national health authority
सत्यमेव जयते

QCI

BRONZE QUALITY CERTIFICATION STANDARDS

FOR AYUSHMAN BHARAT PMJAY EMPANELLED HOSPITALS

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

2019
(Amended in November 2021)

TABLE OF CONTENT

MESSAGE CEO, NHA

national health authority
सत्यमेव जयते

Dr. R.S. Sharma
Chief Executive Officer

सत्यमेव जयते

भारत सरकार
Government of India
राष्ट्रीय स्वास्थ्य प्राधिकरण
National Health Authority

18th November, 2021

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is the flagship scheme of the Government of India and the world's largest health assurance scheme that provides a cover of up to ₹5 lakh per family per year, for secondary and tertiary care hospitalization to over 10.74 crore vulnerable entitled families (approximately 50 crore beneficiaries). PM-JAY provides cashless and paperless access to over 1,670 health benefit packages across a network of over 25,000 empanelled hospitals and health care providers in the country.

The overall vision of AB PM-JAY is to provide affordable, accessible, and quality healthcare to all beneficiaries. PM-JAY aims to enable equitable access to the poorest households with a comprehensive package of patient-centred quality health services. For establishing AB PM-JAY Quality Certification processes, the NHA has collaborated with the Quality Council of India (QCI) to use its well-established systems.

Leveraging their expertise, we are able to offer higher reimbursement rates to hospitals that are certified / accredited by National Accreditation Board for Hospitals & Healthcare Providers (NABH) and other bodies. These reimbursement rates vary across three levels of AB PM-JAY Quality Certification: Bronze, Silver and Gold, with Gold being the highest level. These levels are defined based on the level certification / accreditation by NABH or NQAS.

I am grateful to the QCI and other stakeholders who have participated in the consultation process and provided valuable suggestions in building the AB PM-JAY Quality Certification process. We intend to continuously innovate and enhance the design of the scheme based on our experiences during its implementation.

18/x/

Dr. Ram Sewak Sharma
Chief Executive Officer,
National Health Authority,
Ministry of Health & Family Welfare

3rd, 7th & 9th Floor, Tower-I, Jeevan Bharati Building, Connaught Place, New Delhi-110001
Tel.: 011-2346 8908, 011-2346 8915 E-mail : rssharma3@gmail.com Website: www.pmjay.gov.in

Adil Zainulbhai
Chairman

Quality Council of India
2nd Floor, Institution of Engineers Building,
Bahadur Shah Zafar Marg,
New Delhi - 110 002. India

MESSAGE

Since the onset of the pandemic, a spotlight has been cast on the importance of healthcare quality, affordability, access and efficiency. The health care delivery landscape and the behaviours of consumers it serves have pivoted dramatically, and new preferences and practices are likely to remain in place post pandemic. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PMJAY) will play an important role in solving these challenges and improving the quality of healthcare for all Indians.

Quality Council of India (QCI), with its mandate to improve quality in all aspects of life for Indian citizens, is proud to join hands with the National Health Agency (NHA) to launch a Quality Certification Scheme to ensure and improve the quality of hospitals of all sizes. With the launch of 'Bronze Quality Certification', the first certification of three, a majority of small hospitals in India (~75%) will be able to start their journey to improve quality. The other two certifications, Silver and Gold, are equivalent to existing certification/accreditation of nationally or internally recognised accreditation body.

This joint initiative is also a leap toward accomplishing the Sustainable Development Goal (SDG-3: Good Health and Wellbeing) of ensuring healthy lives and promoting well-being for all. This partnership shall also strive to become a global benchmark for both centre and state healthcare institutions while significantly strengthening the healthcare ecosystem in India.

I extend my appreciation to all those who contributed to the development of this certification process, especially the 'Bronze Certification Standards'. I would like to thank teams of NHA and QCI for ensuring that this joint initiative helps empanelled and non-empanelled hospitals to enhance the quality of services and leads toward the path of continuous development. QCI is committed to extending its support to such initiatives in the future, and to contribute to and strengthen the quality of the healthcare sector.

(Adil Zainulbhai)

MESSAGE FROM SECRETARY GENERAL

Quality Council of India
2nd Floor, Institution of Engineers Building,
Bahadur Shah Zafar Marg,
New Delhi - 110 002, India

MESSAGE

Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB PMJAY) is one of the key programmes launched by Hon'ble Prime Minister, Shri Narendra Modi, to provide an ecosystem of quality and affordable healthcare for poor and underprivileged citizens of the country. It also aims to enhance institutional capacities with time.

Quality Council of India (QCI) is proud to be involved in the 'World's largest government funded healthcare program' with National Health Authority (NHA) to ensure that the hospitals are well-equipped and have adopted patient-centric approach. Therefore, a seamless mechanism has been developed to provide certification to the AB PMJAY empanelled and non-empanelled hospitals to benchmark them on the quality parameters.

Three certification levels have been devised for the hospitals in a hierarchical order as AB PMJAY Bronze, Silver and Gold Quality Certification. The certification would also enable hospitals to comply with quality protocols, improve patient safety and overall healthcare facility of the organization. The initiative will help the hospitals to get fast-track certification while obtaining a financial incentive from NHA based on their compliance status.

The certification process was meticulously designed with the help of healthcare experts to ensure that the critical parameters are covered and continuously validated. Bronze quality standards are the new set of standards with the minimum certification criteria. The Silver quality certification is benchmarked to NABH's Entry-Level certification. NABH's Full Accreditation/ National NQAS certification is benchmarked to AB PMJAY Gold quality certification.

Amid the COVID-19 spread, the healthcare sector went through foundational shift that led government, healthcare providers and other stakeholders around the globe being challenged to pivot, adapt and innovate. To achieve the prime focus of the AB PMJAY scheme, the certification process was developed to motivate healthcare providers and increase the access to quality healthcare, also went through rapid adoption of virtual health and digital innovation.

Our mission is to establish a thrust in quality practices offered by hospitals, which will give necessary boost to initiate good healthcare practices. Both NHA and QCI realise that working together is desirable to promote public health and strengthen healthcare delivery for all.

I thank everyone who have worked towards drafting the new roadmap to monitor healthcare delivery. Special thanks to our board National Accreditation Board of Hospitals and Healthcare Providers (NABH), Association of Healthcare Providers in India (AHPI), teams of NHA and QCI. I am sure that our combined efforts will expand the network of quality healthcare institutions in India.

(Dr. Ravi P. Singh)
Secretary General

ABBREVIATIONS

AB PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
AERB	Atomic Energy Regulatory Board
ALS	Average Length of Stay
BLS	Basic Life Support
BMW	Bio-Medical Waste
BP	Blood Pressure
BSI	Blood Stream Infection
C-PAP	Continuous Positive Airway Pressure
CPR	Cardio Pulmonary Resuscitation
CS	Clinical Services
CSSD	Central Sterile Supply Department
DPIIT	Department for Promotion of Industry and Internal Trade
ECG	Electro-Cardiogram
GoI	Government of India
HAP	Hospital Acquired Pneumonia
HBP	Heath Benefit Packages
HEM	Hospital Empanelment
HO	Health Outcomes
ICU	Intensive Care Unit
IEC	Information Education Communication
IPD	In-Patient Department
JCI	Joint Commission International
KI	Key Inputs
MLC	Medico Legal Cases
MoU	Memorandum of Understanding
NABCB	National Accreditation Board for Certification Bodies
NABET	National Accreditation Board for Education and Training

ABBREVIATIONS

NABH	National Accreditation Board for Hospitals and Healthcare Providers
NABL	National Accreditation Board for Testing and Calibration Laboratories
NBQP	National Board for Quality Promotion
NHA	National Health Authority
NITI	National Institution for Transforming India
NOC	No Objection Certificate
NQAS	National Quality Assurance Standards
OPD	Out-Patient Department
OT	Operation Theatre
PASS	Pull, Aim, Squeeze, and Sweep
PC	Patient Care
PC&PNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PPE	Personal Protective Equipment
QCI	Quality Council of India
RACE	Rescue, Alarm, Confine, Extinguish/Evacuate
RO	Reverse Osmosis
SDG	Sustainable Development Goals
SHCO	Small Health Care Organization
SS	Support Services
TMS	Transaction Management System
TLD	Thermo-luminescent Dosimeter
UPS	Uninterruptible Power Supply
VAP	Ventilator Associated Pneumonia
ZED	Zero Defect Zero Effect

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PMJAY) is the world's largest government-funded healthcare scheme that entails providing healthcare benefits to the under-privileged section of the society. The scheme was launched on September 23, 2018 by Shri Narendra Modi at Ranchi, Jharkhand. The aim is to ensure that all the citizens of India receive healthcare services by making them accessible, cashless and paperless. The scheme has two components: the transformation of existing sub-centers and Primary Health Centers into Health Wellness Centres to cater to the primary services and providing insurance coverage for secondary and tertiary hospitalization. As per the lateral component, financial support of Rs 5 lakh will be provided to nearly 100 million families covering approximately 500 million individuals (~40% population) of the country.

'Quality healthcare' is one of the mottos of the scheme

The scheme plans to build a comprehensive healthcare ecosystem in India by bringing together all the stakeholders in terms of State Governments and Private institutions to result in Universal Healthcare Coverage. As a result, 33 Indian States and Union Territories have agreed to adopt and implement the Center's AB PMJAY scheme. As of July 29, 2021, a strong network of nearly 22,256 empanelled hospitals have been created that can be accessed by the registered beneficiaries and out of which 1,94,86,866 beneficiaries have already used the available services. To further ease the process, services to be availed are categorized into 1592 procedures covering pre- and post-hospitalization, diagnostics, medicines, etc. It is considered to be a major shift in the Indian healthcare horizon where for the first-time people are being treated with no limitation on family size and age.

