NATIONAL AYUSH MISSION KERALA

Government of Kerala

NATIONAL AYUSH MISSION KERALA

KERALA AYUSH KAYAKALP

TRANSFORMING AYUSH HEALTHCARE FACILITIES

Kerala AYUSH

Kayakalp

Transforming AYUSH healthcare

Implementation Handbook

NATIONAL AYUSH MISSION KERALA

Kerala AYUSH Kayakalp

Transforming AYUSH healthcare

Implementation Handbook

Version : 01 | MAY 2025

Editorial Board

Dr. RAJAN N. KHOBRAGADE IAS
ADDITIONAL CHIEF SECRETARY

Health & Family Welfare &
Ayush Departments
Government of Kerala
Thiruvananthapuram-695 001

Phone { Office : 0471-2327865
0471-2518255

E-mail : secy.hlth@kerala.gov.in

Date 27th May 2025

MESSAGE

The **AYUSH Kayakalp** initiative is an important step in improving the overall quality and cleanliness of our traditional healthcare institutions. As AYUSH systems continue to play a key role in community health, it is essential that the facilities offering these services maintain high standards of hygiene, safety, and patient care.

The **AYUSH Kayakalp Implementation Handbook** is a practical tool designed to help our health facilities follow the right steps to improve their surroundings. It provides clear instructions, checklists, and assessment methods to guide teams in ensuring that their institutions are clean, safe, and welcoming for patients.

This initiative also encourages healthy competition by recognizing the efforts of well-performing facilities. More than just awards, it is about creating a culture where cleanliness and quality become a natural part of everyday functioning.

I encourage all medical officers, staff, and administrators to make full use of this Handbook and to approach this mission with commitment and teamwork. With sincere efforts at every level, we can ensure that AYUSH facilities continue to gain public trust and provide quality care in a clean and positive environment.

Rajan Khobragade

MESSAGE

I am pleased to present the AYUSH Kayakalp Implementation Handbook, a comprehensive and practical guide to support AYUSH institutions in the State as they embark on their journey to achieving excellence in cleanliness, hygiene, and infection control.

This Handbook would be a companion to the Implementation Guidelines and provides a step-by-step roadmap for AYUSH facilities to implement standard protocols, conduct internal assessments, and prepare for external evaluations. With clearly defined award criteria and actionable tools, the handbook is designed to empower facility staff at all levels to participate in this transformative mission.

The Kayakalp program is not just about awards; it is about building systems, nurturing responsibility, and fostering a culture that prioritizes patient safety and service quality. Extending the reach of this initiative to AYUSH facilities reinforces our commitment to holistic health and wellness, in alignment with both national directives and local priorities.

I urge all stakeholders—Community Health Officers, medical officers, support staff, and community leaders—to make the best use of this Handbook. Let us work together to ensure that AYUSH institutions become vibrant models of hygiene and care, reflecting the true spirit of the Kayakalp initiative.

Dr. D. Sajith Babu IAS
State Mission Director
National AYUSH Mission

MESSAGE

Our state is committed to keeping public spaces clean, with special focus on improving hygiene in AYUSH healthcare facilities. These centres play an important role in protecting the health of many people, so maintaining cleanliness and following infection control practices is very important.

The Kayakalp scheme encourages and rewards AYUSH public healthcare facilities that follow high standards of cleanliness, hygiene, and infection control. It aims to create a healthy and safe environment for both patients and healthcare workers.

This handbook has been carefully prepared as a simple and practical guide to help AYUSH facilities take part in the Kayakalp Award program. It provides useful information to improve the quality of services and meet the goals of the scheme.

I hope this handbook helps all AYUSH facilities to better understand and implement the Kayakalp standards. We wish everyone success in their efforts to improve healthcare services through cleanliness and quality care.

Warm regards,

Dr. Preeya K.S
Director
Dept. of Indian Systems of Medicine

MESSAGE

The Kerala AYUSH Kayakalp Award Programme recognizes Homoeopathic institutions that demonstrate exemplary performance in adhering to standard protocols of cleanliness and infection control. This prestigious acknowledgment highlights their commitment to delivering high-quality, hygienic, and patient-centric healthcare services within the AYUSH sector. By maintaining excellence in hygiene and infection control practices, these institutions set a benchmark for others, positioning themselves as leaders in providing holistic and patient-centered care. Aligned with the principles of Kayakalp guideline, this initiative fosters a culture of continuous quality improvement, encouraging Homoeopathic institutions to consistently review and enhance their practices to ensure the highest standards of patient safety, satisfaction, and overall well-being.

Wishing all participants continued success and excellence in their journey toward quality healthcare delivery.

Dr. M. P. Beena
Director
Dept. of Homoeopathy

CONTENTS

Introduction

After the launch of the Swachh Bharat Abhiyan (SBA) on 2nd October 2014, the Kayakalp initiative was launched by the Ministry of Health & Family Welfare on 15th May 2015 to complement these efforts. The primary objectives of the Kayakalp scheme are to promote cleanliness, hygiene, and infection control practices in public healthcare facilities by incentivizing and recognizing those that demonstrate exemplary adherence to standard protocols.

In alignment with this national initiative, the Kerala AYUSH Kayakalp programme has been introduced with the aim of strengthening the quality, cleanliness, and infection control standards in AYUSH hospitals and health & wellness centres across the state. This state-specific adaptation of the Kayakalp initiative focuses on improving the overall patient experience in Kerala's public AYUSH facilities by implementing structured protocols, assessment mechanisms, and capacity-building efforts tailored to the local context.

Background

The Government of Kerala is committed to upholding cleanliness and hygiene in public spaces, with a strong focus on improving the standards in AYUSH healthcare **facilities**. These institutions play a critical role in delivering traditional and holistic healthcare to large sections of the population, particularly in rural and underserved areas. Therefore, ensuring clean and safe environments in AYUSH hospitals is not only a matter of infrastructure but a public health priority.

To support this commitment, the Kayakalp programme was adopted and contextualized for AYUSH institutions to recognize and reward excellence in maintaining hygienic and patient-friendly environments. The state has disseminated guidelines and developed structured implementation frameworks that serve as a roadmap for improving facility cleanliness, infection control, waste management, and general upkeep in line with national quality benchmarks.

Objectives

The objective of the AYUSH Kayakalp programme is to improve cleanliness, hygiene, and infection control in AYUSH healthcare facilities by promoting standard practices, encouraging continuous quality improvement, and recognizing institutions that demonstrate exemplary performance. It also aims to build a culture of regular assessment and peer review, and to identify and promote sustainable practices that enhance patient safety, service quality, and overall health outcomes.

The AYUSH Kayakalp Implementation Handbook has been developed as a guiding document to support this mission, providing practical tools and benchmarks to achieve excellence in hygiene and service delivery in AYUSH healthcare institutions throughout Kerala.

A. HOSPITAL / FACILITY UPKEEP

Intent of the Checkpoint A1:-

The purpose of these checkpoints is to ensure that the healthcare facility maintains a clean, safe, and hygienic environment by preventing the entry and presence of stray animals within its premises. Stray animals such as dogs, cats, cattle, or pigs can pose serious threats to infection control, patient and staff safety, and the overall sanitary condition of the facility. Their presence may also lead to contamination of sterile areas, compromise food safety, and potentially cause physical harm. Therefore, a robust pest and animal control policy should be implemented, including preventive infrastructure measures, regular monitoring, and active removal strategies to keep the facility free of stray animals.

A 1	**Pest and animal control**
A1.1	**No stray animals within the facility premises**

Interpretation:

It ensures a clean, safe, and infection-free environment by preventing animal entry. Facilities should maintain secure boundaries, proper waste disposal, and clear signage. Regular monitoring, staff training, and coordination with local authorities are essential. Records of inspections, incidents, and corrective actions must be maintained. Compliance is scored based on prevention measures and actual presence of stray animals.

Means of verification : **OB / SI**

What is to be observed (OB):

- Facility premises (entrance, surroundings, corridors, backyards) are free of stray animals like dogs, cats, cattle, etc.
- Functional gates/fencing or boundary walls to prevent animal entry.
- Presence of warning boards/signage (e.g., “No Animals Allowed”).

What is to be enquired (OB):

- Awareness about the presence or absence of stray animals within or around the facility.
- Knowledge of the steps to be taken if a stray animal is found inside the premises.
- Understanding of the reporting mechanism for stray animal sightings or incidents.
- Familiarity with the designated person or authority responsible for handling such issues.
- Awareness of any past incidents involving stray animals.
- Knowledge of preventive measures in place (e.g., fencing, gate security).
- Confirmation of having received instructions or training regarding animal control within the premises.

Implementation plan :

The facility should ensure boundary walls and gates are secure to prevent animal entry. Regular rounds by security and housekeeping staff should be conducted to monitor for stray animals. Proper waste management practices must be followed to avoid attracting animals. Clear signage should be displayed, and staff should be trained to report and respond to any sightings. Any incidents must be recorded, and local authorities should be contacted if removal is needed. An SOP and necessary documentation should be maintained to support compliance.

Scoring Criteria :

- 2 Mark: No stray animals are present within the facility premises. Adequate preventive measures are implemented and documented. Evidence of monitoring (e.g., logs, photographs, SOPs) is available.
- 1 Mark: Occasional sightings of stray animals but corrective measures are taken promptly. Some preventive actions are in place but not fully effective or documented.
- 0 Mark: Stray animals are commonly seen within the premises. No or minimal preventive actions have been taken. No documentation or monitoring is in place.

Reference : NA

- **NA**

A1.2	**Cattle-trap is installed at the entrance**

Interpretation:
A cattle-trap (also known as a cattle grid) is a physical barrier installed at the entrance of healthcare facilities, particularly in rural or semi-urban settings, to prevent the entry of stray animals such as cattle, which can pose hygiene risks and disrupt services. It ensures that the premises remain clean, safe, and undisturbed, contributing to infection control and environmental cleanliness.

Means of verification : **OB / SI**
What is to be observed (OB):

- Cattle-trap (grill or metal barrier) is physically installed at the main entrance.
- It is properly positioned and functional to prevent cattle entry.
- No visible damage or blockage of the cattle-trap.
- Entrance area is free from signs of cattle intrusion.

What is to be enquired (SI - Staff Interview):

- Awareness of the presence and purpose of the cattle-trap.
- Responsibility for maintenance and cleaning of the cattle-trap.
- Any issues or repairs reported regarding the cattle-trap.
- Preventive measures taken to ensure the trap remains effective

Implementation plan :
The facility management team shall assess the main entrance of the healthcare centre and install a sturdy and appropriately sized cattle-trap, usually made of metal grates or rollers embedded in the ground. Coordination with local authorities or public works departments may be necessary for civil works. Regular maintenance of the trap will be ensured to keep it functional and safe for pedestrians and vehicles. Awareness signage may be placed near the entrance for visitors.

Scoring Criteria :

- 2 Mark -Cattle-trap is properly installed, well-maintained, and effectively prevents animal entry.
- 1 Mark -Cattle-trap is partially installed or is in place but poorly maintained or ineffective.
- 0 Mark -No cattle-trap installed at the entrance.

Reference : NA
NA

A1.3	Pest Control Measures are implemented in the facility

Interpretation:
Pest control measures are essential to maintain a hygienic and safe environment in a healthcare facility. The facility must have a defined pest control program that includes routine pest management activities, documentation of services, and follow-up actions. This ensures prevention of infestation and minimizes the risk of pest-borne infections, thereby supporting overall patient safety and facility hygiene.

Means of verification: **OB / SI**

What is to be observed (OB):

- Facility is visibly free from pests (e.g., cockroaches, rodents, flies, mosquitoes).
- No pest droppings, nesting, or signs of infestation.
- Pest control treatment schedule or logbook displayed or maintained.
- Pest control chemicals stored properly with proper labeling.
- Use of insectocutors /fly catchers in food handling or clinical areas.
- Covered bins and waste disposal practices followed.

What is to be enquired (SI – Staff Interview) – Checkpoints:

- Awareness of regular pest control activity in the facility.
- Knowledge of schedule/frequency of pest control services.
- Awareness of areas commonly targeted during pest control (e.g., kitchen, toilets, storage).
- Action taken when pests are noticed by staff.
- Availability and awareness of Material Safety Data Sheets (MSDS) for pest control chemicals.
- Awareness about precautionary measures taken during pest control treatment.

Implementation plan:
The facility should engage a certified pest control agency to carry out periodic pest management activities. A pest control schedule should be created and strictly followed. Records of each service, including date, areas covered, chemicals used, and the service provider's credentials, should be maintained. Staff must be oriented on reporting any signs of pest activity. Periodic monitoring and review of the pest control effectiveness must be done by the facility in-charge.

Scoring Criteria :

- 2 Mark : A documented pest control plan is in place, implemented regularly by a certified agency, with records available and no visible infestation.
- 1 Mark : Pest control measures are carried out, but documentation is incomplete or irregular; minor signs of pest presence.
- 0 Mark: No pest control measures evident, no documentation available, or there is visible pest infestation.

Reference : NA

- **NA**

A1.4	**Anti-termite Treatment of wooden furniture and fixtures is undertaken periodically**

Interpretation :
This checkpoint ensures that wooden furniture and fixtures in the healthcare facility are protected from termite damage by doing regular anti-termite treatment. It helps keep the furniture safe, clean, and long-lasting.

Means of verification : **OB / SI**

What is to be observed (OB):

- No visible termite infestation on wooden furniture, doors, windows, or fixtures.
- Evidence of anti-termite treatment markings or stickers (date of last treatment).
- Neat, well-maintained condition of wooden items (no damage or holes from termites).
- Presence of service records or tags from pest control agency.

what is to be enquired (SI - Staff Interview):

- Awareness about periodic anti-termite treatment.
- Knowledge of the agency/vendor responsible for the treatment.
- Frequency of the treatment and last treatment date.
- Reporting mechanism for suspected termite issues.
- Staff awareness on identifying signs of termite presence.

Implementation plan:
The facility should plan and carry out anti-termite treatment for all wooden items at regular intervals, like once a year. A pest control company can be hired to do this. Keep records of each treatment, including the date and what was treated. Regular checks should also be done to spot any termite problems early.

Scoring Criteria :

- 2 Mark: Anti-termite treatment is done regularly as per a documented schedule within the last 12 months, with complete records available (date, treated areas, agency, chemicals used), and no signs of infestation.
- 1 Mark: Treatment has been done but not as per schedule, with incomplete records or the last treatment being more than 12 months ago, and minor signs of infestation may be visible.
- 0 Mark: No anti-termite treatment has been done, with no records available, and visible termite infestation is present.

Reference : NA

A1.5	**Measures for Mosquito-free environment are in place**

Interpretation :
The focus of this checkpoint is to ensure a mosquito-free environment in healthcare settings, which is critical for preventing vector-borne diseases. A mosquito-free environment promotes patient safety and reduces the risk of infection. The measure includes addressing stagnant water, regular inspections, and using appropriate mosquito control methods like insecticides, nets, and environmental modifications.

Means of verification : **OB / SI**

What is to be observed (OB):

- Presence of mosquito nets/screens on windows and ventilators where applicable
- Use of mosquito repellents or fumigation (spray machines, coils, vaporizers, etc.)
- No stagnant water in or around the facility premises
- Covered drains and regular cleaning of water collection areas

- Waste bins with covers, and no open water containers
- Display of awareness posters or instructions on mosquito prevention (optional)

What is to be enquired (SI – Staff Interview):

- Staff awareness about mosquito control measures in the facility
- Frequency and responsibility for fumigation or anti-larval activities
- Understanding of the importance of preventing stagnant water
- Process of reporting mosquito breeding areas or complaints
- Staff knowledge of cleaning schedules for water tanks, drains, and outdoor areas
- Any recent mosquito control interventions undertaken

Implementation plan:

the facility will establish a routine for checking potential mosquito breeding grounds such as water stagnation, open drains, and improperly covered containers. Staff will be trained on identifying and eliminating mosquito habitats, and regular fumigation or use of approved insecticides will be scheduled. An environmental monitoring checklist will be created to ensure compliance, with periodic audits to ensure that all areas remain free from mosquitoes.

Scoring Criteria :

- 2 Mark : All mosquito control measures (nets/screens, fumigation, no stagnant water, waste management, etc.) are in place, staff is fully aware of procedures, and preventive measures are followed consistently.
- 1 Mark : Most mosquito control measures are in place, but there are minor gaps (e.g., occasional stagnant water, incomplete staff awareness, or irregular fumigation).
- 0 Mark: No mosquito control measures are in place or staff is unaware of procedures, and mosquito-related issues are not being addressed.

Reference : NA

A2	**Landscaping & Gardening**

The objective of the Landscaping & Gardening component is to ensure that the external and internal environment of the healthcare facility promotes physical and mental well-being through cleanliness, greenery, and organized open spaces. A well-maintained landscape reflects the facility's commitment to patient-centric care by creating a pleasant, safe, and functional outdoor setting. It also supports traditional healthcare practices through the integration of herbal gardens, in alignment with AYUSH principles. These measures not only enhance the visual appeal of the facility but also contribute to infection control, safety, and environmental sustainability.

A2.1	**Facility’s front area is landscaped**
A2.2	**Green Areas/ Parks/ Open spaces are well maintained**

Interpretation:

The front area and green spaces of the facility must be well-maintained to create a clean, visually pleasing, and safe environment for patients and visitors. Wild vegetation must be removed, plants regularly trimmed, and green waste (such as dry leaves) cleared on a daily basis. The facility should take steps to ensure these areas are free from hazards and kept visually appealing at all times.

Means of verification : **OB**
What is to be observed (OB):

- Inspect the condition of the facility's front area and green spaces.
- Observe whether the area is landscaped and visually appealing.
- Check that wild vegetation does not exist. Check if wild vegetation is removed, and plants are regularly trimmed.
- Verify if dry leaves and green waste are cleared daily.
- Ensure that no hazards, like overgrown branches or untrimmed plants, are present.

Implementation plan :
Ensuring the facility's front area is landscaped and well-maintained, with regular care given to green spaces. Wild vegetation must be promptly removed, and plants, trees, and shrubs should be trimmed regularly to prevent overgrowth. Green waste, including dry leaves, must be cleared daily to maintain a clean and hazard-free environment. A designated team or staff member will be responsible for the upkeep, and a routine inspection checklist will be implemented to ensure compliance with cleanliness and safety standards.

Scoring Criteria :

- 2 Mark : The front area is landscaped, wild vegetation is fully removed, plants are regularly trimmed, and green waste is cleared daily.
- 1 Mark: Minor lapses in trimming or clearing green waste, but the area is mostly clean, and hazards are few.
- 0 Mark : The facility's front area is not landscaped, wild vegetation is present, plants are not maintained, or green waste is not cleared regularly.

Reference : NA

A2.3	**Internal Roads, Pathways, waiting area, etc. are even and clean**

Interpretation:
This criterion assesses the cleanliness and condition of internal roads, pathways, courtyards, and waiting areas within the healthcare facility. The objective is to ensure that these areas are even (smooth surfaces, no hazards) and are properly maintained. Cleanliness and landscaping of these spaces contribute to a welcoming environment and enhance patient and visitor experience.
Means of verification : **OB / SI**
What is to be observed (OB):

- Internal roads, pedestrian pathways, corridors, courtyards, and waiting areas within the healthcare facility are clean, levelled, free from potholes or obstructions.
- Proper landscaping or basic maintenance (e.g., trimmed grass, potted plants, swept surfaces) is evident.
- No water stagnation, garbage accumulation, or visible littering is present.
- Surfaces are non-slippery and safe for all patients, including elderly and disabled.

Implementation plan :
The facility should establish a documented cleaning and maintenance schedule for all internal access areas including roads, pathways, courtyards, and waiting spaces. Assign specific responsibilities to housekeeping and maintenance staff, ensuring periodic inspections. Landscaping or basic beautification (e.g., potted plants, trimmed hedges) should be maintained where applicable. Any complaints or identified issues should be addressed immediately, and corrective actions recorded to ensure continuous improvement.

Scoring Criteria :

- **2 Marks:** All internal roads, pathways, and waiting areas are clean, even, landscaped/maintained, with no visible litter or hazards. There is a clear cleaning schedule and designated responsibility with evidence of implementation.
- **1 Mark:** Majority of the areas are clean and even, with minor issues noted in maintenance or consistency of cleaning. Some documentation or routine is in place but may lack full evidence.
- **0 Marks:** Areas are unclean, poorly maintained, uneven, with visible obstructions or hazards. No cleaning routine or responsibility is evident.

Reference : NA

A2.4	**Gardens/ green area are secured with fence**

Interpretation

Securing gardens or green areas within a healthcare facility is essential to ensure safety, hygiene, and controlled access. An enclosed green space prevents unauthorized entry, deters stray animals, and protects the area from misuse or damage. It also contributes to infection control and patient safety by maintaining a clean and well-defined therapeutic environment. The presence of fences, barricades, or other boundary markers reflects the facility's commitment to orderly maintenance and environmental safety.

Means of verification : **OB**

What is to be observed (OB):

- Presence of fencing, barricades, railings, or wire mesh around the green/garden area.
- Continuity and completeness of the fencing – check for gaps, damage, or openings.
- Material quality and sturdiness of the fence (e.g., rust-free, stable, and weather-resistant).
- Gates (if present) are properly installed and functional.
- Signage (if applicable) indicating restricted access or designated use.
- No evidence of encroachment, trespassing, or unauthorized access points.
- Cleanliness and maintenance of the fenced area

Implementation plan :

The facility should identify all garden or green zones and assess the current status of their security. Suitable fencing materials—such as metal railings, wire mesh, or barricades—should be installed around these areas. All sides of the green area must be covered with no entry points left open, except designated gates if required. A regular inspection schedule should be established to monitor the condition of the fences, and timely repairs must be carried out when necessary. Staff should be oriented on reporting damage or breaches to ensure the area remains secure and functional.

Scoring Criteria :

- **2 Marks** –The garden or green area is completely secured with appropriate fencing, barricades, or barriers on all accessible sides.The fencing is intact, stable, and well-maintained, with no rust, breaks, or gaps. Gates (if any) are lockable and functional. The area shows evidence of regular maintenance and monitoring (e.g., clean surroundings, no signs of damage or trespassing).
- **1 Mark** –The garden or green area has fencing or barriers in place, but they are either incomplete (e.g., one side open) or partially damaged (e.g., loose wires, bent railing, rusting). Though the intent to secure the area is visible, repairs or improvements are

needed to ensure full security and usability.

- **0 Mark** –No visible fencing, barricades, or security features are present around the green area. The space is completely open and vulnerable to unauthorized access, stray animals, or misuse. There is no evidence of any effort to secure the area or maintain it as a protected green zone.

Reference : NA

A.2.5	**Provision of Herbal Garden**

Interpretation

The herbal garden is an essential component of the AYUSH Health and Wellness Centre. It demonstrates the integration of traditional medicine into primary health care delivery. A well-maintained herbal garden signifies the facility's intent to promote medicinal plant knowledge, environmental awareness, and support local health traditions. The presence, upkeep, and use of the garden provide evidence of compliance with the NABH/AYUSH HWC quality expectations.

Means of verification : **OB / SI**

What is to be Observed (OB):

- Presence of a designated herbal garden within or adjacent to the facility premises.
- Proper labeling of plants with botanical and local names.
- Adequate fencing or protection to prevent damage.
- Evidence of regular maintenance (watering, weeding, etc.).

What is to be Enquired (SI):

- Ask staff about the number and types of medicinal plants cultivated.
- Enquire about the purpose and use of the herbal garden (e.g., for patient use, awareness, demonstrations).
- Ask who is responsible for maintaining the herbal garden and frequency of maintenance activities.
- Verify if any records/logbooks related to the herbal garden are maintained.

Implementation plan :

If a herbal garden is not available or inadequately maintained, the facility should identify a suitable area within the premises or nearby open land. Collaborate with the Department of AYUSH, local bodies, or NGOs for sourcing medicinal plants. Assign clear responsibilities for garden maintenance, ideally to a trained staff member or community volunteer. Regular upkeep should include watering, weeding, labeling, and record-keeping. Signboards can be used to create awareness, and sessions can be conducted to educate patients and visitors.

Scoring Criteria :

- **2 Marks**: The facility has a fully established and functional herbal garden with a variety of medicinal plants (at least 10 species), all labeled correctly. The garden is clean, protected, regularly maintained, and used for patient/community education. Records/logs of maintenance are available.
- **1 Mark**: A herbal garden exists but is either limited in plant diversity (less than 10 species), has poor or missing labels, or shows signs of irregular maintenance. Educational use or documentation may be lacking.
- **0 Mark**: There is no herbal garden, or the existing area is not functional—plants are missing, dry, or unmaintained, with no signs of active use or upkeep.

Reference : NA

A3	Maintenance of Open Areas

The intent of maintaining open areas within a healthcare facility is to ensure that the external environment is safe, clean, functional, and aesthetically pleasing. Open spaces, if neglected, can pose significant risks such as accidents, spread of infections, vector breeding, unauthorized access, and encroachment, all of which directly impact patient safety, public health, and the reputation of the hospital. Well-maintained surroundings reflect good governance and contribute to a positive healing environment. Therefore, it is essential that all open areas are kept free from hazards such as water logging, dilapidated structures, encroachments, overgrown vegetation, and unauthorized movement.

A3.1	There is no abandoned / dilapidated building within the premises

Interpretation

This standard emphasizes the importance of maintaining a safe, clean, and structurally sound environment within the healthcare facility's premises. The presence of abandoned or dilapidated buildings not only poses safety hazards such as falling debris or unauthorized access but also reflects poorly on the facility's commitment to infrastructure management and overall quality. Structures that are visibly unused, neglected, or in a state of disrepair—whether accessible or cordoned off—can negatively impact the patient and visitor perception and may raise concerns during inspections. A facility meeting this criterion should have no such buildings visible within the premises, or if present, should demonstrate active and documented steps toward rectifying the issue (e.g., repair, demolition, or formal repurposing).

Means of verification : **OB / SI**

What is to be observed (OB):

1. Conduct a complete visual inspection of the facility premises, including outer boundaries, utility areas, parking zones, garden/backyard, and quarters if applicable.
2. Look for signs of structural decay such as cracked walls, broken windows, damaged roofing, rusted supports, leaning walls, or partial collapses.
3. Identify buildings or rooms that appear unused, locked for a long time, or cordoned off without signage or explanation.
4. Check for overgrown vegetation around any structure, which may indicate neglect or abandonment.
5. Observe whether safety warning signs (like "Do Not Enter", "Unsafe Area", etc.) are displayed around any suspect buildings.
6. Note if the area is being used for unauthorized storage or informal dumping of materials/waste.
7. Verify if access to such structures is restricted with physical barriers (e.g., fencing, locking).

What is to be enquired (SI):

1. Ask the facility in-charge, maintenance supervisor, or administrative officer about the purpose and current usage status of each structure on the premises.
2. Enquire whether any building is officially classified as abandoned, dilapidated, or out of service.

