed | Self explanatory. |
| 2.4 | The organization defines a list of high risk medication | The organization shall develop the list taking into consideration statutory requirements e.g. NDPS Act |
| 2.5 | Use of consumable dental materials are recorded along with justification of use | |

**MOM.3 Policies and procedures guide the safe dispensing of medications**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 3.1 | Documented policies and procedures guide the safe dispensing of medications and dental materials | Clear policies to be laid down for dispensing of medication e.g. route of administration, dosage, rate of administration, expiry date, etc. |
| 3.2 | Expiry dates are checked prior to dispensing | Self explanatory |
| 3.3 | Labeling requirements are documented and implemented by the organization | At a minimum, labels must include the drug name, strength and frequency of administration. |

**MOM.4. There are defined procedures for medication administration and for monitoring adverse drug event**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 4.1 | Medications are administered by those who are permitted by law to do so | Self explanatory |
| 4.2 | Patient is identified prior to administration | Self explanatory |

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| 4.3 | Medication dosage, route and timings are verified from the order prior to administration | Staff administering medications should go through the treatment orders before administration of the medication and then only administer them. It is preferable that they also check the general appearance of the medication (e.g melting, clumping, etc.) before dispensing. |
| 4.4 | Medication administration is documented | The organization shall ensure that this is done in a uniform location and it shall include the name of the medication, dosage, route of administration, timing and the name and signature of the person who has administered the medication |
| 4.5 | A proper record is kept of usage administration safe storage and disposal of narcotics and psychotropic medication | This is in context of narcotic drugs and psychotropic substance act These shall be kept in accordance with the statutory requirements. |
| 4.6 | Adverse drug events are defined, documented and reported within specific time | The organization shall define as to what constitutes an adverse drug event. This shall be in consonance with best practices. |
| 4.7 | Adverse drug events are collected and analyzed, if necessary modify practices to reduce the same | All the adverse drug reactions are analyzed regularly by the multi-disciplinary committee (Refer to MOM 1.3). |

**MOM.5. Policies and procedures guide the use of implantable prosthesis**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 5.1 | Documented policies and procedures govern procurement and usage of implantable prosthesis | Self explanatory |
| 5.2 | Selection of implantable prosthesis is based on scientific criteria and internationally recognized standards | The organization shall ensure that relevant and sufficient scientific data are available before selection. It shall also look for international (e.g.US-FDA) or national notification (Drugs and Cosmetics Act notification October 2005) for approval of the particular product |
| 5.3 | The batch and serial number of the implantable prosthesis are recorded in the patient's medical record and the master logbook | Self explanatory |

**MOM.6. Policies and procedures guide the use of medical gases**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 6.1 | Documented policies and procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases. | This shall be applicable to all gases used in the organization. It shall also address the issue of statutory requirements and approvals wherever applicable. It shall follow the international color coding system. |
| 6.2 | Procedures address the safety issues at all levels | This shall include from the point of storage/source area, gas supply lines and the end user area. Appropriate safety measures shall be developed and implemented for all levels. |
| 6.3 | Appropriate records are maintained in accordance with procedures and legal requirements. | This is the context of the Indian explosives act of 1884, Gas cylinder rules 1981 and Static and mobile pressure vessels (unfired) 1981 |

# Chapter 4. Patient Rights and Education (PRE)

**PRE.1. The organization protects patient and family rights and informs them about their responsibilities during care**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | Patient and family rights and responsibilities are documented | Hospital should respect patients' rights. All the rights of the patients should be displayed in the form of a citizens' charter which should also give information of the charges and grievance redressal mechanism. |
| 1.2 | Patients and families are informed of their rights in a format and language that they can understand | Self explanatory |
| 1.3 | Staff is aware of their responsibility in protecting patients rights | Training and sensitization programs shall be conducted to create awareness among the staff. |
| 1.4 | Violation of patient rights is recorded , reviewed and corrective/preventive measures taken by the organizations leader | Where patients' rights have been infringed upon, management must keep records of such violations, as also a record of the consequences, e.g. corrective actions to prevent recurrences. |

**PRE.2. Patient rights support individual beliefs values and involve the patient and family in decision making processes**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Patient and family rights address any special preferences, spiritual and cultural needs | Self explanatory |
| 2.2 | Patient rights include respect for personal dignity and privacy during examination, procedures and treatment | During all stages of patient care, be it in examination or carrying out a procedure, hospital staff shall ensure that patient's privacy and dignity is maintained. The organization shall develop the necessary guidelines for the same. During procedures the organization shall ensure that the patient is explained just before the actual procedure is undertaken. With regards to photographs/recording procedures; the organization shall ensure that consent is taken and that the patient's identity is not revealed. |
| 2.3 | Patient rights include protection from physical abuse or neglect | Self explanatory. Special precautions shall be taken especially w.r.t vulnerable patients e.g. elderly.. |
| 2.4 | Patient rights include treating patient information as confidential | Self explanatory. Statutory requirements w.r.t. privileged communication shall be followed at all times. |

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| 2.5 | Patient rights include refusal of treatment | During management, the patients should be given the choice of treatment. The treating doctor shall discuss all the available options and allow the patient to make an informed choice including the option of refusal. |
| 2.6 | Patient rights include informed consent before anesthesia, blood and blood product transfusions and any invasive/high risk procedures/treatment | Self explanatory |
| 2.7 | Patient rights include information and consent before any research protocol is initiated | The organization shall ensure that International conference on harmonization (ICH) of good clinical practice (GCP) and declaration of Helsinki Somerset (1996) and ICMR requirements are followed. |
| 2.8 | Patient rights include information on how to voice a complaint | Grievance redressal mechanism must be accessible and transparent. Displayed information must be clearly available on how to voice a complaint. |
| 2.9 | Patient rights include information on the expected cost of the treatment or user charges | Refer AAC4d |
| 2.10 | Patient has a right to have an access to his/her clinical records | The organization shall ensure that every patient has access to his/her record. This shall be in consonance with The code of medical ethics and statutory requirements. |

**PRE.3. A documented process for obtaining patient and/or families consent exists for informed decision making about their care**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 3.1 | General consent for treatment is obtained when the patient enters the organization | Self explanatory |
| 3.2 | Patient and/or his family members are informed of the scope of such general consent | The organization shall define as to what is the scope of this consent and the same shall be communicated to the patient and/or his family members. |
| 3.3 | The organization has listed those procedures and treatment where informed consent is required | A list of procedures should be made for which informed consent should be taken. |
| 3.4 | Informed consent includes information on risks , benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand | Self explanatory. The consent shall have the name of the doctor performing the procedure. If it is a “doctor under training” the same shall be specified, however the name of the qualified doctor supervising the procedure shall also be mentioned. Consent form shall be in the language that the patient understands. |

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| 3.5 | The policy describes who can give consent when patient is incapable of independent decision making. | Self explanatory. The organization shall take into consideration the statutory norms. |

**PRE.4 Patient and families have a right to information on expected costs**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 4.1 | There is uniform pricing policy in a given setting (out-patient and ward category) | There should be a billing policy which defines the user charges to be levied for various activities |
| 4.2 | The user charges list is made known to patients | The organization shall ensure that there is an updated user charges list and that this information is available to patients when required. The organization shall charge as per the list. Any additional charge should also be enumerated in the tariff and the same communicated to the patients. The user charges should be uniform and transparent |
| 4.3 | Patients are educated about the estimated costs of treatment | |