'Quality healthcare' is one of the mottos of the scheme. Continuous efforts are being made by the authorities to set clearer guidelines that require stringent enforcement to create a robust regulatory framework for the scheme. It, therefore, becomes critical to define a quality framework based on the basic principles of patient safety that enables monitoring and measure adverse events and take corrective and preventive measures as and when required. Since the treatment rates are fixed and healthcare providers vary based on the type of hospital and State regulations so high-quality treatment becomes a key focus area of the scheme. To improve the quality of healthcare, National Health Authority (NHA) has collaborated with the Quality Council of India (QCI) to use their well-established systems, skillset and credibility to start a quality certification process. It will be used as a catalyst to enhance patient satisfaction and improve quality standards across AB PMJAY empanelled hospitals.

The goal is to build a network of healthcare providers delivering quality clinical and support services while following the healthcare protocols. The process of quality certification will ensure that the hospitals are demonstrating commitment towards quality care and raising the bar for other network hospitals to follow. It will also help them to create a distinct representation and boost the confidence of beneficiaries in the services being provided. NHA plans to incentivize the certified hospitals with higher reimbursement rates over and above the packages decided under AB PMJAY. Financial incentives are provided to the AB PM-JAY Bronze Quality Certified and NABH certified hospitals based on the status of their certification/accreditation.

To ensure that all the hospitals can comply with the certification process a new criterion has been developed. Thus, creating three levels of AB PM-JAY quality certifications that are, Bronze, Silver and Gold in the said chronological order. The levels differ in terms of their certification criteria, financial incentivization, and provides leverage to the empanelled hospitals that are already certified by nationally or internationally recognized accreditation bodies (NQAS, NABH and JCI). NABH's Entry-Level/ NQAS certified hospitals can apply directly for AB PMJAY Silver quality certification and hospitals with NABH's Accreditation/JCI accreditation can apply for AB PMJAY Gold quality certification directly. The hospitals which are not certified by any accreditation body will have to apply for the bronze certificate to get the quality certification.

The certification process involves registration, uploading of documents and submission of nominal fees, followed by desktop and the subsequent on-site assessment using a technology platform. Based on the compliance status of the hospital's assessment the result will be declared on the technology portal. The initiative will help the hospitals to get fast-track and hassle-free certification while obtaining a financial incentive (Bronze) from NHA based on their compliance status. The certification assures that the standard procedures and services provided by the hospitals meet the highest quality benchmark. As the certification will not only enable them to comply with quality protocols, but it will also improve patient safety and the overall healthcare facility of the organization.

COLLABORATION BETWEEN NHA AND QCI

National Health Authority (NHA) and Quality Council of India (QCI) has signed an MoU for launching a joint initiative of digital quality certification for Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB PMJAY) empanelled hospitals. The initiative will help the hospitals to get fast-track certification while enhancing their quality of healthcare services.

The partnership aims to create a process to facilitate the certification of empanelled hospitals to build a network of quality healthcare providers. The MoU seeks to put in place a simple, swift, transparent, and paperless mechanism to encourage hospitals to apply for certification.

The two organizations have come together to ensure that the Indian healthcare ecosystem further strengthens by focusing on quality care and patient safety.

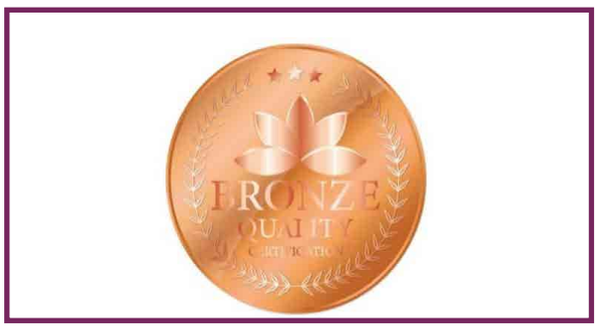
BRONZE QUALITY CERTIFICATION

Overview

Patient Safety has been a fundamental principle in implementing healthcare all over the world. There is a widespread global awakening around this principle. A patient safety movement, therefore, has to be created to achieve safe, high-quality, and high-value care rooted in continuous quality improvement.

Hospitals have followed various practices over time to address patient-centric issues. It is, however, now required to validate and evaluate the practices to ensure that they are compliant as per the healthcare protocols. Also, to encourage both public and private sector hospitals to adopt the minimum quality assurance practices that comprise medical and non-medical parameters. Therefore, the Bronze Quality Certification Standards have been laid out to ensure that patient safety is an integral part of all the healthcare practices being followed by hospitals. It is the most basic level of certification that promises quality assured safe care to patients across the health sector in the country.

Bronze quality certification is the first step towards improvement in patient safety and quality of care. Once the bronze quality certification is achieved, the hospital can then prepare and move to the next stage i.e. Silver Quality Certification, and finally to the Gold Quality Certification. This methodology provides a step-by-step and staged approach, which is practical and achievable at the same time for the hospitals.



The bronze quality certificate is a pre-entry level certificate in AB PMJAY Quality Certification that intends to develop the necessary thrust to initiate quality practices in the health sector, especially in Small Health Care Organizations (SHCOs). It also aims to bring both private and public AB PMJAY empanelled hospitals at par in terms of quality of service provided by them since the standards remain the same for all kinds of hospitals irrespective of their ownership.

Salient Features

Following are the salient features of the AB PMJAY Bronze Quality Standards:

1. **Comprehensive**: The standards are inclusive and capture all the aspects of patient care and safety. The certification criteria are accompanied by commensurate means of verification making the standards easier to understand and implement.

2. **User Friendly:** The certification criteria have been drafted in a way to avoid complex language and jargon. The standards are also universally applicable as they remain the same

for all kinds of hospitals irrespective of their ownership and the scope of services provided. So that the standards remain user-friendly for easy understanding and implementation by the healthcare providers.

3. **Evidence-Based:** The certification criteria have been developed after consulting various healthcare experts, referring to the best practice manuals available on quality, and studying the healthcare scenario around the globe. Each question is linked to the verification of a document or pictorial evidence to make the certification process robust.

4. **Digital Certification:** The assessment for the certification encompassing desktop and onsite assessment would be done using the technology platform. Each standard is evaluated based on a series ofquestions that are verified using relevant documents or geo-tagged and geo-stamped photographs to measure the compliance status. The use of technology efforts will ensure that the assessment process is transparent and efficient.

5. **Objectivity:** Clear means of verification have been laid out for each standard so that the assesses and assessors have similar interpretations. The aim is also to engage the hospitals in the process and help them comprehend easily the areas where they have to improve further.

6. **Balanced:** All the three components of Quality – Structure, Process, and Outcomes are given due importance while preparing the Bronze Quality Standards.

Eligibility

Hospitals that are empaneled with the AB PM-JAY scheme and do not possess any accreditation or certification from any other recognized certification body (NQAS, NABH and JCI) can apply for this certificate.

Process

Hospitals need to login into the HEM portal and register themselves for the certification process by clicking on the 'Apply for Certification' button on the portal. They will then be redirected to another portal where application-related required information has to be filled in while uploading the relevant documents and then submitting the application along with the payment of the nominal application fee. Once the application is submitted, it will go through the 'Desktop Assessment Process' where the provided information and uploaded documents will be checked and verified. In case any deviations are found in the application during the 'Desktop Assessment Process' the Non-Compliances (NCs) will be raised and the hospital will be offered two chances for rectification of the same. Only after the application of the hospital clears the desktop assessment part, their application will be transferred to the 'Onsite Assessment Process'. The hospitals will be allocated a date of assessment, under this process hospital premises will be physically verified by an assessor, and data will be collected using the mobile-based application. Later, the

data captured will be reviewed and in case any deviations are found, Non-Compliances (NCs) will be raised and the hospitals will be given one

The steps of the certification process are as follows:

1. Login on HEM Portal
2. Click "Apply for certificate"
3. Fill the "Registration Form"
4. Fill up the "Application Form"
5. Submit and pay the nominal Application Fee
6. Desktop Assessment
7. Reply to the desktop non-Compliances (if any)
8. On-site Assessment
9. Reply to on-site non-Compliances (if any)
10. Review of the application
11. Issue of the Digital Quality Certificate

The Assessor will gather the required information along with evidence to assess the compliance of the certification criteria at the hospitals using the following three methods:

1. **Documentation Review:** As it is not possible to observe all the clinical procedures being followed by a hospital so documents and records act as the objective evidence to triangulate the observations. The documents uploaded by the hospitals during the 'Desktop Assessment Process' will be verified by the assessor to verify the compliance against the standards. Some of the examples are as follows:

a. Review of patients' clinical records – pre, intra, and post-operative notes, pre, intra, and post-anesthesia notes, etc.

b. Review of department registers like admission, referral, etc.

c. Review of licenses and statutory compliances

d. Review of SOPs and procedures

e. Review of staff training and monitoring records

2. **Direct Observation:** Compliances to the certification criteria will be checked directly during the 'On-site assessment process' by the visiting assessor. They will observe the articles, processes, building infrastructure, and surrounding environment to evaluate the adoption of healthcare protocols. Some of the examples are as follows:

a. Display of signage, work instructions, etc.

b. Facilities like patient amenities, ramps, etc.

c. An environment like cleanliness, loose wires, temperature control, etc.

d. Procedures of Bio-medical waste disposal etc.