3. Verify if there is a documented plan for repair, demolition, or repurposing of any such structure (maintenance register, DPR, engineering reports).
4. Check if periodic infrastructure assessments are conducted and documented.
5. Ask about budget allocations or proposals submitted for the restoration or safe removal of such buildings.
6. Confirm whether any reported structural risk has been escalated to relevant authorities or flagged in internal audits.
7. Enquire about actions taken following the last inspection – has anything been done to address structural safety concerns?

Implementation plan :

The facility administration should initiate a full site survey to identify all structures within the premises and assess their current condition and usage status. A checklist or structural audit form should be developed to capture observations such as physical integrity, cleanliness, and occupancy status. If any abandoned or dilapidated structures are found, the facility must take immediate action—either by initiating repairs, restricting access with signage and barriers, or starting the legal and administrative process for demolition. Documentation of actions taken, including photographs, approval notes, maintenance plans, and communication with higher authorities, should be maintained. Moving forward, regular (e.g., quarterly) inspections of infrastructure should be scheduled, and the results should be reviewed during facility quality or safety meetings to ensure continuous compliance.

Scoring Criteria :

- **2 Marks:** Entire premises are clear of abandoned or dilapidated buildings. Facility appears well maintained with documentation (e.g., maintenance logs, inspection reports) to prove regular structural checks.
- **1 Mark:** Minor unused or poorly maintained structures are present but do not pose a risk to staff/patient safety. Documentation exists showing that action (repair/demolition) is planned or in progress.
- **0 Mark:** One or more abandoned or structurally unsafe buildings are visibly present within the premises, with no corrective measures or plans initiated.

Reference : NA

A3.2	**No water logging in open areas**

Interpretation

This checkpoint ensures there is no stagnant water in open areas due to faulty drainage, pipe leakage, or other issues. Water logging can lead to hygiene problems, mosquito breeding, and safety hazards. Facilities must maintain a functional drainage system, regularly inspect for blockages, and address water accumulation promptly. Compliance means no visible water stagnation, with ongoing maintenance and inspections. Non-compliance indicates poor drainage management, posing health and safety risks.

Means of verification : **OB / SI**

What is to be observed (OB):

1. Conduct a physical inspection of all open areas including courtyards, pathways, parking lots, backyards, garden areas, and zones near water outlets.
2. Look for stagnant water, wet patches, foul smell, or mosquito breeding areas.
3. Check for signs of poor drainage like blocked manholes, clogged storm water drains, or broken water pipes.
4. Observe the condition of gutters, slopes, and whether the terrain supports proper water flow.

5. Check if temporary water accumulation exists after rain or washing activities

Implementation plan :

The facility must establish a routine inspection schedule for all open areas, particularly during and after rain or cleaning activities. Maintenance teams should ensure drains are cleaned regularly and slopes are maintained to prevent stagnation. Areas prone to waterlogging must be identified and corrective civil works (e.g., repair of damaged drains, slope adjustments, pipeline leak correction) planned and executed. Staff should be instructed to report any signs of water accumulation immediately. If required, drainage maps should be updated and preventive action planned before the rainy season.

Scoring Criteria :

- **2 Marks:** No visible water logging in any open area. Drainage systems are functional and maintained. Documentation or visual proof of regular drain cleaning and inspections is available.
- **1 Mark:** Minor instances of water accumulation observed, but they are localized and not hazardous. Corrective measures are planned or ongoing. Documentation supports action.
- **0 Mark:** Significant water logging observed in one or more areas. Evident neglect in drainage maintenance. No corrective action is documented or visible.

Reference : NA

A 3.3	**No thoroughfare / general traffic in hospital premises**

Interpretation

This checkpoint focuses on ensuring that the hospital premises are secure, patient-centered, and free from non-essential or unrelated foot or vehicular traffic. A hospital is a sensitive environment where unrestricted public movement can compromise patient privacy, safety, infection control, and overall discipline within the facility. The presence of a thoroughfare—used by the general public as a shortcut or passage—indicates a serious lapse in physical and administrative control. Facilities are expected to have boundary demarcation, controlled entry and exit points, signage, and active surveillance to prevent such unauthorized access. Effective compliance with this criterion demonstrates the hospital's commitment to maintaining a safe and professionally managed environment for patients, visitors, and staff.

Means of verification : **OB / SI**

What is to be observed (OB):

1. Observe entry and exit points of the hospital premises to check if people not associated with the hospital (patients, visitors, staff, vendors) are passing through the premises as a shortcut.
2. Check for signs of non-hospital-related pedestrian or vehicle movement across the campus.
3. Look for physical barriers (gates, fencing) or signage restricting public access through internal roads or pathways.
4. Assess whether internal roads or passages connect two public areas (markets, roads, etc.), which may encourage through traffic.
5. Observe the presence of security personnel and their monitoring of movements at access points

What is to be enquired (SI):

1. Ask hospital administration or security personnel whether general public or local residents use hospital roads as a shortcut.

2. Enquire if any complaints or security issues have been reported due to non-hospital traffic.
3. Check if any formal instructions, circulars, or local authority notices exist regarding restricting public through traffic.
4. Verify if visitor entry is recorded, especially in sensitive zones.
5. Ask about surveillance measures (CCTV, entry logs) and actions taken to control unauthorized movement.

Implementation plan :

The hospital administration must assess the layout of the premises and identify any potential paths being misused as public shortcuts. Based on the assessment, entry and exit points should be secured using gates or fencing, and clear signage ("Hospital Access Only", "No Through Road", etc.) must be installed. Security staff must be trained to regulate and monitor access, and unauthorized thoroughfare should be actively discouraged. Collaboration with local authorities may be needed if public access is rooted in community usage. Surveillance systems like CCTV should be installed at strategic points to support monitoring. Regular reviews must be conducted to ensure ongoing control and compliance.

Scoring Criteria :

2 Marks:

- No evidence of public using hospital as a shortcut.
- Premises secured with gates/fencing.
- Security personnel actively regulate entry.
- Signage and CCTV surveillance are in place.

1 Mark:

- Occasional or limited public movement observed.
- Partial fencing or control measures implemented.
- Signage or security instructions exist.
- Action plan or proposal for full restriction available.

0 Mark:

- Regular public traffic through premises without restriction.
- No fencing, signage, or entry control.
- No plan or initiative taken to address the issue.

Reference : NA

A3.4	**Open areas are well maintained**

Interpretation

This checkpoint emphasizes the importance of maintaining open areas as part of a clean, safe, and aesthetically pleasing healthcare environment. Unkempt open spaces not only affect the visual impression of the facility but also contribute to potential health and safety hazards such as pest breeding, slips/trips, or injuries. Proper upkeep reflects the facility's commitment to hygiene, safety, and environmental responsibility.

Means of verification : **OB**

What is to be observed (OB):

1. Inspect all open areas such as lawns, gardens, walkways, approach roads, courtyards, and open utility spaces.
2. Look for the presence of overgrown shrubs, weeds, tall grass, or accumulated dry leaves.
3. Check for potholes, surface water stagnation, or bumps that may pose hazards.

4. Observe if there is any scattered garbage, construction debris, or broken paving stones.
5. Verify whether pathways are even and clean, and drains in open areas are not clogged.
6. Check if there are proper demarcations for green areas and pathways, and if fencing (if applicable) is intact.

Implementation plan :
The facility should ensure a **routine outdoor maintenance plan** is implemented, including scheduled grass cutting, weed removal, debris clearance, and surface repairs. Designated housekeeping or ground staff must perform regular inspections of open areas. Responsibilities should be clearly allocated, and records maintained in a maintenance log. In case of any potholes or surface damage, prompt action must be taken for repair. Drainage should be checked to prevent water stagnation. Open areas must also be included in internal housekeeping audits.
Scoring Criteria :

- **2 Marks:** All open areas are visibly well maintained—clean, free from weeds, overgrown grass, debris, or potholes. There is documented evidence of routine maintenance and inspections.
- **1 Mark:** Minor lapses are observed (e.g., slightly overgrown grass or minor uneven surface), but these do not pose safety or cleanliness issues. Maintenance is planned or in progress.
- 0 **Mark:** Open areas are poorly maintained, with visible signs of neglect such as overgrown weeds, stagnant water, potholes, or garbage. No action plan or maintenance record is available.

Reference : NA

A3.5	**There is no unauthorised occupation within the facility, nor there is encroachment on Hospital land**

Interpretation
This checkpoint ensures that hospital land and premises, including access roads, are free from unauthorized occupation or encroachment by vendors, shops, vehicles, or individuals. Such intrusions can obstruct patient movement, emergency services, and compromise safety, hygiene, and security. It reflects the hospital's responsibility to protect its property, maintain clear boundaries, and ensure that all space is used appropriately for healthcare delivery. Regular monitoring and coordination with local authorities are essential for compliance.
Means of verification : **OB / SI**
What is to be observed (OB):

1. Conduct a physical inspection of the hospital premises, including the main campus, approach roads, boundary walls, parking areas, and surrounding land.
2. Look for unauthorized structures such as temporary stalls, tea shops, vendors' kiosks, parked private vehicles permanently stationed, or informal settlements.
3. Observe any structures or activities that do not belong to the hospital operations but occupy hospital space.
4. Check if boundary walls or fences are broken or missing, potentially allowing encroachment.
5. Verify if hospital land is clearly demarcated with visible signage or boundary markers.

What is to be enquired (SI):

1. Enquire with the facility head or administrative officer about the total sanctioned land and any known issues of encroachment or occupation.
2. Ask if the facility has received any complaints or legal notices regarding encroachment.

3. Check for the availability of land records, approved site plan/layout, or property registration documents.
4. Confirm if any measures have been taken (legal, administrative, or physical) to remove encroachments or prevent unauthorized occupation.
5. Ask about routine monitoring of hospital land, especially in high-risk or busy zones.
6. Verify whether the hospital coordinates with local authorities (Panchayat, Municipality, Revenue Department) for land protection.

Implementation plan :
The hospital administration should regularly review and monitor the use of its land, starting with the verification of legal ownership and boundary maps. A demarcation survey may be conducted jointly with the local land authority if boundaries are unclear. Any unauthorized occupants or vendors identified should be addressed through proper legal or administrative channels in coordination with local governing bodies. Boundary walls or fences must be intact and periodically inspected. Awareness signage (e.g., "Hospital Property – Trespassing Prohibited") should be installed. Internal audits and community engagement can help prevent and resolve unauthorized use.

Scoring Criteria :

- **2 Marks:** No unauthorized occupation or encroachment visible; hospital premises are secure, clearly demarcated, and free from third-party use. Supporting documents (land ownership records, site plan) are available.
- **1 Mark:** Minor unauthorized activities (e.g., 1–2 vendors outside gates) not affecting hospital functioning, with corrective action planned or initiated. Demarcation exists, but needs improvement.
- **0 Mark:** Clear encroachment within hospital boundaries or access roads by shops, homes, or unrelated services. No visible action taken or boundary demarcation missing.

Reference : NA

A4	Hospital / Facility Appearance

The physical appearance of a healthcare facility significantly influences patients' perceptions of care quality, safety, and organizational professionalism. A clean, well-maintained, and visually organized environment fosters trust and comfort among beneficiaries and enhances staff morale. The intent of this criterion is to ensure that the hospital infrastructure — including walls, signage, and visual displays — is aesthetically pleasing, functionally relevant, and consistent across the facility. This involves ensuring that building surfaces are in good condition, the name of the facility is clearly visible, a standard signage system is used, and outdated or irrelevant materials are removed to maintain cleanliness and clarity. These measures collectively support a healing environment, reduce confusion, and reinforce the institution's commitment to quality care.

A4.1	Walls are well-plastered and painted

Interpretation
The observation under A4.1 confirms that the facility's walls are well-plastered and uniformly painted or whitewashed, without any chipped plaster, cracks, stains, or faded paint. This demonstrates regular upkeep and adherence to cleanliness and aesthetic standards, which is

essential for creating a positive impression on patients and visitors. Well-maintained walls also reduce the risk of dust accumulation, support effective infection control practices, and reflect the organization's commitment to quality and safety in the healthcare environment.

Means of verification : **OB**

What is to be observed (OB):

- Wall plaster is not chipped, cracked, or peeling.
- Walls are evenly painted or whitewashed.
- Paint is of uniform colour and has not faded or discoloured significantly.
- There are no visible stains, fungal growth, or signs of water seepage on walls

Implementation plan :

A comprehensive inspection of all interior and exterior walls will be conducted to identify areas with chipped plaster, faded paint, or inconsistent coloring. Identified damages will be prioritized for repair, followed by re-plastering and uniform repainting/whitewashing using durable, hospital-grade paint. The maintenance team will create a schedule for periodic wall inspections and touch-ups every six months to maintain aesthetic and hygienic standards. Documentation of the repair and painting activities will be maintained for quality audits and continuous monitoring.

Scoring Criteria :

What is to be observed (OB):

- Check that wall plaster is not chipped off.
- Verify that the building is painted or whitewashed in a uniform color.
- Ensure that the paint has not faded away or peeled off.

What is to be enquired (SI):

- Enquire about the last date of wall maintenance, painting, or whitewashing.
- Ask whether any damage to the plaster or paint has been identified and when it will be repaired.
- Verify whether there is a regular maintenance schedule for the walls to ensure they remain well-plastered and painted.

Reference : NA

A4.2	Interior of patient care areas are plastered & painted

Interpretation

This checkpoint ensures that all patient care areas, both indoor and outdoor, have well-plastered and painted walls and ceilings in soothing colors. It reflects the hospital's commitment to maintaining a clean, pleasant, and therapeutic environment. Soothing, intact paint enhances patient comfort, supports infection control, and indicates regular upkeep. The absence of faded or peeling paint is a sign of good facility maintenance and a patient-friendly atmosphere.

Means of verification : **OB / SI**

What is to be observed (OB):

- The interior walls and ceiling of patient care areas (including both outdoor and indoor spaces) should be plastered and painted.
- The paint should be of soothing colors and should not have faded or peeled off over time.
- There should be no visible damage to the plaster or paint in these areas.

Implementation plan :

all patient care areas—both outdoor and indoor—will undergo assessment to identify any

sections where plastering or painting is inadequate or has deteriorated. Areas with chipped plaster, faded paint, or unsoothing colors will be prioritized for renovation. A schedule will be developed for repainting using non-toxic, washable, and soothing-colored paints that promote a healing environment. The work will be carried out in phases to avoid disruption of patient services. Post-completion, periodic inspections will be conducted to maintain the aesthetic and hygienic condition of the interiors.

Scoring Criteria :

- **2 Marks:** If all patient care areas have well-maintained, properly plastered, and freshly painted walls and ceilings in soothing colors, without any visible damage or fading.
- **1 Mark:** If most areas are well-maintained but some minor issues are observed (e.g., slight fading, minor damage to plaster/paint).
- **0 Mark:** If multiple areas show significant wear and tear, including peeling paint, major fading, or damaged plaster in patient care zones.

Reference : NA

A4.3	Name of the hospital is prominently displayed at the entrance

Interpretation

This checkpoint ensures that the hospital's identity is clearly visible and accessible to the public. A visible, well-lit name board not only improves accessibility but also reinforces trust, especially for first-time visitors. It reflects the hospital's commitment to transparency and patient orientation. A fully compliant name board demonstrates operational readiness and public visibility, while deficiencies in this area can hinder patient access and create confusion.

Means of verification : **OB / SI:**

What is to be Observed (OB):

- The name of the hospital is prominently displayed at the main entrance.
- The board is clearly visible from a reasonable distance.
- The display follows the state's signage policy or guidelines.
- The board is illuminated and legible during the night.

What is to be Enquired (SI):

- Ask staff or facility manager about the installation and maintenance of the name board.
- Check whether the signage complies with the state's standards (e.g., language, font size, illumination, bilingual/multilingual display if required).
- Enquire if the name board was placed considering visibility and public convenience.

Implementation plan :

The facility shall first conduct an internal audit to check the presence and compliance of the existing hospital name board with state norms. If the board is missing or non-compliant (e.g., poor visibility, no lighting), steps must be taken to install or upgrade it. The board should be made using durable materials, sized appropriately, and placed at a strategic point where it is clearly visible to incoming patients and visitors. Illumination, such as LED lighting or backlit display, should be installed to ensure nighttime readability. A maintenance schedule must be established to ensure the board remains clean, intact, and well-lit at all times. Documentation of procurement, installation, and maintenance should be maintained for verification.

Scoring Criteria:

- **2 Marks:**
  - Name of the hospital is clearly and prominently displayed at the entrance.
  - The board adheres fully to the state's signage policy.

- It is well-illuminated and visible even during night hours.

- **1 Mark:**
  - The name is displayed and visible, but does not fully comply with state policy (e.g., poor illumination, incorrect placement, or outdated format).
- **0 Mark:**
  - Name of the hospital is not prominently displayed or completely absent.
  - The board is non-functional (e.g., broken, faded, not readable at night).

Reference : NA

A4.4	**Uniform signage system in the Hospital**

Interpretation

evaluates whether the hospital has implemented a uniform and patient-friendly signage system. It assesses both the visual consistency and linguistic appropriateness of signage used throughout the facility. The key intent is to ensure that all patients, including those with low literacy or unfamiliarity with English, can navigate the hospital easily. Signage must be standardized, reflect a common colour scheme, and be in the local language to enhance accessibility and reduce confusion. This checkpoint reflects the hospital's commitment to patient-centered care, safety, and communication, especially for vulnerable groups.

Means of verification : **OB**

What is to be Observed (OB):

- All signage (directional, departmental, emergency, amenities) are in **local language**.
- A **uniform colour scheme** is followed across all signboards (same background and font colour, size, and style).
- Signage is placed at **appropriate locations** for easy visibility.
- Signs are **clearly legible** and made of durable materials.
- **Pictograms/symbols** used wherever applicable, as per universal standards

Implementation plan :

The hospital should conduct a signage audit to identify inconsistencies in language, design, and placement. A signage policy should be established, mandating the use of the **local language**, **uniform colour codes**, and **standard fonts and symbols**. Non-compliant signage must be replaced, covering all areas including departments, amenities, and emergency zones. Staff should be trained on proper signage use and upkeep. A designated team should be responsible for **monitoring compliance**, maintaining a **logbook**, and ensuring **periodic review** and replacement as needed.

Scoring Criteria :

2 Marks :

- All signage is in the **local language**.
- A **uniform colour scheme** is followed throughout the hospital.
- Signage is **clearly legible** and placed at **appropriate locations**.
- Includes **directional, departmental, and emergency** signage.
- Signage is **well-maintained** and up to date.

1 Mark :

- Majority of signage is in the **local language**, but a **few** are not.
- A colour scheme is used, but there are **some inconsistencies**.

- Some signage may be **faded, misplaced, or missing** in minor areas.
- **Partial coverage** (e.g., only departmental signage standardized).

0 Mark :

- Signage is **not in local language**.
- There is **no uniform colour scheme**.
- Signage is **missing, unclear, or inconsistent**.
- Many signs are **worn out**, **inadequate**, or **difficult to understand**.

Reference : NA

A 4.5	**No unwanted/Outdated posters**

Interpretation

The **Interpretation** emphasizes the importance of a clean and organized appearance to uphold the professionalism of the healthcare facility. Outdated or irrelevant materials can detract from the facility's image, potentially affecting patient perceptions. Therefore, maintaining up-to-date, relevant, and well-maintained wall decor is crucial for creating a welcoming and professional environment. Regular checks and a proactive approach are essential to meet this standard consistently.

Means of verification : **OB**

What is to be observed (OB):

- Ensure external and internal walls are free from outdated posters, slogans, graffiti, or clutter.
- Verify if materials are organized and strategically placed to maintain a professional appearance.
- Ensure all displayed posters are current and relevant to hospital services or initiatives.

What is to be enquired:

- Ask if there is a regular process for updating or removing outdated materials.
- Inquire about the frequency of wall checks and who is responsible for maintenance.
- Confirm if staff are aware of guidelines for wall decoration and cleanliness.

Implementation plan :

The **Implementation Plan** ensures that the facility remains visually professional by implementing regular checks and updates to wall materials. It outlines a clear, systematic approach for maintaining the cleanliness and organization of the walls, ensuring that all posters and materials are current and relevant. Designating staff responsibilities and providing training are key to making this process consistent and efficient. Regular monitoring ensures that the facility's walls always reflect a clean, professional image.

Scoring Criteria :

- **2 Marks:** The facility is entirely free of outdated posters, slogans, graffiti, or any unnecessary materials on both external and internal walls. The area maintains a neat, professional appearance.
- **1 Mark:** Some areas of the facility show outdated posters or graffiti, but efforts are being made to address the issue, such as regular checks or removal.
- **0 Marks:** The facility has significant instances of outdated posters, slogans, or graffiti on

both external and internal walls, and there is no apparent effort to maintain the wall's cleanliness or professionalism. **Reference : NA**

A5	**Infrastructure Maintenance**

The intent of **Standard A5: Infrastructure Maintenance** is to ensure that the hospital's physical infrastructure, including its buildings, electrical systems, parking areas, and boundary walls, is maintained in a safe, functional, and compliant state. This standard focuses on the importance of regular inspections, preventive maintenance, and timely repairs to avoid risks to patient safety, minimize operational disruptions, and ensure the hospital environment is secure and conducive to high-quality healthcare. Proper maintenance of infrastructure supports not only the safety and well-being of patients, staff, and visitors but also the smooth and uninterrupted delivery of healthcare services. It is essential that all infrastructure elements are regularly checked for wear and tear, functional compliance, and operational efficiency to maintain a secure, hygienic, and operational healthcare environment

A5.1	**Hospital Infrastructure is well maintained**

Interpretation
This checkpoint ensures that the hospital's infrastructure is well-maintained and free from major defects that could compromise patient safety or the quality of care. A well-maintained environment contributes significantly to a positive healthcare experience, ensuring that patients and staff operate in a safe and comfortable setting. By implementing a structured maintenance program, the hospital demonstrates its commitment to preserving the physical environment and preventing infrastructure-related issues that could disrupt hospital operations.
Means of verification : **OB / SI**

- **What is to be observed (OB):**
  - **No major cracks, seepage, chipped plaster & floors** in the hospital.
  - **Cleanliness and order**: Ensure common areas are well-maintained and free of damage.
  - **Condition of utilities**: Check plumbing, electrical systems, and HVAC for any issues.
  - **Accessibility**: Ensure pathways, doorways, and ramps are clear and functional.
- **What is to be enquired (SI):**
  - **Maintenance records**: Inquire about the hospital's maintenance schedule and history of repairs.
  - **Staff awareness**: Ask if staff is trained to identify and report infrastructure issues.
  - **Scheduled inspections**: Confirm the frequency of infrastructure inspections and responsible personnel.
  - **Maintenance budget**: Enquire about the allocated budget for routine repairs.

Implementation plan :
The hospital must establish a regular inspection schedule to monitor the condition of the

infrastructure across all areas. This includes examining walls, floors, ceilings, plumbing, and electrical systems for any signs of damage such as cracks, seepage, or wear and tear. A designated maintenance team should be responsible for addressing any identified issues and carrying out necessary repairs in a timely manner. Additionally, a clear reporting system should be in place for staff and patients to report any infrastructure concerns, ensuring that repairs are promptly addressed. A comprehensive maintenance plan should outline the frequency of inspections and the required actions to be taken for any damage observed, ensuring the hospital remains safe and fully operational.

Scoring Criteria :

- **2 Marks:** Represents a well-maintained hospital with no issues or visible damage. The infrastructure is robust, and any maintenance work is carried out as required.
- **1 Mark:** Indicates that while the infrastructure is mostly sound, minor issues still exist. The presence of a maintenance plan suggests that these issues are being addressed.
- **0 Mark:** Points to a failure to maintain the infrastructure properly, with potentially hazardous issues like cracks or seepage present, indicating a lack of ongoing maintenance or oversight.

Reference : NA

A5.2	**Hospital has a system for periodic maintenance of infrastructure at pre-defined interval**

Interpretation

This checkpoint requires that the hospital have a clear and systematic approach to periodic infrastructure maintenance. The process should include scheduled maintenance intervals, documentation, and the tracking of activities. Ensuring that maintenance is performed regularly prevents deterioration of hospital facilities, reduces safety risks, and ensures compliance with healthcare standards. This also guarantees that the hospital infrastructure is safe, functional, and reliable, minimizing potential disruptions to patient care.

Means of verification: **OB / SI**

What is to be observed (OB):

- **Observe** the overall condition of infrastructure (building, utilities, etc.) for signs of regular maintenance.
- **Observe** if any maintenance work (repairs, painting, etc.) is completed on time, especially key safety features like electrical or plumbing systems.
- **Observe** if maintenance is carried out in an organized manner, by trained personnel or contractors.

What is to be enquired:

- **Enquire** with the facility management team about the maintenance schedule and intervals (e.g., annual, semi-annual).
- **Enquire** about how maintenance tasks are tracked and documented.
- **Enquire** if there is a system in place to prioritize urgent maintenance needs.

Implementation plan:

The hospital should develop and document a comprehensive maintenance plan that includes scheduled intervals for different infrastructure components, such as annual inspections and semi-annual checks. Maintenance tasks must be tracked using either a manual or computerized system, with detailed records for each completed task. The hospital should also ensure that maintenance

is carried out by qualified personnel or contractors, with evidence of the work completed. Regular reviews and audits of the maintenance process should be conducted to confirm that the schedule is followed, and any issues are promptly addressed. This system will ensure that the hospital's infrastructure remains safe, functional, and compliant with healthcare standards.

Scoring Criteria:

What is to be observed (OB):

- **Observe** the overall condition of infrastructure (building, utilities, etc.) for signs of regular maintenance.
- **Observe** if any maintenance work (repairs, painting, etc.) is completed on time, especially key safety features like electrical or plumbing systems.
- **Observe** if maintenance is carried out in an organized manner, by trained personnel or contractors.

What is to be enquired:

- **Enquire** with the facility management team about the maintenance schedule and intervals (e.g., annual, semi-annual).
- **Enquire** about how maintenance tasks are tracked and documented.
- **Enquire** if there is a system in place to prioritize urgent maintenance needs

Reference : NA

A5.3	**Electric wiring and Fittings are maintained**

Interpretation

The checkpoint A5.3 focuses on the safety and maintenance of electric wiring and fittings, ensuring that there are no visible hazards such as loose hanging wires or exposed panels. This is crucial for minimizing electrical risks, such as short circuits, fire hazards, or electrocution, which could jeopardize the safety of staff, patients, and visitors. Regular maintenance and immediate rectification of any identified issues demonstrate the institution's commitment to a safe and compliant environment. Ensuring that electrical installations meet safety standards and are properly maintained reflects adherence to regulatory guidelines and contributes to the overall safety culture in the healthcare facility.