# Chapter 5. Hospital Infection Control (HIC)

**HIC 1 The organization has a well-designed, comprehensive and coordinated Hospital Infection Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The hospital infection control programme is documented which aims at preventing and reducing risk of nosocomial infections. | Self explanatory |
| 1.2 | The hospital has a multi-disciplinary infection control committee. | Self explanatory. This shall preferably have administrator, microbiologist, physician, surgeon and the hospital infection control nurse. |
| 1.3 | The hospital has an infection control team. | The team is responsible for day-to-day functioning of infection control program. They shall support surveillance process and detect outbreaks. They shall also participate in audit activity and in infection prevention and control on a day-to-day basis. |
| 1.4 | The hospital has designated and qualified infection control nurse(s)/assistant for this activity | The qualification shall be either a graduate nurse or qualified nurse with competence gained by experience |

**HIC 2 The hospital has an infection control manual, which is periodically updated. (and conducts surveillance activities**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | The manual identifies the various high-risk areas and procedures | The manual should clearly identify the high risk areas of the hospital e.g. OT, specialized dental clinics, radiology department and dental labs. |
| 2.2 | It outlines methods of surveillance in the identified high-risk areas. | It shall define the frequency and mode of surveillance. |
| 2.3 | It focuses on adherence to standard precautions at all times. | Self explanatory |
| 2.4 | Equipment cleaning and sterilization practices are included. | It shall address this at all levels e.g. ward, OT and CSSD. It is preferable that the organization follow a uniform policy across different departments within the organization. |

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| 2.5 | An appropriate antibiotic policy is established and implemented. | The facility shall develop a system of monitoring drug susceptibility (based on culture sensitivity) and accordingly develop its antibiotic policy. which shall be reviewed at periodic intervals (may be once in 3 months) for its continuing applicability. |
| 2.6 | Laundry and linen management processes are also included. | Self explanatory. If outsourced the organization shall ensure that it establishes adequate controls to ensure infection control. |
| 2.7 | Engineering controls to prevent infections are included | Engineering controls shall address air changes, air conditioning, replacement of filters, seepage leading to fungal colonization, etc. |
| 2.8 | The organization defines the periodicity of updating the infection control manual. | Self Explanatory |
| 2.9 | Surveillance activities are appropriately directed towards the identified high risk areas and surveillance data is collected, verified,analysed | The organization shall ensure that it has a process in place to collect surveillance data and also to ensure that it is able to capture all such data which is verified ,analysed and take suitable steps to control infection |

**HIC 3 The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 3.1 | The organization monitors surgical site infections. | This shall be done by sending pus/swab for culture. |
| 3.2 | Appropriate feedback regarding HAI rates are provided on a regular basis to dental and nursing staff. | The feedback shall include the rates, trends and opportunities for improvement. It could also provide specific inputs to reduce the HAI rate. |

**HIC 4 Proper facilities and adequate resources are provided to support the infection control program**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 4.1 | Hand washing facilities in all patient care areas are accessible to health care providers. | The organization shall ensure that it provides necessary infrastructure to carry out the same. |
| 4.2 | Compliance with proper hand washing is monitored regularly. | The organization shall preferably display the necessary instructions near every hand washing area. Compliance could be verified by random checking, observation, etc. |

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| 4.3 | Adequate gloves, masks, soaps, and disinfectants are available and used correctly. | Self explanatory. They should be available at the point of use and the organization shall ensure that it maintains an adequate inventory. |

**HIC 5 There are documented procedures for sterilization activities in the hospital.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 5.1 | There is adequate space available for sterilization activities | Self explanatory |
| 5.2 | Regular validation tests for sterilization are carried out and documented. | This shall be done by accepted methods e.g. bacteriologic, strips, etc. |
| 5.3 | There is an established recall procedure when breakdown in the sterilization system is identified. | The organization shall ensure that the sterilization procedure is regularly monitored and in the eventuality of a breakdown it has a procedure for withdrawal of such items. |

**HIC 6 Statutory provisions with regard to bio-medical waste (BMW) management and handling, 1998 are complied with.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 6.1 | The hospital is authorized by prescribed authority for the management and handling of bio-medical waste. | The occupier shall apply in the prescribed form and get approval from the prescribed authority e.g. pollution control board/committee |
| 6.2 | Proper segregation and collection of bio-medical waste from all patient care areas of the hospital is implemented and monitored. | Wastes to be segregated and collected in different color coded bags and containers as per statutory provisions. Monitoring shall be done by members of the committee |
| 6.3 | The organization ensures that bio-medical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner. | The waste is transported to the pre-defined site at definite time intervals (maximum within 48 hours) through proper transport vehicles in a safe manner. If this activity is outsourced the organization shall ensure that it is done to an authorized contractor. |
| 6.4 | Bio-medical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorized contractor(s). | If the hospital has waste treatment facility within its premises then they have to be in accordance with statutory provisions or they can outsource it to a central facility. |

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| 6.5 | Requisite fees, documents and reports are submitted to competent authorities on stipulated dates. | The facility facility ensure that the fees are deposited in a timely manner. In addition, the annual reports have to be submitted by the 31st of January of every year and accident reporting has to be carried out in the prescribed form. |
| 6.6 | Appropriate personal protective measures are used by all categories of staff handling bio-medical waste. | Self explanatory |
| 6.7 | Policy and procedure for proper storage, handling and disposal of mercury and mercury waste/amalgam | There needs to be provision of Mercury spill kit and a SOP for mercury spills |

**HIC 7 The infection control program is supported by hospital management and includes training of staff and employee health.**

| ***Objective Element*** | | ***Guidance*** | | |
|---|---|---|---|---|
| 7.1 | Hospital management makes available resources required for the infection control program | The facility shall ensure that the resources required by the personnel should be available in a sustained manner. This includes both men and materials. | | |
| 7.2 | The hospital regularly earmarks adequate funds from its annual budget in this regard. | There shall be a separate budget demarcated for HIC activity. This shall be prepared taking into consideration the scope of the activity and previous years' experience. | | |
| 7.3 | It conducts regular pre-induction training for appropriate categories of staff before joining concerned department(s). | Self explanatory | | |
| 7.4 | It also conducts regular "in-service" training sessions for all concerned categories of staff at least once in a year. | Self explanatory | | |
| 7.5 | Appropriate pre and post exposure prophylaxis is provided to all concerned staff members. | Self explanatory | | |
| 7.6 | There needs to be Implementation of Engineering systems to reduce dust, aerosol/splash contamination | The Dental chairs must have an in built hi-vacuum suction system to prevent aerosol contamination | Aerosol/Dust Evacuation Hood in Dental Laboratory | Splash guard for lathe and table top rotary devices |

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|---|---|---|
| 7.7 | These Engineering controls should be examined and tested periodically and the same should be documented | Maintenance records |
| 7.8 | All personnel handling patients are provided with specific personal protective equipment and eye shield, mask, apron, gloves and shoe cover, etc. | Self explanatory |

# Chapter 6. Continuous Quality Improvement (CQI)

**CQI 1. There is a structured quality improvement and continuous monitoring program in the organization.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The quality improvement program is developed, implemented and maintained by a multi-disciplinary committee. | This committee shall have representation from management, various clinical and support departments of the facility. This program shall be developed, implemented and maintained in a structured manner. |
| 1.2 | The quality improvement programme is documented. | This could be documented as a manual. This shall incorporate the mission, vision, quality policy, quality objectives, service standards, etc. The manual could be stand alone or it could have cross linkages with other manuals. |
| 1.3 | There is a designated individual for coordinating and implementing the quality assurance program | This should preferably be a person having a good knowledge of accreditation standards, statutory requirements, hospital quality assurance principles and evaluation methodologies, hospital functioning and operations. |
| 1.4 | The quality improvement program is comprehensive and covers all the major elements related to quality assurance and risk management. | This shall preferably cover all aspects including documentation of the program, monitoring it, data collection, review of policy and corrective action. Also refer to CQI 1b |
| 1.5 | The designated program is communicated and coordinated amongst all the employees of the organization through proper training mechanism. | Self explanatory |
| 1.6 | The quality improve mental program is reviewed at predefined intervals and opportunities for improvement are identified. | As quality improvement is a dynamic process, it needs to be reviewed at regular pre-defined intervals (as defined by the facility in the quality assurance manual) by the multi-disciplinary committee. The review shall also include analysis of key indicators as defined by the standards. Refer to CQI 2 and CQI 3. |
| 1.7 | The quality improvement program is a continuous process and updated at least once in a year. | Self explanatory. The inputs for updating could be based on the review carried out by the quality assurance committee. |