3. **Interview:** Interaction with the hospital staff helps to understand the knowledge and skillset required for performing the designated job role. It also provides information about the organization and its work culture in terms of adherence to the guidelines. Some of the examples are as follows:

a. Staff Awareness about the scope of services provided, patient rights, etc.

b. To assess skill sets and competence of the staff in carrying out day to day procedures.

Benefits

Some of the major benefits of the Bronze Quality certification are as follows:

1. **Additional Financial Incentive:** Bronze quality certified hospitals will get additional 5% financial incentives above the Health Benefit Packages (HBP) laid out under AB PM-JAY by NHA.

2. **Nationwide Recognition:** The list of certified hospitals will be published online in a public domain that would help hospitals obtain recognition among their peers and with the digital certificate valid for two (2) year.

3. **Increased Credibility of Healthcare Provider:** This certificate will establish trust amongst the beneficiaries for quality treatment in the certified hospital.

4. **Patient Safety and Increased Care for Patients:** The certification focuses on quality protocols and patient safety, which will help the hospital in increasing its service quality with time.

5. **Easier Standards and Simple Process:** These standards are intended to motivate and support hospitals to reach minimum level of quality and move above the ladder of quality certification over time.

SUMMARY OF CERTIFICATION CRITERIA

The certification criteria have been grouped within five (5) chapters namely – Key Inputs, Clinical Services, Support Services, Patient Care, and Health Outcomes. Each standard further has specific 'Means of Verification(s)'. The means of verifications will be assessed at two stages i.e., Desktop and On-Site Assessment using the technology platform by qualified and trained assessors.

The summary of the chapter of Bronze Quality Standards are as follows:

Chapters	No. of Standards	No. of Means of Verification
Chapter 1: Key Inputs	10	40
Chapter 2: Clinical Services	11	41
Chapter 3: Support Services	10	40
Chapter 4: Patient Care	11	41
Chapter 5: Health Outcome	11	20
Total	**53**	**182**

At a Glance: Certification Criteria	
Chapter 1: Key Inputs	
KI 1	Physical condition of the building and hospital environment shall be developed and maintained for the safety of patients, visitors, and staff
KI 2	Hospital should have adequate space for the ambulance and patient movement
KI 3	Access to the hospital should be provided without any physical barrier and friendly to people with disabilities
KI 4	The indoor and outdoor areas of the facility should be well-lit
KI 5	Basic amenities should be provided for all patients, hospital staff, and visitors
KI 6	The hospital should ensure that all medical staff is adequately qualified, trained and credentialed as per the statutory norms
KI 7	The facility has functional equipment and instruments as per the scope of services
KI 8	Hospital should have fire detection and fire-fighting equipment installed as per fire safety norms along with a display of RACE and PASS and the records of staff training on the same
KI 9	Staff involved in direct patient care shall be trained in Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) along with an algorithm display of the same in all critical care areas
KI 10	Trainings should be conducted for all staff as per Annual Training Plan is prepared as per training needs.
	CHAPTER 2: CLINICAL SERVICES
CS 1	Patients' privacy and confidentiality should be maintained at all times including Out-Patient Department (OPD) and In-Patient Department (IPD)
CS 2	The lab diagnostic services, whether in-house or outsourced, should be as per the scope of services
CS 3	Blood bank services if available shall be as per the statutory/ regulatory norms.
CS 4	The hospital should adhere to the radiation safety precautions as per the regulatory requirements
CS 5	Intensive Care Unit (ICU) services should be available as per the scope of services along with the required infrastructure and manpower
CS 6	OT complex should be available as per the regulatory requirements
CS 7	Look-alike and sound-alike medicines need to be identified and stored separately to avoid any dispensing and administration errors.

CS 8	Policies and procedures for identification, safe dispensing, and administration of all high-risk medicines should be documented and implemented
CS 9	The facility has a defined and established an antibiotic policy
CS 10	Pre-operative, Intra-operative, and post-operative assessments should be done and documented by appropriately qualified staff in a standardized format.
CS 11	Pre-Anaesthesia assessments, type of Anaesthesia, and Post Anaesthesia status should be documented.
	CHAPTER 3: SUPPORT SERVICES
SS 1	Hospital should be clean and have well-managed building, roofs, flooring and exterior.
SS 2	Temperature control and ventilation should be maintained in all inpatient care and nursing areas
SS 3	The hospital should have an arrangement of water storage and should be tested periodically as per requirement
SS 4	The hospital should have 24 hours supply of electricity, either through direct supply or from other sources with facility of power back-up for all critical areas.
SS 5	Medical gases and vacuum shall be made available all the time and stored safely. Compressed air should be made available as per the scope of services.
SS 6	The facility should adhere to the practices specified under statutory compliances as per the scope of services - Licenses with the Certificate number, date of issue, and date of expiry
SS 7	The hospital should ensure that appropriate infection control practices are being followed along with hand hygiene practices
SS 8	Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules,)
SS 9	Hospital should ensure that services i.e. (Laundry, Housekeeping, Dietary, security, Ambulance, Mortuary, Central Sterile Supply Department (CSSD), etc. are available (in-house or outsourced).
SS 10	Sexual harassment and grievance handling procedures should be established.

Chapter 4: Patient Care	
PC 1	Hospital should have a uniform and user-friendly signage system in English and the local language understood by the Patient/family and community.
PC 2	All Signage's that are required by law should be displayed at all strategic location
PC 3	Contact information of key medical staff and specialists should be readily available in the emergency department
PC 4	Service counters for the enquiry are available as per the patient load and are duly managed by hospital staff for the registration of patients
PC 5	Hospital should have established procedures for the admission of patients
PC 6	The patient should be referred to another facility along with the documented clinical information, in case of non-availability of services and/or beds.
PC 7	General Consent and Informed Consent should be taken during the admission and before any procedures /surgery and anaesthesia/ sedation.
PC 8	User charges are displayed and communicated to patients effectively at the time of registration, admission to the ward, and in case of a change in medical or surgical plan.
PC 9	Patients should be properly educated on additional care as deem required and all the vital information should be recorded for continuity of care.
PC 10	Hospital should ensure that all medications and associated instructions are written in the prescription.
PC 11	Medical records should be retained as per the policies of the hospital based on national and local law.

Chapter 5: Health Outcomes	
HO 1	Monthly Out Patient Department (OPD) and In-Patient Department (IPD) census
HO2	Mortality Rate and the average length of stay
HO3	Infection Rates - Surgical Site, Catheter-Associated Urinary Tract Infection (CAUTI), Central Line Blood Stream Infection (CLABSI), Ventilator-Associated Pneumonia (VAP)
HO 4	Transfusion reaction (if applicable)
HO 5	Bed occupancy
HO 6	Percentage of Patient satisfaction
HO 7	Percentage of Employee satisfaction
HO 8	Waiting time - Out Patient Department (OPD) and discharge
HO 9	Reporting of Adverse events
HO 10	Reporting of Thefts / Security related incidents
HO 11	Reporting of needle stick injuries

Chapter 1: Key Inputs

Overview

It is essential that a hospital should have a framework to support ongoing quality improvements and patient wellbeing. This section of key inputs broadly covers the structural part of the hospital. The certification criteria given in this chapter take into consideration the facility infrastructure, human resources requirements, and training, appropriate space in the hospital for patient movement, proper lighting facility in the hospital, medical instruments and equipment requirements and maintenance, fire-fighting equipment, and basic amenities like drinking water, waiting area, canteen, suitable toilets for men and women, etc. However, the focus of the standards has been in ensuring compliance to the minimum level of inputs, which are required for ensuring delivery of the committed level of the services.

Summary

Chapter 1: Key Inputs	
KI 1	Physical condition of the building and hospital environment shall be developed and maintained for the safety of patients, visitors, and staff
KI 2	Hospital should have adequate space for the ambulance and patient movement
KI 3	Access to the hospital should be provided without any physical barrier and friendly to people with disabilities
KI 4	The indoor and outdoor areas of the facility should be well-lit
KI 5	Basic amenities should be provided for all patients, hospital staff, and visitors
KI 6	The hospital should ensure that all medical staff is adequately qualified, trained and credentialed as per the statutory norms
KI 7	The facility has functional equipment and instruments as per the scope of services
KI 8	Hospital should have fire detection and fire-fighting equipment installed as per fire safety norms along with a display of RACE and PASS and the records of staff training on the same
KI 9	Staff involved in direct patient care shall be trained in Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) along with an algorithm display of the same in all critical care areas
KI 10	Trainings should be conducted for all staff as per Annual Training Plan s prepared as per training needs.

KI 1 - Physical condition of the building and hospital environment shall be developed and maintained for the safety of patients, isitors, and staff

Interpretation – The standard guides the provision of a safe and secure environment for patients, visitors, and staff. To ensure this, the hospital premises must have basic essentialities of infrastructure and shall have an annual maintenance plan for infrastructure development. This includes the appearance of the facility, cleaning processes, infrastructure maintenance, and control of stray animals at the facility.