Means of verification : **OB**

What is to be observed (OB):

- Ensure that there are **no loose hanging wires** (which can present a hazard).
- Check that there are **no open or exposed electricity panels** that could lead to potential electrical shocks or fire hazards.
- Confirm that all **electrical fittings** (such as sockets, switches, and panel boards) are properly secured and in good condition.
- Look for any **damage to cables** or connectors that could indicate wear and tear or improper handling.

Implementation plan :

an initial inspection of all electrical wiring and fittings should be conducted to identify any loose

wires, open panels, or damage. A maintenance schedule should be set, with regular checks performed quarterly or after repairs. Qualified electricians should be responsible for inspections, addressing issues promptly. Records of inspections and repairs must be maintained, and any hazards should be rectified immediately. Temporary signage should be placed for areas with ongoing electrical issues until resolved.

Scoring CRITERIA :

- **2 Marks:** All electric wiring and fittings are properly maintained, with no loose hanging wires, open, or broken electricity panels. The installation is secure, and there is clear evidence of regular maintenance and safety checks.
- **1 Mark:** Some minor issues are observed, such as a few loose wires or minor damages to the electricity panels, but these are not critical, and there is evidence of ongoing efforts to address these issues.
- **0 Marks:** Significant issues with electric wiring and fittings, such as multiple loose hanging wires, exposed electrical panels, or damaged fittings, with no evidence of proper maintenance or corrective actions taken.

Reference : NA

A5.4	**Hospital has intact boundary wall and functional gates at entry**

Interpretation:
This standard emphasizes the importance of maintaining all electric wiring and fittings in a healthcare facility to ensure safety and prevent electrical hazards. It requires that there should be no loose hanging wires, open or broken electrical panels, or damaged electrical components that could pose a risk to patients, staff, or visitors. Properly installed and secured electrical systems are crucial for the safe operation of medical equipment and for preventing fire or electrocution hazards.
Means of verification : **OB / SI**

What is to be observed (OB):
• Check to ensure that there are no loose hanging wires
• Check for any open or broken electrical panels
• Ensure all switches and sockets are intact and functional
• Look for signs of overheating, burning, or damage in wiring or fittings

What is to be enquired (SI):
• Ask maintenance staff about the frequency of electrical checks
• Verify if there is a preventive maintenance schedule for electrical systems
• Check if recent maintenance records/logbooks are available and updated
• Enquire about procedures followed in case of electrical faults

Implementation plan :
To meet this standard, the facility should conduct a comprehensive assessment of all electrical installations, including wiring, switches, sockets, lighting fixtures, and distribution boards. Regular inspections should be scheduled and performed by qualified electricians to identify and correct any defects or safety issues. Any loose wires should be secured, broken panels replaced, and damaged fittings repaired immediately. A preventive maintenance log should be maintained to document the inspection dates, observations, and corrective actions taken. Additionally, areas

containing electrical panels should be clearly marked with appropriate safety signage, and access should be restricted to authorized personnel only.

Scoring Criteria :

- **2 Marks**: All electrical wiring and fittings are in good condition, with no loose hanging wires, open, or broken electricity panels. No safety hazards are present.
- **1 Mark**: Minor issues detected, such as slight damage or unorganized wiring, but no significant safety concerns or immediate risk.
- **0 Marks**: Major issues with the wiring or fittings, such as loose hanging wires, broken panels, or visible safety hazards.

Reference :

A.5.5	**Hospital has adequate facility for parking of vehicles**

Interpretation

This checkpoint requires that the hospital provides a clearly designated area for vehicle parking, including a separate and marked space for ambulances. The focus is not only on availability but also on the systematic arrangement of parked vehicles to ensure smooth traffic flow and accessibility. Observers are expected to verify physical demarcations and observe the organization of parked vehicles during the assessment.

Means of verification : **OB / SI**

What is to be observed (OB):

- Check that there is a **demarcated space for parking** of vehicles.
- Confirm that there is **separate parking for ambulances**.
- Observe whether the vehicles are **parked systematically** in the designated areas.

Implementation plan :

To ensure the hospital has adequate parking facilities, the administration should first assess the current parking capacity and determine if it meets the needs of staff, patients, visitors, and emergency vehicles. If required, additional space should be allocated or alternative arrangements made. Clear demarcation using signage and ground markings (e.g., painted lines and symbols) must be implemented to distinguish areas designated for ambulances, patient vehicles, staff, and visitors. Security personnel or signage should guide systematic parking and monitor compliance. Periodic audits can help maintain the order and identify any need for further improvement.

- **2 Marks**: The hospital has a well-defined and appropriately sized parking area that can accommodate the expected number of vehicles of patients, visitors, and staff. The parking area is clearly demarcated, easily accessible, safe, and maintained regularly.
- **1 Mark**: The hospital has a designated parking facility, but it may be limited in capacity, not easily accessible to all users, or lacking proper signage or maintenance. Some effort has been made to provide parking, but it does not fully meet the expected requirements.
- **0 Mark**: The hospital does not have any designated parking facility, or the available area is grossly inadequate, unorganized, or poses safety and accessibility issues for users.

Reference : NA

A6	Illumination

The purpose of this criterion is to ensure that adequate and efficient lighting is provided throughout the healthcare facility, contributing to a safe, comfortable, and effective environment for both patients and staff. Proper illumination is essential for enhancing visibility, supporting clinical and operational activities, and minimizing risks. It is also important to use energy-efficient lighting solutions to reduce operational costs and support sustainability goals. This criterion ensures that all areas of the hospital, including circulation areas, indoor spaces, procedure areas, and the hospital's exterior, meet the required lighting standards for optimal functionality and safety.

A6.1	Adequate illumination in Circulation Area

Interpretation

Checkpoint A6.1 emphasizes the importance of proper lighting in circulation areas within the outpatient block to ensure patient safety, ease of movement, and a pleasant environment. Adequate illumination reduces the risk of accidents, facilitates better navigation for patients and staff, and contributes to the overall quality of care. The standard expects that lighting levels are not only sufficient but also consistently maintained, aligning with recommended norms. This checkpoint reflects the organization's commitment to providing a safe and patient-friendly infrastructure.

Means of verification : **OB**

What is to be observed (OB):

- The lighting levels in the circulation area (hallways, corridors, staircases, etc.) should meet the recommended standards as per NABH guidelines.
- Illumination should be evenly distributed without dark spots or excessive brightness.
- Check for functioning lights and proper placement of lighting fixtures.
- Ensure that lighting is non-glare and suitable for the safety of patients and staff.

Implementation plan :

To ensure adequate illumination in the circulation areas of the outpatient block (OB), a comprehensive lighting assessment should be conducted. Begin by identifying all circulation areas, including corridors, waiting areas, and connecting pathways. Measure the current lux levels using a calibrated lux meter, ensuring compliance with the standard illumination levels as per NABH or BIS guidelines (typically 100-150 lux for circulation areas). If deficiencies are noted, upgrade to energy-efficient LED lighting fixtures, ensuring uniform light distribution and avoidance of glare or dark spots. Install emergency lighting for power outages. Regular maintenance schedules should be established to clean fixtures and replace faulty bulbs. Documentation of lighting assessments, maintenance records, and any corrective actions taken must be maintained and readily available for inspection.

Scoring Criteria :

2 Marks:

- Adequate illumination is provided in the circulation area, meeting the required standards as per the NABH guidelines.
- The lighting in the circulation area is sufficient to ensure visibility and safety for all patients, staff, and visitors.

- There is no flickering, shadows, or dimly lit areas in the circulation area, and the lighting is appropriately maintained.

 1 Mark:
- Illumination is partially adequate, with minor deficiencies in certain areas of the circulation zone (e.g., slight shadowing or dimness in a few spots).
- The lighting is generally functional but does not fully meet the NABH guidelines.

 0 Mark:
- Illumination is inadequate, leading to poor visibility in the circulation area.
- Significant portions of the circulation area are poorly lit, making it unsafe or difficult for patients and staff to navigate through the area.

Reference : NA

A6.2	**Adequate illumination in Indoor Areas**

Interpretation
A6.2 ensures sufficient indoor lighting for safety, task efficiency, and comfort. Proper lighting prevents accidents, reduces eye strain, and improves productivity in clinical and administrative spaces. It is crucial for patient safety, particularly in corridors, treatment rooms, and waiting areas. Adequate lighting also contributes to a positive atmosphere for patients and visitors, supporting overall wellbeing in the healthcare environment.
Means of verification : **OB**

What is to be observed (OB):

- Ensure that the lighting system in indoor areas provides sufficient illumination for the intended tasks.
- Check that the lighting levels meet the recommended standards for the specific areas (e.g., patient rooms, corridors, medical examination rooms, and administrative areas).
- Verify the functioning of lights, ensuring there are no flickering or malfunctioning lights.
- Observe the placement of light fixtures to ensure that all parts of the room or space are adequately illuminated.
- Inspect emergency lighting systems for proper operation in case of power failure.

What is to be Enquired (SI):

- Ask about the specific lighting standards or guidelines followed for each indoor area.
- Inquire if there is a regular maintenance or inspection schedule for the lighting system.
- Ask the staff or facility management about the process for reporting and addressing any issues with illumination or lighting failures.
- Confirm whether there are periodic assessments to ensure lighting levels remain adequate.

Implementation plan :
To ensure adequate illumination, a lighting assessment should be conducted for each indoor area, considering factors like the type of work, natural light, and specific lighting needs of different spaces. Install appropriate lighting systems that meet required brightness levels, using energy-efficient LEDs and adjustable controls. Ensure uniform lighting distribution to avoid shadows or glare. Regular maintenance and bulb replacement schedules should be established, with an emphasis on minimizing downtime. Additionally, provide emergency lighting in critical areas.

Staff should be trained to use lighting effectively to enhance safety and comfort.
Scoring Criteria :

 2 Marks (Full Compliance):

- Adequate and well-distributed lighting throughout all indoor areas.
- Illumination levels meet the required standards as per regulatory guidelines or standards (e.g., 300 lux for general areas, 500 lux for work areas).
- Lighting fixtures are appropriately maintained, and there are no issues with glare, shadows, or insufficient light.

 1 Mark (Partial Compliance):

- Some areas may have adequate illumination, but certain spaces may experience inadequate lighting or uneven distribution.
- Lighting fixtures may need maintenance or adjustment to meet optimal standards.
- There might be occasional issues with glare or shadows in specific areas.

 0 Marks (Non-Compliance):

- Indoor areas consistently lack adequate illumination, with noticeable issues such as dim or uneven lighting.
- Lighting fixtures may be broken, poorly maintained, or absent in areas requiring adequate lighting.
- Significant glare or shadowing affects functionality or safety.

Reference : NA

A6.3	**Adequate illumination in Procedure Areas (OT)**

Interpretation
This checkpoint emphasizes the need for proper lighting in AYUSH treatment areas, particularly for Panchakarma and Ayurvedic therapies. Clear and adjustable illumination ensures safe and effective treatments, helping practitioners perform procedures like Virechana, Shirodhara, and Abhyanga accurately. Adequate lighting enhances patient safety, reduces errors, and supports high-quality care in Ayurvedic practices.
Means of verification : **OB**

What is to be observed (OB):

- Adequacy of lighting in all OT areas, particularly surgical sites.
- Availability and functionality of specialized surgical lights.
- Cleanliness and condition of lights.

Implementation plan :
Adequate Illumination in Procedure Areas (OT) in the AYUSH sector, the first step is to assess the current lighting in treatment areas used for Ayurvedic procedures like Panchakarma, Shirodhara, Abhyanga, and others. This assessment helps identify areas where lighting may be

insufficient or uneven. Based on the findings, the lighting system should be upgraded to include high-intensity lights that minimize shadows and are adjustable to meet the specific needs of different therapies. Proper placement of lighting is crucial to ensure full coverage of the treatment area, particularly in zones where close visibility is needed. Regular maintenance checks should be scheduled to replace bulbs and ensure that the electrical components are functioning properly. Additionally, staff should be trained on how to adjust the lighting according to the requirements of each procedure, ensuring safety and optimal performance. Finally, ongoing monitoring and review of the lighting system will help make necessary adjustments based on feedback from practitioners and patient outcomes.

Scoring Criteria :

 2 Marks: Adequate illumination is provided, ensuring proper lighting in all procedure areas (OT) to meet safety and functional requirements for the healthcare activities being performed. This includes appropriate intensity, distribution, and absence of shadows.

 1 Mark: Some issues with the illumination may exist, such as insufficient lighting or poorly distributed lighting in certain procedure areas. However, it does not critically impact the safety or functionality of procedures being carried out.

 0 Marks: Illumination is inadequate or absent, potentially affecting the quality of procedures and patient safety. There are significant gaps or deficiencies in the lighting setup in procedure areas.

Reference : NA

A6.4	Adequate illumination in Front of Hospital and Access Road (OB)

Interpretation

The checkpoint A6.4 focuses on ensuring that there is sufficient lighting in the areas surrounding the hospital, specifically the front of the hospital building and the access roads leading to it. This requirement is crucial for patient and visitor safety, providing clear visibility to avoid accidents or security risks, especially during low-light conditions such as at night or in inclement weather. Adequate illumination supports easy navigation for pedestrians and vehicles, contributing to the overall safety and accessibility of the hospital premises. It also plays a vital role in creating a welcoming and secure environment for those entering the hospital.

Means of verification : **OB / SI**

What is to be observed (OB):

- Adequate illumination of the front of the hospital and access road during the evening or night time.
- Placement and number of light sources to ensure proper visibility and safety.
- The condition of light fixtures, ensuring they are operational, clean, and not obstructed.
- Coverage of light ensuring there are no dark spots in critical areas, such as entrances, walkways, and driveways.

What is to be enquired (SI):

- Confirmation of maintenance schedules for lighting fixtures.

- Whether any lighting failures or complaints have been reported, and how they were addressed.
- If there are any plans for upgrades or improvements in the lighting system.

Implementation plan :
To ensure adequate illumination in front of the hospital and on access roads, an assessment of the current lighting system must first be conducted. This involves identifying areas with insufficient lighting, including hospital entrances, parking areas, and access roads. Based on this assessment, additional lighting fixtures should be installed, ensuring compliance with local regulations and safety standards. The selected lighting system should be energy-efficient and durable, with a focus on LED or solar-powered lights for cost savings and sustainability. Regular maintenance schedules should be established to ensure the lighting system remains functional, including periodic checks and cleaning of fixtures to prevent malfunctions. Additionally, the positioning and placement of lights should be planned to minimize shadows and ensure clear visibility, especially during nighttime hours.

Scoring Criteria :

2 Marks:
- Adequate illumination is provided in front of the hospital and along the access road, ensuring safe and well-lit pathways for patients, staff, and visitors during both day and night hours. The lighting should be in compliance with safety standards and ensure visibility in all weather conditions.

1 Mark:
- Partial illumination is provided, but the coverage is not sufficient for all areas or the illumination does not meet the required standards in terms of safety and functionality.

0 Marks:
- There is no or inadequate illumination in front of the hospital and along the access road, creating potential safety hazards for pedestrians and vehicles.

Reference : NA

A6.5	Use of Energy-Efficient Bulbs

Interpretation
Checkpoint A6.5 focuses on the healthcare facility's commitment to sustainability through the adoption of energy-efficient lighting. This measure is a part of the broader energy conservation strategy and aims to reduce the environmental footprint of the facility by minimizing electricity consumption. By using energy-efficient bulbs, the facility not only cuts down on energy costs but also supports environmental goals. This checkpoint ensures that energy management practices are being implemented and that the facility is continuously improving its sustainability practices in line with industry standards.

Means of verification : **OB**

What is to be observed (OB):
- Presence and use of energy-efficient bulbs (such as LED or CFL bulbs) in all relevant areas.
- Condition and functioning of the bulbs (ensure they are in working order).
- Proper installation and placement of energy-efficient bulbs in key areas, such as common areas, offices, hallways, and other spaces.

- Adequacy of lighting provided by the energy-efficient bulbs compared to traditional bulbs.

What is to be enquired (SI):

- Whether energy-efficient bulbs have been installed as a standard practice throughout the facility.
- Details on the procurement process for energy-efficient bulbs (e.g., vendor selection, cost analysis, etc.).
- Training or awareness provided to staff regarding the benefits and proper use of energy-efficient lighting.
- Any records or documents that show the switch to energy-efficient bulbs (e.g., purchase orders, maintenance logs).
- The impact of using energy-efficient bulbs on electricity consumption and cost savings (if available).

Implementation plan :

The implementation plan for A6.5 involves transitioning all lighting systems within the healthcare facility to energy-efficient bulbs, such as LED or CFL bulbs. This will be executed in a phased manner, beginning with the most frequently used areas like patient rooms, corridors, and administrative offices. A team will be designated to assess the current lighting infrastructure, calculate the energy consumption savings, and procure energy-efficient bulbs. Electrical systems will be checked for compatibility, and any necessary wiring upgrades will be completed to ensure safe installation. Staff will be trained on the importance of energy conservation, and monitoring systems will be set up to track the reduction in energy usage. The installation will be completed within a set timeline, and regular audits will be conducted to ensure compliance.

Scoring Criteria :

Scoring Criteria (for the use of energy-efficient bulbs):

- **2 Marks**: Full implementation of energy-efficient bulbs across all relevant areas or complete adherence to standards for energy-saving practices.
- **1 Mark**: Partial implementation or a few energy-efficient bulbs in some areas but not fully meeting the required standards.
- **0 Marks**: No energy-efficient bulbs used or no effort made to implement them.

Reference : AYUSH Kayakalp implementation guidelines

Intent for Criteria A7: Maintenance of Furniture & Fixture

The intent behind Criterion A7, "Maintenance of Furniture & Fixture," is to ensure that all furniture and fixtures in patient care areas and hospital premises are kept in good, functional, and aesthetically pleasing condition. This includes the upkeep of essential items such as windows, doors, patient beds, trolleys, stretchers, wheelchairs, and the furniture used by hospital staff. The overall goal is to provide a safe, comfortable, and hygienic environment for patients, staff, and visitors. The proper maintenance of these elements not only supports the operational efficiency of the facility but also ensures safety, cleanliness, and a pleasant working environment, which is critical in a healthcare setting.

A7	**Maintenance of Furniture & Fixture**

A7.1	Window and doors are maintained

Interpretation
Checkpoint A7.1 ensures that windows are secure, with intact panes and protective grills or meshwork in place. It also ensures that doors are intact, free from damage, and maintained with appropriate paint or varnish. This checkpoint focuses on enhancing the facility's safety, security, and aesthetic appearance while ensuring that windows and doors are functional and well-maintained over time. Regular checks help prevent wear and tear, contributing to the long-term durability of the building's entry points.
Means of verification : **OB / SI**

What is to be observed (OB):

- Check if the **window panes** are intact.
- Verify if the windows are **provided with a grill** or **wire meshwork**.
- Ensure the **doors** are intact (not broken or damaged).
- Confirm that the **doors** are properly **painted** or **varnished**.

Implementation plan :
The implementation plan for A7.1 involves a thorough inspection of windows and doors to ensure their integrity. Window panes will be checked for any cracks or damage, and the presence of grills or wire meshwork will be verified for added security. Doors will be inspected for structural soundness, ensuring there are no broken hinges or cracks, and the paint or varnish will be evaluated for wear. If any issues are identified, repairs or replacements will be carried out immediately. A regular maintenance schedule will be created to ensure ongoing upkeep, with periodic checks to prevent deterioration. All inspections, maintenance, and repairs will be documented for transparency and future reference.

Scoring Criteria :

 2 Marks:

- All windows are intact with no cracks or damages.
- Window panes are properly fixed with grills or wire meshwork in place.
- Doors are intact, with no visible damage or wear.
- Doors are well-maintained, painted, or varnished to prevent wear and tear.

 1 Mark:

- Some windows or doors show minor signs of damage, such as a few chipped or cracked panes or slight wear on the door surface.
- Either grills or meshwork are missing on some windows, or some parts of the doors are not painted/varnished.

 0 Mark:

- Windows are damaged or missing panes and grills/meshwork.
- Doors have significant damage (e.g., broken hinges, cracks, or no varnish/paint).

Reference : NA

A7.2	Patient Beds & Mattresses are in good condition

Interpretation
The checkpoint A7.2 ensures that patient beds and mattresses are maintained in a safe and comfortable condition for patient use. It emphasizes the importance of hygiene and safety, as rusted or poorly maintained beds could present a risk to patient safety, and torn mattresses could lead to discomfort or infection. This requirement highlights the need for regular maintenance, cleaning, and repair of patient beds and mattresses to ensure a high standard of care. By meeting this standard, the hospital demonstrates a commitment to providing a safe and pleasant environment for patients during their stay.

Means of verification : **OB**

What is to be observed (OB):
- Check that patient beds are not rusted and are painted properly.
- Ensure that the mattresses are clean, well-maintained, and not torn or damaged.

Implementation plan :
The implementation plan for this checkpoint involves conducting a thorough inspection of all patient beds and mattresses in the healthcare facility. A designated team will be assigned to check whether the beds are free from rust and properly painted. Additionally, the team will verify the condition of the mattresses by ensuring they are clean, free from any stains or damage, and not torn. If any beds or mattresses fail to meet these standards, corrective actions will be taken, such as repainting rusted beds or replacing or repairing damaged mattresses. The inspection will be carried out periodically, with an annual or semi-annual review of the patient beds and mattresses, and immediate corrective measures will be implemented if deficiencies are identified.

Scoring Criteria :
- **2 Marks**: The patient beds are well-maintained, free from rust, properly painted, and the mattresses are clean, undamaged, and in excellent condition (no visible wear or tears).
- **1 Mark**: The patient beds may have minor rust or paint peeling, but overall, they are functional. The mattresses are clean with minor visible wear, but not torn.
- **0 Marks**: The patient beds are rusty, poorly maintained, or significantly damaged, and the mattresses are visibly soiled, torn, or in poor condition.

Reference : NA

A7.3	**Trolleys, Stretchers, Wheel Chairs, etc. are well maintained**

Interpretation
This checkpoint ensures that trolleys, stretchers, and wheelchairs are safe, functional, and hygienic for use in patient care. It focuses on the physical condition of these items, verifying that they are free from damage, thoroughly cleaned, and well-maintained. The specific mention of wheel alignment and lubrication highlights the importance of smooth operation to avoid any mechanical issues during patient transportation. By fulfilling this checkpoint, the hospital ensures that the equipment is both patient-friendly and compliant with safety standards.

Means of verification : **OB / SI**

What is to be observed (OB):

- Check that trolleys, stretchers, and wheelchairs are intact, free from damage, and are in good working condition.
- Ensure that the trolleys, stretchers, and wheelchairs are properly painted, with no signs of rust or wear.
- Verify that the wheels of stretchers and wheelchairs are aligned, functioning properly, and free from any obstruction.
- Ensure that the wheels are adequately lubricated for smooth operation.
- Check cleanliness of all equipment to ensure no dirt or stains.

What is to be enquired:

- Inquire about the routine maintenance schedule for trolleys, stretchers, and wheelchairs.
- Ask if there are any records available for regular checks or repairs performed on these items.
- Enquire about the process followed in case any maintenance or replacement of parts is needed.

Implementation plan :

The hospital staff will conduct regular inspections of trolleys, stretchers, and wheelchairs to ensure they are in optimal condition. A designated team will be assigned to check the structural integrity of each item, verifying that no parts are broken or damaged. Additionally, these items will undergo periodic cleaning procedures to maintain hygiene standards. The wheels of the stretchers and wheelchairs will be checked for alignment, ensuring they are properly lubricated for smooth movement. A schedule for these checks will be established, with logs maintained to document each inspection and maintenance action taken.

Scoring Criteria :

 2 Marks:

- Trolleys, stretchers, and wheelchairs are intact (no damage or broken parts).
- Items are painted (free from rust or chips).
- Items are clean (free from dirt, dust, or stains).
- Wheels are properly aligned and well-lubricated to ensure smooth operation.

 1 Mark:

- Items are mostly intact, but there may be minor cosmetic issues (e.g., small scratches or faded paint).
- Wheels are aligned, but they may require minor adjustments for smoothness or lubrication.

 0 Mark:

- Items are damaged or in poor condition (e.g., broken parts, rust, or peeling paint).
- Items are dirty or have visible signs of neglect.
- Wheels are misaligned or require significant repair (e.g., not properly lubricated, wobbling, or making noise during use).
-

Reference : NA

A7.4	**Furniture at the nursing station, staff room, administrative office are maintained**

Interpretation

The checkpoint is focused on evaluating the physical condition of the furniture in key areas such as the nursing station, staff room, and administrative office. It aims to ensure that the furniture is

functional (i.e., not broken or damaged), aesthetically presentable (painted or polished), and hygienic (clean). The goal is to maintain a professional and comfortable environment for staff, which directly impacts their productivity and overall job satisfaction. Ensuring that the furniture is in optimal condition also reflects the facility's commitment to maintaining high standards of care and workplace safety. Regular checks and timely repairs are crucial to meeting this standard.

Means of verification : **OB / SI**

What is to be observed (OB):

- Check the condition of the furniture at the nursing station, staff room, and administrative office. Ensure that:
  - The furniture is not broken or damaged.
  - The furniture is clean, painted, and polished, if required.
  - All pieces of furniture are in good working condition and suitable for their intended use.

What is to be enquired (SI):

- Enquire with relevant staff about the maintenance schedule of the furniture and who is responsible for periodic cleaning, painting, or repairs.
- Ask if any furniture has been reported as damaged and how long it has been since the last maintenance or repair was carried out.

Implementation plan :

To ensure the condition of furniture at the nursing station, staff room, and administrative office is well-maintained, a scheduled assessment process should be put in place. The plan includes conducting a monthly inspection of all furniture in these areas to verify that it is free from damage, clean, and well-maintained. Any furniture found to be broken or in poor condition should be reported immediately and scheduled for repair or replacement. In addition, the furniture should be periodically cleaned and polished to maintain a neat appearance. Staff members should be educated on the importance of reporting any issues with furniture and encouraged to do so proactively. A designated team member should be assigned responsibility for overseeing these maintenance activities, and a logbook should be maintained to track inspections and corrective actions taken.

Scoring Criteria :

- **2 Marks**: The furniture is in excellent condition (no damage, clean, well-maintained, polished, and properly functioning).
- **1 Mark**: The furniture is in acceptable condition (some wear and tear but still usable, clean, and maintained to a reasonable extent).
- **0 Mark**: The furniture is in poor condition (broken, dirty, or unkempt).

Reference : NA

A7.5	**There is a system of preventive maintenance of furniture and fixtures**

Interpretation

The checkpoint A7.5 underlines the necessity for a documented and implemented preventive maintenance system specifically for furniture and fixtures within the hospital. "SI/RR" denotes that the compliance will be verified through system inspection and record review. The assessor

will check whether the hospital has an established and functional annual preventive maintenance program for these assets. This implies that the program must not only be documented but also executed at least once per year. Maintenance records, service logs, and reports must be available to demonstrate that each item has been inspected and serviced according to the schedule. This checkpoint ensures that the hospital environment remains safe, functional, and aesthetically acceptable, thereby supporting overall patient care and satisfaction.