**CQI 2. The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Monitoring includes appropriate patient assessment. | Self explanatory. The facility shall develop appropriate key performance indicators suitable to it. The data pertaining to the identified indicators shall be captured from all patients; however, monitoring could be done using suitable samples. Certain illustrative examples are given in the remarks column. |
| 2.2 | Monitoring includes diagnostic services' safety and quality control programs. | As stated in the remarks column |
| 2.3 | Monitoring includes all invasive procedures. | As stated in the remarks column |
| 2.4 | Monitoring includes adverse drug events. | As stated in the remarks column |
| 2.5 | Monitoring includes use of anesthesia. | As stated in the remarks column |
| 2.6 | Monitoring includes use of blood and blood products. | As stated in the remarks column |
| 2.7 | Monitoring includes availability and content of medical records. | As stated in the remarks column |
| 2.8 | Monitoring includes infection control activities. | As stated in the remarks column |
| 2.9 | Monitoring includes clinical research. | As stated in the remarks column |
| 2.10 | Monitoring includes data collection to support further improvements | |
| 2.11 | Monitoring includes data collection to support evaluation of these improvements. | |

**CQI 3. The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 3.1 | Monitoring includes procurement of medication and dental materials essential to meet patient needs. | Self explanatory. |

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|---|---|---|
| 3.2 | Monitoring includes reporting of activities as required by laws and regulations. | The facility shall identify all these requirements and accordingly report them as laid down by the law/regulation |
| 3.3 | Monitoring includes risk management. | Refer to glossary for definition of "risk management" |
| 3.4 | Monitoring includes utilization of space, manpower and equipment. | Self explanatory. |
| 3.5 | Monitoring includes patient satisfaction which also incorporates waiting time for services. | Self explanatory. |
| 3.6 | Monitoring includes employee satisfaction. | Self explanatory. |
| 3.7 | Monitoring includes adverse events and near misses. | Self explanatory. The organization shall define "adverse events" and capture the same. |
| 3.8 | Monitoring includes data collection to support further study for improvements. | This shall include any data as deemed fit by the facility and should enable it to improve its services. |
| 3.9 | Monitoring includes data collection to support evaluation of the improvements. | All improvement activities carried out by the facility shall have an evaluable outcome. The same shall be captured and analyzed. |

**CQI 4. The quality improvement program is supported by the management.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 4.1 | Hospital management makes available adequate resources required for quality improvement program. | This shall include the men, material, machine and method. These should be in steady supply so as to ensure that the program functions smoothly |
| 4.2 | Hospital earmarks adequate funds from its annual budget in this regard. | Appropriate fund allocation is done by the organization for the smooth functioning of the program. |
| 4.3 | Appropriate statistical and management tools are applied whenever required. | Self explanatory |

**CQI 5. There is an established system for audit of patient care services.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 5.1 | Dental staff participates in this system. | The facility shall identify such personnel. It could be a mix of clinicians, administrators and nurses. |
| 5.2 | The parameters to be audited are defined by the organization. | As medical audits are retrospective/concurrent in nature, it is imperative that this be done using predefined parameters so that there is no bias. |
| 5.3 | Patient and clinician anonymity is maintained. | Self explanatory. |
| 5.4 | All audits are documented. | Self explanatory. |
| 5.5 | Remedial measures are implemented | Self explanatory. |

**CQI 6. Sentinel events are intensively analyzed.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 6.1 | The organization has defined sentinel events. | Self explanatory |
| 6.2 | The organization has established processes for intense analysis of such events when occurs | Self explanatory |
| 6.3 | Corrective and preventive actions are taken upon findings of such analysis. | This should be done based on root cause analysis so as to prevent recurrences. |

# Chapter 7. Responsibility of Management (ROM)

**ROM 1 The responsibilities of the management are defined**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The organization has a documented organogram | The shall have an organization structure/chart and this shall clearly document the hierarchy line of control and function |
| 1.2 | Those responsible for governance appoint the senior leaders in the organization | Self explanatory |
| 1.3 | Those responsible for governance support research activities and quality improvement plans. | Self explanatory |
| 1.4 | The organization complies with the laid down and applicable legislations and regulations | Self explanatory |
| 1.5 | Those responsible for governance address the organization's social responsibility | The facility shall develop social responsibility policy and accordingly address it. |
| 1.6 | The management defines the rights and responsibilities of employees | |

**ROM 2 The services provided by each department are documented**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Each organizational program, service, site or department has effective leadership | The organization of hospital is usually a matrix one. There needs to be an effective leadership style by which it is governed. |
| 2.2 | Scope of services of each department is defined | Each department's activity is to be predefined. This could be documented either at individual department level or the facility could have a brochure detailing the scope of each department. |
| 2.3 | Administrative policies and procedures for each department is maintained | This shall include administrative procedures like attendance, leave, conduct, etc. |
| 2.4 | Departmental leaders are involved in quality improvement | Self explanatory |

**ROM 3 The organization is managed by the leaders in an ethical manner.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 3.1 | The leaders make public the mission statement of the organization | The facility shall have a mission statement and the same shall be displayed prominently. |
| 3.2 | The leaders establish the organization's ethical management | The facility shall function in an ethical manner. |
| 3.3 | The organization discloses its ownership | The ownership of the hospital e.g. trust, private, public has to be disclosed |
| 3.4 | The organization honestly portrays the services which it can and cannot provide | Self explanatory |
| 3.5 | The organization honestly portrays its affiliations and accreditations. | |
| 3.6 | The organization accurately bills for its services based upon a standard billing tariff/ user charges. | Self explanatory |

**ROM 4 A suitably qualified and experienced individual heads the organization**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 4.1 | The designated individual has requisite and appropriate administrative qualifications | Self explanatory. |
| 4.2 | The designated individual has requisite and appropriate administrative experience | Self explanatory. |

**ROM 5 Leaders ensure that patient safety aspects and risk management issues are an integral part of patient care and hospital management**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 5.1 | The organization has an interdisciplinary group assigned to oversee the hospital wide safety program. | Self explanatory |

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| 5.2 | The scope of the program is defined to include adverse events ranging from “no harm” to “sentinel events”. | Self explanatory |
| 5.3 | Management ensures implementation of systems for internal and external reporting of system and process failures. | The facility has a system in place for internal and external reporting of system and process failures in the context of adverse events as defined above. |

# Chapter 8. Facility of Management and Safety (FMS)

**FMS.1. The organization is aware of and complies with the relevant rules and regulations, laws and byelaws and requisite facility inspection requirements.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The management is conversant with the laws and regulations and knows their applicability to the organization and regularly updates | A designated management functionary has been given the responsibility to enlist the laws and regulation as applicable to the. This functionary has identified the appropriate personnel in the facility who are supposed to implement the respective laws and regulations. |
| 1.2 | The management ensures implementation of these requirements. | Self explanatory |
| 1.3 | There is a mechanism to regularly update licenses/ registrations/certifications. | Self explanatory |

**FMS.2. The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | There is a documented operational and maintenance (preventive and breakdown) plan. | Self explanatory |
| 2.2 | Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes. | Designated personnel maintain the drawings. |
| 2.3 | There is internal and external sign posting in the organization in language understood by patient, families and community | |
| 2.4 | The provision of space shall be in accordance with the available literature on good practices (Indian or International standards) and directives from government agencies | Self explanatory |