Means of verification:

1. There should be no cattle or stray animals within the premises
2. The facility should have a guard available 24*7
3. The hospital boundary should be intact and not broken
4. Hospital (Building(s)) should be well maintained i.e. walls are well plastered (no cracks or seepage) and painted
5. Windows and doors are intact and have grill/ wire meshwork
6. The facility should have an annual maintenance plan for its infrastructure
7. Non-structural components such as cupboards, cabinets, and other heavy equipment or hanging objects should be properly fastened and secured
8. Hospital buildings should not have a wire hanging loosely
9. There should be no stains, grease, cobwebs, and birds' nest on walls and roofs of the hospital
10. There should be a closed drainage system with no direct contact with the environment

KI 2 - Hospital should have adequate space for the ambulance and patient movement

Interpretation – This standard requires that the facility should ensure adequate space for ambulance movement and parking. The access to the emergency/ receiving area should be smooth and spacious for the ease of patient movement and safe handling.

Means of verification:

1. Ambulance should have direct access to the emergency/ receiving/ triage area and the access road to an emergency should be wide enough to streamline the movement of the patient till the emergency/ receiving area
2. No vehicle should be parked on the way or in front of the emergency entrance
3. Dedicated parking area for the ambulance

KI 3 - Access to the hospital should be provided without any physical barrier and friendly to people with disabilities

Interpretation –Provisions should be available for physically challenged/ vulnerable persons to make the entrance accessible with ramps and grab bars. The facility should have the facility of wheelchair, stretcher, and trolleys with safety belts for immediate support of the patient.

Means of verification:

1. Availability of wheelchair, stretcher for an emergency with straps to protect the patient from falling
2. The wheelchair, stretcher, and trolleys should be clean, operational and their wheels should be properly aligned.
3. Availability of ramps with railings at the entrance of the facility

KI 4 - The indoor and outdoor areas of the facility should be well-lit

Interpretation – In order to provide a safe, secure and comfortable environment to patients and staff the hospital should have the provision of a comfortable environment in terms of illumination either through electric bulbs and tubes at all the places, accompanied by a natural source of light. Also, the front, entry, and exit areas should be well lit.

Means of verification:

1. There should be proper lighting in the indoor areas through natural light and by using sufficient electric bulbs
2. The facility's front, entry gate, and access road are well illuminated

KI 5 - Basic amenities should be provided for all patients, hospital staff, and visitors

Interpretation – The hospital must have an appropriate waiting area with seating arrangement, drinking water, clean toilets sensitive to gender, and physically challenged visitors and staff personnel should be present within the premises.

1. Availability of seating arrangement in the waiting area(s) within the hospital premises for attendants
2. Availability of potable drinking water on each floor (functional RO/filters)
3. There should be a provision of canteen facility for visitors and staff inside the premises
4. Every floor should have at least one toilet for hospital staff and visitors
5. Availability of clean and functional toilets with no foul smell in and around the toilet along with functional water taps
6. The toilets floor should be dry and no drain should be overflowing
7. Availability of disabled-friendly toilet with bars or railings and is accessible through a ramp
8. Availability of 24*7 working telephone helpline in hospital for effective communication

KI 6 - The hospital should ensure that all medical staff is adequately qualified, trained and credentialed as per the statutory norms

Interpretation – The organization shall ensure that the medical professionals who have the required qualification, training, experience, and consonance with the law are permitted to provide the services and such information should be appropriately verified. Also, the facility should maintain an adequate number and mix of staff to meet the care, treatment, and services needs of patients.

Means of verification:

1. Doctor/ Nurse/ Paramedic Staff/ Admin and Support Staff along with the current designation, educational qualification, registration council of name and the associated registration number along with the date of joining and area/working department

2. Hospital should plan human resources with an adequate number and with a mix and credentials of staff as per the statutory norms

3. Hospital has dedicated staff (3 members) for AB PMJAY

KI 7 - The facility has functional equipment and instruments as per the scope of services

Interpretation – The hospital must have all the equipment and instruments according to the scope of services they are offering. Basic functional diagnostic equipment should also be readily available.

Means of verification:

1.Availability for examination and monitoring of patients - BP apparatus, Multipara meter Torch, hammer, an instrument to measure height, weight, and Blood Pressure (BP) to conduct a general examination

KI 8 - Hospital should have fire detection and fire-fighting equipment installed as per fire safety norms along with a display of RACE and PASS and the records of staff training on the same

Interpretation – The facility should have a plan and provisions for early detection, abatement, and containment of fire emergencies such as documented safe fire exit plan and trained staff. The periodic training shall include information, demonstration to use the fire extinguisher, and mock drills.

Means of verification:

1. Check if fire extinguishers, fire/smoke detectors are installed in patient care areas with fire-panel

2. Check for date of expiry on fire extinguisher which should be beyond the current date

3. The organization has a documented safe exit plan in case of fire and non-fire emergencies

4. Periodic training with the mock drill is provided for using fire extinguishers

KI 9 - Staff involved in direct patient care shall be trained in Cardio

Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) along with an algorithm display of the same in all critical care areas

Interpretation – The organization shall provide regular training to the staff providing direct patient care. If the facility has a CPR team (e.g. code blue team) it shall ensure that it is trained in advanced cardiopulmonary resuscitation (adult, pediatric and neonatal) and is present in all shifts. All doctors and nurses working in ICU/ HDU should undergo appropriate training and display the CPR algorithm in all the critical areas.

Means of verification:

1. Training Records for Basic Life Support (BLS)
2. There should be a code blue protocol in the organization
3. Check the display of CPR algorithm in or near ICU, Clinical area, and Emergency areas.
4. Check the records for CPR events and CPR Mock drill along with the corrective and Preventive measures taken

KI 10 - Trainings should be conducted for all staff as per Annual Training Plan is prepared as per training needs

Interpretation – The hospital should document plan and prepare a training calendar to ensure staff is able to identify the patient's rights and responsibilities, potential hazards, maintain required quality, and take appropriate actions during any disaster.

Means of verification:

1. Facility prepares training calendar as per training need assessment, training feedback records - Training on Disaster Management, Patient Safety, and rights, facility-level Quality Assurance
2. AB PMJAY specific training (e.g. BIS, TMS, HEM and Support Portal, etc.) to all concerned staff.

Chapter 2: Clinical Service

Overview

The definitive motive of a hospital is to provide clinical care. Therefore, clinical services are the most basic and significant in hospitals. These are the processes that determine the outcome of services and quality of care. These standards include processes such as consultation, clinical assessment, continuity of care, nursing care, identification of high-risk and vulnerable patients, prescription practices, safe drug administration, blood bank requirement, antibiotic policy, maintenance of clinical records, etc. These standards are based on the technical guidelines published by the Government of India (GoI) on individual programs and processes. It may be difficult to assess clinical processes; as direct observation of clinical procedure may not always be possible at the time of certification assessment. Therefore, assessment of these standards would largely depend upon a review of the clinical records and documents as well.

Summary

Chapter 2: Clinical Services	
CS 1	Patients' privacy and confidentiality should be maintained at all times including Out-Patient Department (OPD) and In-Patient Department (IPD)
CS 2	The lab diagnostic services, whether in-house or outsourced, should be as per the scope of services
CS 3	Blood bank services if available shall be as per the statutory/regulatory norms.
CS 4	The hospital should adhere to the radiation safety precautions as per the regulatory requirements
CS 5	Intensive Care Unit (ICU) services should be available as per the scope of services along with the required infrastructure and manpower
CS 6	OT complex should be available as per the regulatory requirements
CS 7	Look-alike and sound-alike medicines need to be identified and stored separately to avoid any dispensing and administration errors.
CS 8	Policies and procedures for identification, safe dispensing, and administration of all high-risk medicines should be documented and implemented
CS 9	The facility has defined and established an antibiotic policy
CS 10	Pre-operative, Intra-operative, and post-operative assessments should be done and documented by appropriately qualified staff in a standardized format.
CS 11	Pre-Anesthesia assessments, type of Anesthesia, and Post Anesthesia status should be documented.

CS 1 – Patients' privacy and confidentiality should be maintained at all times including Out Patient Department (OPD) and In-Patient Department (IPD)

Interpretation – During all the stages of patient care, be it examination or carrying out a procedure, hospital staff shall ensure that the patient's privacy and dignity are maintained. There should be a provision of screens and curtains to ensure precautions are taken while providing care to patients.

Means of verification:

1. Check availability for privacy screens or curtains in OPD and wards for maintaining visual privacy for the patients.

CS 2 - The laboratory diagnostic services, whether in-house or outsourced, should be as per the scope of services

Interpretation – The facility should have an MoU/Agreement for the out-sourced laboratory services, which incorporates quality assurance and requirements of this standard. Also, a list of services provided by the hospital or outsourced should be available. If the services are outsourced, then the hospital should ensure safe and timely transportation of specimens.

Means of verification:

1. List the number of in-house laboratory services
2. List the number of outsourced laboratory services with their scope of work.
3. In the case of outsourced services, is there a sample collection room and a procedure to monitor the quality and adequacy of these services.
4. There should be a system in place for the daily round by matron/hospital manager/hospital superintendent / Hospital Manager / Matron in charge of monitoring diagnostic services

CS 3 - Blood bank services if available shall be as per the statutory/regulatory norms.

Interpretation – The blood bank should be functioning and adhere to standards procedures for blood collection and testing. In case the hospital doesn't have a blood bank, it shall have an MoU with the blood bank or the organization having a blood bank that has a valid license. IEC material for blood donation should also be displayed at all strategic locations.