Means of verification : **SI/RR**

What is to be enquired (SI):

- Ask housekeeping/maintenance staff how preventive maintenance is planned and executed.
- Enquire about the frequency and responsibility of maintenance activities.
- Ask clinical or administrative staff if there are mechanisms to report and follow up on faulty furniture or fixtures.

What is to be reviewed (RR):

- Preventive maintenance records/logs showing maintenance done at least once a year.
- Maintenance plan/schedule and any related checklists or formats.
- Complaint register/work order records showing follow-up actions for reported issues.

Implementation plan :

To implement a system of preventive maintenance for furniture and fixtures, the hospital should first develop an annual preventive maintenance (PM) schedule that covers all areas where furniture and fixtures are used. This includes patient rooms, consultation areas, waiting rooms, administrative offices, and staff areas. The maintenance department should categorize items based on their type and usage (e.g., patient beds, chairs, tables, storage units) and assign responsibilities for inspection, cleaning, tightening, lubrication, repainting, or replacement as needed. Documentation formats, such as checklists and logs, should be developed and maintained to record each maintenance activity. Training for the housekeeping and maintenance staff should be conducted to ensure proper execution of PM tasks. The hospital should also review and revise the PM plan annually to incorporate feedback and address recurring issues.

Scoring Criteria :

- 2 Marks: The hospital has a documented preventive maintenance plan for furniture and fixtures, and records of maintenance being conducted at least once a year are readily available and up to date.
- 1 Mark: The hospital has a preventive maintenance plan, but records are incomplete, outdated, or maintenance is irregularly conducted (e.g., not done for all items or missed in the past year).
- 0 Mark: There is no documented preventive maintenance programme, or no evidence of furniture and fixture maintenance being carried out.

Reference : NA

A8	**Removal of Junk Material**

The intent of this criterion is to ensure a clean, safe, and organized hospital environment by systematically identifying, removing, and disposing of all junk and condemned materials.

Accumulation of unused, outdated, or condemned items in patient care and critical areas poses a risk to patient safety, obstructs movement, harbors pests, and compromises infection control. The hospital must maintain clutter-free corridors, open areas, and especially critical service zones such as OTs and labour rooms. It is essential to have a designated, secure area for temporary storage of such materials and to follow a clearly documented and implemented condemnation policy. This contributes to operational efficiency, patient safety, and compliance with quality standards.

A8.1	**No junk material in patient care areas**

Interpretation
This checkpoint assesses whether patient care areas are free from unnecessary or potentially hazardous materials. The objective is to ensure that unused equipment, condemned items, and outdated records are not stored in areas where patients receive care, as they can contribute to clutter, confusion, and increased risk of infection. Surveyors will physically inspect these areas to verify cleanliness, organization, and adherence to disposal or storage protocols.

Means of verification : **OB**

Verification: OB

- Check nursing stations, OPDs, wards
- Ensure no unused/condemned items
- Remove outdated records
- Keep areas clean and clutter-free

Implementation plan :
To ensure compliance with A8.1, the hospital shall implement a structured housekeeping and material management policy. All patient care areas, including nursing stations, OPD clinics, and wards, will be routinely inspected to identify and remove any unused, condemned, or outdated items. Each department will designate a responsible staff member to conduct weekly checks and maintain a log of removed items. A central storage or disposal process will be defined for condemned articles and outdated records. Training will be provided to all staff on the importance of maintaining a clutter-free environment for patient safety and infection control.

Scoring Criteria :

- **2 Marks:**
  No junk/unused/condemned materials or outdated records are found in any patient care areas including nursing stations, OPDs, and wards. Areas are clean and well-maintained.
- **1 Mark:**
  Minor presence of junk/unused materials or outdated records observed in 1-2 locations, but does not obstruct patient care or safety.
- **0 Mark:**
  Significant junk/condemned materials or outdated records are found in multiple patient care areas, indicating poor housekeeping and risk to safety.

Reference : NA

A8.2	**No junk material in Open Areas and corridors**

Interpretation

The checkpoint for A8.2 requires a thorough inspection of all areas, including corridors, pathways, under stairs, rooftops, and balconies, to ensure that no unused or condemned materials are left in these open spaces. It aims to ensure that these areas remain free from clutter, allowing for clear passageways and promoting safety. The presence of such items can not only obstruct movement but also pose safety hazards. By checking for and removing these materials, the hospital or facility will create a more organized and safe environment for both staff and visitors, aligning with the principles of cleanliness and efficiency required for NABH accreditation.

Means of verification : **OB**

What is to be observed (OB):

- Check if unused or condemned equipment, vehicles, or any other items are being stored in the corridors, pathways, under the stairs, open areas, rooftops, balconies, or any other common spaces.
- Ensure that these areas are free from clutter and hazardous materials that could block pathways or pose a risk to safety.

What is to be enquired (SI):

- Inquire whether there is a designated storage area for unused or condemned equipment and materials.
- Ask if there are regular audits or inspections to identify and remove any junk materials that may accumulate in open areas and corridors.
- Ask about the process for disposing of or recycling outdated materials.

Implementation plan :

The implementation of A8.2, which focuses on eliminating junk material in open areas and corridors, requires a thorough assessment and regular monitoring. The first step is to conduct a detailed inventory check of all unused or condemned equipment, vehicles, and other materials in all open spaces, including corridors, pathways, areas under stairs, rooftops, and balconies. A designated team should be assigned to identify and tag such items. The next phase involves creating a disposal or storage plan for the condemned items. If the materials can be repurposed or repaired, they should be stored in a designated storage area. For materials that cannot be salvaged, disposal through appropriate waste management channels should be planned. To maintain compliance, regular checks should be scheduled, with designated personnel responsible for monitoring the cleanliness and accessibility of these areas.

Scoring Criteria :

- **2 Marks**: No unused/condemned equipment, vehicles, or materials are found in any of the areas mentioned (corridors, pathways, rooftops, balconies, under stairs, etc.).
- **1 Mark**: Some unused/condemned equipment or materials are present but are isolated or clearly labeled for disposal. Minor non-compliance observed in a few areas.
- **0 Mark**: Significant amount of unused/condemned equipment or materials found in open areas, corridors, rooftops, balconies, or under stairs, causing obstruction or safety risks.

Reference : NA

A8.3	**No junk material in critical service area**

Interpretation

The checkpoint A8.3 aims to ensure that critical service areas remain clear of unnecessary materials that could hinder the smooth operation of healthcare activities. By maintaining a clutter-free environment, the hospital ensures higher safety, hygiene, and efficiency, reducing the risk of infection, improving accessibility, and minimizing distractions during critical procedures. This also contributes to a more organized space, which is essential for quick response times in emergency situations and improving overall patient care. The implementation of this checkpoint is vital for meeting NABH standards related to cleanliness and safety in high-risk areas.

Means of verification : **OB**

What to observe (OB):

- Check for unused articles, old records, or non-essential items in the Labour room, OT, Dressing room, and other critical service areas.
- Ensure all spaces are clean, organized, and free from any clutter or items not in use.
- Observe if storage areas for essential equipment and supplies are well-maintained and clutter-free.

Implementation plan :

The implementation of the A8.3 checkpoint will involve a thorough inspection of critical service areas such as the Labour Room, Operation Theatre (OT), and Dressing Room. A designated team will be assigned to check for unused articles, old records, or any non-essential materials in these areas. Regular audits should be conducted to ensure that only necessary equipment, supplies, and records are stored in these spaces. Staff members will be trained to identify and dispose of any items that do not contribute to the immediate functionality of the space. A cleaning schedule will also be established to maintain a clutter-free environment, and the staff will be encouraged to follow this practice consistently.

Scoring Criteria :

2 Marks:

- All unused articles, old records, and non-essential items are completely absent from critical service areas such as the labor room, OT (operation theater), injection room, dressing room, etc.
- The area is well-organized and free of clutter, ensuring that only essential equipment and materials are present.

1 Mark:

- Some unused articles or old records may be present, but they are not obstructing or interfering with critical service functions. There may be minimal clutter, but it does not impact patient care or safety.

0 Marks:

- Junk material, unused articles, and old records are present in critical service areas, creating a disorganized environment. These items could potentially affect patient safety or interfere with the functionality of the service areas.

Reference : NA

A8.4	**Hospital has demarcated space for keeping condemned junk material**

Interpretation

The checkpoint A8.4 assesses whether the hospital has identified and secured a specific area for the safe storage of condemned materials before they are properly disposed of. The key elements to verify include the existence of a demarcated space that is clearly separated from other operational areas, ensuring it is safe, accessible only to authorized personnel, and well-maintained. The availability of such a space is critical in preventing contamination or hazards and

in promoting an orderly and efficient waste management system within the hospital environment.

Means of verification : **OB / SI**

What is to be observed (OB):

- Check for the presence of a clearly demarcated and secured space designated for storing condemned junk material within the hospital premises.
- Inspect if the area is segregated from operational areas and is appropriately marked to prevent unauthorized access.

What is to be enquired (SI):

- Inquire with hospital staff or management about the procedure for handling condemned junk material, including how and when it is segregated, stored, and disposed of.
- Ask for documentation or records related to the disposal of condemned junk material to confirm proper procedures are followed

Implementation plan :

To comply with the requirement for A8.4, the hospital will designate a specific area within the premises for the collection and storage of condemned junk material. This space should be well-marked and secured to prevent unauthorized access, ensuring safety and hygiene. The area will be equipped with proper labeling, containment bins, and signs indicating that it is a designated space for junk materials. The hospital will establish protocols for regular inspection and maintenance of this space to ensure compliance with the health and safety regulations. Additionally, staff will be trained to properly segregate and dispose of condemned materials in line with hospital guidelines.

Scoring Criteria :

- **2 Marks**: The hospital has a clearly demarcated, secure space designated specifically for storing condemned junk material, and it is maintained properly, ensuring safe collection and storage until disposal.
- **1 Mark**: The hospital has a demarcated space for storing condemned junk material, but it may not be secure or appropriately maintained.
- **0 Mark**: The hospital does not have a demarcated or secure space for storing condemned junk material, or it is not available at all.

Reference : NA

A8.5	Hospital has documented and implemented Condemnation policy

Interpretation

A8.5 ensures that the hospital has a formalized and consistent process for condemning items that are no longer fit for use, whether due to damage, obsolescence, or safety risks. Having a documented policy helps reduce the risk of operating with unsafe or outdated equipment, thus maintaining patient safety and the hospital's operational integrity. Compliance with this policy also ensures adherence to regulatory requirements. Proper documentation of condemned items and the rationale for their removal is critical for maintaining accountability and transparency in the hospital's asset management practices.

Means of verification : **SI/RR**

What is to be observed (OB):

- Review whether the hospital has a documented condemnation policy.
- Verify if the policy includes specific guidelines and procedures for condemning medical equipment, furniture, and supplies.
- Check whether the policy is easily accessible to staff and being followed during the condemnation process.
- Ensure that the policy specifies the roles and responsibilities of the personnel involved in the condemnation process.

What is to be enquired (SI):

- Inquire with the relevant department (e.g., Facility Management, Administration) if the hospital follows the documented condemnation policy.
- Ask if the hospital is using a state-issued condemnation policy or if they have created their own.
- Check if the policy has been reviewed periodically and updated as necessary.
- Confirm whether staff members involved in condemnation are trained in the procedures outlined in the policy.
- Enquire if there are any instances of non-compliance and how these are addressed.

Implementation plan :

The hospital must first verify whether a condemnation policy is documented and in place, either created internally or provided by the state. The policy should be reviewed to ensure it aligns with state or regulatory guidelines. Staff should be trained on how to apply the policy effectively. The hospital should implement a system to track condemned items, which includes maintaining clear records of the reasons for condemnation, dates, and actions taken. Regular audits should be conducted to ensure compliance with the policy and to make certain that it is updated as necessary to reflect any changes in regulations or internal procedures.

Scoring Criteria :

2 Marks (Full Compliance):

- The hospital has a **well-documented condemnation policy** that has been created in alignment with state guidelines or relevant authorities.
- The policy is **clearly implemented**, with evidence of it being followed, such as records of condemned items, approvals, and disposal processes.
- There is **proof of periodic reviews** of the policy to ensure its relevance and adherence to current standards or regulations.

1 Mark (Partial Compliance):

- The hospital has a **documented condemnation policy**, but it might lack clarity in certain areas, or it may not fully align with state guidelines.
- **Implementation is partial**; some records or practices show adherence, but there may be gaps in compliance, such as incomplete documentation of condemned items.
- The policy may not be reviewed regularly.

0 Marks (Non-Compliance):

- The hospital **does not have a documented condemnation policy** or relies solely on verbal procedures.
- There is **no evidence of policy implementation** or the hospital does not follow any formal process for condemnation and disposal.
- The condemnation process is **not monitored or documented** at all.

Reference : NA

A9	Water Conservation

The intent of this criterion is to ensure that hospitals manage water as a vital and finite resource in a sustainable manner. Adequate and safe water supply is essential for delivering quality healthcare

services. In addition to ensuring availability and maintaining water supply systems, hospitals must implement measures to minimize wastage, regularly inspect water infrastructure, raise awareness among stakeholders, and adopt eco-friendly practices such as rainwater harvesting. These actions reflect a hospital's commitment to environmental stewardship, operational efficiency, and public health responsibility.

A9.1	Water supply is adequate in Quantity & Quality

Interpretation

The checkpoint A9.1 focuses on ensuring that the healthcare facility has a sufficient and safe water supply. The "Quantity" aspect means that the water available should meet the demands of the institution, ensuring that there are no shortages. The "Quality" aspect means that the water must be safe for consumption and usage in medical procedures, adhering to health standards. By checking both the quantity (e.g., reservoir levels, flow rates) and quality (e.g., water test results), the facility ensures that it is providing a safe and reliable water supply to patients, staff, and visitors. Proper documentation of both parameters is necessary to demonstrate compliance with the standards and regulations.

Means of verification : **OB / SI/RR**

1. **What is to be observed (OB):**
    - Observation of the water supply system, including visible water sources such as reservoirs, pipelines, or storage tanks.
    - Water flow rate (if applicable) to check adequacy.
    - Inspection of water storage areas for cleanliness and proper maintenance.
    - Check for any signs of contamination or issues with water supply infrastructure.
2. **What is to be enquired (SI):**
    - Inquire with relevant staff (e.g., maintenance or facilities management) about the regular monitoring and maintenance of the water supply system.
    - Ask for the water quality test reports, including details of recent tests for physical, chemical, and microbiological parameters.
    - Enquire about the water supply volume (daily, weekly, etc.) and confirm that it meets the required standards for the facility's needs.
    - Inquire about the contingency plans in case of water supply interruptions or quality issues.

Record Review (RR):

- Verify **daily/weekly water quality testing records** (e.g., pH, chlorine level, bacterial count).
- Review **maintenance records** of water storage and purification systems (e.g., cleaning schedule, filter replacements).
- Check **logs of water supply quantity** (e.g., meter readings, tanker delivery logs if applicable).

Implementation plan :

To implement this checkpoint, the first step is to conduct a thorough assessment of the water supply system within the healthcare facility, ensuring that it meets both quantity and quality standards. The facility's water sources, such as wells, reservoirs, and pipelines, should be inspected to confirm they are capable of providing the required amount of water. The quantity can be monitored by checking water storage levels and flow rates in the reservoir. Additionally, water quality must be assessed by testing it for physical, chemical, and microbiological parameters. Regular testing should be carried out according to established standards, and the findings should be recorded consistently.

Scoring Criteria :

2 Marks:

- Water supply is adequate in both quantity and quality, supported by clear evidence such as accurate records of water reservoir levels and documented water quality tests that meet health standards. The supply is consistent and reliable, ensuring continuous availability for the facility's needs.

1 Mark:

- Water supply is either adequate in quantity or quality, but not both. There may be irregularities in the reservoir or minor deviations in water quality, though these do not pose a significant health risk. Documentation exists, but may not be comprehensive or up-to-date.

0 Marks:

- Water supply is inadequate in both quantity and quality, or there is no documented evidence of reservoir levels or water quality testing. Water shortages or quality issues are present, posing a risk to health and hygiene.

Reference : NA

A9.2	**Water supply system is maintained in the Hospital**

Interpretation

This checkpoint ensures the hospital's water supply system is fully operational and free from issues that could disrupt the provision of safe and clean water. Leaking taps or pipes, overflowing tanks, and dysfunctional cisterns can lead to water wastage, which increases costs, and may even result in water shortages in certain areas of the hospital. Maintaining the water supply system not only helps in reducing operational inefficiencies but also ensures that the hospital meets health and safety standards, providing reliable access to clean water for both patients and staff.

Means of verification : **OB / SI**

What is to be observed (OB):

- Check for leaking taps, pipes, overflowing tanks, and dysfunctional cisterns.
- Inspect the overall condition of the water storage tanks, including cleanliness and the presence of any contamination.
- Ensure proper functioning of water filtration systems (if present).
- Check for adequate water pressure in all areas, including patient wards, restrooms, and emergency departments.
- Observe whether water supply points are accessible and well-maintained in critical areas (ICU, operating rooms, etc.).
- Verify if water is available consistently, especially in high-demand areas.

Implementation plan :

To implement the checkpoint for maintaining the water supply system in the hospital, the facility management team will conduct a thorough inspection of all water-related infrastructure. This includes checking for leaking taps, broken pipes, overflowing tanks, and dysfunctional cisterns. The maintenance team will assess the entire water distribution system, identifying any areas where leaks or malfunctions are present. For any faulty or malfunctioning components, immediate repairs or replacements will be scheduled. Routine inspections will also be scheduled quarterly to ensure the system remains functional and efficient. The hospital's maintenance team will be trained on identifying water supply issues and addressing them promptly.

Scoring Criteria :

- **2 Marks**: The water supply system is fully functional, with no issues such as leaking taps, pipes, overflowing tanks, or dysfunctional cisterns. The system is regularly checked, and any maintenance issues are promptly addressed.
- **1 Mark**: The water supply system has minor issues such as a few leaking taps or minor maintenance needs, but they are being addressed within a reasonable time frame. No major disruptions or hazards are present.
- **0 Mark**: The water supply system has significant issues, such as leaking pipes, overflowing tanks, or dysfunctional cisterns, and no maintenance or corrective actions have been taken.

Reference : NA

A9.3	**There is a system of periodical inspection for water wastage**

Interpretation

The checkpoint for A9.3 aims to confirm whether staff members have been assigned clear responsibility for conducting periodical inspections for water wastage. This inspection includes checking for issues such as leaking taps and any other water-related inefficiencies. The purpose of this checkpoint is to ensure that a systematic and proactive approach is in place to minimize water wastage and enhance sustainability practices in the hospital. By verifying the assignment of duties to the appropriate staff, the hospital demonstrates a commitment to reducing water waste and managing resources efficiently.

Means of verification : **OB / SI**

What is to be observed (OB):

- Check whether staff are visibly conducting or assigned duties for the periodical inspection of water wastage sources (e.g., leaking taps, faucets, pipelines, etc.).
- Inspect maintenance logs or checklists to confirm that periodical inspections are being documented and followed.
- Ensure the presence of any preventive maintenance systems or reporting mechanisms for identifying and addressing water wastage.

Implementation plan :

To implement a system of periodical inspection for water wastage, the hospital management should assign specific staff members to regularly inspect various areas, focusing on water fixtures such as taps, toilets, and other plumbing systems. A schedule should be developed that outlines the frequency of inspections (e.g., weekly or monthly) to ensure that any issues like leaking taps or pipes are promptly identified and addressed. Additionally, the management should provide training to staff on how to recognize and report water wastage issues, and establish a reporting mechanism to document the findings and corrective actions taken. This inspection system should be incorporated into the hospital's regular maintenance protocols and linked to performance metrics for staff responsible for water management.

Scoring Criteria :

2 Marks (Fully Compliant):

- There is a clear and documented system for periodical inspection of water usage, with designated staff responsible for checking leaks, tap wastage, and other potential sources of water loss. Regular inspections are performed as per a defined schedule.

1 Mark (Partially Compliant):

- A system exists for periodical inspection, but it lacks proper documentation or the inspection schedule is inconsistent. Some staff are assigned duties for water inspection,

but the frequency and thoroughness may be insufficient.

0 Marks (Non-Compliant):

- No system in place for periodical inspection of water wastage. There are no designated staff or there is no defined schedule for checking water wastage issues like leaks or running taps.

Reference : NA

A9.4	Hospital promotes water conservation

Interpretation

The purpose of this checkpoint is to ensure that the hospital is actively promoting water conservation through awareness initiatives. The display of IEC materials serves as a visible reminder for both staff and users about the importance of saving water. The emphasis is not only on putting up educational content but also on making sure that staff and users understand and are motivated to implement water-saving practices. By making water conservation an integral part of hospital culture, this measure aligns with broader sustainability goals and fosters a sense of responsibility among everyone in the facility.

Means of verification : **OB / SI**

What is to be Observed (OB):

- Check if water conservation-related IEC (Information, Education, and Communication) material is displayed prominently in the hospital.
- Observe if the hospital has visible signage, posters, or pamphlets that promote water-saving practices, such as turning off taps after use or reporting leaks.
- Confirm that there are water-saving devices installed and visible, such as low-flow faucets or water-saving systems in restrooms.

What is to be Enquired (SI):

- Ask staff members about the hospital's water conservation initiatives and whether they are trained on the importance of water conservation.
- Enquire if there are specific programs or policies in place to educate patients and visitors about water conservation.
- Inquire if any regular monitoring or assessment is done to track water consumption patterns in the hospital.

Implementation plan :

To implement the A9.4 checkpoint, the hospital will first develop and display clear Information, Education, and Communication (IEC) materials that highlight the importance of water conservation. These materials will be strategically placed in key areas such as waiting rooms, staff areas, and other high-traffic zones to ensure visibility. The content will include educational posters, flyers, and digital signage that explain the significance of water conservation and practical ways to reduce water wastage. Additionally, staff members will be trained to emphasize water-saving practices in their daily routines. This could include encouraging the use of water-efficient equipment, reporting leaks promptly, and monitoring water usage patterns. Regular awareness sessions and reminders will be held to ensure that both staff and users are engaged in the water conservation effort.

Scoring Criteria :

2 Marks:

- IEC (Information, Education, Communication) material for water conservation is prominently displayed in multiple areas (e.g., common areas, washrooms, staff rooms).

- Staff and users are regularly informed and educated about the importance of water conservation through training sessions, posters, newsletters, or meetings.

1 Mark:

- IEC material for water conservation is displayed, but the efforts for educating staff and users are inconsistent or limited to specific areas.
- There is some awareness about water conservation, but no systematic training or information dissemination is conducted.

0 Marks:

- No IEC material on water conservation is displayed.
- There is little or no awareness of the importance of water conservation among staff and users.

Reference : NA

A 9.5	Hospital has a functional rain water harvesting system

Interpretation

Checkpoint A 9.5 requires the hospital to have a functional rainwater harvesting (RWH) system that is properly integrated into its infrastructure. This means the system should not merely exist as a structure but must be actively operational, collecting and storing rainwater effectively. The rainwater should be directed through a properly designed drainage system, filtered to remove impurities, and stored in tanks or used for groundwater recharge. The emphasis is on functionality and adequacy of storage capacity, ensuring the system contributes meaningfully to water conservation efforts. During assessment, the surveyor will verify the presence, functionality, and usage of the RWH system as part of sustainable hospital practices.

Means of verification : **OB / SI**

- **What is to be observed (OB):**
  - Presence of rainwater harvesting infrastructure integrated with the hospital's drainage system
  - Physical condition and cleanliness of the collection tanks/pits
  - Proper piping and filtration systems connected to the rainwater harvesting unit
  - Adequate storage capacity based on hospital size and rainfall volume
- **What is to be enquired (SI):**
  - Frequency of maintenance and cleaning of the rainwater harvesting system
  - Year of installation and any records of upgrades or repairs
  - Availability of documentation or maintenance logs
  - Staff knowledge about the system's functionality and purpose

Implementation plan :

To implement this requirement, the hospital should begin by assessing its roof area and local rainfall data to design an appropriate RWH system. A qualified engineer should be engaged to develop the infrastructure, including catchment areas, drainage pipes, filtration units, and storage tanks or recharge pits, all tailored to the estimated water yield. Once installed, the system must be tested during the rainy season to ensure effective collection and storage. The harvested water can be used for non-potable purposes such as gardening, toilet flushing, or cleaning, depending on its quality. Regular maintenance and documentation are essential, including records of cleaning schedules, inspections, and water usage. Staff responsible for facility management should be trained on the system's operation and upkeep, and general awareness should be created among all

employees about the benefits and proper use of the harvested rainwater. This comprehensive approach will ensure compliance with the checkpoint and promote environmental sustainability.

Scoring Criteria :

2 Marks:

- Hospital has a fully functional rainwater harvesting system.
- System is properly integrated with the drainage infrastructure.
- Sufficient storage capacity is available.
- Regular maintenance is done.
- Evidence of active utilization.

1 Mark:

- Rainwater harvesting system is present.
- System may be partially functional or not fully integrated with drainage.
- Storage capacity is limited or inadequate.
- Maintenance is irregular or insufficient.
- Some components may not be in active use.

0 Mark:

- No rainwater harvesting system is available.
- System exists but is completely non-functional.
- Not integrated with drainage infrastructure.
- No evidence of use or maintenance.

Reference : NA

A10 . Work Place Management

The intent of this criterion is to ensure that all healthcare facility workstations—including nursing stations, pharmacies, laboratories, and administrative desks—are maintained in an organized, clean, and functional state to support patient safety, operational efficiency, and staff well-being. Implementing workplace management practices based on the principles of 5S (Sort, Set in Order, Shine, Standardize, Sustain) helps eliminate waste, reduce errors, enhance productivity, and create a professional work environment that supports high-quality healthcare delivery.

A.10	Work Place Management
A10.1	Staff periodically sort useful and unnecessary articles at work station

Interpretation

Checkpoint A10.1 emphasizes maintaining a clean and organized work environment by periodically identifying and removing items that are no longer needed. During assessment, surveyors will speak with staff to determine how often they perform this task and evaluate their understanding of its importance. They will also visually inspect workstations for the presence of unnecessary items such as expired materials, excess stationery, broken equipment, or personal belongings. The goal is to ensure that work areas are functional, hygienic, and safe, supporting operational efficiency and patient safety.

Means of verification : **OB / SI**

What is to be observed (OB):

- Workstations are clutter-free.
- Use of “Red Tags” to identify unnecessary items.

- Essential items are in designated areas.
- Proper disposal/storage of unnecessary items.
- Presence of 5S/organization posters.
- Drawers/cabinets are organized.
- Compliance with cleaning/sorting schedules.

What is to be enquired (SI):

- "How often do you sort unnecessary items?"
- "Are all staff involved in sorting?"
- "Are you aware of any sorting protocols?"
- "Can you give an example of recently removed items?"
- "How do you decide what to remove?"