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| 2.5 | There are designated individuals responsible for the maintenance of all the facilities. | A person in the facility management is designated to be in-charge of maintenance of facilities. The facility has the required number of supervision and tradesmen to manage the facilities. |
| 2.6 | Maintenance staff is contactable round the clock for emergency repairs. | A complaint attendance register is to be maintained to indicate the date and time of receipt of complaint, allotment of job and completion of job |
| 2.7 | The organization has a system to identify the potential safety and security risks includes the hazardous material | |

**FMS.3 The organization has a program for clinical and support service equipment management.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 3.1 | The organization plans for equipment in accordance with its services and strategic plan | Self explanatory. This shall also take into consideration future requirementsans has a collaborated process where equipment selection is done end user and by management.. |
| 3.2 | All equipment is inventoried and proper logs are maintained as required. | Self explanatory. |
| 3.3 | Qualified and trained personnel operate and maintain the equipment | Self explanatory. |
| 3.4 | Equipment is periodically inspected and calibrated for their proper functioning. | The facility has weekly/monthly/ annual schedules of inspection and calibration of equipment which involve measurement, in an appropriate manner. The facility either calibrates the equipment in-house or out sources; maintaining traceability. |
| 3.5 | There is a documented operational and maintenance (preventive and breakdown) plan | Self explanatory. |

**FMS.4 The organization has provisions for safe water, electricity, medical gases and vacuum system.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 4.1 | Potable water and electricity are available round the clock | The facility shall make arrangements for supply of adequate potable water and electricity. |
| 4.2 | Alternate sources are provided for in case of failure. | Alternate electric supply could be from DG sets, solar energy, UPS and any other suitable source. |
| 4.3 | The organization regularly tests the alternate sources. | Self explanatory |
| 4.4 | There is a maintenance plan for piped medical gas and vacuum installation | Self explanatory |

**FMS.5 The organization has plans for fire and non-fire emergencies within the facilities.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 5.1 | The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergences including community emergencies | The facility has a fire and non-fire emergency committee (FNEC) to review the facility's preparedness. The facility has conducted an exercise of hazard identification and risk analysis (HIRA) and accordingly taken all necessary steps to eliminate or reduce such hazards and associated risks. The facility has:<br>a) fire plan covering fire arising out of burning of inflammable items, explosion, electric short circuiting or act of negligence or due to incompetence of the staff on duty.<br>b) deployed adequate and qualified personnel for this<br>c) acquired adequate fire-fighting equipment for this which records are kept up-to-date.<br>d) adequate training plans<br>e) scheduled for conduct of mock fire drills<br>f) mock drill records<br>g) exit plans well displayed<br><br>The facility has a dedicated emergency illumination system which comes into effect in case of a fire. The facility takes care of non-fire emergency situations by identifying them and by deciding appropriate course of action. These may include:<br>a) terrorist attack<br>b) invasion of swarms of insects and pests<br>c) earthquake |

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| | | d) invasion of stray animals<br>e) hysteric fits of patients and/or relatives<br>f) civil disorders effecting the facility<br>g) anti-social behavior by patients/ relatives<br>h) temperamental disorders of staff causing deterioration in patient care<br>i) spillage of hazardous (acids, mercury, etc, infected materials (used gloves, syringes, tubing, sharps, etc) medical wastes (blood, pus, amniotic fluid, vomits, etc)<br>j) building or structural collapse<br>k) fall or slips (from height or on floor) or collision of personnel in passageway<br>l) fall of patient from bed<br>m) bursting of pipe lines<br>n) sudden flooding of areas like basements due to clogging in pipe lines<br>o) Sudden failure of supply of electricity, gas, vacuum, etc.<br>p) Bursting of boilers and/or autoclavesThe facility has established liaison with civil and police authorities and fire brigade as required by law for enlisting their help and support in case of an emergency. |
| 5.2 | The organization has a documented safe exit plan in case of fire and non-fire emergencies. | Fire exit plan shall be displayed on each floor particularly close to the lifts. Exist doors should remain open on the time. |
| 5.3 | Staff is trained for their role in case of such emergencies | In case of fire designated person are assigned particular work. |
| 5.4 | Mock drills are held at least twice in a year | Self explanatory |

**FMS 6 The organization has a plan for management of hazardous materials**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 6.1 | Hazardous materials are identified within the organization | Special attention to be given for management of Mercury spill and amalgam. |
| 6.2 | The hospital implements processes for sorting, handling, storage, transporting and disposal of hazardous material. | |

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| 6.3 | There is a plan for managing spills of hazardous materials | |
| 6.4 | Staff is educated and trained for handling such materials. | |

## FMS 7. The organization has system in place to provide a safe and secure environment

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 7.1 | The hospital has a safety committee to identify the potential safety and security risks. | Facility should have a RO system to supply safe water for dental chairs to prevent infection |
| 7.2 | This committee coordinates development, implementation, and monitoring of the safety plan and policies. | |
| 7.3 | Patient Safety devices are installed across the organization and inspected periodically | |
| 7.4 | Facility inspection rounds to ensure safety are conducted at least twice in a year in patient are areas and at least once in a year in non-patient care areas. | |
| 7.5 | Inspection reports are documented and corrective and preventive measures are undertaken. | |
| 7.6 | There is a safety education programme for all staff | |

# Chapter 9: Human Resource Management

**HRM.1 The Organization has a documented system of human resource planning.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient. | Self explanatory |
| 1.2 | The required job specifications and job description are well defined for each category of staff | Self explanatory |
| 1.3 | The organization verifies the antecedents of the potential employee with regards to criminal/negligence background. | Self explanatory |

**HRM.2 The staff joining the organization is socialized and oriented to the hospital environment.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Each staff member, employee student and voluntary worker is appropriately oriented to the organization's mission and policies and procedure | Self explanatory |
| 2.2 | Each staff member is made aware of his/her rights and responsibilities | The facility shall define the same in consonance with statutory requirements and the same shall be communicated to the employees. |
| 2.3 | All employees are educated with regard to patients' rights and responsibilities. | For patient rights refer to PRE 2. |

**HRM.3 There is an ongoing program for professional training and development of the staff.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 3.1 | A documented training and development policy exists for the staff. | Self explanatory |

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| 3.2 | Training also occurs when job responsibilities change/new equipment is introduced. | Self explanatory |
| 3.3 | Feedback mechanisms for assessment of training and development program exist | Self explanatory |
| 3.4 | All staff is trained on the risks within the hospital environment. | The facility shall define such risks which shall include both patient and employee related. |
| 3.5 | Staff members can demonstrate and take actions to report, eliminate/ minimize risks. | Self explanatory |
| 3.6 | Reporting processes for common problems, failures and user errors exist | The facility has a defined procedure for reporting of these events. |

**HRM.4 An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 4.1 | A well-documented performance appraisal system exists in the organization. | Self explanatory |
| 4.2 | The employees are made aware of the system of appraisal at the time of induction | Self explanatory |
| 4.3 | Performance is evaluated based on the performance expectations described in job description. | Self explanatory |
| 4.4 | Performance appraisal is carried out at pre defined intervals and is documented. | Self explanatory |

**HRM.5 The organization has a well-documented disciplinary and grievance handling mechanism procedure.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 5.1 | Documented procedures with regards to disciplinary action and grievances handling exist in | Self explanatory |