Means of verification:

1. Blood bank services are available in-house or outsourced. If outsourced, then adequate supply/storage shall be ensured from a nearby authorized blood bank
2. Blood bank has a valid license under Rule 122(G) Drug and Cosmetics Act
3. Blood bank has a facility for blood collection and storage along with the emergency stock of blood
4. IEC material is displayed in blood bank and nearby areas to provide information and promote blood donation

5. Check for availability of adequate functional equipment for blood products - Blood bags refrigerator with thermograph and alarm device, insulated carrier boxes with ice packs, blood bag weighing machine, and deep freezer

CS 4 - The hospital should adhere to the radiation safety precautions as per the regulatory requirements

Interpretation – Shielding of body parts of staff and patients, attendants should be adhered to by using protective devices and equipment, along with precautions as per law for radiation safety. The facility should also ensure standard practices, usage, and supply of Personal Protective Equipment (PPE).

Means of verification:

1. Clean gloves, aprons, and masks are available at the point of use

2. TLD badges should be provided to each staff member in the radiation room

3. Lead aprons, thyroid shields, and other radiation protection devices should be provided for the staff in the radiation field. These should be tested once in 2 years as per AERB norms

4. Availability of ECG services

CS 5 - Intensive Care Unit (ICU) services should be available as per the scope of services along with the required infrastructure and manpower

Interpretation – The ICU should be equipped with necessary monitoring equipment along with the suitably manned by trained staff. The hospital should provide a proper and safe environment to the infected patients and necessary procedures should be followed for the same.

Means of verification:

1. Flooring of the ICU should be non-slippery and smooth

2. Windows/ air vents if any should be intact and sealed

3. Comfortable temperature and humidity should be maintained

4. Availability of general duty doctor, nursing staff, paramedic, and security staff as per requirements

5. Critical care equipment is available and maintained- Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley, Ventilator, Infusion pump, C-PAP, tray, monitors, Electrical panel with a bed, bedhead panel with an outlet for Oxygen and vacuum, X-ray view box, defibrillator

6. Availability of isolated area for infectious patient

7. Isolation and barrier nursing procedures are followed for septic cases

CS 6 - Operation Theater (OT) should be available as per the regulatory requirements

Interpretation – The organization shall ensure that the operation theater has facilities for demarcated areas, separate changing rooms for males and females along with proper illumination and temperature.

Means of verification:

1. Proper demarcation of the following areas: protective zone, clean zone, sterile zone, and disposal zone
2. Availability of signage stating that the entry to OT is restricted
3. Pre-operative and post-operative areas should be well-lit
4. Change rooms are available for male and female staff; entry in OT should be allowed only after change in attire
5. Temperature and humidity are maintained and a record of same is kept

CS 7 - Look-alike and sound-alike medicines need to be identified and stored separately to avoid any dispensing and administration errors.

Interpretation – The drug store should arrange the stock in alphabetic/ uniform/ standardized order and the storage requirement of the drugs should be adhered to. The overall cleanliness and temperature of the storage area should be maintained. One look-alike should be stored apart from its other look alike.

Means of verification:

1. Product of similar name and different strength (look-alike and sound-alike drugs) should be stored separately.
2. Medicine storage shall be in a clean, well-lit, and safe environment in accordance with the applicable laws and regulations.
3. Stock is arranged neatly in alphabetic order with the name facing the front and labels must have drug name, strength, and frequency
4. Drug store has inventory management software

CS 8 - Policies and procedures for identification, safe dispensing, and administration of all high-risk medicines should be documented and implemented

Interpretation – Clear policies to be laid down for dispensing of high-risk medicines and the list of such medicines should be available at the drug store. The narcotics drugs should be stored in a secure manner.

Means of verification:

1. Documented procedure incorporating storage, prescription, and dispensing of medications
2. Narcotic medicines are kept in double lock
3. Pharmacy has a list of high-risk drugs available with it

CS 9 - The facility has a defined and established antibiotic policy

Interpretation – The hospital must have a documented and established antibiotic policy ensuring rational use of antibiotics/drugs.

Means of verification:

1.Facility should ensure the rational usage of antibiotics/ drugs and policy for the same is in place and implemented.

CS 10 - Pre-operative, Intra -operative, and post-operative assessment should be done and documented by appropriately qualified staff in a standardized format.

Interpretation – All the patients undergoing surgery should be assessed pre-operative, intra-operative, and post-operative by the trained staff, which should be documented in a standardized format. Also, a documented procedure should be available for preventing adverse like the wrong site, wrong patient, and wrong surgery.

Means of verification:

1. There is a procedure for pre-operative and intra-operative assessment - Physical examination, the result of lab investigation, diagnosis, and proposed surgery (3 samples)

2. Patient reports with post-operative notes that should contain vital signs, pain control, urine, and gastrointestinal fluid output, other medications, and Laboratory investigations (3 samples)

3. Documented procedures to address the prevention of adverse events like the wrong site, wrong patient, and wrong surgery.

CS 11 - Pre-Anesthesia assessments, type of Anesthesia, and Post Anesthesia status should be Documented

Interpretation – The pre-anesthesia, post-anesthesia, and type of anesthesia should be monitored and documented in a standardized format. Also, the patient records must contain regular and periodic monitoring records of patients who are under observation Post Operative/Anesthesia for the purpose of taking corrective and preventive actions.

Means of verification:

1. Department has documented procedure for pre-operative anesthesia checkup

2. Anesthesia plan is documented before entering into OT

3. Post-anesthesia status is monitored and recorded

4. Post-Operative/Anesthesia monitoring includes the regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security, and patency

Chapter 3: Support Services

Overview

Support services are the fundamental foundation of every healthcare facility and help other departments things run smoothly. And when things are running well, patients receive better care, so the expected clinical outcome cannot be visualized in the absence of support services. This chapter includes parameters to evaluate cleanliness, sterilization, infection control practices, security and facility management, water and power supply, dietary services, and laundry. These standards also cover some of the administrative processes like legal and statutory compliances, contract management, Bio-Medical waste disposal, etc. If these services and facilities are in place and are managed efficiently, supported, and maintained mainline healthcare delivery will be effective.

Summary

Chapter 3: Support Services	
SS 1	Hospital should be clean and have well-managed building, roofs, flooring and exterior.
SS 2	Temperature control and ventilation should be maintained in all patient care and nursing areas
SS 3	The hospital should have the arrangement of water storage and should be tested periodically as per requirement
SS 4	The hospital should have 24 hours supply of electricity, either through direct supply or from other sources with facility of power back-up for all critical areas.
SS 5	Medical gases and vacuum shall be made available all the time and stored safely. Compressed air should be made available as per the scope of services.
SS 6	The facility should adhere to the practices specified under statutory compliances as per the scope of services - Licenses with the Certificate number, date of issue, and date of expiry
SS 7	The hospital should ensure that appropriate infection control practices are being followed along with hand hygiene practices
SS 8	Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules)
SS 9	Hospital should ensure that services i.e. (Laundry, Housekeeping, Dietary, security, Ambulance, Mortuary, Central Sterile Supply Department (CSSD), etc. are available (in-house or outsourced).
SS 10	Sexual harassment and grievance handling procedures established.

CERTIFICATION CRITERIA AND MEANS OF VERIFICATION

SS 1 - Hospital should be clean and have well-managed building, roofs, flooring and exterior.

Interpretation – The flooring of the hospital should be well managed and have adequate cleaning processes like mopping, scrubbing, etc. conducive for infection control.

Means of verification:

1. The floor should be non-slippery and dry
2. The floor surface should be smooth enough for effective cleaning and walking
3. The facility should be cleaned at least twice in the day with a wet mop and are also rigorously cleaned with scrubbing at least once a month. Check cleaning records for regular and frequency of cleaning

SS 2 - Temperature control and ventilation should be maintained in all patient care and nursing area

Interpretation – Arrangement for a comfortable work environment in terms of temperature control should be available in-patient care areas and workstations.

Means of verification:

1. Availability of fans/ air conditioning/ heating/ exhaust/ air vents as per the requirement and weather condition

SS 3 - The hospital should have the arrangement of water storage and should be tested periodically as per requirement

Interpretation – The hospital shall ensure that there is sufficient water supply to meet the requirements at all points of use round the clock. Alternate sources of water should be available as backup for any failure or shortage and the same should be tested on regular basis. The results of the tests should be documented.

Means of verification:

1. At least 200 liters of water per bed per day is available on a daily 24x7 basis. Adequate backup for continuous water supply should be available (check alternate sources also)
2. Water is available at all points of use for handwashing, OT, Labor room, wards, Patients' toilet, and bathroom.
3. All water tanks are kept tightly closed to ensure safety
4. Check the records for periodic tests of the quality of water from the source (municipal supply, borewell, etc.) for bacterial and chemical content as per the guidelines

SS 4 - The hospital should have 24 hours supply of electricity, either through direct supply or from other sources with facility of power back-up for all critical areas.

Interpretation – Hospital should have availability of power back up in the form of emergency lights, DG sets, solar energy, UPS, noiseless generators, or any other suitable source. The staff involved in the maintenance of electricity

must have rubber mats, gloves, and boots for safe working and prevention from any mishappening.

Means of verification:

1. Check the availability of power back up, availability of UPS, emergency lights, or noiseless generators

2. Rubber mats are available in the electrical room below the panels and rubber gloves, boots, and safety gear are provided to the electrical staff

SS 5 - Medical gases and vacuum shall be made available all the time and stored safely. Compressed air should be made available as per the scope of services.

Interpretation – Manifold room should be accessible and have adequate backup of oxygen cylinders. Availability of central oxygen and vacuum supply should especially be assessed in critical areas like OT and ICU with standardized colour coding of cylinders and pipelines. A prompt replacement procedure and alarm system should be available to indicate any abnormal pressure change in the room. The instructions for operating different equipment in the manifold room should be displayed clearly.