Implementation plan :

To ensure compliance with checkpoint A10.1, a structured implementation plan should be established. First, a standard operating procedure (SOP) must be developed, outlining the process and frequency (e.g., weekly or bi-weekly) for sorting and removing unnecessary items from workstations such as nursing stations, pharmacy dispensing counters, and laboratory work benches. Staff should be trained on 5S or similar workplace organization techniques to maintain tidiness and efficiency. Regular sensitization sessions and visual reminders (e.g., posters or signage) can help reinforce the importance of maintaining clutter-free work areas. Additionally, department heads or designated housekeeping supervisors can conduct routine audits and maintain checklists to monitor adherence.

Scoring Criteria :

2 Marks:

- Staff is able to clearly explain the process and **practice regular sorting (at least weekly)**.
- **No unnecessary articles** are observed at the workstation (e.g., Nursing stations, work benches, Pharmacy counters).
- **Documented evidence** or visual cues (e.g., 5S checklist, labels, marked areas) support the sorting process.

1 Mark:

- Staff mention **occasional or irregular sorting** (e.g., monthly or only when asked).
- **Few unnecessary items** are seen, but overall the area is relatively organized.
- No formal documentation or consistent visual management observed.

0 Mark:

- Staff are **not aware** of sorting practices or **do not perform** it.
- **Cluttered work areas** with several unnecessary or unused items present.
- **No system** or process in place for sorting.

Reference : NA

A10.2	The Staff arrange the useful articles, records in systematic manner

Interpretation

The checkpoint for A10.2 assesses whether items are stored in an orderly and efficient way, without being left in a disorganized state. It confirms that materials such as drugs, instruments, and records are kept near the point of use and within clearly marked designated areas. This ensures that the right materials are readily accessible, improving workflow efficiency while minimizing safety risks and operational errors. Proper organization in this manner not only contributes to a smoother operational process but also enhances overall safety and effectiveness in the workplace.

Means of verification : **OB / SI**

What is to be observed (OB):

- Observe whether drugs, instruments, and records are stored in a systematic, organized manner.
- Check if items are kept near the point of use to ensure easy access.
- Ensure that there is a clear demarcation or defined space for storing different articles (e.g., drugs in one area, instruments in another, and records in their designated place).

What is to be enquired (SI):

- Ask the staff about the procedures they follow for organizing and storing materials.
- Inquire whether any training or guidelines exist to ensure items are stored properly and systematically.

Implementation plan :

The implementation of A10.2 requires several steps to ensure that useful articles, records, and instruments are arranged in a systematic manner. First, training sessions should be conducted for all staff members to emphasize the importance of organizing materials properly and ensuring they are stored near the point of use. Clear demarcation of storage areas for drugs, instruments, and records is essential, with labels or color codes for easy identification. Regular audits and inspections must be established to monitor the organization of materials, ensuring that they are not left in a disorganized or haphazard manner. Additionally, a feedback mechanism should be put in place to allow staff to report challenges in maintaining the arrangement, enabling continuous improvements in the system.

Scoring Criteria :

2 Marks:

- All items, including drugs, instruments, and records, are systematically arranged in a neat and organized manner.
- There is a designated space for each type of article, and they are stored close to the point of use, ensuring easy accessibility.
- No items are found in a haphazard manner or out of place.

1 Mark:

- Most items are arranged in an organized manner, with only a few exceptions where some items are not systematically stored or placed too far from the point of use.
- Some items might be slightly disorganized or not in their designated places, but the overall order is acceptable.

0 Marks:

- Items are stored in a haphazard manner, and no clear organization or demarcation of

space for different articles is visible.
- Drugs, instruments, and records are either misplaced, disorganized, or not stored near their point of use.

Reference : NA

A10.3	**Staff label the articles in identifiable manner**

Interpretation
The checkpoint refers to the practice of ensuring all essential articles in the healthcare setting are clearly labeled for identification. This includes drugs, instruments, records, and any other items that need to be distinguished easily for safety, organization, and operational efficiency. Observing and verifying the labeling process will ensure compliance with safety standards and the smooth functioning of the facility.
Means of verification : **OB / SI**
OB (Observation):
- Check storage areas to ensure labels are visible and easy to read.
- Verify labeling consistency across similar items (e.g., drugs, instruments).
- Inspect label condition to ensure they are legible, intact, and not faded.
- Check for special instructions on labels (e.g., expiry dates, warnings).
- Ensure records (patient files, documents) are clearly labeled with identifiable information.

SI (Staff Interview):
- Ask staff about labeling protocols and if they follow a standard format.
- Inquire about training on labeling practices and if it's regularly updated.
- Ask staff from different departments how they label items and ensure correctness.
- **Check if staff face any challenges** with labeling (e.g., unclear labels, material issues).
- **Inquire about audits** and how staff ensure compliance with labeling standards.

Implementation plan :
To ensure that all articles are labeled in an identifiable manner, the hospital or healthcare facility should initiate a systematic process for labeling essential items like drugs, instruments, and records. This involves selecting a clear, legible labeling system that is standardized across the organization. Staff will need to be trained on proper labeling practices and the importance of maintaining consistent, easily readable labels for all items in the facility. A monitoring system should be established to regularly check the condition and accuracy of labels, and corrective action plans should be in place for non-compliance.
Scoring Criteria :
- **2 Marks:** The items are consistently and accurately labeled, and all staff are knowledgeable and follow the labeling procedures.
- **1 Mark:** Some items are labeled properly, but there are inconsistencies or gaps in the labeling process. Staff might have limited awareness or adherence to the guidelines.
- **0 Marks:** Items are not labeled in a recognizable or standard manner, and staff are not following the correct procedures for labeling.

Reference : NA

A10.4	**Work stations are clean and free of dirt/dust**

Interpretation

The checkpoint, "Workstations are clean and free of dirt/dust," assesses the cleanliness and hygiene of key areas in the healthcare facility. This includes high-touch surfaces such as nursing stations, dispensing counters, and lab benches, which are critical to patient safety and operational efficiency. Observing whether these areas are clean and shining will reflect the facility's commitment to maintaining a safe and hygienic environment. The evaluation involves verifying that these areas are not only clean but also free from dust, dirt, or any other contamination that could negatively impact the quality of care and safety standards.

Means of verification : **OB / SI**

Interview (SI):

- Ask staff if they have received any specific training on maintaining cleanliness in their work areas and if they are aware of proper cleaning techniques and standards.
- Inquire whether the cleaning supplies and materials are readily available and if staff follow a documented checklist for maintaining cleanliness in their workstations.

OB (Observation):

- Inspect the overall cleanliness of key areas such as nursing stations, dispensing counters, and lab benches during different times of the day to ensure consistent cleanliness.
- Check for the presence of any dust accumulation on equipment, furniture, or counters.
- Observe if the workstations have any visible stains, clutter, or non-functional items that may affect cleanliness.
- Assess if cleaning supplies (e.g., disinfectants, wipes, gloves) are easily accessible and well-stocked near these workstations.
- Review the condition of flooring and walls around the workstations for cleanliness, ensuring no dirt buildup or stains.

Implementation plan :

To ensure that workstations are clean and free of dirt/dust, the healthcare facility should establish a routine cleaning schedule. This schedule should involve daily cleaning of nursing stations, dispensing counters, and lab benches, with a focus on maintaining cleanliness throughout the day. Staff should be assigned specific areas to clean and be provided with cleaning supplies that meet hygiene standards. Additionally, the implementation plan should include regular monitoring and audits to ensure that all areas are maintained according to the cleanliness requirements. Staff should be trained in proper cleaning protocols and the importance of maintaining a hygienic environment.

Scoring Criteria :

- **2 Marks:** All workstations (nursing station, dispensing counter, lab benches) are visibly clean, shining, and free of any dirt or dust. Cleaning protocols are followed rigorously, and staff demonstrate knowledge of these procedures.
- **1 Mark:** Some workstations may have minor dust or dirt, but overall cleanliness is maintained. Staff may need some improvement in cleaning procedures or adherence to the cleaning schedule.
- **0 Marks:** Workstations are visibly dirty or dusty, and cleaning protocols are not followed. Staff is not adhering to cleaning standards, and there is a lack of structured cleaning procedures in place.

Reference : NA

A10.5	**Staff has been trained for work place management**

Interpretation

Checkpoint A10.5 assesses whether the facility staff has received proper training in managing the workplace using specific frameworks like the 5S system. This evaluation ensures that the staff is well-equipped to maintain a clean, organized, and efficient work environment, which is crucial for overall quality and operational efficiency. The focus is on verifying that the staff has not only received theoretical knowledge but also practical, hands-on training, ensuring that the systems are effectively implemented and maintained in the workplace. The evidence of such training should be documented and easily accessible for quality audits or assessments.

Means of verification : **SI/RR**

What to Observe (OB):

- Cleanliness and organization of the workspace.
- How staff organize their tools, equipment, and supplies.
- Presence of visual aids like labels or signage for organization.

What to Ask (SI - Staff Interview):

- Ask if staff have received training on workplace management (e.g., 5S).
- Inquire about what topics were covered in the training (sorting, organizing, cleaning, etc.).
- Ask how they apply the training in their daily work.
- Get feedback on how helpful the training has been and if they need more support.

Record Review (RR):

- Verify **training records** or **attendance sheets** of 5S or workplace management training sessions**.**
- **Review** training material or certificates **issued to staff.**
- **Check for** evidence of internal or external trainers**, session agendas, and feedback forms (if available).**

Implementation plan :

The implementation of checkpoint A10.5 requires a structured plan to ensure that all facility staff receives formal or hands-on training for effective workplace management, particularly focusing on methodologies such as the 5S system (Sort, Set in order, Shine, Standardize, Sustain). The first step is to assess the existing level of workplace management knowledge among staff members. Based on this assessment, training modules should be developed or sourced, ensuring they cover all aspects of the 5S methodology. Training should be hands-on, with practical exercises to ensure that staff can directly apply the concepts in their work environment. The training sessions should be scheduled to allow all staff to attend, and records of attendance, along with the training materials, should be maintained for future reference. After training, a follow-up assessment or observation can be conducted to verify the practical application of the knowledge.

Scoring Criteria :

2 Marks:

- Staff has received formal or hands-on training specifically related to workplace management practices, such as 5S or similar methodologies.
- Documentation or records of such training (e.g., training sessions, attendance, content) are available and well-maintained.

1 Mark:

- Staff has received informal or on-the-job training related to workplace management, but there is no formal or structured training program in place.
- There may be limited or incomplete records of training sessions or staff awareness is not

consistent.

0 Marks:

- No formal or informal training for staff on workplace management practices.
- There is no evidence of any structured approach to training staff on workplace management.

Reference : NA

SANITATION AND HYGEINE

B1	Cleanliness of Circulation Area

The objective of this criterion is to ensure that all circulation areas within the healthcare facility—such as corridors, staircases, waiting areas, and rooftops—are maintained in a visibly clean and hygienic state. These areas are frequently accessed by patients, attendants, and staff, and therefore, maintaining a high level of cleanliness minimizes the risk of cross-contamination and improves the overall patient experience. Proper sanitation also reflects the hospital's commitment to infection prevention and control. The implementation of routine and deep cleaning practices, along with the use of surfaces that facilitate effective cleaning, ensures a sustainable hygiene standard in high-traffic zones.

B1.1	No dirt/Grease/Stains in the Circulation area

Interpretation

The checkpoint B1.1 requires that there should be no visible dirt, grease, or stains present in any part of the circulation areas, including the floors, walls, corridors, waiting areas, stairs, and rooftops. The purpose of this checkpoint is to maintain a hygienic and professional environment in high-traffic areas, ensuring that patients, visitors, and staff have a clean and safe space to move through. Regular inspection and maintenance are critical to upholding this standard and preventing the buildup of grime that could affect both the aesthetics and health standards of the healthcare facility.

Means of verification : **OB / SI**

OB (What is to be observed):

- Check for any visible dirt, stains, or grease on floors, walls, ceilings, and handrails in corridors, waiting areas, and stairs.
- Observe the cleanliness and maintenance of these areas, ensuring there are no accumulated dust, debris, or markings.
- Inspect the roof for any visible signs of dirt or water stains.
- Ensure there are no visible wear and tear marks or any other signs of neglect on floors and walls.
- Look for any cleaning equipment or supplies being used in these areas, indicating active maintenance.
- Observe that waste bins are clean and appropriately placed.

SI (What is to be enquired):

- Inquire about the cleaning schedule for the circulation areas (how often cleaning is carried out and if there is a documented routine).
- Ask if there are any specific cleaning agents used for different surfaces, ensuring they are suitable for the type of flooring and walls.
- Enquire if there have been any recent incidents (like leaks or spills) that could contribute to stains or grease accumulation.
- Ask the staff if they notice any areas that are more prone to dirt or stains and if they are receiving additional attention.
- Inquire about the process for maintaining cleanliness in areas that are high-traffic or harder to access, like staircases and corners.

Implementation plan :

To ensure that the circulation areas are clean and free from dirt, grease, or stains, a routine cleaning schedule should be established for all common areas such as corridors, waiting areas, stairs, and rooftops. This schedule should include daily cleaning tasks, as well as periodic deep cleaning sessions to address areas that may accumulate dirt or grease over time. Designated staff should be assigned to inspect these areas regularly and be equipped with appropriate cleaning materials and tools. Additionally, staff training on maintaining cleanliness and proper waste disposal should be conducted to ensure consistency in cleanliness standards across the facility.

Scoring Criteria :

- **2 Marks**: The floors and walls of corridors, waiting areas, stairs, and rooftops are clean, with no visible or tangible dirt, grease, stains, or other contaminants. The area is well-maintained and visibly spotless.
- **1 Mark**: There may be minor visible dirt, stains, or grease in some areas, but they do not significantly detract from the cleanliness of the space. These issues are relatively easy to clean and are not pervasive.
- **0 Marks**: The area has noticeable visible dirt, grease, stains, or other contaminants, indicating poor maintenance or lack of cleanliness in the circulation areas.

Reference : NA

B1.2	No Cobwebs/Bird Nest/ Dust on walls and roofs of corridors

Interpretation

The checkpoint B1.2 requires the evaluation of the cleanliness in areas such as corridors, waiting areas, stairs, and rooftops. It specifically focuses on the absence of cobwebs, bird nests, and dust, which can pose a hygiene risk and detract from the aesthetic quality of the environment. The means of verification involve direct observation (OB), where the cleanliness of these areas will be visually assessed to ensure that there are no visible cobwebs, nests, or accumulated dust. Regular monitoring of these spaces will ensure that the cleanliness standards are consistently maintained.

Means of verification : **OB / SI**

OB (Observation):

1. Check for cobwebs, bird nests, and dust on walls, roofs, corners of corridors, waiting areas, stairs, and rooftops.
2. Inspect high or hard-to-reach areas like corners, ceiling spaces, and ventilation systems

for cleanliness.
3. Ensure cleaning is done regularly in all the mentioned areas.
4. Check if there's a visible accumulation of dust or dirt in any area.
5. Verify that the areas have been cleaned according to the schedule.

SI (Staff Interview):

1. Ask staff if they are trained to look out for cobwebs, bird nests, and dust in the corridors and common areas.
2. Inquire how often the corridors, waiting areas, and stairs are cleaned.
3. Ask if staff use proper cleaning tools like extendable dusters or vacuums for hard-to-reach places.
4. Find out if there's a checklist or log for cleaning and maintenance.
5. Check if staff know who to report to if an area needs special attention or deep cleaning.
6. Ask if any specific procedures are followed to clean ceilings or high walls.

Implementation plan :

The implementation plan for checkpoint B1.2 involves a systematic approach to maintaining cleanliness and ensuring that the physical environment remains free from cobwebs, bird nests, and dust in specific areas such as corridors, waiting areas, stairs, and rooftops. Regular checks will be scheduled as part of routine cleaning protocols, with designated staff responsible for inspecting these areas. The cleaning team will use appropriate tools and equipment to remove cobwebs, bird nests, and dust. If any issues are found, the necessary corrective action will be taken, such as cleaning or reporting pest issues to the appropriate authorities for further intervention. The inspection should be thorough, covering all corners, ceilings, and less accessible areas to ensure a clean and safe environment.

Scoring Criteria :

- **2 Marks:** No cobwebs, bird nests, or dust are observed in any of the checked areas.
- **1 Mark:** Some cobwebs, bird nests, or dust are observed in one or more areas, but they are promptly removed or addressed.
- **0 Mark:** Cobwebs, bird nests, or significant dust accumulation are observed and not addressed within an acceptable timeframe.

Reference : NA

B1.3	Corridors are cleaned at least twice in the day with wet mop

Interpretation

Checkpoint B1.3 requires that the corridors of the facility be cleaned at least twice daily using a wet mop. The goal is to ensure cleanliness and hygiene in high-traffic areas. The verification process involves speaking with the cleaning staff to confirm the frequency of cleaning and cross-referencing this information with the housekeeping records to ensure compliance with the standard. If the cleaning schedule is not being followed as outlined, corrective actions will need to be implemented to ensure proper sanitation.

Means of verification : **OB / SI**

What is to be observed (OB):

1. **Cleanliness of the corridor**: Ensure there are no visible dirt, stains, or dust.
2. **Mop marks or wet surfaces**: Check for signs that the corridor has been mopped, such as damp floors or mop marks.
3. **Frequency of cleaning**: Check if the corridors look consistently clean throughout the day, indicating regular cleaning.

What is to be enquired (SI):

1. **Cleaning schedule**: Ask the cleaning staff when the corridors are cleaned and how often.
2. **Cleaning method**: Inquire about the use of wet mops and whether they follow a standard cleaning routine for the corridors.
3. **Any challenges in cleaning**: Ask if there are any issues with maintaining the cleanliness or meeting the required cleaning frequency.

Means of Verification (RR):

1. **Housekeeping records/logs**: Review daily logs to confirm the cleaning times and mop usage.
2. **Cleaning checklist**: Check if there's a checklist that staff follow to confirm cleaning was done.
3. **Supervisor confirmation**: Ask supervisors or managers about the cleaning schedules and if they do any spot checks to verify cleanliness.

Implementation plan :
To implement checkpoint B1.3, the cleaning staff will be instructed to clean the corridors twice a day using a wet mop. A clear schedule will be established to ensure consistency in cleaning practices. The cleaning team should follow the schedule diligently, and the housekeeping department will maintain detailed records of the cleaning activities. These records should include the times and dates of cleaning, which will be regularly reviewed for accuracy and adherence to the schedule.
Scoring Criteria :

- **2 Marks**: If corridors are cleaned at least twice a day with a wet mop, as verified by the cleaning staff and housekeeping records.
- **1 Mark**: If corridors are cleaned once a day with a wet mop, but this is not aligned with the requirement for twice a day.
- **0 Marks**: If corridors are cleaned less than once a day or there is no evidence of wet mopping in the housekeeping records.

Reference : NA

B1.4	Corridors are rigorously cleaned with scrubbing / flooding once in a month

Interpretation
The checkpoint, "Ask the staff about cleaning schedule and activities," serves to ensure that there is a clear communication and understanding among the staff about the cleaning schedule. By verifying the schedule and activities with staff, it confirms that the cleaning tasks are being carried out as planned. This also serves as a means to assess whether the cleaning procedure is

followed consistently, ensuring that the corridors remain hygienic and meet the required standards. Regular inquiries and audits of cleaning practices also contribute to accountability and compliance with the cleaning protocol.

Means of verification : **OB / SI**

Observation (OB):

- Check floor cleanliness and absence of stains/dirt.
- Look for evidence of recent scrubbing/flooding.
- Ensure all corridor areas are covered.
- Verify safety measures like proper drying to avoid slips.

Staff Interview (SI):

- Ask about cleaning frequency and methods used.
- Confirm staff awareness of cleaning protocols and safety measures.
- Check if they received training for scrubbing/flooding.
- Inquire about any challenges faced in maintaining schedule.
- Confirm if enough staff are allocated for monthly deep cleaning.

Records Review (RR):

- Verify monthly cleaning logs.
- Check maintenance records of cleaning equipment.
- Review incident/complaint reports related to cleanliness.
- Look at any feedback related to corridor hygiene.

Implementation plan :

To implement the requirement for ensuring that corridors are rigorously cleaned with scrubbing or flooding once a month, the first step is to create a cleaning schedule outlining the specific dates and tasks to be completed each month. The assigned cleaning staff will be responsible for carrying out the scrubbing or flooding procedure, with emphasis on ensuring that the corridors are thoroughly cleaned. Supervisors will need to verify that the cleaning is done as per the prescribed standards. Staff will be trained on the importance of maintaining cleanliness in corridors and the necessary techniques for scrubbing and flooding. Additionally, all necessary cleaning equipment and supplies, such as cleaning detergents and water, should be available for the task. Documentation of each cleaning session will be maintained to track completion.

Scoring Criteria :

2 Marks:

- The corridors are **rigorously cleaned** with scrubbing or flooding **once a month** as per the established schedule.
- Confirmed through asking the staff about the cleaning schedule and the activities carried out.
- Evidence of thorough cleaning practices, proper documentation, and adherence to the schedule.

1 Mark:

- The corridors are cleaned, but it's unclear whether they follow a **rigorous cleaning** process, or there may be inconsistencies in the schedule or cleaning method.
- Cleaning may happen, but not according to the documented or expected procedure.

0 Marks:

- The corridors are **not cleaned rigorously** or at all, or there is no evidence of regular cleaning.
- Staff are unaware of the cleaning schedule, or no evidence of cleaning activities is available.

Reference : NA

B1.5	Surfaces are conducive of effective cleaning

Interpretation

This checkpoint assesses whether the surfaces in patient care and support areas are designed and maintained in a way that facilitates easy and effective cleaning. The surfaces should be smooth, non-absorbent, and seamless where possible to avoid microbial growth and ensure proper infection control. Rough, cracked, or porous surfaces can hinder cleaning and pose a risk to patient safety. Observers should physically inspect surfaces to ensure they meet these criteria and that cleaning practices are not compromised by substandard material quality.

Means of verification : **OB / SI**

OB:

Check if surfaces are smooth, non-porous, and easy to clean.
Check for cracks, damage, or open joints.
Check if corners are sealed or have coving.
Check for peeling paint, rust, or broken tiles.
Check if wet areas have proper drainage.

SI:

Enquire if surfaces are easy to clean.
Enquire about difficulties in cleaning certain areas.
Enquire about cleaning agents used.
Enquire if damaged surfaces are repaired regularly.
Enquire if surface conditions are checked during infection control rounds.
Enquire if any surfaces are found unfit for proper cleaning.

Implementation plan :

To ensure that all surfaces within the healthcare facility are conducive to effective cleaning, an initial infrastructure audit will be conducted. This includes examining floors, walls, countertops, and furniture for surface texture and material. Surfaces must be non-porous, smooth, and free from cracks or joints that can harbor dirt or microbes. Any non-compliant surfaces will be documented and scheduled for replacement or repair with smooth, durable, and cleanable materials. Staff training will be conducted on the importance of maintaining these surfaces, and periodic checks will be included in the housekeeping supervision checklist to ensure ongoing compliance.

Scoring Criteria :

- **2 Marks:** All patient care and support area surfaces (floors, walls, furniture, counters, etc.) are smooth, non-porous, intact, and conducive to effective cleaning. There is documented evidence of regular maintenance and monitoring to ensure surface integrity.
- **1 Mark:** Most surfaces are smooth and cleanable, but there are minor issues (e.g., few cracks, chipped edges, or wear) that do not significantly hinder cleaning. Corrective

actions are planned or underway.

- **0 Mark:** Multiple surfaces are damaged, porous, or not conducive to effective cleaning. There is no evidence of corrective action or maintenance plan, posing a risk to hygiene and infection control.

Reference : NA

B2	Cleanliness of Wards

Intent of B2: Cleanliness of Wards (Paragraph Form)

The intent of this standard is to ensure a consistently clean and hygienic environment in patient wards, which is essential for infection control, patient safety, and overall patient satisfaction. Cleanliness of the physical environment including floors, walls, roofs, furniture, and fixtures plays a critical role in reducing the risk of hospital-acquired infections and promoting a sense of well-being among patients and caregivers. This checkpoint emphasizes routine and thorough cleaning practices, timely removal of dirt, stains, and biological contaminants, and systematic documentation to maintain high standards of hygiene in inpatient areas.

B2.1	No dirt/Grease/ Stains/ Garbage in wards

Interpretation

The checkpoint B2.1 focuses on maintaining the cleanliness and hygiene of the wards. It requires a regular inspection of the floors and walls within the indoor departments, ensuring there are no visible signs of dirt, grease, stains, or garbage. This ensures that the environment is sanitary, which is crucial for patient safety and comfort. It also helps in creating a positive and professional atmosphere within the healthcare facility. The observation checklist (OB) mentioned here indicates that the process is based on visual and tangible inspections to identify cleanliness issues.

Means of verification : **OB / SI**

OB (Observation):

- Inspect floors, walls, and ceilings for dirt, stains, or grease.
- Check furniture and corners for cleanliness.
- Ensure waste bins are emptied and areas like toilets and windows are clean.
- Observe cleanliness in corridors and shared spaces.
- Verify that cleaning equipment is maintained.

SI (Structured Interview):

- Ask housekeeping staff about the cleaning schedule and SOPs.
- Inquire about the checklist for cleaning tasks, especially in critical areas.
- Check with staff on waste segregation and disposal practices.
- Ask about deep cleaning routines and any audit processes in place.

Implementation plan :

To ensure that the wards are free from dirt, grease, stains, and garbage, a daily cleaning and maintenance schedule will be established. The cleaning staff will be assigned specific tasks, such

as mopping the floors, wiping the walls, and removing any garbage. They will also inspect each ward for any visible stains, dirt, or grease, particularly in high-touch areas. The hospital will use appropriate cleaning materials to maintain hygiene standards, and a checklist will be provided to track the completion of these tasks. Supervisors will conduct random checks to ensure compliance, and any issues will be addressed immediately. Training sessions for the cleaning staff will also be conducted to ensure proper cleaning techniques and standards are followed.

Scoring Criteria :

- **2 Marks:** No visible dirt, grease, stains, or garbage present on the floors or walls in the wards or indoor department.
- **1 Mark:** Minor visible dirt, grease, or stains present in some areas of the wards or indoor department, but they do not affect the overall cleanliness.
- **0 Marks:** Significant visible dirt, grease, stains, or garbage present in multiple areas of the wards or indoor department, indicating a lack of cleanliness and maintenance.

Reference : NA

B2.2	**No Cobwebs/Bird Nest/ Dust/Seepage on walls and roofs of wards**

Interpretation

The checkpoint B2.2 ensures that the wards are maintained in a manner that promotes a clean and hygienic environment for patients. Cobwebs, bird nests, dust, and seepage can contribute to poor air quality, attract pests, and pose infection risks. This standard seeks to eliminate any such hazards by mandating routine inspections and cleaning of all areas, particularly the roof and corners of wards. A well-maintained environment not only enhances the aesthetic appeal of the facility but also ensures the health and safety of patients and staff.