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|---|---|---|
| | the organization | |
| 5.2 | The policy and procedure is known to all categories of employees of the organization. | This implies that both parties (employee and employer) are given an opportunity to present their case and decision is taken accordingly |
| 5.3 | The disciplinary procedure is in consonance with the prevailing laws. | Self explanatory |
| 5.4 | There is a provision for appeals in all disciplinary cases. | The facilityc designate an appellate authority to consider appeals in disciplinary cases. |
| 5.5 | Actions are taken to redress the grievance | Self explantory |

**HRM.6 The organization addresses the health needs of the employees.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 6.1 | A pre-employment medical examination is conducted on all the employees | Self explanatory. This shall however be in consonance with the law of the land |
| 6.2 | Health problems of the employees are taken care of in accordance with the organization's policy. | Self explanatory. This shall be in consonance with the law of the land and good clinical practices. |
| 6.3 | Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented. | Self explanatory. The results should be documented in the personal file. |
| 6.4 | Occupational health hazards are adequately addressed. | Self explanatory |

**HRM.7 There is a documented personal record for each staff member.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 7.1 | Personal files are maintained in respect of all employees. | Self explanatory |
| 7.2 | The personal files contain personal information regarding the employees qualification, disciplinary background and health status. | Self explanatory |

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| 7.3 | All records of in-service training and education are contained in the personal files. | Self explanatory |
| 7.4 | Personal files contain results of all evaluations. | Evaluations would include performance appraisals, training assessment and outcome of health checks. |

**HRM.8 There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical and Dental professionals permitted to provide patient care without supervision.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 8.1 | Medical/ Dental professionals permitted by law, regulation and the hospital to provide patient care without supervision is identified. | The facility identifies the individuals who have the required qualification (s), training and experience to provide patient care in consonance with the law. |
| 8.2 | The education, registration, training and experience of the identified medical professionals is documented and updated periodically. | Self explanatory. Updating is done after acquisition of new skills and/or qualification |
| 8.3 | All such information pertaining to the medical/ Dental professionals is appropriately verified when possible. | The facility shall do the same by verifying the credentials from the organization which has awarded the qualification/ training |

**HRM.9 There is a process for authorizing all medical and Dental professionals to admit and treat patients and provide other clinical services commensurate with their qualifications.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 9.1 | Dental professionals admit and care for patients as per the laid down policies and authorization procedures of the organization. | The facility shall identify as to what each medical professional is authorized to do. |
| 9.2 | The services provided by the Dental professionals are in consonance with their qualification, training and registration. | Self explanatory |

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| 9.3 | The requisite services to be provided by the Dental professionals are known to them as well as the various departments/units of the hospital. | Self explanatory |

**HRM.10 There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of nursing staff/Dental Hygienist, Dental Technician and Dental Assistant**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 10.1 | The education, registration, training and experience of nursing staff/ dental Hygienist, dental, technician and dental Assistant is documented and updated periodically. | The facility identifies the individuals who have the required qualification (s), training and experience to provide nursing care to patients in consonance with the law. Updating is done after acquisition of new skills and/or qualification |
| 10.2 | All such information pertaining to the nursing/ Dental Hygienist, dental technician and Dental Assistant staff is appropriately verified when possible. | The facility shall do the same by verifying the credentials from the organization which has awarded the qualification/training |

**HRM.11 There is a process to identify job responsibilities and make clinical work assignments to all nursing staff Dental Hygienist, Dental Technician/ Dental Mechanic and Dental Assistant commensurate with their qualifications and any other regulatory requirements.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 11.1 | The clinical work assigned to nursing staff, dental hygienist, dental mechanics and assistant is in consonance with their qualification, training and registration. | The facility shall identify as to what each nurse is authorized to do. |
| 11.2 | The services provided by nursing staff, dental hygienist, dental mechanics and assistants are in accordance with the prevailing laws and regulations. | Self explanatory |

# Chapter 10. Information Management System (IMS)

**IMS.1.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 date and information from the organization.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 1.1 | The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization and the complexity of the organization. | The facility has manual and/or electronic Hospital Information System and/or Management Information System which provides relevant information to all concerned stakeholders. |
| 1.2 | Policies and procedures to meet the information needs are documented. | A policy document is available where the HIS/MIS is described |
| 1.3 | These policies and procedures are in compliance with the prevailing laws and regulations. | Self explanatory |
| 1.4 | The organization contributes to external databases in accordance with the law and regulations. | Self explanatory |

**IMS.2. The organization has processes in place for effective management of data.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 2.1 | Formats for data collection are standardized. | MIS/HIS data is collected in standardized format from all areas/services in the facility. |
| 2.2 | Necessary resources are available for analyzing data. | This could be men, material, space and budget. |
| 2.3 | Documented procedures are laid down for timely and accurate dissemination of data. | Self explanatory |
| 2.4 | Documented procedures exist for storing and retrieving data. | Self explanatory |

**IMS.3. The organization has a complete and accurate medical record for every in patient.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 3.1 | Every medical record has a unique identifier. | This shall also apply to records on digital media |
| 3.2 | Organization policy identifies those authorized to make entries in medical record. | Facility has a written policy stating who all can make entries. |
| 3.3 | Every medical record entry is dated and timed. | Self explanatory |
| 3.4 | The author of the entry can be identified. | This could be by writing the full name or by mentioning the employee code number, with the help of stamp, etc. In case of electronic based records, authorized e-signature provision as per statutory requirements must be kept. |
| 3.5 | The contents of medical record are identified and documented. | The facility identifies which documents form part of the medical records, documents and implements the same |
| 3.6 | The record provides an up-to-date and chronological account of patient care. | The facility decides the format (POMR/SOMR/IMR) for maintaining medical records. |

**IMS.4. The medical record reflects continuity of care.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 4.1 | The medical record contains information regarding reasons for admission, diagnosis and plan of care. | Self explanatory |
| 4.2 | Operative and other procedures performed are incorporated in the medical record. | Self explanatory |
| 4.3 | 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. | Self explanatory. It is mandatory to mention the clinical condition of the patient before transfer is effected |
| 4.4 | The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel. | Self explanatory. Discharge note is the same as discharge summary |

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| 4.5 | In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death. | Self explanatory. The facility provides the death certificate as per the International Certification of cause of death |
| 4.6 | Care providers have access to current and past medical record. | The facility provides access to medical records to designated health care providers (those who are involved in the care of that patient). |

**IMS.5. Policies and procedures are in place for maintaining confidentiality, integrity and security of information.**

| ***Objective Element*** | | ***Guidance*** |
|---|---|---|
| 5.1 | Documented policies and procedures exist for maintaining confidentiality, security and integrity of information | Self explanatory. This is applicable for both manual and electronic |
| 5.2 | Policies and procedures are in consonance with the applicable laws. | This is in the context of Indian Evidence Act, Indian Penal Code of medical Ethics and code of dental ethics |
| 5.3 | The policies and procedures incorporate safeguarding of data/record against loss, destruction and tampering. | For physical records the facility shall ensure that there is adequate pest and rodent control measures. For electronic data there should be protection against virus/Trojans and also a proper backup procedure. To prevent tampering, for physical records access shall be limited only to the concerned health care provider. In electronic format this could be done by adequate passwords. |
| 5.4 | Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization. | Self explanatory |
| 5.5 | 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. | Self explanatory. In this context the release of information in accordance with the Code of Medical Ethics 2002 and Code of Dental Ethics should be kept in mind. |

**IMS.6. Policies and procedures exist for retention time of records, data and information.**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 6.1 | Documented policies and procedures are in place on retaining the patient's clinical records, data and information. | Self explanatory |
| 6.2 | The policies and procedures are in consonance with the local and national laws and regulations. | Some of the related laws in this context are Code of Medical Ethics 2002, Code of Dental Ethics, Consumer protection act 1987 and relevant state legislation, if any. |
| 6.3 | The destruction of medical records, data and information is in accordance with the laid down policy. | Destruction can be done after the retention period is over and after taking approval of the competent authority. |