Means of verification:

1. The manifold room should be located on the ground floor and entry to the room is prohibited for unauthorized people.

2. The manifold room should have at least 3 days of oxygen and other medical gases stock, that is chained appropriately

3. Colour of the gas pipeline (if applicable) and the gas cylinder has to be as per the standards

4. The alarm system should be operational to indicate any abnormal pressure change

5. Adequate back-up of B-type cylinders in critical areas like ICU, OT, and for patient transfer purpose

6. The procedure is followed for prompt replacement of empty cylinders with filled cylinders

7. Instruction for operating different equipment in the manifold room should be clearly displayed

SS 6 - The facility should adhere to the practices specified under statutory compliances as per the scope of services - Licenses with the Certificate number, date of issue, and date of expiry

Interpretation – Hospital should adhere to the statutory norms/ compliances laid down by the government as per the scope of services and must provide certificates/ licenses for the same.

Means of verification:

1. Fire Department Clearance Certificate

2. NOC from Pollution Control Board for air and water pollution

3. Lift License (if applicable)

4. Hospital Registration Certificate

5. Bio-Medical Waste Management

6. PCPNDT Act Registration

7. AERB

8. Pharmacy License and Narcotics Drugs License (if applicable)

9. Ambulance Registration Certificate, Insurance Policy, pollution control, and Driver License

SS 7 - The hospital should ensure that appropriate infection control practices are being followed along with hand hygiene practices

Interpretation – The hospital infection control and prevention process should be documented which aims at preventing and reducing the risk of healthcare-associated infection. The organization shall also adhere to hand hygiene, cleaning, disinfection, and sterilization guidelines.

Means of verification:

1. Availability of washbasin near the point of use along with antiseptic soap with soap dish/ liquid antiseptic with dispenser

2. Availability of alcohol-based hand rub

3. Availability of disinfectant/cleaning agent as per requirement

4. Check if infection control manual showing periodic updates and surveillance activities available/ monitoring takes place

5. The facility should follow standard practices and materials for disinfection and sterilization of instruments/ equipment

6. Staff should be trained for all infection control practices, hand hygiene guidelines, occupational risk, and its prevention.

SS 8 - Hospital should ensure Bio-Medical Waste management practices as per the statutory norms (BMW (Amendment) Rules)

Interpretation – The organization shall be authorized by the appropriate authority for the management of bio-medical waste. The waste should be segregated and collected in different color-coded bags and containers as per statutory norms and the same should be available at all the points of waste generation. Management of biomedical waste including its segregation, transportation, management, and disposal of waste should be done by an authorized agency with a designated place for waste collection and segregation near the premises.

Means of verification:

1. Availability of color-coded bins at the point of waste generation along with the display of work instructions for segregation and handling of Biomedical waste

2. The waste should be handed over to an authorized agency and not discharged in any drain. If outsourced, check the contract document of outsourced services. Register with the weight of waste collected from different colored bags should be maintained

3. Facility has secured a designated place for segregation and storage of Bio-Medical waste before disposal at the waste collection site

4. Transportation of bio-medical waste should be done in a closed container/trolley

SS 9 - Hospital should ensure that services i.e. (Laundry, Housekeeping, Dietary, security, Ambulance, Mortuary, Central Sterile Supply Department (CSSD), etc. are available (in-house or outsourced).

Interpretation – The services like laundry, housekeeping, dietary, security, mortuary, ambulance CSSD, etc. should be available in-house or out-sourced. The hospital shall ensure that they establish adequate controls by having the policy to monitor/ audit these services. If these services are outsourced, then they should have an MoU/ agreement for the same.

Means of verification:

1. The mentioned services are available in-house or outsourced. If the services are outsourced, then MoU/ agreement should be available for the same.

2. Internal audits of the services to be conducted at regular intervals

SS 10 - Sexual harassment and grievance handling procedure should be established.

Interpretation – There should be disciplinary and grievance handling procedures in place with a dedicated committee/team established to handle cases against sexual harassment and various other grievances.

Means of verification:

1. A committee against sexual harassment is constituted at the facility
2. Documented disciplinary and grievance handling procedure

Chapter 4: Patient Care

Overview

The sheer availability of healthcare services does not serve the purpose until the services are accessible to the users, and are provided with dignity and confidentiality. Access to healthcare services includes physical access as well as financial access. The government has launched AB PMJAY schemes for ensuring that the service packages are available cashless to different targeted groups. Giving quality patient care have a positive effect on patient outcomes and recovery experience. Patients' rights are also an integral part of patient care. The important patient rights include informed consent, the confidentiality of medical records, legible prescriptions, etc. This chapter includes standards such as uniform user-friendly signage, IEC for educating patients, patient-friendly admission and referral process, consent policies, retaining of medical records, and education of patients.

Summary

Chapter 4: Patient Care	
PC 1	Hospital should have a uniform and user-friendly signage system in English and in the local language understood by the patient/family and community.
PC 2	All signage those are required by law should be displayed at all strategic location
PC 3	Contact information of key medical staff and specialists should be readily available in the emergency department
PC 4	Service counters for the enquiry are available as per the patient load and are duly managed by hospital staff for the registration of patients
PC 5	Hospital should have established procedures for the admission of patients
PC 6	The patient should be referred to another facility along with the documented clinical information, in case of non-availability of services and/or beds.
PC 7	General Consent and Informed Consent should be taken during the admission and before any procedures /surgery and anesthesia/ sedation.
PC 8	User charges are displayed and communicated to patients effectively at the time of registration, admission to the ward, and in case of a change in medical or surgical plan.
PC 9	Patients should be properly educated on additional care as deem required and all the vital information should be recorded for continuity of care.
PC 10	Hospitals should ensure that all medications and associated instructions are written in the prescription.
PC 11	Medical records should be retained as per the policies of Hospital-based on national and local law.

PC 1 - Hospital should have a uniform and user-friendly signage system in English and in the local language understood by the patient/family and community.

Interpretation – Adequate signage should be displayed at all strategic locations which are permanent in nature. The services, departmental and directional signage and list of departments should be prominently displayed at all strategic locations in a uniform color scheme. Also, essential information like a list of emergency contact numbers, a list of doctors, patient rights and responsibilities, etc. should be displayed within the hospital premises. It is preferable that the signage is displayed in bilingual language for the ease and understanding of patients.

Means of verification:

1. The name of the hospital and entry-exit should be clearly displayed outside the hospital. Entry to the emergency department should also be defined and displayed strategically
2. Hospital has directional signage with a uniform color scheme.
3. List of departments (as per the scope of services) should be displayed in bilingual language
4. The scope of services should be displayed in the waiting area/ OPD/ Emergency/ Reception in bilingual language
5. All the services registered under AB PM-JAY are clearly defined and displayed in prominent places in understandable language.
6. Display of floor layout at each floor
7. Display of patients' rights and responsibility and other related IEC material (outdated and torn posters/wallpapers etc. should not be put on display)
8. Hospital has IEC specific to AB PM-JAY
9. List of doctors (as per the scope of services) with their departments and availability
10. No smoking signage to be present within the hospital premises
11. Display of handwashing instruction at the point of use (5 moments and 7 steps of hand hygiene)
12. Display of emergency numbers including ambulance, blood bank, police, and referral centers

PC 2 - All Signage's those are required by law should be displayed at all strategic location

Interpretation – All the signage which are compulsory by law for hospitals to display such as PC&PNDT Act, AERB and radiation hazards, biohazard signage, and fire exit signage should be displayed in the hospitals at all the strategic locations.

Means of verification:

1. Fire exit signage to be displayed at exit route plan along with the do's and don'ts in case of fire

2. PC&PNDT Act Signage board to be displayed at the waiting room and reception area

3. AERB and Radiation hazard signage

4. Bio-hazard signage to be present

PC 3 - Contact information of key medical staff and specialists should be readily available in the emergency department

Interpretation – The hospital must have accessible and readily available contact details of doctors and staff members. Also, a nurse call facility and at least one medical officer should be available at all times in the hospital in case of emergencies.

Means of verification:

1. Check if the contact details (telephone or residence address) of doctors/staff are readily available

2. A nurse call facility should be available to address any patient emergency.

3. At least one medical officer and a nurse should be available all the time for emergency cases.

PC 4 - Service counters for the enquiry are available as per the patient load and are duly managed by hospital staff for the registration of patients

Interpretation – There should be a dedicated area for enquiry as per the number of patients that visit the hospital and a dedicated kiosk for AB PM-JAY manned round the clock. The hospital must make sure that every patient is given a unique identification number at the time of registration of the first interaction of the patient with the organization. To ensure continuity of care these numbers shall be linked to the unique number.

Means of verification:

1. Check availability of a dedicated enquiry area or reception

2. The unique identification number is given to each patient during the process of registration while also recording patient details such as name, age, gender, address, and chief complaint, etc.

3. Hospital has AB PM-JAY Kiosk manned 24 x 7

PC 5 - Hospital should have established procedure for admission of patients

Interpretation – There should be documented procedures for registering and admitting the patient. All patients assessed in the hospital shall be registered and all admissions must be authorized by a doctor. The policy should be defined with respect to documentation and intimation to police in case of Medico-Legal Cases (MLC) as per statutory requirement.

Means of verification:

1. Admission is done by written order of a qualified doctor

2. There is an established criterion for admission through the emergency department

3. There is an established procedure for admission of Medico-Legal Cases (MLC) as per prevalent laws and procedures to inform the police. Records for such patients are also maintained.