Means of verification: **OB / SI**

 What to observe (OB):

- Check the roof and corners of the ward for cobwebs, bird nests, dust, or seepage.
- Inspect the walls for any signs of dampness or water stains.
- Look for any visible damage or cracks in the walls or ceiling.

 What to enquire (SI):

- Ask maintenance or housekeeping about the regular cleaning and inspection schedules.
- Inquire if pest control measures are in place.
- Check if there have been any recent repairs or issues with seepage in the area.
- Ask staff about the frequency of wall and roof inspections.

Implementation plan :

To ensure compliance with B2.2, the implementation plan will involve a systematic inspection of all wards, focusing on the roof and corners. A scheduled cleaning routine will be established for ward maintenance staff to conduct regular checks for cobwebs, bird nests, dust, and any signs of seepage on the walls and roofs. Cleaning tools and supplies should be provided, and staff should be trained on the importance of maintaining cleanliness in these areas to ensure a safe and hygienic environment for patients. The ward in-charge should be responsible for reporting any issues found and ensuring immediate rectification. A checklist will be used to document the condition of the ward at regular intervals.

Scoring Criteria :

- **2 Marks:** No cobwebs, bird nests, dust, or seepage on the walls or roof. The ward is clean, well-maintained, and free of any visible issues in this regard.
- **1 Mark:** Minor dust, cobwebs, or small signs of seepage that do not significantly affect the ward's cleanliness and overall atmosphere.
- **0 Marks:** Significant cobwebs, bird nests, or dust accumulation on the walls or roof. Noticeable seepage or poor maintenance that negatively impacts the cleanliness or hygiene of the ward.

Reference : NA

B2.3	**Wards are cleaned at least thrice in the day with wet mop**

Interpretation

This checkpoint evaluates the cleanliness and hygiene standards within the wards. The key factor here is the frequency and method of cleaning, ensuring that cleaning is done at least three times a day using a wet mop to reduce the risk of infection. It focuses on both the compliance of staff in performing the cleaning tasks as required and the documentation of this activity for verification. Proper verification is essential to ensure that the hospital is maintaining an adequate level of hygiene in line with healthcare standards.

Means of verification : **OB / SI**

OB (What is to be observed):

1. Check if cleaning staff is using a wet mop to clean the wards at least three times a day.
2. Observe the cleanliness of the ward after each cleaning session to ensure it's being done properly.
3. Look for any signs of neglect or missed cleaning tasks.

SI (What is to be enquired):

1. Ask cleaning staff how often they clean the wards in a day (at least three times).
2. Check if the cleaning staff faces any challenges in sticking to the schedule.
3. Verify cleaning frequency with housekeeping records, making sure the schedule is documented and matches the staff's reports.
4. Ensure that the housekeeping records are signed and time-stamped to confirm accuracy and consistency.

Implementation plan :

The implementation of this checkpoint involves ensuring that wards are cleaned at least three times a day with a wet mop. The designated cleaning staff should be instructed to perform this task in accordance with the set frequency. The cleaning schedule must be documented in the housekeeping records for accountability. The cleaning supervisor or relevant personnel should oversee the process, ensuring adherence to the established procedure.

Scoring Criteria :

 2 Marks: The wards are cleaned at least three times a day with a wet mop as per schedule, and this is consistently documented in the housekeeping records.

 1 Mark: Wards are cleaned less than three times a day, but there is partial evidence or inconsistent documentation of the cleaning schedule.

 0 Marks: Wards are not cleaned at the required frequency, and there is no documentation of the cleaning process.

Reference : NA

B2.4	Patient Furniture, Mattresses, Fixtures are without grease and dust

Interpretation

This checkpoint evaluates the cleanliness of patient furniture, mattresses, and fixtures. During the observation (OB), the inspector will check for visible dirt, dust, or grease on these items. They will also verify whether the items are wiped or dusted on a daily basis. The means of verification will involve checking the condition of the furniture and fixtures directly and enquiring about the frequency and method of cleaning to ensure compliance.

Means of verification : **OB / SI**

- **OB (Observation):**
  - Look for visible signs of dirt, dust, grease, or stains on patient furniture, mattresses, and fixtures.
  - Check the overall cleanliness and upkeep of these items during rounds or inspection.
  - Observe whether furniture and fixtures appear recently cleaned and maintained.
- **SI (Staff Interview):**
  - Enquire with housekeeping or nursing staff about the cleaning schedule and procedures.
  - Ask how frequently these items are cleaned and whether there is a checklist or log maintained.
  - Confirm whether SOPs for cleaning are being followed and how often they are monitored.

Implementation plan :

To ensure that patient furniture, mattresses, and fixtures are free from grease and dust, a cleaning schedule should be implemented in the facility. Designated staff should be assigned to regularly clean and wipe down these items, focusing on daily dusting and maintenance. Staff should also use appropriate cleaning agents and techniques to ensure that the furniture and fixtures remain free from grease and dirt. Additionally, staff should be trained on the importance of maintaining cleanliness for patient safety and comfort, and proper documentation of cleaning activities should be maintained for accountability.

Scoring Criteria :

 2 Marks: If there is no visible dirt, dust, or grease, and items are wiped/dusted daily as per the

cleaning schedule.

 1 Mark: If there is minimal dirt or dust but the items are generally clean, and cleaning is done but not consistently daily.

 0 Marks: If the items are visibly dirty or greasy and there is no documented evidence of daily cleaning.

Reference : NA

B2.5	**Floors, walls, furniture and fixture are thoroughly cleaned once in a week.**

Interpretation

This checkpoint assesses whether a facility maintains a consistent deep cleaning routine for its infrastructure. The means of verification include observation (OB) of the physical environment to confirm cleanliness and enquiry (SI) with cleaning staff regarding the frequency and schedule of cleaning tasks. Inspectors may also review housekeeping records, such as cleaning logs or checklists, to validate that thorough cleaning of floors, walls, furniture, and fixtures is conducted at least once a week. This ensures hygienic conditions and supports overall infection control practices in the healthcare facility.

Means of verification : **OB / SI**

OB (What is to be Observed):

- Visually inspect the cleanliness of floors, walls, furniture, and fixtures in different patient care and non-clinical areas.
- Look for signs of dust accumulation, cobwebs, stains, or dampness indicating irregular cleaning.
- Observe cleaning activities if happening during the visit – check use of appropriate cleaning materials and equipment.
- Spot-check corners, behind furniture, and under beds/tables to assess thoroughness.

SI (What is to be Enquired):

- Ask cleaning/housekeeping staff about:
  - Frequency and method of daily and weekly cleaning routines.
  - Use of any disinfectants or specific protocols for deep cleaning.
  - Challenges they face in following the cleaning schedule.
- Enquire with the housekeeping supervisor about how cleaning schedules are monitored and supervised.
- Ask nursing staff or unit in-charge whether they are satisfied with the cleaning standards.

Records to be Verified (if available):

- Weekly deep cleaning checklist/logbook showing date, area cleaned, staff signature, and supervisor verification.
- Daily cleaning schedules and duty rosters.
- Standard Operating Procedures (SOPs) for cleaning practices (daily, weekly, monthly).
- Internal audit reports or checklists, if any, showing compliance with cleaning frequencies.

- Staff training records related to housekeeping protocols and infection control practices.

Implementation plan :
To ensure that floors, walls, furniture, and fixtures are thoroughly cleaned once a week, a structured cleaning schedule should be developed and prominently displayed in the housekeeping department. The schedule must clearly outline weekly deep cleaning tasks in addition to daily routine cleaning. Designated housekeeping staff should be assigned these tasks with specific days allocated for each area. Regular training should be provided to the staff to maintain cleanliness standards, and supervisors must conduct periodic inspections to ensure compliance. Cleaning checklists should be maintained and signed after task completion, and any deviations should be documented and addressed promptly.
Scoring Criteria :

- **2 Marks**: Cleaning staff confirms that thorough cleaning is done weekly, and housekeeping records are available to support this.
- **1 Mark**: Cleaning staff confirms weekly cleaning, but no records are available or records are incomplete.
- **0 Marks**: Cleaning is not done weekly, or staff is unaware of the frequency, and no records are available.

Reference : NA

B3	Cleanliness of Procedure Areas

The intent of the checkpoints under section **B3 – Cleanliness of Procedure Areas** is to ensure that operation theatres (OTs), procedure rooms, and associated areas such as dressing rooms are maintained in a state of high cleanliness and hygiene. This is critical for infection prevention and control, minimizing the risk of healthcare-associated infections (HAIs), and promoting patient safety. The presence of visible dirt, biological contaminants, or structural neglect (like seepage or cobwebs) reflects poorly on institutional cleanliness and poses a serious hazard to surgical and procedural outcomes. Regular and thorough cleaning, both routine and deep, must be carried out and documented diligently to uphold the sterile environment required in procedural zones.

B3.1	No dirt/Grease/ Stains/ Garbage in Procedure Areas

Interpretation
This checkpoint focuses on the **cleanliness and hygiene** of critical clinical areas where procedures are performed. Specifically, it evaluates whether the **floors and walls** of the OT and Dressing Room are free from **visible or tangible dirt, grease, stains, or garbage**. Cleanliness in these areas is essential to prevent healthcare-associated infections and maintain a sterile environment for patient care. The absence of such contaminants indicates effective implementation of cleaning protocols and infection control practices.
Means of verification : **OB / SI**

Means of Verification: Observation (OB) – What is to be Observed

1. Physical infrastructure (e.g., cleanliness, signage, fire safety equipment).

2. Availability and display of protocols, policies, and SOPs.
3. Documentation – registers, patient records, consent forms, etc.
4. Equipment functionality and maintenance records.
5. Waste segregation practices and biomedical waste bins.
6. Hand hygiene facilities (sanitizers, soap, washbasins).
7. Emergency preparedness (evacuation plans, mock drill records).
8. Identification of patients and staff (ID bands, nameplates).

Means of Verification: Staff Interview (SI) – What is to be Enquired

1. Awareness about institutional policies and SOPs.
2. Knowledge of infection control practices (e.g., 5 moments of hand hygiene).
3. Understanding of waste management protocols.
4. Familiarity with fire safety and emergency procedures.
5. Process of obtaining and documenting consent.
6. Roles and responsibilities in patient care or specific tasks.
7. Reporting mechanisms for incidents and grievances.

Implementation plan :

To ensure cleanliness in procedure areas such as the Operation Theatre (OT) and Dressing Room, a regular and documented cleaning schedule must be established. The housekeeping staff should be trained in standard operating procedures (SOPs) for cleaning and sanitization specific to clinical areas. Daily cleaning, as well as terminal cleaning protocols, should be strictly followed and supervised. Checklists should be maintained and reviewed by the nursing in-charge or quality team regularly. Any deviation should be corrected immediately through corrective and preventive action (CAPA). Monthly internal audits can be conducted to ensure sustained compliance.

Scoring Criteria :

- **2 Marks**: No visible dirt, grease, stains, or garbage; area appears visibly clean and well-maintained.
- **1 Mark**: Minor issues such as small stains or negligible dirt that do not pose an infection risk.
- **0 Mark**: Presence of visible dirt, grease, garbage, or significant stains indicating poor housekeeping and risk of infection.

Reference : NA

B3.2	**No Cobwebs/Bird Nest/ Seepage in OT & procedure Room**

Interpretation

This checkpoint assesses the **structural cleanliness and integrity** of procedure areas, specifically focusing on the absence of **cobwebs, bird nests, and seepage**. These issues can compromise the sterility of the OT environment and pose a risk of infection or contamination. Their presence may also reflect poor facility upkeep or infrequent inspections. Ensuring that these areas are free of such elements indicates a robust maintenance and infection control system.

Means of verification : **OB / SI**

What is to be Observed (OB):

- **Ceiling & Walls:** Inspect for cobwebs, bird nests, or signs of seepage.
- **Corners & Hidden Areas:** Examine areas like ceiling corners, behind equipment, and under shelves.
- **Dressing Room:** Ensure cleanliness and absence of pests or structural issues

What is to be Enquired (SI – Staff Interview):

- **Cleaning Frequency:** Inquire about the frequency of cleaning in these areas.
- **Housekeeping Records:** Verify cleaning schedules and records with housekeeping staff.

Implementation plan :
To ensure a sterile and safe environment in the Operation Theatre (OT) and Procedure Room, a preventive maintenance and housekeeping plan must be in place. Routine cleaning schedules should include inspection of high and hard-to-reach areas such as ceilings, corners, and ventilation ducts to remove cobwebs. Regular facility maintenance rounds must be conducted to detect and repair any signs of seepage or damage that may lead to water intrusion. External contractors or in-house maintenance teams should be alerted immediately if a bird nest or seepage is detected. All findings must be documented in maintenance logs and verified by supervisory personnel during daily rounds. Staff should be trained to report such observations proactively.

Scoring Criteria :

 2 Marks:
No cobwebs, bird nests, or seepage found on the roof, walls, or corners of the OT and Dressing Room. The area is clean, well-maintained, and shows evidence of regular upkeep.

 1 Mark:
Minor issues observed such as a small cobweb or slight seepage stain, but they do not affect the sterility or functionality of the area. Maintenance appears to be in place but not perfectly executed.

 0 Marks:
Presence of multiple cobwebs, any bird nest, or noticeable seepage in the OT or Dressing Room. Indicates poor maintenance and lack of regular inspection and cleaning.

Reference : NA

B3.3	**OT/procedure Room floors and surfaces are cleaned at least twice a day / after every procedure**

Interpretation
This checkpoint evaluates the **frequency and documentation of cleaning** activities in OT and procedure rooms. It ensures that cleaning is not only scheduled but actually performed as required — **at least twice a day and after every procedure**. Adequate cleaning helps maintain

aseptic conditions, reduce microbial load, and prevent hospital-acquired infections. Inconsistent or undocumented cleaning practices may indicate a lapse in infection control measures.
Means of verification : **OB / SI**

 SI (Staff Interview): Ask housekeeping staff about the **number of times cleaning is done per day** and specifically whether it is performed **after every procedure**.

 RR (Record Review): Review housekeeping records/logbooks to verify **documentation of cleaning activities**, including date, time, and staff signature. Cross-check for completeness and consistency with staff responses.

Implementation plan :
To ensure compliance with hygiene standards, a formal cleaning schedule should be established for the Operation Theatre (OT) and Procedure Rooms. This schedule must specify that all **floors and surfaces are to be cleaned at least twice daily and after every procedure**. Housekeeping staff must be trained in proper cleaning protocols, including terminal cleaning practices. A **cleaning logbook** should be maintained at each procedure area, where every cleaning activity is recorded with date, time, and staff signature. Supervisors must regularly verify these records for completeness and accuracy. Additionally, the cleaning process should be periodically audited by the infection control or quality team to ensure consistency and effectiveness.
Scoring Criteria :
 2 Marks:
Cleaning staff confirm that floors and surfaces in the OT/Procedure Room are cleaned **at least twice daily and after every procedure**. This is **consistently documented** in housekeeping records.
 1 Mark:
Cleaning staff report that cleaning is done **once daily or not consistently after every procedure**. Records exist but may be incomplete or inconsistently maintained.
 0 Marks:
Cleaning frequency is **below standard** (less than once a day or not at all after procedures). Records are missing or do not support staff claims.

Reference : NA

B3.4	OT & Procedure Room Tables are without grease, body fluid and dust

Interpretation
This checkpoint ensures that all patient-contact surfaces — especially **procedure tables** — are **free from contaminants** such as **grease, dust, dried blood, or other body fluids**. These residues pose a serious risk of cross-infection and contamination. Ensuring tables are properly cleaned reflects the hospital's commitment to **infection prevention and control**. Regular and thorough cleaning demonstrates not only staff compliance but also reinforces patient safety protocols within the clinical environment. The **absence of visible contaminants** is a clear indicator of adherence to hygiene and asepsis standards.
Means of verification : **OB / SI**

 OB (Observation):

- Visually inspect the **top, sides, and legs** of OT tables, procedure room tables, and

dressing tables for **any signs of dust, grease, dried human tissue, or body fluids**.

- Use a gloved hand or a clean cloth to gently swipe surfaces to check for hidden residues or dust.

 SI (Staff Interview):

- Enquire with the cleaning or housekeeping staff about the **cleaning procedures**, **disinfectants used**, and **frequency of cleaning**.
- Ask OT or procedure room staff (e.g., nursing or technicians) about their **pre- and post-procedure cleaning checklist** and how compliance is monitored.

Implementation plan :

To maintain asepsis in procedure areas, especially in Operation Theatres (OTs) and Procedure Rooms, a clear protocol must be followed for the cleaning and disinfection of all **tables used during procedures**. This includes OT tables, dressing room tables, and procedure room tables. Cleaning staff must be trained to **thoroughly clean the top, sides, and legs** of tables using appropriate disinfectants **before and after every procedure**. The protocol should emphasize the **immediate removal of blood, body fluids, grease, or tissue remnants** using hospital-grade disinfectants like 1% sodium hypochlorite followed by a clean water wipe. A **checklist or log** must be maintained to record each cleaning activity, and supervisors should perform **daily visual inspections**. Additionally, a designated team (such as infection control or OT technicians) should be responsible for verifying cleanliness before and after every procedure.

Scoring Criteria :

 2 Marks:

No visible grease, dust, dried human tissue, or body fluid on any part of the OT, dressing room, or procedure room tables.

 1 Mark:

Minor dust or grease observed, but **no dried human tissue or body fluids** present.

 0 Marks:

Presence of visible dirt, grease, dried human tissue, or body fluids on the tables.

Reference : NA

B3.5	**Floors, walls, furniture and fixture are thoroughly cleaned once in a week.**

Interpretation

This checkpoint ensures that **deep cleaning of environmental surfaces** such as floors, walls, furniture, and fixtures is conducted regularly to prevent the buildup of dirt, dust, and microorganisms that could contribute to infections or compromise patient safety. While daily cleaning maintains surface hygiene, thorough weekly cleaning is critical to address areas that might be missed during routine cleaning. Proper documentation and staff awareness demonstrate compliance with infection control standards and contribute to a safer clinical environment.

Means of verification : **OB / SI**

 SI (Staff Interview):

Ask cleaning staff about the **frequency of thorough cleaning** for floors, walls, furniture, and fixtures.

 RR (Record Review):

Verify the **housekeeping cleaning records or logs** to confirm that thorough cleaning is performed at least once a week.

Implementation plan :
To maintain a hygienic and safe environment, a routine schedule should be established for **thorough cleaning of floors, walls, furniture, and fixtures at least once a week**. Housekeeping staff must be trained on the importance of deep cleaning beyond daily surface cleaning, using appropriate cleaning agents and disinfectants. The cleaning process should include scrubbing floors, wiping walls and furniture, and polishing fixtures to remove accumulated dirt, stains, and microbial buildup. A cleaning log or record should be maintained to document each thorough cleaning activity, including the date, area cleaned, and the name of the staff responsible. Supervisors should conduct regular inspections to verify that weekly cleaning protocols are followed consistently.

Scoring Criteria :
 2 Marks:
Thorough cleaning of floors, walls, furniture, and fixtures is **performed at least once weekly**, consistently documented, and confirmed by staff.
 1 Mark:
Cleaning is performed but **not consistently weekly** or documentation is incomplete/inconsistent.
 0 Marks:

Thorough cleaning is **not performed weekly** or there is no documentation to confirm it.

Reference : NA

B4	Cleanliness of Ambulatory Area (OPD, Emergency, Lab)

The intent of this standard is to ensure that all ambulatory care areas—including OPD, Emergency, Laboratory, and Radiology—maintain high levels of cleanliness and hygiene at all times to prevent hospital-acquired infections and enhance patient satisfaction. The physical environment of these frequently accessed areas must be free from visible dirt, grease, stains, and biological contaminants such as cobwebs and nests. A regular cleaning schedule must be in place, including daily and weekly cleaning routines, with clearly defined responsibilities and documentation. Furniture and fixtures should also be kept clean and dust-free to promote a safe and pleasant healthcare environment.

B4.1	No dirt/Grease/Stains / Garbage in Ambulatory Area

Interpretation
This checkpoint emphasizes the importance of maintaining a **clean and contamination-free ambulatory area**, which is critical for infection control and patient safety. Visible dirt, grease, stains, or garbage in areas like OPD, Emergency, Laboratory, or Radiology not only degrade the environment but also pose risks of cross-contamination. Consistent cleaning and maintenance reflect the facility's commitment to quality care and hygiene standards. The absence of such contaminants serves as a clear indicator of effective housekeeping and operational discipline.
Means of verification : **OB / SI**

 Observation (OB):

- Direct inspection of the physical environment including floors, walls, equipment, and waste disposal areas.
- Check for visible dirt, stains, grease, garbage, and overall cleanliness.
- Review signage, records, and compliance with safety and hygiene standards.
- Observe actual practices being followed on-site.

 Staff Interview (SI):

- Ask staff about their knowledge of relevant procedures and protocols.
- Enquire about the frequency and method of tasks like cleaning and maintenance.
- Understand how staff respond to issues such as dirt, stains, or equipment faults.
- Verify staff training and awareness regarding their responsibilities.

Implementation plan :
To ensure cleanliness in ambulatory areas such as the OPD, Emergency, Laboratory, and Radiology, a structured cleaning protocol should be established. This protocol must include **regular and frequent cleaning of floors and walls** using appropriate detergents and disinfectants to remove dirt, grease, stains, and any other contaminants. Cleaning staff should be trained to pay special attention to high-traffic areas and corners where dirt accumulation is common. Scheduled inspections by supervisors should be conducted to ensure that the cleaning is thorough and consistent. Any garbage must be promptly removed and disposed of in accordance with biomedical waste management guidelines to maintain a safe and hygienic environment.

Scoring Criteria :

 2 Marks:

All mentioned areas (OPD, Emergency, Laboratory, Radiology) are **visibly clean** and **free from dirt, grease, stains, and garbage**. Staff are **aware of cleaning protocols**, and cleaning is done as per the schedule.

 1 Mark:

Minor cleanliness issues are noted in **one or two areas**, such as small stains or uncollected waste. Staff are **partially aware** of cleaning protocols or inconsistencies in cleaning frequency are reported.

 0 Mark:

Significant cleanliness issues such as **visible dirt, grease, garbage**, or **persistent stains** in multiple areas. Housekeeping staff **unaware** of standard cleaning protocols or irregular cleaning practices are evident.

Reference : NA

B4.2	No Cobwebs/Bird Nest/ Seepage on walls and roofs of ambulatory area

Interpretation

This checkpoint ensures a clean, safe, and hygienic environment in critical patient care areas. The absence of cobwebs, bird nests, dust, and seepage indicates proper maintenance and reduces the risk of contamination, infection, and patient discomfort. It also reflects the institution's commitment to quality and attention to detail. Failure to maintain these standards can compromise patient safety and the overall perception of hospital hygiene, affecting accreditation outcomes.

Means of verification : **OB / SI**

What is to be observed:

- The roof, walls, and corners of the OPD, Emergency, Laboratory, and Radiology areas must be inspected.
- Check for the presence of cobwebs, bird nests, dust, and seepage marks.
- All these areas should be clean and well maintained without any contamination.

What is to be enquired:

- Ask staff about how often these areas are cleaned.
- Confirm who is responsible for cleaning and maintaining these areas.
- Verify if there is a regular cleaning and inspection schedule in place.

Implementation plan :

To ensure that there are no cobwebs, bird nests, dust, or seepage on the walls and roofs of ambulatory areas, a regular cleaning and inspection schedule must be established. Cleaning staff should be trained and assigned specific responsibilities for maintaining the OPD, Emergency, Laboratory, and Radiology areas. Supervisors should conduct routine inspections at least weekly to verify cleanliness and identify any issues early. Any detected cobwebs, bird nests, dust, or seepage must be promptly removed and repaired. Documentation of cleaning and inspection activities should be maintained for accountability and continuous monitoring.

Scoring Criteria :

2 Marks: There are no cobwebs, bird nests, dust, or seepage present on the walls, roofs, or corners of the OPD, Emergency, Laboratory, and Radiology areas. All areas are clean and well-maintained.

1 Mark: Minor presence of cobwebs, dust, or seepage is noticed in some areas but it is limited and does not affect the overall cleanliness of the ambulatory areas.

0 Mark: There is a significant presence of cobwebs, bird nests, dust, or seepage in many areas, indicating poor maintenance and cleanliness.

Reference : NA

B4.3	Ambulatory Areas are cleaned at least thrice in the day with wet mop

Interpretation
Checkpoint B4.3 requires that ambulatory areas be cleaned with a wet mop a minimum of three times daily to maintain cleanliness and reduce infection risks. Verification involves two key steps: firstly, asking the cleaning staff directly about how often they clean the ambulatory areas, and secondly, cross-checking this information against the documented housekeeping records. Consistency between staff testimony and housekeeping documentation indicates compliance with the standard, ensuring that cleaning protocols are effectively implemented and recorded.
Means of verification : **OB / SI**

 Observation (OB):

- Check if ambulatory areas are visibly clean and wet-mopped.
- Look for cleaning schedules displayed.

 Staff Interview (SI):

- Ask cleaning staff how many times ambulatory areas are cleaned daily.
- Confirm their knowledge of cleaning procedures and frequency.

 Records Review (RR):

- Verify housekeeping records/logbooks for at least three cleanings per day.
- Match records with actual days of observation.

Implementation plan :
To ensure ambulatory areas are cleaned at least three times daily with a wet mop, develop a detailed cleaning schedule specifying the exact times for cleaning rounds. Train housekeeping staff on the importance of frequent wet mopping to maintain hygiene and prevent infections. Maintain daily logs or housekeeping records documenting the time and frequency of cleaning. Supervisors should conduct random spot checks during the day to verify compliance. Additionally, periodically interview cleaning staff to confirm their understanding and adherence to the cleaning frequency.
Scoring Criteria :

 2 Marks: Ambulatory areas are cleaned at least three times a day using a wet mop. Verification: Ask the cleaning staff about the frequency of cleaning in a day and verify with housekeeping records.

 1 Mark: Ambulatory areas are cleaned once or twice a day using a wet mop. Verification: Confirm with cleaning staff and check housekeeping records for partial compliance.

 0 Marks: Ambulatory areas are cleaned less than once a day or not cleaned using a wet mop. Verification: Confirm with cleaning staff and housekeeping records, indicating non-compliance.

Reference : NA

B4.4	Furniture, & Fixtures are without grease and dust and cleaned daily

Interpretation
This checkpoint requires that all furniture and fixtures within the facility remain free from grease and dust and are cleaned on a daily basis. The method to verify compliance includes both direct observation (OB) of the cleanliness and condition of the furniture and fixtures, and staff interviews (SI) to confirm their understanding and adherence to the cleaning frequency. Consistent removal of grease and dust is essential for maintaining hygiene, appearance, and safety, as well as contributing to a healthy environment for patients and staff.
Means of verification : **OB / SI**

What is to be Observed (OB):

- Check the physical condition of furniture and fixtures for the presence of dust, stains, or grease.
- Observe whether the furniture looks well-maintained and recently cleaned.
- Look for signs of regular upkeep, such as absence of cobwebs, clean surfaces, and tidy arrangement.
- Verify availability of a cleaning checklist or log, if displayed.