**IMS.7. The organization regularly carries out review of medical records and Dental records**

| *Objective Element* | | *Guidance* |
|---|---|---|
| 7.1 | The medical records are reviewed periodically. | Self explanatory |
| 7.2 | The review uses a representative sample based on statistical principles. | Self explanatory. The review could be based on conditions of clinical and/or community importance |
| 7.3 | The review is conducted by identified care providers. | Self explanatory |
| 7.4 | The review focuses on the timeliness, legibility and completeness of the medical records. | Self explanatory |
| 7.5 | The review process includes records of both active and discharged patients. | Self explanatory |
| 7.6 | The review points out and documents any deficiencies in records. | Self explanatory |
| 7.7 | Appropriate corrective and preventive measures undertaken are documented. | Self explanatory |

# GLOSSARY

The commonly used terminologies in the NABH standards are briefly described and explained herein to remove any ambiguity regarding their comprehension. The definitions narrated have been taken from various authentic sources as stated where ever possible. Notwithstanding the accuracy of the explanations given, in the event of any discrepancy with a legal requirement enshrined in the law of the land, the provisions of the latter shall apply.

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| Accreditation | 1. A process of external review of the quality of the health care being provided by a health care organization. This is generally carried out by a non-governmental organization<br>2. It also represents the outcome of the review and the decision that an eligible organization meets an applicable set of standards. |
| Accreditation survey | The evaluation process for assessing the compliance of an organization with the applicable standards for determining its accreditation status.<br><br>NABH survey includes the following:<br>a) Documentation review.<br>b) Facility tour<br>c) Interview of staff, patients and visitors<br>d) On-site observations by surveyors<br>e) Education about standards compliance |
| Advance life support | Emergency medical care for sustaining life, including defibrillation, airway management, and drugs and medications.<br><br>The main algorithm of ALS, which is invoked when actual cardiac arrest has been established, relies on the monitoring of the electrical activity of the heart on a cardiac monitor. Depending on the type of cardiac arrhythmia, defibrillation is applied, and medication is administered. Oxygen is administered and endotracheal intubation may be attempted to secure the airway. At regular intervals, the effect of the treatment on the heart rhythm, as well as the presence of cardiac output, is assessed.<br><br>Medication that may be administered may include adrenaline (epinephrine), amiodarone, atropine, bicarbonate, calcium, potassium and magnesium. Saline or colloids may be administered to increase the circulating volume. |

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| | While CPR is given (either manually, or through automated equipment such as AutoPulse), members of the team consider eight forms of potentially reversible causes for cardiac arrest, commonly abbreviated as "4H4T":<br>• Hypoxia (low oxygen levels in the blood)<br>• Hypovolemia (low amount of circulating blood, either absolutely due to blood loss or relatively due to vasodilatation)<br>• Hyperkalemia or hypokalemia (disturbances in the level of potassium in the blood) and related disturbances of calcium or magnesium levels and hypoglycaemia (low glucose levels).<br>• Hypothermia (under-cooling)<br>• Tension pneumo-thorax (tear in the lung leading to collapsed lung and twisting of the large blood vessels)<br>• Tamponade (fluid or blood in the pericardium, compressing the heart)<br>• Toxic and/or therapeutic (chemicals, whether medication or poisoning)<br>• Thrombo-embolism and related mechanical obstruction (blockage of the blood vessels to the lungs or the heart by a blood clot or other material) |
| Amalgam | This is a mixture of silver alloy and mercury to prepare a restorative material used in the cavities of teeth. The union of mercury with an alloy of other metals is accomplished by the process of amalgamation. Silver alloy is a mixture of silver And tin with small amounts of copper and zinc. (CLINICAL PEDODONTICS FINN) |
| Ambulance | A patient carrying vehicle having facilities to provide unless otherwise indicated at least basic life support during the process of transportation of patient. There are various types of ambulances that provide special services viz. coronary care ambulance, trauma ambulance, air ambulance, etc. |
| Anaesthesia | It consists of general anaesthesia and spinal or major regional anaesthesia and does not include local anaesthesia. General anaesthesia is a drug-induced loss of consciousness during which patient cannot be aroused even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. |
| Assessment | All activities including history taking, physical examination, laboratory investigations that contribute towards determining the prevailing clinical status of the patient. |
| Autopsy | 1 An examination of a cadaver in order to determine the cause of death or to study pathologic changes.<br>2. A surgical procedure performed after death to examine body tissues and determine the cause of death |

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| Barrier nursing | Type of nursing for Immuno-compromised patients with a view to prevent any secondary infections e.g. use of gloves, masks and relatively disinfected environment. |
| Basic life support | Emergency procedures performed to sustain life that include cardiopulmonary resuscitation, control of bleeding, treatment of shock, stabilization of injuries and wounds and first, aid.Basic life support consists of a number of life-saving techniques which are focused on the "ABC"s of pre-hospital emergency care:<br>• **Airway**: the protection and maintenance of patient airway including the use of airway adjuncts such as an oral or nasal airway<br>• **Breathing**: the actual flow of air through respiration, natural or artificial respiration, often assisted by emergency oxygen<br>• **Circulation**: the movement of blood through the beating of the heart or the emergency measure of CPR<br><br>BLS may also include considerations of patient transport such as the protection of the cervical spine and avoiding additional injuries through splinting and immobilization. |
| Bylaws | A rule governing the internal management of an organization. It can supplement or complement the government law but cannot countermand it. e.g. municipal bylaws for construction of hospitals/nursing homes, for disposal of hazardous and/or infectious waste |
| Cast | In Dentistry should always imply that it is an accurate reproduction of the tissues being studied or on which restoration may be fabricated.<br>(McCracken's removable partial Prosthodontics) |
| Clincal audit | Analysis of clinical aspects of patient care for improving the quality of health care services e.g. tissue audit, X-Ray audit, lab investigation audit, etc. |
| Clinical practice guidelines | Guidelines that assist practitioners to provide appropriate clinical care for specific clinical conditions, for example recommendation on management of cerebral malaria. The guidelines include relevant history taking, physical signs to look for, lab investigations to be carried out and treatment to be prescribed. |
| Competence | Demonstrated ability to apply knowledge and skills.<br>Knowledge is the understanding of facts and procedures. Skill is the ability to perform specific action. For example, a competent gynaecologist knows about the patho-physiology of the female genitalia and can conduct both normal as well as abnormal deliveries. |
| Confidentiality | Restricted access to information to individuals who have a need, a reason and permission for such access. It also includes an individual's right to personal privacy as well as privacy of information related to his/her health care records. |

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| Consent | 1. Willingness of a party to undergo examination/procedure/ treatment by a health care provider. It may be implied (e.g. patient registering in OPD), expressed which may be written or verbal. Informed consent is a type of consent in which the health care provider has a duty to inform his/her patient about the procedure, its potential risk and benefits, alternative procedure with their risk and benefits so as to enable the patient to take an informed decision of his/her health care.<br>2. In law, it means active acquiescence or silent compliance by a person legally capable of consenting. In India legal age of consent is 18 years. It may be evidenced by words or acts or by silence when silence implies concurrence. Actual or implied consent is necessarily an element in every contract and every agreement. |
| Credentialing | The process of obtaining, verifying and assessing the qualification of a health care provider. |
| Data | Raw facts, clinical observations, or measurements collected during an assessment activity. |
| Dental Laboratory: Laboratory Procedure Authorizations | The written instructions sent to commercial laboratories. It serves two primary functions (1) it identifies the laboratory procedures delegated to the technician, the materials to be used and any special instructions requested by the dentist that differ from customary laboratory procedures and, (2) it is a legal document that may be used in arbitration between the dentist & laboratory technician or in cases of alleged illegal practice of dentistry.<br><br>The laboratory procedure authorization should contain the following information:<br>1) name& address of the dental laboratory to which the work is sent<br>2) name& address of the dentist delegating the laboratory work<br>3) the date of the work authorization<br>4) identification of the patient<br>5) specific instructions for the work to be performed by the laboratory technicians<br>6) desired date the work is to be completed<br>7) signature of the dentist; and<br>8) the registered licence number of the dentist<br><br>Laboratory Procedure Authorizations are prepared in duplicate .The original copy is sent to the laboratory. The copy is retained in the dentist's file. It should be retained by the dentist & laboratory for atleast two years. (John E.Ward, Essentials of complete denture prosthodontics Sheldon Winkler Pg 292-293) |
| Discharge summary | A part of a patient record that summarizes the reasons for admission, significant clinical findings, procedures performed, treatment rendered, patient's condition on discharge and any specific instructions given to the patient or family (for example follow-up medications). |