PC 6 - The patient should be referred to another facility along with the documented clinical information, in case of non-availability of services and/or beds.

Interpretation – The documented procedure addressing managing patients in case of non-availability of beds. Patients needing transfer including those who have come to the emergency but need to be transferred after basic first-aid, the hospital shall have documented procedure for managing patients. Transferring/referring patients to another facility should be done by issuing referral slips.

Means of verification:

1. There is an established procedure for managing patients in case beds are not available at the facility

2. The patient should be referred while issuing a referral slip and should be a bi-directional referral system. The record of the same should be maintained

3. Adequate emergency facilities should be available to provide basic first aid before transfer/referral

4. AB PMJAY beneficiaries referred to AB PMJAY empaneled Hospitals

PC 7 - General Consent and Informed Consent should be taken during the admission and before any procedures /surgery and anesthesia/ sedation.

Interpretation – Patients and family rights include that hospital shall take informed consent, preferably in bi-lingual and language they can understand, signed by patient/relatives/caretaker at the time of admission and before undergoing any surgery or procedure which discuss about all the risks and benefits. The informed consent should be taken at all specific steps pf patient care involved with responsibility.

Means of verification:

1. Consent forms available in bilingual language should be signed by the patients or any caretaker during admission and before surgery (separate forms)

2. All risks, benefits, and alternatives about anesthesia should be discussed and mentioned as part of the consent form signed by the patients or their caretaker.

PC 8 - User charges are displayed and communicated to patients effectively at the time of registration, admission to the ward, and in case of a change in medical or surgical plan.

Interpretation – The list of user charges must be displayed at strategic places (Reception, waiting areas, lobby) in the hospital premises for better

communication to patients and to maintain transparency. The list must be updated in case of any change in medical and surgical plans.

Means of verification:

1. The facility prepares a comprehensive list of user charges and displays them at strategic points in the hospital.

2. AB PMJAY beneficiaries are provided cashless services

PC 9 - Patient should be properly educated on additional care as deemed required and all the vital information should be recorded for continuity of care.

Interpretation – Patients should be educated for additional care in respect to usage and effect of medication, diet, and nutrition which can be done with the help of discharge summary and growth summary respectively. All the vital information must be recorded for the reassessment of patients undergoing observation in the language the patient/ family members can understand.

Means of verification:

1. Patients should be educated for usage and effect of medication, diet and nutrition, immunizations and to prevent infections (as deemed appropriate)

2. Discharge summary should contain a diagnosis, history, physical examination, investigation details, treatment provided, and instructions thereof in easy-to-understand manner (Check 3 samples)

3. There should be a fixed schedule for the reassessment of the patient under observation based on clinical need

PC 10 - Hospitals should ensure that all medications and associated instructions are written in the prescription.

Interpretation – The organization shall ensure that the at the minimum the prescription shall have the name of the patient, unique patient number, name of the medicine with the frequency of administration, name, and signature of the doctor. All handwritten prescriptions should be legible, clear, and understandable by the patient/ family member i.e. preferably in capital letters.

Means of verification:

1. The prescription should be legible, clear, and be explained in the language understood by the patients and is comprehendible by the clinical staff

2. Every medical advice and procedure are accompanied by a date, time and signature, unique patient number.

PC 11 - Medical records should be retained as per the policies of the hospital-based on national and local law

Interpretation – Hospital must abide by the national and local laws for retaining medical records for each category of records: outpatient, in-patient, and MLC. The retention and destruction process should be included in the process to maintain confidentiality and security of both manual and electronic records

systems. Also, there should be a documented process for medical records of AB PMJAY scheme beneficiaries.

Means of verification:

1. Hospital has a policy of retention period with respect to different kinds of records and their disposal.
2. Confidentiality of patient records should be maintained by keeping them properly in the record room or digitally saved on a secure network
3. Hospital has process documentation for the AB PMJAY scheme

Chapter 5: Health Outcomes

Overview

The importance of measuring and reporting the healthcare outcomes is to improve patient experience of care and fosters improvement and adoption of best practices, thus further improving outcomes. This chapter has standards for measuring healthcare outcomes like OPD and IPD census, mortality rate, average length of stay, Surgical Site Infection, Urinary Tract Infection, Blood Stream Infection, Ventilator-Associated (VAP) Infection / Hospital Acquired Pneumonia, Transfusion reaction, Bed occupancy, Patient and employee satisfaction, reporting of adverse events, theft and security-related events, etc. The data provided by health outcomes guide decisions and effective policy-making processes.

Summary

Chapter 5: Health Outcomes	
HO 1	Monthly Out Patient Department (OPD) and In-Patient Department (IPD) census
HO 2	Mortality Rate and the average length of stay
HO 3	Infection Rates - Surgical Site, Catheter-Associated Urinary Tract Infection (CAUTI), Central Line Blood Stream Infection (CLABSI), Ventilator-Associated Pneumonia (VAP)
HO 4	Transfusion reaction (if applicable)
HO 5	Bed occupancy
HO 6	Percentage of Patient satisfaction
HO 7	Percentage of Employee satisfaction
HO 8	Waiting time - Out Patient Department (OPD) and discharge
HO 9	Reporting of Adverse events
HO 10	Reporting of Thefts / Security related incidents
HO 11	Reporting of needle stick injuries

HO 1 - Monthly Out-Patient Department (OPD) and In-Patient Department (IPD) census

Interpretation: A monthly Out-Patient Department (OPD) and In-Patient Department (IPD) census data can help to monitor how much OPD patients are converting into IPD, how many patients visited the OPD and IPD, and track the trend of OPD to IPD conversion. The rate is generally affected by poor patient satisfaction, the high cost of IPD, or the low motivation of doctors to admit OPD patients.

Means of verification:

1. Out Patient Department (OPD) census for the last 6 months
2. In-Patient Department (IPD) census for the last 6 months
3. AB PMJAY In-Patient Department (IPD) census for the last 6 months

HO 2- Mortality Rate and Average Length of Stay (ALS)

Interpretation: Mortality statistics provide a valuable measure for assessing community health status. The importance of mortality statistics derives both from the significance of death in an individual's life as well as their potential to improve the public's health when used to systematically assess and monitor the health status of a whole community. ALS is a very common performance measure that is used not only important for hospital performance but also clinical quality and infection control.

Means of verification:

1. Mortality Rate (from the data of last 6 months) = (Number of Patients died/ Total number of admissions) * 100

Note:

- If deaths of new-born inpatients are included in the numerator, all discharges of new-born inpatients must be included in the denominator.
- Patients who are dead on arrival (DOA) are not included in the gross death rate because DOAs are not admitted to the hospital.
- Patients who die in the Emergency Services Department (ESD) are not included in the gross death rate because they were not admitted to the hospital.
- Patients who die in the hospital while as an outpatient are not included in the gross death rate.

2. Length of Stay (from the data of for last 6 months) = Total number of inpatient days in last 6 months/ Total number of discharges, LAMA, DAMA and death in past 6 months

HO 3 - Infection Rates

Interpretation: An infection rate is the probability or risk of infection in a population. It is used to measure the frequency of occurrence of new instances of infection within a population during a specific period. It will help to identify if any recurrent infections persist and improve infection control in the hospital.

Means of verification:

1. Surgical Site Infection Rate (from the data of for last 6 months)= (Number of surgical site infections/ Number of surgeries performed) *100

2. Catheter-Associated Urinary Tract Infection (CAUTI) (from the data of for last 6 months) = (Sum of Urinary Catheter-Associated Infections/ Total Number of catheter days) *1000

3. Central line-associated Blood Stream Infection (CLABSI) (from the data of for last 6 months) = (Number of central line-associated bloodstream infections/ Number of central line days) * 1000

4. Ventilator-Associated Pneumonia (VAP) (from the data of last 6 months) = (Number of Ventilator-Associated Pneumonia / Number of ventilator days in past 6 months) * 1000

HO 4 – Reporting of Transfusion Reaction

Interpretation: They are responsible for completing blood request forms, administering blood, monitoring transfusions, and being vigilant for the signs and symptoms of adverse reactions. These guidelines are intended to enhance the implementation of standard clinical transfusion practices for improved patient safety.

Means of verification:

1. Number of Transfusion Reactions in last 6 months

HO 5 - Bed occupancy

Interpretation: Good hospital management includes effective allocative planning for beds in a hospital. Bed-occupancy rates and length of stay are the measures that reflect the functional ability of a hospital.

Means of verification:

Bed occupancy Rate = (Total inpatient bed days of last 6 months/ Functional beds available in hospital for last 6 month) * 100

Where, Total patient bed days = Sum of the inpatient census (Midnight) for the 6 months.

HO 6 - Percentage of Patient satisfaction

Interpretation: Patient satisfaction is an important and commonly used indicator for measuring the quality of health care. A measure of care quality, patient satisfaction gives providers insights into various aspects of medicine, including the effectiveness of their care and their level of empathy.

Means of verification:

1. Copy of the filled feedback form clearly showing the questions asked (at least 5 samples)

2. Patient Satisfaction Index= (Cumulative score achieved/ Maximum possible scores) *100

HO 7 - Percentage of Employee satisfaction

Interpretation: Strong employee satisfaction is linked with significant improvements in patient care and satisfaction therefore it becomes crucial to study the percentage of employees who are satisfied and perform to their best efforts in the hospital.