What is to be Enquired (Staff Interview):

- Ask housekeeping or assigned staff about the frequency and routine of cleaning furniture and fixtures.
- Enquire if there is a documented cleaning schedule they follow.
- Confirm if specific staff are designated for this task and whether supervision or monitoring is done.
- Ask what materials or methods are used for cleaning and how often deep cleaning is done.

Implementation plan :
To ensure that furniture and fixtures are maintained without grease and dust and are cleaned daily, a clear cleaning schedule will be established and communicated to the housekeeping or maintenance staff. Daily cleaning checklists will be created specifying the areas and items to be cleaned. Staff will be trained on proper cleaning techniques and the importance of maintaining cleanliness to prevent dust and grease buildup. Supervisors will conduct regular inspections to verify compliance with the cleaning schedule and address any lapses immediately. Cleaning supplies and equipment appropriate for removing grease and dust will be readily available to staff.
Scoring Criteria :

 2 Marks: Furniture and fixtures are free from grease and dust and are cleaned daily. Assessment method: Observe the cleanliness and ask staff about the cleaning frequency.

 1 Mark: Furniture and fixtures are mostly clean but may have some minor dust or grease. Assessment method: Observe and ask staff about cleaning practices.

 0 Marks: Furniture and fixtures are dirty, greasy, or not cleaned regularly.

Assessment method: Observe and staff are unable to confirm cleaning frequency.

Reference : NA

B4.5	**Floors, walls, furniture and fixture are thoroughly cleaned once in a week.**

Interpretation

Checkpoint B4.5 underlines the importance of regular deep cleaning within the healthcare facility to ensure infection control and maintain a clean environment. The assessor will verify compliance by asking staff about the frequency and method of weekly cleaning, as well as by reviewing documented records that support the practice. Evidence of a consistent weekly cleaning routine—covering all floors, walls, furniture, and fixtures—should be available. The staff must be aware of their duties and should be able to describe the cleaning schedule accurately. Proper documentation will validate that the checkpoint is being followed regularly and effectively.

Means of verification : **OB / SI**

What is to be observed (OB):

- Cleanliness of floors, walls, furniture, and fixtures.
- Availability and proper maintenance of cleaning schedules/logbooks.
- Use of appropriate cleaning materials and tools.
- Evidence of recent thorough cleaning (e.g., no visible dust, cobwebs, or stains).
- Proper storage of cleaning equipment and supplies.

What is to be enquired (Staff Interview - SI):

- Ask housekeeping or responsible staff about the frequency and process of thorough weekly cleaning.
- Inquire whether a cleaning schedule is followed and who monitors it.
- Ask staff to explain what areas are covered during the weekly cleaning.
- Check if staff are aware of the documentation process and can locate cleaning records.

Implementation plan :

To ensure compliance with checkpoint B4.5, the healthcare facility must develop and maintain a structured cleaning schedule that includes thorough weekly cleaning of floors, walls, furniture, and fixtures. This schedule should clearly assign responsibilities to designated staff members, specifying the day and time of cleaning activities. The plan should include training housekeeping staff on proper cleaning techniques and the importance of maintaining a hygienic environment. Standard Operating Procedures (SOPs) must be created and followed diligently. Additionally, a cleaning logbook or register should be maintained, documenting the date, time, and areas cleaned, along with the name and signature of the responsible staff and supervisor.

Scoring Criteria :

2 Marks:

Thorough weekly cleaning of floors, walls, furniture, and fixtures is being done as per a defined

schedule. Staff are aware of the process, and complete records are available and up to date.

1 Mark:

Weekly cleaning is being done but either records are incomplete or staff awareness is lacking.

0 Mark:

Weekly cleaning is not done, or no documentation/awareness is observed among staff.

Reference : NA

B5	Cleanliness of Auxiliary Areas

The intent of checkpoint B5: Cleanliness of Auxiliary Areas is to ensure a consistently high standard of hygiene and sanitation in all non-clinical yet critical support areas of the healthcare facility such as the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative Offices. Maintaining cleanliness in these areas is essential to prevent contamination, safeguard health and safety of staff and patients, and support efficient hospital operations. This includes regular cleaning routines, attention to visible cleanliness, and scheduled deep-cleaning protocols.

B5.1	No dirt/Grease/ Stains/ Garbage in Auxiliary Area

Interpretation

This checkpoint focuses on ensuring that all auxiliary areas within the healthcare facility are free from visible and tangible contaminants such as dirt, grease, stains, or garbage. The term "auxiliary areas" refers to support spaces like the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative Offices, which, although not directly involved in patient care, play a crucial role in overall hygiene and safety. During assessment, surveyors will physically inspect the cleanliness of floors and walls in these areas. Any visible dirt, stains, or garbage will be considered non-compliance. Cleanliness in these spaces directly impacts infection control and the quality image of the institution, making it essential to maintain high standards at all times.

Means of verification : **OB / SI**

Observation (OB):

- Visually inspect the floors and walls of the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative Offices for any visible dirt, grease, stains, cobwebs, or garbage.
- Check corners, behind furniture or equipment, and under worktables for accumulated dust or stains.
- Ensure waste bins are not overflowing and are covered appropriately.
- Assess whether cleaning equipment (mops, buckets, etc.) is clean and stored properly after use.
- Look for proper signage and cleanliness-related instructions in auxiliary areas.

- Verify if cleaning records/logbooks are maintained and updated regularly.

Staff Interview (SI):

- Ask housekeeping staff about the cleaning schedules and SOPs followed for each area.
- Enquire how frequently the areas are cleaned and who monitors the cleanliness.
- Ask staff whether they have received training on cleaning protocols and handling of waste.
- Interview administrative or department staff about how they report cleanliness issues or gaps.
- Inquire if there is any internal checklist or supervisory round conducted for monitoring auxiliary area cleanliness.

Implementation plan :

To meet the requirements of checkpoint B5.1, a systematic cleaning schedule should be developed and implemented for all auxiliary areas, including the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative Offices. This includes assigning cleaning responsibilities to housekeeping staff with clear documentation of frequency (daily, weekly, deep cleaning, etc.). Standard Operating Procedures (SOPs) must be developed for cleaning and disinfection of floors and walls, including procedures for handling spills or contamination. Periodic audits and inspections should be conducted by the quality or infection control team to ensure compliance. Adequate cleaning supplies and protective gear must be made available, and staff should be trained in cleaning protocols and proper waste disposal methods. A record of cleaning and supervision should be maintained.

Scoring Criteria :

- **2 Marks**: All auxiliary areas including Pharmacy, Kitchen, Laundry, Mortuary, and Administrative Offices are clean and well-maintained with no visible dirt, grease, stains, or garbage. Cleaning schedules and records are available and up to date. Staff are aware of cleaning protocols and can explain the procedures followed.
- **1 Mark**: Most auxiliary areas are generally clean, but minor lapses such as small stains or isolated instances of dirt or garbage are observed. Cleaning records may be partially maintained or not up to date. Staff have partial awareness of the cleaning procedures.
- **0 Marks**: Several auxiliary areas are visibly unclean with noticeable dirt, stains, or garbage. Cleaning protocols are not being followed or documented, and staff are unaware or unable to explain cleaning procedures.

Reference : NA

B5.2	No Cobwebs/Bird Nest/ Seepage on walls and roofs of Auxiliary Area

Interpretation

This checkpoint ensures the upkeep and hygienic maintenance of non-clinical but functionally critical spaces within a healthcare facility. The presence of cobwebs, bird nests, or seepage in areas like the Pharmacy, Kitchen, or Mortuary reflects poor facility maintenance and can pose serious risks to hygiene and safety. For instance, seepage may lead to mold growth, which can contaminate medicines or food, and bird nests can carry diseases. Therefore, regular inspections and maintenance are crucial not only to meet NABH standards but also to prevent potential health

hazards and maintain the credibility and safety of the institution. The observation ("OB") method implies that the assessor will directly verify the physical condition of the premises during the assessment visit.

Means of verification : **OB / SI**

What is to be observed (OB):

- Inspect the roof, walls, and corners of the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative offices.
- Look carefully for any cobwebs, bird nests, seepage, or water leakage.
- Ensure that none of these issues are present in the auxiliary areas.

What is to be enquired (SI):

- Ask staff if regular inspections are conducted to check for cobwebs, bird nests, and seepage in auxiliary areas.
- Enquire about the frequency and process of cleaning and maintenance to prevent these issues.
- Confirm who is responsible for monitoring and reporting any such problems.

Implementation plan :

To comply with checkpoint B5.2, a systematic housekeeping and maintenance schedule should be established and implemented for all auxiliary areas such as the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative offices. Designated housekeeping staff should conduct daily cleaning and visual inspections of walls, roofs, and corners in these areas. A weekly inspection checklist should be developed and maintained by the facility manager or designated supervisor to record the presence of any cobwebs, bird nests, or signs of seepage. In case of any findings, immediate action must be taken—cleaning cobwebs, removing bird nests humanely with the help of appropriate personnel, and repairing seepage through proper civil maintenance. Training should be provided to staff to recognize early signs of damage or contamination. Preventive maintenance activities, including sealing of cracks and waterproofing, should be planned periodically.

Scoring Criteria :

 2 marks if there are no cobwebs, bird nests, or seepage visible on the roofs, walls, and corners of all auxiliary areas including the Pharmacy, Kitchen, Laundry, Mortuary, and Administrative offices.

 Award **1 mark** if minor presence of cobwebs, bird nests, or seepage is noticed but it does not affect the overall cleanliness or safety of the auxiliary areas and corrective actions are planned or ongoing.

 Award **0 marks** if there is a significant presence of cobwebs, bird nests, or seepage on the walls, roofs, or corners of any auxiliary area and no action has been taken to address these issues.

Reference : NA

B5.3	Auxiliary Areas are cleaned at least twice in the day with wet mop

Interpretation

This checkpoint ensures that auxiliary areas are maintained in a hygienic condition to prevent infection and ensure a safe environment. Cleaning twice daily with a wet mop is critical for removing dust and microbial contaminants. Verification involves both direct confirmation from cleaning personnel and documentary evidence from housekeeping logs.

Means of verification : **OB / SI**

Observation (OB):

- Observe the auxiliary areas to check for cleanliness and signs of recent wet mopping.
- Verify presence of cleaning equipment such as wet mops and cleaning agents near the auxiliary areas.
- Check the condition of the floor surface (wet, dry, visibly clean).

Staff Interview (SI):

- Ask the cleaning staff about the frequency of cleaning auxiliary areas each day.
- Inquire about the time schedule followed for cleaning these areas.
- Confirm the cleaning method used (wet mop).
- Ask if any challenges affect the cleaning frequency.

Records Review (RR):

- Verify housekeeping cleaning logs or records for entries related to auxiliary area cleaning frequency.
- Cross-check if the records show at least two cleanings per day with wet mopping.

Implementation plan :

Auxiliary areas must be cleaned at least twice daily using a wet mop to maintain hygiene and prevent contamination. Cleaning staff should be scheduled and trained to follow this frequency strictly. The housekeeping supervisor will maintain cleaning records for these areas, documenting the times and methods of cleaning. Periodic checks by the quality team will verify compliance by reviewing these records and confirming with staff.

Scoring Criteria :

 2 Marks: Auxiliary areas are cleaned at least twice a day with a wet mop, which is confirmed by both the cleaning staff and housekeeping records.

 1 Mark: Auxiliary areas are cleaned once a day with a wet mop, as verified by cleaning staff or housekeeping records.

 0 Marks: Auxiliary areas are cleaned less than once a day or not cleaned with a wet mop, or there is no evidence from cleaning staff or housekeeping records to confirm cleaning frequency.

Reference : NA

B5.4	Furniture & Fixtures are without grease and dust and cleaned daily

Interpretation

This checkpoint requires that all furniture and fixtures in the facility be free from grease and dust and cleaned on a daily basis to maintain hygiene and a professional environment. During assessment, the evaluator should observe the condition of the furniture and fixtures and ask the staff about how frequently they clean these areas. The goal is to verify that the cleaning is regular, consistent, and effective in preventing accumulation of dirt, which could impact patient safety and comfort.

Means of verification : **OB / SI**

 Observation (OB):

Observe the furniture and fixtures in different areas of the facility such as patient rooms, waiting areas, staff rooms, corridors, and administrative offices. Check if surfaces are free from visible dust, grease, or stains. Notice if cleaning supplies and equipment are available and stored properly near cleaning areas. Look for signs of daily cleaning like wet floors or recently wiped surfaces.

 Staff Interview (SI):

Ask cleaning staff or housekeeping personnel about the cleaning schedule and frequency specifically related to furniture and fixtures. Inquire about the cleaning agents used, whether they follow any checklist or cleaning protocol, and how they handle difficult stains like grease. Confirm if there are any challenges they face in maintaining cleanliness. Also, ask supervisory staff about monitoring and verification processes to ensure cleaning is done daily.

Implementation plan :

To ensure that all furniture and fixtures are free from grease and dust and cleaned daily, establish a routine cleaning schedule that clearly defines the frequency and responsibility for cleaning. Assign specific staff members the task of cleaning furniture and fixtures daily, using appropriate cleaning agents and tools. Conduct regular supervision through visual inspections and spot checks to verify compliance. Provide training to the cleaning staff on the importance of cleanliness and proper cleaning techniques. Maintain a cleaning logbook where staff record the date, time, and person responsible for the cleaning activity to ensure accountability.

Scoring Criteria :

 2 Marks: Furniture and fixtures are consistently free from grease and dust, and cleaning is done daily as confirmed by both observation and staff interview. The cleaning process is thorough and maintained regularly without lapses.

 1 Mark: Furniture and fixtures are mostly clean, with minor traces of grease or dust visible occasionally. Cleaning is done regularly but may not be strictly daily, as indicated by observation and staff responses.

 0 Mark: Furniture and fixtures show visible grease and dust buildup, and cleaning is infrequent or not done daily, as confirmed by observation and staff interview.

Reference : NA

B5.5	**Floors, walls, furniture and fixture are thoroughly cleaned once in a month**

Interpretation
This checkpoint mandates that all structural surfaces and furniture in the facility receive a comprehensive cleaning at least once every month to maintain hygiene and prevent contamination. Verification is done by asking housekeeping staff about their cleaning routine and cross-checking their statements with documented cleaning records. Consistent documentation and staff awareness are key to demonstrating compliance with this standard.
Means of verification : **OB / SI**

Observation:

- Visually inspect floors, walls, furniture, and fixtures in different areas to check for cleanliness and absence of dust, stains, or dirt buildup.
- Look for any signs of neglect or areas that appear to be cleaned irregularly.
- Check whether cleaning supplies and equipment are available and properly maintained.
- Observe if cleaning schedules or checklists are posted or accessible in the cleaning areas.
- Verify if cleaning activities follow infection control protocols (especially important in healthcare settings).

Staff Interview:

- Ask housekeeping staff or the assigned cleaning team about the routine cleaning schedule specifically for floors, walls, furniture, and fixtures.
- Enquire how often thorough cleaning is done and who is responsible for it.
- Ask what cleaning methods and materials are used for thorough cleaning.
- Confirm whether there are any challenges or barriers faced by the staff in carrying out thorough cleaning monthly.
- Ask if cleaning records or logs are maintained and how these are updated and verified.

Implementation plan :
To ensure that floors, walls, furniture, and fixtures are thoroughly cleaned once a month, a detailed cleaning schedule must be developed and communicated to all relevant housekeeping staff. The schedule should specify exact dates and areas to be cleaned each month. Supervisors should monitor adherence by maintaining cleaning logs or records, which staff must sign after completing the tasks. Periodic audits should be conducted by the quality team to verify the accuracy of these records and to confirm the cleaning meets the required standards.
Scoring Criteria :

 2 Marks: The staff clearly explain the cleaning schedule, and records fully verify that floors, walls, furniture, and fixtures are thoroughly cleaned once every month without fail. Evidence shows consistent adherence to the monthly cleaning schedule.

 1 Mark: The staff provide some information about the cleaning schedule, and records partially confirm that thorough cleaning happens monthly, but there are occasional gaps or

inconsistencies in the documentation or practice.

 0 Mark: The staff are unable to explain the cleaning schedule, or records do not exist or show that thorough cleaning of floors, walls, furniture, and fixtures is not performed once a month.

Reference : NA

B6	Cleanliness of Toilets

The intent of this standard is to ensure that the sanitation facilities within a healthcare facility are maintained in a hygienic, odor-free, and functional condition at all times. Clean and well-maintained toilets are essential for infection control, patient satisfaction, and upholding the dignity of both patients and visitors. This checkpoint also aims to reinforce regular monitoring and prompt housekeeping services to maintain cleanliness, ensure functionality, and promote a safe environment in compliance with healthcare quality standards.

B6.1	No dirt/Grease/Stains/ Garbage in Toilets

Interpretation
This checkpoint focuses on the visible cleanliness and hygiene of toilet facilities within the institution, both indoor and outdoor. It mandates that toilets must be free from dirt, grease, stains, and garbage, as these factors directly impact user comfort and infection control. Random checks serve as a quality assurance measure to ensure continuous adherence to cleanliness standards. The absence of water accumulation also prevents breeding grounds for mosquitoes and other vectors. Meeting this checkpoint reflects the institution's commitment to maintaining a safe and hygienic environment for patients, visitors, and staff.
Means of verification : **OB / SI**

Observation:

- Conduct random checks of toilets in various locations including indoor wards, outpatient areas, staff restrooms, and outdoor public toilets.
- Look for any visible dirt, grease, or stains on walls, floors, toilets, sinks, and fixtures.
- Check for presence of garbage or litter such as used tissues, sanitary napkins, wrappers, or other waste materials inside the toilets or surrounding areas.
- Inspect for stagnant water, water spillage, or dampness that may cause hygiene issues or odors.
- Verify if cleaning tools (mops, brushes) are clean and stored properly after use.
- Assess the availability and condition of cleaning agents and disinfectants in the vicinity.
- Observe whether waste bins inside toilets are adequate in number, clean, and covered.

Staff Interview:

- Ask housekeeping staff about the frequency and timing of toilet cleaning activities during the day and night shifts.
- Inquire about the specific cleaning procedures used to remove stains, grease, and dirt effectively.

- Confirm if there is a checklist or log maintained for cleaning activities and who supervises the process.
- Ask if there are any challenges faced in keeping the toilets clean (e.g., lack of supplies, high foot traffic, broken plumbing).
- Enquire how staff handle complaints or reports from patients or visitors about toilet cleanliness.
- Check if staff have received training on hygiene and infection control related to toilet maintenance.
- Verify if there are designated persons responsible for monitoring and ensuring the cleanliness standards are maintained.

Implementation plan :
To ensure toilets remain free from dirt, grease, stains, and garbage, a regular cleaning and maintenance schedule will be established and strictly followed. Cleaning staff will be assigned specific toilets for frequent inspection and cleaning throughout the day. Supervisors will conduct random spot checks in both indoor and outdoor toilet facilities to verify cleanliness standards. Any issues identified during these checks will be immediately addressed by cleaning staff. Adequate supplies of cleaning agents, disinfectants, and garbage disposal bins will be maintained to facilitate effective cleaning. Training will be provided to cleaning personnel emphasizing hygiene protocols and the importance of maintaining toilets in a clean condition at all times.
Scoring Criteria :

 2 Marks: All toilets checked, both indoor and outdoor, are completely clean with no visible dirt, grease, stains, garbage, or water accumulation anywhere.

 1 Mark: Most toilets checked are clean, but a few toilets have minor visible dirt, grease, stains, garbage, or small water accumulation that do not affect overall hygiene significantly.

 0 Marks: Several toilets checked have visible dirt, grease, stains, garbage, or water accumulation, indicating poor maintenance and cleanliness.

Reference : NA

B6.2	**No foul smell in the Toilets**

Interpretation
This checkpoint emphasizes the importance of maintaining a hygienic and odor-free environment in all toilet facilities within the institution. The absence of foul smell reflects effective cleaning protocols, good ventilation, and proper maintenance of sanitation infrastructure. It also indicates the commitment of the facility to patient comfort, infection control, and overall environmental safety. Random checks ensure that cleanliness is not limited to visible surfaces but extends to controlling odors that can negatively impact user experience and may indicate underlying sanitation issues. Consistent compliance with this checkpoint contributes to improved patient satisfaction and a healthier environment for both staff and visitors.
Means of verification : **OB / SI**

Observation (OB):

- Check some of the toilets randomly in both indoor and outdoor areas for any foul smell.
- Observe the cleanliness of the toilets, including the presence of water in the floor traps, functional exhaust fans, and availability of air fresheners or deodorants.
- Verify the presence and proper functioning of ventilation systems.
- Check for availability and use of cleaning materials and deodorizing agents in the toilet areas.
- Look for any visible signs of blockage or leakage in the drainage system that may cause odor.

Staff Interview:

- Enquire with housekeeping staff about the frequency and timing of cleaning the toilets.
- Ask about the cleaning procedures and products used to prevent foul smell.
- Check if the staff monitor and document toilet maintenance and odor control activities regularly.
- Confirm whether there are any protocols for handling complaints related to toilet smell and how promptly these are addressed.
- Verify if the staff have received any training regarding toilet hygiene and odor management.

Implementation plan :
To ensure there is no foul smell in the toilets, a regular monitoring system will be implemented. Random checks of toilets will be conducted both in indoor and outdoor areas during different times of the day to identify any presence of foul odors. Cleaning staff will be trained and assigned specific responsibilities to maintain hygiene, including timely cleaning, proper ventilation, and use of appropriate deodorizers or disinfectants. Maintenance schedules will include regular inspection and servicing of plumbing and drainage systems to prevent odor build-up. Any issues detected during random checks will be immediately addressed by notifying the housekeeping team for corrective action. Documentation of each check, findings, and corrective measures will be maintained for continuous quality monitoring.
Scoring Criteria :

 2 Marks: No foul smell is detected in any of the toilets checked randomly, both in indoor and outdoor areas. The toilets are consistently clean and odor-free.

 1 Mark: A foul smell is detected in some toilets during random checks, but the majority are free from foul odor. The issue is occasional and not widespread.

 0 Marks: A foul smell is detected in most or all toilets checked randomly in indoor and outdoor areas, indicating poor maintenance and hygiene.

Reference : NA

B6.3	**Toilets have running water and functional cistern**

Interpretation
This checkpoint verifies that the toilets are equipped with continuous running water and a properly functioning cistern, which are essential for maintaining hygiene and sanitation in healthcare facilities. Functional cisterns ensure efficient flushing, and running water supports proper cleaning and hand hygiene practices. Regular operation by cleaning staff confirms that these utilities are in working order, preventing any hygiene risks associated with non-functional or dry toilets.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether the toilets have continuous running water supply.
- Check if the water taps in the toilets operate smoothly without leakage or blockages.
- Inspect the cistern to see if it fills adequately after flushing.
- Confirm that the flushing mechanism works effectively and clears the toilet bowl.
- Look for signs of water stagnation or poor drainage in the toilet area.
- Verify cleanliness and maintenance of the toilet area including no unpleasant odor.

Staff Interview:

- Ask the cleaning staff to operate the cistern and water taps to confirm they function properly.
- Enquire if they experience any frequent issues with water supply or plumbing in the toilets.
- Ask how often the toilets are cleaned and maintained to ensure hygiene.
- Discuss with the maintenance staff or janitor regarding the repair and upkeep schedule of plumbing fixtures.
- Confirm if any complaints have been received related to toilet water supply or cistern functionality.

Implementation plan :
To ensure that toilets have running water and a functional cistern, the cleaning staff will be instructed and trained to regularly operate the cistern and water taps throughout the day. This will help identify any malfunction or interruption in water supply promptly. Maintenance requests will be raised immediately if any issues are detected to guarantee uninterrupted water availability. Additionally, routine checks and documentation will be maintained to ensure consistent functionality of the cisterns and water taps.
Scoring Criteria :

 2 Marks: Toilets have running water with functional cisterns, and on request, cleaning staff can operate both the cistern and water taps without any difficulty.

 1 Mark: Toilets have either running water or functional cisterns, but not both fully functional; the cleaning staff can operate either the cistern or water taps, but not both properly.

 0 Marks: Toilets lack running water and/or functional cisterns, and the cleaning staff are unable to operate the cistern or water taps when asked.

Reference : NA

B6.4	**Sinks and Cistern are cleaned every two hours or whenever required**

Interpretation
This checkpoint ensures that sinks and cisterns are maintained in a hygienic state by frequent cleaning to prevent microbial contamination and maintain a clean environment. Verification involves direct communication with the cleaning staff about the frequency of cleaning and cross-checking these details against housekeeping records such as cleaning logs or registers. Consistent documentation and adherence to the cleaning schedule demonstrate effective implementation of infection control and facility maintenance protocols.
Means of verification : **OB / SI**

 Observation (OB): Check the sinks and cisterns to see if they appear clean and well-maintained. Look for signs of dirt, stains, or buildup that would indicate insufficient cleaning frequency.

 Staff Interview (SI): Ask the cleaning staff about the frequency of cleaning the sinks and cisterns—specifically whether they clean them every two hours or as needed.

 Record Review (RR): Verify the cleaning frequency by reviewing housekeeping records or cleaning logs to confirm the documented cleaning times and schedules.

Implementation plan :
To ensure compliance with the standard B6.4, sinks and cisterns will be cleaned every two hours or as needed. The housekeeping team will follow a strict cleaning schedule documented in a cleaning log. Cleaning staff will be trained on the importance of timely cleaning to maintain hygiene and prevent contamination. Supervisors will conduct regular inspections to verify that cleaning activities are carried out according to the schedule. Any deviations or special circumstances requiring additional cleaning will be recorded and addressed immediately to maintain the required standard.
Scoring Criteria :

 2 Marks: The cleaning staff confirms that sinks and cisterns are cleaned every two hours or more frequently as needed, and this is fully supported by housekeeping records showing documented cleaning at the required frequency without gaps.

 1 Mark: The cleaning staff confirms the sinks and cisterns are cleaned regularly but the housekeeping records show some irregularities or occasional lapses in maintaining the two-hour cleaning frequency.

 0 Mark: The cleaning staff cannot confirm regular cleaning every two hours, or housekeeping records do not reflect the required frequency, indicating sinks and cisterns are cleaned less frequently than specified or cleaning is not properly documented.

Reference : NA

B6.5	Floors of Toilets are Dry

Interpretation
To ensure compliance with the standard that the floors of toilets remain dry, routine inspections will be conducted randomly throughout the facility. Designated staff members will perform spot checks on various toilet locations during their rounds, focusing on verifying that the floors are free from any water accumulation or residues. Any instances of wet floors will be promptly addressed by cleaning teams to prevent slip hazards and maintain hygiene. Records of these checks will be maintained, noting the date, time, location, and findings to ensure accountability and continuous monitoring.
Means of verification : **OB / SI**

Observation:
Randomly select some toilets within the facility and visually inspect the floors. Verify that the floors are dry and do not have any visible residue or accumulation of water. Ensure that there is no dampness or water pooling on the floor surface.