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| Disciplinary proceedings | Sequence of activities to be carried out when staff does not conform to the laid down norms, rules and regulations of the health care organization. |
| Employees | All members of the health care organization who are employed full time and are paid suitable remuneration for their services as per the laid down policy. |
| End of life | Period of time marked by disability or disease that is progressively worse until death. |
| Ethics | Medical ethics is the discipline of evaluating the merits, risks, and social concerns of activities in the field of medicine.(en.wikipedia.org/wiki/Medical ethics) |
| Evidence based medicine | 1.It is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patient<br>2. It also implies making medical decisions and applying the same to patients based on the best external evidence combined with the physician's clinical expertise and the patient's desires. |
| Family | The person(s) with a significant role in the patients' life. It mainly includes spouse, children, and parents. It may also include a person(s) not legally related to the patient but can make health care decisions for a patient if the patient loses decision making ability. |
| Formulary | An approved list of prescription drugs that a health care facility may provide to their clientele. Some plans restrict prescriptions to those contained on the formulary and others also provide non-formulary prescriptions. Drugs contained on the formulary are generally those that are determined to be cost effective and medically effective.<br>The list is compiled by professionals and physicians in the field and is updated preferably each year Changes may be made depending on availability or market. |
| Grievance handling procedures | Sequence of activities carried out to address the grievances of patients, visitors, relatives and staff. |
| Hazardous materials | Substances dangerous to human and other living organisms. They include radioactive or chemical materials. |
| Hazardous waste | Waste materials dangerous to living organisms. Such materials require special precautions for disposal .They include biologic waste that can transmit disease (for example, blood, tissues) radioactive materials, and toxic chemicals. Other examples are infectious waste such as used needles, used bandages and fluid soaked items. |
| Health care organization | Generic term is used to describe the various types of organization that provide health care services. This includes ambulatory care centres, hospitals, laboratories, etc. |

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| High dependency unit | A high dependency unit (HDU) is an area for patients who require more intensive observation, treatment and nursing care than are usually provided for in a general ward. It is a standard of care between the general ward and full intensive care. |
| Impression | Defined as an imprint or negative likeness of the teeth, of the edentulous areas where the teeth have been removed, or of both, made in a plastic material that becomes relatively hard or set while in contact with these tissues. (George E. Smutko Essentials of complete denture prosthodontics Sheldon Winkler Pg 88). |
| In service education/ training | Organized education/ training usually provided in the workplace for enhancing the skills of staff members or for teaching them new skills relevant to their jobs/ tasks. |
| Indicator | A statistical measure of the performance of functions, systems or processes overtime. For example, hospital acquired infection rate, mortality rate, caesarean section rate, absence rate, etc. |
| Information | Processed data which lends meaning to the raw data. |
| Intent | A brief explanation of the rational, meaning and significance of the standards laid down in a particular chapter. |
| Inventory control | The method of supervising the intake, use and disposal of various goods in hands. It relates to supervision of the supply, storage and accessibility of items in order to ensure adequate supply without stock outs/excessive storage. It is also the process of balancing ordering costs against carrying costs of the inventory so as to minimise total costs. |
| Isolation | Separation of an ill person who has a communicable disease (e.g., Measles, chicken pox, mumps, SARS) from those who are healthy. Isolation prevents transmission of infection to others and also allows the focused delivery of specialized health care to ill patients. The period of isolation varies from disease to disease. Isolation facilities can also be extended to patients for fulfilling their individual, unique needs. |
| Job description | 1. It entails an explanation pertaining to duties, responsibilities and conditions required to perform a job.<br>2. A summary of the most important features of a job, including the general nature of the work performed (duties and responsibilities) and level (i.e., skill, effort, responsibility and working conditions) of the work performed. It typically includes job specifications that include employee characteristics required for competent performance of the job. A job description should describe and focus on the job itself and not on any specific individual who might fill the job. |

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| Job specification | 1. The qualifications/physical requirements, experience and skills required to perform a particular job/task.<br><br>2. A statement of the minimum acceptable qualifications that an incumbent must possess to perform a given job successfully. |
| Laws | Legal document setting forth the rules of governing a particular kind of activity e.g. organ transplantation act which governs the rules for undertaking organ transplantation. |
| Medical audit | A peer review carried out by analysis of medical records with a view to improve the quality of the patient care |
| Medical equipment | Any fixed or portable non drug item or apparatus used for diagnosis, treatment, monitoring and direct care of patient. |
| Mission | A written expression that sets forth the purpose of the organization. It usually precedes the formation of goals and objectives. |
| Model | Term used to only designate a reproduction for display or demonstration purpose. A model of a dental arch or any portion thereof may be made of durable and attractive material. it need not be an accurate reproduction but should be a reasonable facsimile of the original.(McCracken's removable partial prosthodontics) |
| Monitoring | The performance and analysis of routine measurements aimed at identifying and detecting changes in the health status or the environment, e.g. monitoring of growth and nutritional status, air quality in operation theatre. It requires careful planning and use of standardised procedures and methods of data collection. |
| Multi-disciplinary | A generic term which includes representatives from various disciplines, professions or service areas. |
| Nosocomial/ hospital acquired/ hospital associated infection (s) | An infection occurring in a patient in a hospital or other healthcare facility in whom it was not present or incubating at the time of admission; or the residual of an infection acquired during a previous admission. Includes infections acquired in the hospital but appearing after discharge, and also such infections among the staff of the facility (Synonym: hospital-acquired-infection).(www.hardydiagnostics.com/ Glossary N.html) |

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| Notifiable disease | Certain specified diseases which are required by law to be notified to the public health authorities. Under the international health regulation the following diseases are notifiable to WHO:-<br>(a) Cholera<br>(b) Plague<br>(c) Yellow fever<br><br>In India the following diseases are also notifiable and may vary from state to state:<br>(a) Polio<br>(b) Influenza<br>(c) Malaria<br>(d) Rabies<br>(e) HIV/AIDS<br>(f) Louse-borne typhus<br>(g) Tuberculosis<br>(h) Leprosy<br>(i) Leptospirosis<br>(j) Viral hepatitis<br>(k) Dengue fever<br><br>The various diseases notifiable under the factories act are lead poisoning, bysinnosis, anthrax, asbestosis and silicosis. |
| Objective element | It is that component of standard which can be measured objectively on a rating scale. The acceptable compliance with the measureable elements will determine the overall compliance with the standard. |
| Occlusion | It refers to the contact relationship of the teeth resulting from neuro-muscular control of the masticatory system (musculature, temporomandibular joints, mandible and the periodontium). Clinical Periodontology Carranza Newman. |
| Occupational health hazard | The hazards to which an individual is exposed during the course of performance of his job. These include physical, chemical, biological, mechanical and psychosocial hazards. |
| Organogram | A graphic representation of reporting relationship in an organization. |
| Outsourcing | Hiring of services and facilities from other organization based upon ones own requirement in areas where such facilities are either not available or else are not cost-effective. e.g. outsourcing of house keeping, security, laboratory/certain special diagnostic facilities with other institutions after drawing a memorandum of understanding that clearly lays down the obligations of both the organizations, the one which is outsourcing and the one which is providing the outsourced facility. It also addresses the quality related aspects. |