Means of verification:

1. Copy of the filled feedback form clearly showing the questions asked (at least 5 samples)

2. Employee Satisfaction Index= (Cumulative score achieved/ Maximum possible scores) *100

HO 8 - Waiting time - Out Patient Department (OPD) and Discharge

Interpretation: Delay in the discharge of the patient increases the pressure on beds of the hospital and delay in discharge is bad for both hospitals and the patients. Thus, it becomes important to calculate the waiting time in the hospital to decrease the waiting time and increase patient safety by providing prompt services.

Means of verification:

1. Out-Patient Department Waiting Time = Sum of time from when the patient entered the outpatient clinic to the time the patient leaves the OPD/ Total Number of Out-Patients

2. Discharge Waiting Time = (Total time taken for the medical record to reach the billing department from the ward + Total time taken in the billing department)/Total Number of In-patients

HO 9 - Reporting of Adverse events

Interpretation: Adverse events are usually defined as an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge, or death caused by healthcare management rather than by the patient's underlying disease. A substantial part of these events are avoidable and it is important to report them in order to prevent such events in the future.

Means of verification:

1. Data for last 6 months

HO 10 - Reporting of Thefts / Security related incidents

Interpretation: Thefts of medical equipment or medical records is a major concern in hospitals. Health records are being digitized and hence there is the danger of health information becoming compromised or stolen outright. It is important to decrease the number of such incidents by enhancing security in the facility.

Means of verification:

1. Data for last 6 months

HO 11 - Reporting of needle stick injuries

Interpretation: Needlestick injury is defined as a penetrating wound typically induced by a needlepoint or other sharp instrument or object which could be infected with another person's secretion. These injuries can lead to the transmission of blood-borne viral infections. A continuous follow-up and reporting of needlestick injuries in surgeons are important to prevent future events of needle stick injuries for higher patient safety.

Means of verification:

1. 6 months at least or annual

NEXT LEVEL OF CERTIFICATIONS

Silver Quality Certification

Silver Quality Certificate is the second level of Ayushman Bharat Quality Certification after becoming Bronze Quality Certified hospital. It indicates that the hospital has a better quality of services and patient care but needs to focus next on organization-centered standards in terms of the responsibility of management, and information management systems amongst others. It is intended to motivate hospitals to keep increasing the level of quality in their services. Hospitals with NABH Entry level Certification can directly apply for Silver Quality Certification without getting Bronze Quality Certification with a simplified process. Hospitals applying for Silver Quality Certificate are not required to pay any additional fee.

Gold Quality Certification

Gold Quality Certificate is the highest level of Ayushman Bharat Quality Certification signifying that the certified hospital is complying with most of the healthcare protocols to ensure the best quality of services and patient care.

Hospitals with NABH Full/ JCI accreditation and NQAS National level full without any conditionality Certificate can directly apply for Gold Quality Certification without getting Silver or Bronze Quality Certification with a simplified process. Hospitals applying for Gold Quality Certificate are not required to pay any additional fee.

Processes

NABH Entry level certified hospitals are directly eligible for silver certification while NABH Full/ JCI Accredited or NQAS National level (without conditionality) hospitals are directly eligible for Gold certification. They need to login into the HEM portal and register for the certification process. From there, they will be redirected to another portal where they need to answer some AB PM-JAY specific questions and upload their documents/certificates as per the requirements. Once they submit the application, it will be a move to the document verification stage, post which the application will be sent to the certification committee for further process and recommendation. Following the completion of the process, the result

Steps of the certification process for already certified hospitals:

1. Login on HEM Portal
2. Click “Apply for certificate”
3. Fill the “Registration Form”
4. Fill up the “Application Form”
5. Document verification (via Desktop Assessment)
6. Reply to desktop non-Compliances (if any)
7. Review of the application
8. Issue of the Quality Certificate

National Health Authority (NHA)

The National Health Agency had been restructured as National Health Authority (NHA) through a January 2019 cabinet decision. As per the notification dated 1st February 2019, the Union Cabinet approved the restructuring of the existing National Health Agency as 'National Health Authority' for better implementation of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). Through the decision, the National Health Agency registered as a Society under Societies Registration Act 1860, has been dissolved and has been replaced by National Health Authority as an attached office to the Ministry of Health and Family Welfare. With the dismantling of the earlier two-tiered management structure, NHA will have full functional autonomy and shall be governed by a Governing Board comprising of the union minister for Health and Family Welfare as its Chairman and 11 members.

Headed by a full-time Chief Executive Officer (CEO), NHA is responsible for the design, roll-out, implementation, and management of the AB PM-JAY across the country. To effectively carry out the tasks allotted to it, the NHA through the Governing Board will be responsible for framing, amending, and repealing policies and administrative and financial procedures relating to hiring/utilization/retention of resources, outsourcing of various tasks, budgetary support, and release of funds including guidelines for bank accounts for the management and administration of the authority.

To implement the scheme at the state level, states have formed State Health Agencies (SHAs) in the form of a society/trust. SHAs have full operational control over the implementation of the scheme in the state.

NHA provides the overall vision and stewardship for design, roll-out, implementation, and management of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in alliance with state governments. Inter-alia, this will include, formulation of AB PM-JAY policies, development of operational guidelines, implementation mechanisms, coordination with state governments, monitoring and oversight of AB PM-JAY amongst others.

The National Health Authority plays a critical role in fostering linkages as well as the convergence of AB PM-JAY with health and related programs of the Central and State Governments.

The NHA leads the development of strategic partnerships and collaborations with Central and State Governments, civil society, financial and insurance agencies, academia, think tanks, national and international organizations, and other stakeholders to further the objectives of AB PM-JAY.

The National Health Authority provides technical advice and operational inputs, as relevant, to states, districts, and sub-districts for AB PM-JAY including formulating standards/ SOPs/guidelines/manuals to guide implementation, identification of capacity gaps and related training,

development of health information, and IT systems, facilitating cross-learnings, documentation of best practices, research and evaluation and undertake associated administrative and regulatory functions.

Quality Council of India (QCI)

Established in 1997 through a Cabinet decision of the Government of India (GoI) – the Quality Council of India (QCI) is an autonomous organization under the Department for Promotion of Industry and Internal Trade (DPIIT), Ministry of Commerce and Industry. It was established as the national body for accreditation and certification based on the recommendations submitted by a committee that included various interested ministries and stakeholders to the Cabinet in 1996. Key recommendations included the need for establishing an organization jointly by the Government and the industry and the need for the organization to be self-sustaining and be away from the government.

Accepting the recommendations, the Cabinet Committee decided to set up the Quality Council of India as a non-profit autonomous society registered under Societies Registration Act XXI of 1860 to establish an accreditation structure in the country and to spread quality movement in India by undertaking a National Quality Campaign.

It is the Quality Apex and National Accreditation Body for accreditation and quality promotion in the country. The Council was established to provide a credible, reliable mechanism for third-party assessment of products, services, and processes which is accepted and recognized globally. The Mission of QCI is to lead a nationwide quality movement in India by involving all stakeholders for emphasis on adherence to quality standards in all spheres of activities primarily for promoting and protecting the interests of the nation and its citizens.

QCI is governed by a Council comprising of 38 members including the Chairman and Secretary General. The Council has an equal representation of Government, Industry, and other Stakeholders. The Chairman of QCI is appointed by the Hon'ble Prime Minister of India.

QCI functions through the executive boards, i.e.-

1. National Accreditation Board for Hospitals and Healthcare Providers (NABH)
2. National Board for Quality Promotion (NBQP)
3. National Accreditation Board for Certification Bodies (NABCB)
4. National Accreditation Board for Education and Training (NABET)
5. National Accreditation Board for Testing and Calibration Laboratories (NABL)

QCI has been engaged with several ministries and government institutions including NITI Aayog, Ministry of

Medium, Small and Micro Enterprise (for ZED), Ministry of Health and Family Welfare, Ministry of Railways, Ministry of Petroleum and Natural Gas, Ministry of Urban Development, Ministry of Drinking Water and Sanitation, Ministry of Skill Development and Entrepreneurship, etc. In addition, QCI is engaged with various State Governments as well, namely, Gujarat, Jharkhand, Punjab, Uttar Pradesh among others on a variety of projects dedicated to improvement in quality.

List of Contributors

S.No.	Name	Designation
NHA Team		
1	Dr. Ajai Agarwal	Director - HPQA
2	Dr. J L Meena	Joint Director – SPE
3	Dr. Parminder Gautam	Principal Consultant – NAFU
4	Dr. Sukhdeep Kaur	Senior Consultant – HPQA
5	Mr Prateek Sundriyal	Consultant – HPQA
6	Dr Priyanka Bhadoria	Consultant – HPQA
QCI Team		
1	Dr. R.P. Singh	Secretary General
2	Ms. Ridhima Madaan	Project Manager
3	Ms. Ankita Garg	Project Manager
4	Mr. Paras Goel	Junior Associate
5	Ms. Twinkle Khanna	Junior Analyst
6	Mr. Vishal Kandwal	Junior Analyst
Subject Matter Experts		
1	Dr. Atul Mohan Kochhar	Principal Assessor, NABH
2	Dr. Girdhar Gyani	Director General, AHPI
3	Dr. K. K. Kalra	Advisor, AHPI
4	Dr. Pawan Kapoor	NABH Technical Committee
5	Dr. Murali Srinivasan	NABH Technical Committee
6	Dr. Lallu Joseph	Secretary General, CAHO

national health authority

सत्यमेव जयते

7th & 9th Floor, Tower-I,
Jeevan Bharati Building
Connaught Place, News Delhi - 110001

mera.pmjay.gov.in /AyushmanBharatGOI /AyushmanNHA