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| Patient care setting | The location where a patient is provided health care as per his needs e.g. ICU, speciality ward, private ward and general ward. |
| Patient record/ medical record/clinical record | A document which contains the chronological sequence of events that a patient undergoes during his stay in the health care organization. It includes demographic data of the patient, assessment findings, diagnosis, consultations, procedures undergone, progress notes and discharge summary. (Death certificate where required). |
| Performance appraisal | It is the process of evaluating the performance of employees during a defined period of time with the aim of ascertaining their suitability for the job, potential for growth as well as determining training needs. |
| Plan of care | A plan that identifies patient care needs, lists the strategy to meet those needs, documents treatment goals and objectives, outlines the criteria for ending interventions, and documents the individual's progress in meeting specified goals and objectives. The format of the plan may be guided by specific policies and procedures, protocols, practice guidelines or a combination of these. It includes preventive, promotive, curative and rehabilitative aspects of care. |
| Policies | They are the guidelines for decision making, e.g. admission, discharge policies, antibiotic policy, etc. |
| Privileging | It is the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications and skills. |
| Procedure | 1. A specified way to carry out an activity or a process.<br>2. A series of activities for carrying out work which when observed by all help to ensure the maximum use of resources and efforts to achieve the desired output. |
| Process | A set of interrelated or interacting activities which transforms inputs into outputs |
| Program | A sequence of activities designed to implement policies and accomplish objectives |
| Protocol | A plan or a set of steps to be followed in a study, an investigation or an intervention. |
| Quality | 1. Degree to which a set of inherent characteristics fulfil requirements; Characteristics imply a distinguishing feature; Requirements are a need or expectation that is stated, generally implied or obligatory.<br>2. Degree of adherence to pre-established criteria or standards. |
| Quality assurance | Part of quality management focussed on providing confidence that quality requirements will be fulfilled. |

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| Re-assessment | It implies continuous and on-going assessment of the patient which are recorded in the medical records as progress notes. |
| Resources | It Implies all inputs in terms of men, material, money, machines, minutes (time), methods, meters (space), skills, knowledge and information that are needed for efficient and effective functioning of an organization. |
| Restraints | Devices used to ensure safety by restricting and controlling a person's movement. Many facilities are "restraint free" or use alternative methods to help modify behaviour. |
| Risk management | Clinical and administrative activities to identify, evaluate and reduce the risk of injury. |
| Safe transfer | In these standards refers to Transfer of the patients who are in In-patient department and those who have any kind of complications on the Dental chair. |
| Safety | The degree to which the risk of an intervention/ procedure, in the care environment are reduced for a patient, visitors and health care providers. |
| Scope of services | Range of clinical and supportive activities that are provided by a health care organization. |
| Security | Protection from loss, destruction, tampering, and unauthorized access or use. |
| Sedation | The administration to an individual, in any setting for any purpose, by any route, moderate or deep sedation. There are three levels of sedation:<br><br>Minimal sedation (anxiolysis) A drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, vertilatory and cardiovascular functions are not affected.<br><br>Moderate sedation / analgesia (Conscious sedation) – A drug induced depression of consciousness during which patients respond purposefully to verbal commands either alone or accompanied by light tactile stimulation. No interventions are needed to maintain a patent airway.<br><br>Deep sedation/Analgesia – A drug induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. Patients may need help in maintaining a patent airway. |

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| Sentinel events | A relatively infrequent, unexpected incident, related to system or process deficiencies, which leads to death or **major and enduring loss of function*** for a recipient of health care services<br><br>* **Major and enduring loss of function** *refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition* |
| Social rresponsibility | A balanced approach for organization to address economic, social and environmental issues in a way that aims to benefit people, communities and society, e.g. adoption of villages for providing health care, holding of medical camps and proper disposal of hospital wastes. |
| Staff | All personnel working in the organization either as full paid employees or as consultants on honorarium basis. |
| Standard precautions | 1. A method of infection control in which all human blood and other bodily fluids are considered infectious for HIV, HBV and other blood-borne pathogens, regardless of patient history. It encompasses a variety of practices to prevent occupational exposure, such as the use of personal protective equipment (PPE), disposal of sharps and safe housekeeping<br>2. A set of guidelines protecting first aiders or healthcare professionals from pathogens. The main message is "Don't touch or use anything that has the victim's body fluid on it without a barrier." It also assumes that all body fluid of a patient is infectious, and must be treated accordingly<br><br>**Standard Precautions** apply to Blood, all body fluids, secretions, and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin and mucous membranes. |
| Standards | A statement of expectation that defines the structures and process that must be substantially in place in an organization to enhance the qualify of care. |
| Sterilization | It is the process of killing or removing microorganisms including their spores by thermal, chemical or irradiation means. |
| Surveillance | The continuous scrutiny of factors that determines the occurrence and distribution of diseases and other conditions of ill health. It implies watching over with great attention, authority and often with suspicion. It requires professional analysis and sophisticated interpretation of data leading to recommendations for control activities. |
| Unstable patient | A patient whose vital parameters need external assistance for their maintenance. |

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| Validation | 1. Confirmation through the provision of **objective evidence** that the requirements for a specific intended use or application have been fulfilled<br>**Objective Evidence** – Data supporting the existence or variety of something<br><br>2. The checking of data for correction or for compliance with applicable standards, rules or conventions. These are the tests to determine whether an implemented system fulfils its requirements. It also refers to what extent does a test accurately measures what it purports to measure. |
| Vulnerable patient | Those patients who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status, e.g. infants, elderly, physically and mentally challenged those on immunosuppressive and/or chemotherapeutic agents. |

# REFERENCE GUIDE ON SENTINEL EVENTS

**Definition:**

An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function* for a recipient of health care services.

*Major and enduring loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.*

**Event type description**

**1. Surgical events**

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on the wrong patient
- Retained instruments in patient discovered after surgery/procedure
- Patient death during or immediately post surgical procedure
- Anesthesia related event

**2. Device or product events** Patient death or serious disability associated with:

- the use of contaminated drugs, devices, products supplied by the organization
- the use or function of a device in a manner other than the device's intended use
- the failure or breakdown of a device or medical equipment
- intravascular air embolism

**3. Patient protection events**

- Discharge of an infant to the wrong person
- Patient death or serious disability associated with elopement from the health care facility
- Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability
- Intentional injury to a patient by a staff member, another patient, visitor, or other
- Any incident in which a line designated for oxygen or other came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances
- Nosocomial infection or disease causing patient death or serious disability

**4. Environmental events**

Patient death or serious disability while being cared for in a health care facility associated with:

- a burn incurred from any source
- a slip, trip, or fall
- an electric shock
- the use of restraints or bedrails

## 5. Care management events

- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy
- Medication error leading to the death or serious disability of patient due to incorrect administration of drugs, for example:
    - omission error
    - dosage error
    - dose preparation error
    - wrong time error
    - wrong rate of administration error
    - wrong administrative technique error
    - wrong patient error

  Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results

## 6. Criminal events

- Any instance of care ordered by or provided by an individual impersonating a clinical member of staff
- Abduction of a patient
- Sexual assault on a patient within or on the grounds of the health care facility
- Death or significant injury of a patient or staff member resulting from a physical assault or other crime that occurs within or on the grounds of the health care facility.