Staff Interview:
Enquire with cleaning staff or housekeeping personnel about the frequency and procedure of cleaning the toilet floors. Ask how they ensure that floors remain dry throughout the day, especially during high usage periods. Confirm if any specific measures or products are used to maintain dryness and prevent water accumulation.

Implementation plan :
This checkpoint emphasizes the importance of maintaining dry floors in toilet areas to promote safety and hygiene. A dry floor indicates effective cleaning practices and proper drainage, reducing risks such as slips, falls, and microbial growth associated with moisture. Random checking of toilets helps in identifying potential lapses in maintenance routines, allowing timely corrective actions. Meeting this standard is critical for patient safety, staff welfare, and overall facility cleanliness.
Scoring Criteria :

 2 Marks: All toilets checked randomly have dry floors with no visible water residue or accumulation anywhere.

 1 Mark: Most toilets checked are dry, but a few have minor areas with some water residue or slight dampness without pooling.

 0 Mark: Several toilets have wet floors with noticeable water accumulation or residue, indicating poor maintenance or drainage.

Reference : NA

B7	Use of standards materials and Equipment for Cleaning

The intent of this checkpoint is to ensure that the healthcare facility maintains high standards of cleanliness and infection prevention by using standard, effective, and safe cleaning materials and equipment. It emphasizes the use of good quality, preferably ISI-marked, disinfectants and detergents, and mandates proper dilution practices to ensure efficacy. Additionally, the checkpoint ensures that appropriate cleaning tools, such as mops, buckets, and carts, are adequately available and properly segregated for general and critical areas. These practices are critical for maintaining a hygienic environment, minimizing cross-contamination, and ensuring patient and staff safety.

B7.1	Availability of Detergent Disinfectant solution / Hospital Grade Phenyl for Cleaning purpose

Interpretation

This checkpoint ensures that cleaning solutions used in the hospital are effective and safe, thereby maintaining hygiene standards critical for infection control. The presence of an ISI mark and proper labeling of composition and concentration confirm the quality and suitability of the disinfectant. Regular communication with cleaning staff guarantees that the supplies meet actual needs, preventing lapses in cleaning routines. Monitoring consumption records provides an objective measure to verify consistent availability and appropriate use, supporting a clean and safe hospital environment.

Means of verification : **OB / SI**

What is to be observed (OB):
Observe the availability of a good quality hospital cleaning solution, preferably with an ISI mark. Check the label on the cleaning solution to verify that the composition and concentration are clearly mentioned.

What is to be enquired:
Interview the cleaning staff to confirm whether they are receiving an adequate and consistent supply of the detergent disinfectant or hospital-grade phenyl. Additionally, verify the consumption records to ensure proper usage and supply management.

Implementation plan :
To ensure the availability of hospital-grade detergent disinfectant solutions or phenyl for cleaning purposes, the hospital will procure only high-quality cleaning agents, preferably those with an ISI mark to guarantee standard compliance. The procurement team will verify the composition and concentration of the solution by checking the product labels to confirm they meet the required specifications. The housekeeping supervisor will regularly communicate with cleaning staff to confirm that they receive an adequate and uninterrupted supply of the cleaning agents. Additionally, consumption records will be maintained and reviewed periodically to monitor usage patterns and prevent shortages.

Scoring Criteria :

 2 Marks: Good quality hospital-grade cleaning solution (preferably ISI marked) is available. The composition and concentration are clearly mentioned on the label. Cleaning staff confirm receiving an adequate supply consistently. Consumption records are complete, accurate, and show regular use matching the needs.

 1 Mark: Hospital-grade cleaning solution is available, but either the ISI mark is missing or the composition/concentration details on the label are incomplete or unclear. Cleaning staff report occasional shortages or inconsistent supply. Consumption records exist but may be incomplete or irregular.

 0 Marks: No hospital-grade cleaning solution or detergent disinfectant is available. Composition and concentration details are missing or not legible. Cleaning staff report insufficient or no supply. Consumption records are absent or show no usage.

Reference : NA

B7.2	**Cleaning staff uses correct concentration of cleaning solution**

Interpretation
Checkpoint B7.2 requires verification that cleaning staff are knowledgeable and competent in preparing cleaning solutions at the correct concentration. This involves confirming that they understand the correct dilution ratios and can practically demonstrate the preparation process. The verification should be cross-checked with the instructions provided on the cleaning solution container to ensure accuracy. This checkpoint helps maintain the efficacy of cleaning procedures, ensuring safety, hygiene, and compliance with infection control standards.

Means of verification : **OB / SI**

 Observation:

- Observe the cleaning staff while preparing the cleaning solution.
- Check if they are using the correct concentration and dilution method according to the instructions on the solution bottle.

 Staff Interview:

- Ask the cleaning staff if they are aware of the correct concentration and dilution method.
- Request the cleaning staff to demonstrate how they prepare the cleaning solution.

Implementation plan :
To ensure that the cleaning staff uses the correct concentration of cleaning solution, organize training sessions focused on the proper dilution methods and handling of cleaning agents. Provide written instructions and demonstration videos if possible. Display clear dilution charts and guidelines near the cleaning supply storage and preparation areas. Conduct regular hands-on assessments where staff demonstrate their preparation technique. Supervisors or quality assurance personnel should periodically observe and verify the cleaning solution preparation process against the instructions on the solution bottle. Maintain records of these checks to ensure continuous

compliance and to identify any training needs.
Scoring Criteria :

 2 Marks: The cleaning staff is fully aware of the correct concentration and dilution method for preparing the cleaning solution. They demonstrate the preparation correctly, matching the instructions given on the solution bottle without any errors.

 1 Mark: The cleaning staff shows partial awareness of the correct concentration and dilution method and can demonstrate the preparation, but minor errors or deviations from the instructions are observed.

 0 Marks: The cleaning staff is not aware of the correct concentration or dilution method, cannot demonstrate the preparation correctly, or the preparation does not match the instructions on the solution bottle.

Reference : NA

B7.3	Availability of Buckets and carts for Mopping

Interpretation
This checkpoint emphasizes the need for proper segregation of cleaning tools to uphold hygiene standards. Having adequate buckets and carts means the facility is prepared to perform mopping efficiently without delays caused by equipment shortages. Separate equipment for general and critical areas reduces the risk of spreading contaminants, particularly in sensitive zones such as patient care or sterile areas. This segregation is critical in infection control and maintaining a safe and clean environment within the healthcare setting.
Means of verification : **OB / SI**

Observation:

- Check the availability and adequacy of buckets and mopping carts in the facility.
- Verify that there are separate buckets and carts designated for general areas and critical areas to prevent cross-contamination.
- Observe the physical condition and cleanliness of the buckets and carts.
- Ensure that the buckets and carts are readily accessible where cleaning is performed.

Staff Interview:

- Enquire from housekeeping or cleaning staff about the availability and adequacy of buckets and carts for mopping.
- Ask whether separate buckets and carts are used for general and critical areas as per protocol.
- Confirm if the staff is trained or instructed on the importance of using separate equipment to prevent cross-contamination.
- Ask about the process followed when buckets or carts are damaged or missing.

Implementation plan :
To ensure compliance with checkpoint B7.3, the facility will conduct a thorough inventory assessment to verify the availability of an adequate number of buckets and mopping carts. The

stock will be evaluated to confirm that there are separate buckets and carts designated specifically for general areas and critical areas, thereby preventing cross-contamination. Procurement will be planned proactively to maintain sufficient quantities based on the size and layout of the facility. Staff will be trained on the importance of using the designated buckets and carts for their respective areas. Regular audits will be scheduled to monitor compliance and prompt replacement or repair of damaged equipment.

Scoring Criteria :

 2 Marks: Adequate numbers of buckets and carts are available for mopping, with separate buckets and carts provided for both general and critical areas without any shortage.

 1 Mark: Buckets and carts are available but either not in adequate numbers or there is no clear separation between general and critical areas (i.e., shared buckets/carts).

 0 Marks: Buckets and carts are either not available or are grossly inadequate, and there is no separation between general and critical areas.

Reference : NA

B7.4	Availability of Cleaning Equipment

Interpretation

This checkpoint focuses on confirming that all necessary cleaning tools are present and sufficient to meet the routine cleaning demands of the facility. The presence of adequate cleaning equipment ensures that cleaning activities can be performed efficiently and hygienically, contributing directly to infection control and maintaining a safe environment. Lack of required cleaning equipment could lead to compromised cleanliness, which may affect patient safety and overall facility hygiene standards.

Means of verification : **OB / SI**

 What to Observe (OB):

Physically inspect the cleaning equipment available on-site, such as mops, brooms, collection buckets, and other necessary cleaning tools. Verify that these items are present and in adequate quantity according to the facility's requirements.

 What to Enquire (SI):

Interview cleaning staff or relevant personnel to confirm the availability and accessibility of cleaning equipment. Ask if the equipment is sufficient to meet daily cleaning needs and if it is maintained properly to ensure hygiene and efficiency.

Implementation plan :

To ensure compliance with this standard, the facility will conduct a regular inventory check of all essential cleaning equipment such as mops, brooms, collection buckets, and other related items. The cleaning staff will be trained to report shortages immediately, and the procurement team will maintain a minimum stock level based on the size and cleaning requirements of the facility. Scheduled audits will verify that the equipment is functional, available in adequate quantity, and easily accessible for housekeeping personnel to maintain hygiene standards effectively.

Scoring Criteria :

 2 Marks: All required cleaning equipment such as mops, brooms, collection buckets, and other necessary tools are fully available and in good condition as per the requirement.

 1 Mark: Some of the required cleaning equipment are available, but there are minor shortages or some items are not in optimal condition.

 0 Mark: Cleaning equipment such as mops, brooms, and collection buckets are not available or are grossly inadequate to meet the cleaning requirements.

Reference : NA

B8	Use of Standard Methods Cleaning

The intent of the B8 standard is to ensure effective and safe cleaning practices within healthcare facilities to prevent cross-contamination and maintain high standards of hygiene, particularly in patient care areas. These methods are designed to standardize cleaning protocols, minimize infection risks, and promote best practices in environmental cleaning. The focus is on structured cleaning processes such as the three-bucket system, unidirectional mopping, restricted use of brooms, segregation of cleaning tools for different risk zones, and proper disinfection of cleaning equipment. Implementing these methods ensures a clean, safe, and infection-controlled environment conducive to patient safety and quality care.

B8.1	Use of Three bucket system for cleaning

Interpretation

This checkpoint evaluates whether the cleaning staff consistently follow the three bucket system during cleaning activities. The presence of three buckets—one for the cleaning solution, one for rinsing with plain water, and one for wringing the mop—is essential to prevent contamination and ensure cleaning efficiency. Verification includes direct observation of the cleaning process and interaction with cleaning personnel to confirm their understanding and proper application of the system. Successful compliance indicates effective infection control practices and maintenance of hygiene standards within the facility.

Means of verification : **OB / SI**

- **Observation (OB):**
  - Check if cleaning staff use three buckets during cleaning.
  - Confirm one bucket contains cleaning solution.
  - Confirm second bucket contains plain water.
  - Confirm third bucket is used for wringing the mop.
- **Staff Interview (SI):**
  - Ask cleaning staff to explain the cleaning process they follow.
  - Enquire about the purpose of each bucket in the three bucket system.

- Ask why the three bucket method is used and its importance.

Implementation plan :
To implement the three bucket system effectively, the cleaning staff will be trained on the proper procedure involving three distinct buckets: one containing the cleaning solution, the second filled with plain water for rinsing, and the third designated for wringing the mop. Clear instructions and demonstrations will be provided during training sessions to ensure understanding. Cleaning supervisors will conduct routine monitoring and spot checks to verify compliance. The cleaning supplies will be arranged conveniently to facilitate ease of use and reduce cross-contamination risks. Additionally, a checklist will be maintained to document daily adherence, and feedback will be gathered from cleaning staff to address any challenges or suggestions for improvement.

Scoring Criteria :

 2 Marks: The cleaning staff correctly use the three bucket system for cleaning, with one bucket for cleaning solution, one for plain water, and one for wringing the mop. The staff clearly explain the process accurately when asked.

 1 Mark: The cleaning staff partially use the three bucket system but do not follow the correct procedure fully or are unsure when explaining the process.

 0 Marks: The three bucket system is not used at all, or the cleaning staff are unaware of the process and cannot explain it.

Reference : NA

B8.2	Use unidirectional method and out word mopping

Interpretation
This checkpoint ensures that floor cleaning is performed efficiently to minimize the risk of cross-contamination. Using a unidirectional mopping method means the mop moves in one consistent direction—from the inner area to the outer edges—without retracing steps back to the starting point. This technique helps prevent dirt or microorganisms from being spread back onto already cleaned surfaces, thereby maintaining a higher standard of hygiene in the facility.
Means of verification : **OB / SI**

Means of Verification: Staff Interview / Observation (SI/OB)

- **Observation (OB):**
  - Watch cleaning staff demonstrate floor mopping.
  - Mop should be applied in one direction only.
  - Mop movement should not return to the starting point.
  - Mop strokes should move from the inner area of the room to the outer area.
- **Staff Interview (SI):**
  - Ask cleaning staff to explain their mopping technique.
  - Confirm their understanding of the unidirectional mopping method.
  - Ensure they know why it is important not to move the mop back to the starting

point.

Implementation plan :
Conduct a training session for the cleaning staff to demonstrate the proper mopping technique. Emphasize the use of a unidirectional method where the mop is moved in a single direction, startg from the inner area of the room and progressing outward toward the edges. Supervisors should observe the cleaning staff during their routine tasks and provide real-time feedback to ensure compliance. Regular monitoring and spot checks should be conducted to verify that the mop is not returned to the starting point during cleaning, thereby preventing re-contamination of cleaned areas.
Scoring Criteria :

 2 Marks: The cleaning staff correctly demonstrates the unidirectional mopping technique by applying the mop in one continuous direction without returning to the starting point, moving systematically from the inner area to the outer area of the room.

 1 Mark: The cleaning staff shows an attempt at unidirectional mopping but occasionally moves the mop back towards the starting point or does not consistently move from the inner to the outer area.

 0 Marks: The cleaning staff does not demonstrate the unidirectional method and mops randomly, frequently crossing back over already cleaned areas or not following the inner-to-outer movement.

Reference : NA

B8.3	**No use of brooms in patient care areas**

Interpretation
This checkpoint verifies the implementation of a basic infection control practice—avoiding the use of brooms in patient care areas to prevent the spread of dust and pathogens. During assessment, the assessor will inspect storage spaces within or near patient care areas to ensure brooms are not kept there. They will also inquire with cleaning staff to determine actual cleaning practices. If brooms are found or staff admit to using them in these areas, it will be considered a non-conformance. The intent is to ensure that cleaning methods do not compromise the sterility or cleanliness of areas where patients are treated, especially in high-risk zones like OTs and Labour Rooms.
Means of verification : **OB / SI**

Observation (OB):

- Check all patient care areas (wards, OT, labour rooms, procedure rooms) for the presence of brooms.
- Ensure that brooms are not stored in any of these areas.
- Observe the type of cleaning equipment in use – only mops, scrubbers, or other approved tools should be seen.
- Verify that no staff are using brooms for sweeping within patient care zones.

Staff Interview (SI):

- Ask housekeeping or cleaning staff about their cleaning practices in patient care areas.
- Specifically enquire if brooms are ever used in wards, OT, or labour rooms.
- Confirm staff awareness that brooms are not permitted in patient care areas due to infection control concerns.

Implementation plan :
To comply with standard B8.3, the facility must strictly prohibit the use of brooms in patient care areas such as wards, Operation Theatres (OT), Labour Rooms, and consultation areas. First, all brooms should be removed from these areas and stored only in designated housekeeping rooms. Replace brooms with mops, microfiber cloths, or other appropriate cleaning equipment suited for clinical environments. Conduct training sessions for housekeeping and support staff to educate them on the rationale behind this protocol and the infection control risks associated with broom usage. Display visual reminders (posters or signage) in patient care areas to reinforce the message. Regular internal audits should be scheduled to ensure continued compliance, and any non-conformity should be corrected with immediate retraining.
Scoring Criteria :

 2 Marks: No brooms are found stored or used in any patient care areas such as wards, OT, or labour rooms. Cleaning staff confirm that they strictly use only appropriate cleaning equipment (e.g., mops, microfiber cloths) in these areas, and there is full compliance with the guideline.

 1 Mark: Brooms are not being used in patient care areas, but one or two are found stored inappropriately within those areas (e.g., behind doors or in utility rooms). Cleaning staff acknowledge the presence but affirm that they do not use them for sweeping patient areas.

 0 Mark: Brooms are visibly stored and/or actively used for sweeping in patient care areas such as wards, operation theatres, or labour rooms. Cleaning staff confirm their use, indicating non-compliance with the guideline.

Reference : NA

B8.4	**Use of separate mops for critical and semi critical areas and procedures surfaces**

Interpretation

Checkpoint B8.4 ensures that there is no cross-utilization of mops and cleaning cloths between critical and general areas, as well as between procedure surfaces and floors. During assessment, the assessor will observe whether the cleaning staff uses different sets of mops for cleaning critical areas like the OT and Labour Room and whether the same cloths used to clean procedure surfaces (e.g., OT tables) are being inappropriately used on floors. The use of the same cleaning tools across different zones can lead to hospital-acquired infections due to microbial transfer. Hence, this standard checks both the awareness of cleaning protocols among staff and the implementation of segregation in cleaning practices.

Means of verification : **OB / SI**

Observation (OB):

- Check if separate mops are used for critical areas such as the Operation Theatre and

Labour Room.

- Verify that the same mop is not used in both critical areas and general areas like corridors or outpatient departments.
- Observe whether mops are color-coded or clearly labelled to indicate area-specific use.
- Ensure that cleaning cloths used for wiping procedure surfaces like OT tables and Labour Room tables are not used for floor cleaning.
- Confirm that cleaning materials are stored in a way that maintains their designated area-specific use.

Staff Interview (SI):

- Ask the housekeeping staff if they know the requirement to use separate mops and cloths for critical and general areas.
- Enquire whether they can correctly identify which mop or cloth is used in each specific area.
- Check if the staff understands the reason behind not mixing cleaning tools between procedure surfaces and floors.
- Confirm whether the staff has received training on area-specific cleaning protocols.
- Ask how frequently such training is conducted and how their compliance is monitored.

Implementation plan :
To ensure compliance with checkpoint B8.4, the healthcare facility should develop and enforce a Standard Operating Procedure (SOP) that mandates the use of color-coded mops and cleaning materials for different zones: critical areas (e.g., Operation Theatre, Labour Room), semi-critical areas, and general/outer areas. Each cleaning staff member must be trained on infection control protocols emphasizing the importance of using dedicated equipment for each area to prevent cross-contamination. Critical area mops should be stored separately, disinfected regularly, and clearly labeled. Routine supervisory audits should be conducted to verify compliance, and non-compliance should be addressed with immediate corrective actions. The facility should also maintain logs for mop usage and replacement schedules as evidence for assessment.
Scoring Criteria :

2 Marks: Separate mops and cleaning cloths are used consistently for critical areas (e.g., OT, Labour Room), semi-critical areas, and procedure surfaces. There is clear evidence that cleaning staff adhere strictly to this practice without any crossover of materials. Staff are aware of the protocol and can demonstrate it in practice.

1 Mark: Separate mops and cleaning cloths are available and the practice is generally followed, but there is occasional or minor non-compliance. For example, staff may not always clearly distinguish between mops used for different areas, or some staff are unsure of the protocol.

0 Mark: The same mops and cleaning cloths are used for both general and critical areas or for both floor cleaning and procedure surfaces. There is no system in place to ensure separation, or staff are unaware of the requirement.

Reference : NA

B8.5	Disinfection and washing of mops after every cleaning cycle

Interpretation
The checkpoint B8.5 requires verification that cleaning staff properly disinfect, wash, and dry mops after every cleaning cycle before reuse. This is critical to prevent cross-contamination and maintain hygiene standards in healthcare or any facility environment. A mop that is not properly disinfected can harbor harmful microorganisms, increasing the risk of infection spread. The assessment involves observing the cleaning process, checking for the availability of disinfectants, and confirming that mops are completely dry before reuse. The objective is to ensure that the mop is free from contaminants and safe to use for the next cleaning cycle.
Means of verification : **OB / SI**

OB – What is to be observed:

- Observe whether mops are washed, disinfected, and dried after each cleaning cycle.
- Check if a designated area is available for mop cleaning and drying.
- Look for the availability and correct use of appropriate disinfectants and cleaning equipment (e.g., buckets, gloves).
- Ensure that separate mops are used for different areas such as toilets, wards, and general floors.
- Confirm that used mops are not stored wet or left on the floor after cleaning.

SI – What is to be enquired through staff interview:

- Ask cleaning staff to explain the process they follow after each cleaning cycle.
- Enquire how and where they disinfect and dry the mop.
- Ask if they use different mops for different cleaning areas.
- Confirm their understanding of the importance of mop disinfection to prevent cross-contamination.
- Ask how frequently the mops are replaced or discarded.

Implementation plan :
To ensure effective disinfection and washing of mops after every cleaning cycle, a clear protocol will be established for cleaning staff. This includes training all housekeeping personnel on the importance of disinfecting, washing, and thoroughly drying mops after each use. A designated area with proper facilities such as sinks, disinfectants, and drying racks will be allocated for mop cleaning. Supervisors will conduct regular checks and maintain logs to verify that mops are disinfected according to the schedule. Use of appropriate disinfectants that are effective against common pathogens will be mandated. Additionally, routine audits will be conducted to ensure compliance, and refresher training sessions will be organized periodically.
Scoring Criteria :

 2 Marks: The cleaning staff consistently disinfect, thoroughly wash, and properly dry the mops after every cleaning cycle without fail. This practice is observed and documented regularly as part of the cleaning protocol.

 1 Mark: The cleaning staff generally follow the procedure of disinfecting, washing, and drying the mops, but there are occasional lapses or inconsistencies in practice or documentation.

 0 Mark: The cleaning staff do not follow the procedure of disinfecting and drying mops after each use, or there is no evidence to show that such a practice is being followed.

Reference : NA

B9	Monitoring of Cleanliness Activities

Intent of B9 – Monitoring of Cleanliness Activities:

The intent of this standard is to ensure that cleanliness and hygiene are consistently maintained across all functional areas of the healthcare facility through structured and monitored housekeeping practices. Proper implementation of housekeeping checklists, designated oversight, and quality assurance of cleaning materials are crucial for maintaining a safe, infection-free environment for patients, staff, and visitors. The monitoring mechanism not only ensures accountability but also supports early identification and rectification of gaps in cleaning processes, which is essential for infection control and patient satisfaction.

B9.1	Use of Housekeeping Checklist in Toilets

Interpretation
This checkpoint ensures that there is a systematic and documented approach to maintaining cleanliness and hygiene in the toilet areas through the use of a Housekeeping Checklist. The visible display of the checklist in toilets serves as a constant reminder to housekeeping staff and reassures users that cleanliness standards are actively monitored. The daily updating and maintenance of records over a one-month period confirm ongoing compliance and help identify any lapses or trends in housekeeping practices. Overall, this practice supports infection control, patient safety, and enhances the overall environment of care within the facility.
Means of verification : **OB / SI**

Means of Verification: Observation / Staff Interview

What is to be Observed (OB):

- Check that the Housekeeping Checklist is displayed clearly inside the toilet.
- Verify that the checklist is regularly updated and properly filled out.
- Review housekeeping records to confirm that the checklists have been updated daily for at least the last one month.

What is to be Enquired (Staff Interview):

- Ask housekeeping staff how often the toilet cleaning is done and how frequently the checklist is updated.
- Enquire about the process followed to maintain the checklist and how they ensure it is complete and accurate.
- Confirm whether there is any supervision or audit mechanism in place to monitor

checklist compliance and how issues are addressed.

Implementation plan :
To implement checkpoint B9.1 effectively, the facility should ensure that a standardized Housekeeping Checklist specific to toilets is developed and displayed prominently within all toilet areas. The checklist must include critical cleaning tasks, frequencies, and responsible personnel. Housekeeping staff should be trained on the importance of the checklist and their role in updating it daily. Supervisors must conduct routine audits to verify that the checklist is being updated accurately each day. The housekeeping records, including the completed checklists, should be maintained systematically and readily accessible. To meet the NABH requirement, the daily updating of these checklists should be verified for at least the previous one month to demonstrate consistent adherence.
Scoring Criteria :

 2 Marks: The Housekeeping Checklist is clearly displayed in the toilet area and is updated regularly. The housekeeping records show that the checklist has been filled out daily without any gaps for at least the last one month.

 1 Mark: The Housekeeping Checklist is displayed in the toilet but may not be consistently updated daily. The housekeeping records show some gaps or irregularities in daily updates over the last one month.

 0 Marks: The Housekeeping Checklist is either not displayed in the toilet or is not updated. The housekeeping records do not show daily updates or are missing for the last one month.

Reference : NA

B9.2	Use of Housekeeping Checklist in Patient Care Areas

Interpretation

This checkpoint requires verification that the Housekeeping Checklist is not only displayed but actively used in all patient care areas to maintain hygiene standards. The presence of the checklist in visible locations like OPD, IPD, and Labs indicates a commitment to organized and monitored cleaning practices. Checking housekeeping records for daily updates over the last month confirms that the process is consistently followed, ensuring ongoing cleanliness and minimizing infection risks. This continuous documentation also helps in accountability and traceability, enabling the hospital to detect patterns or recurring issues in housekeeping and take timely corrective measures. Compliance with this checkpoint reflects adherence to patient safety and infection control protocols, which are critical components of overall quality care.
Means of verification : **OB / SI**

Observation (OB):

- Check if the Housekeeping Checklist is displayed in OPD, IPD, Lab, and other patient care areas.
- Verify housekeeping records to ensure daily updates of the checklist for the last one

month.

Staff Interview (RR):

- Ask housekeeping staff if they use the checklist daily in patient care areas.
- Confirm how they maintain and update the checklist records regularly.
- Enquire about any issues noted and actions taken based on checklist findings.

Implementation plan :
To implement this checkpoint, first ensure that the Housekeeping Checklist template is prepared according to hospital policy and NABH standards. The checklist should cover all critical patient care areas such as OPD (Outpatient Department), IPD (Inpatient Department), Laboratory, and any other relevant clinical zones. The checklist must be visibly displayed in each area for easy reference by housekeeping staff and supervisors. Train housekeeping staff on the importance of using the checklist daily to ensure consistent cleanliness and infection control. Assign responsibility to a designated supervisor to monitor and verify the completion of the checklist every day. Establish a system to maintain and archive completed checklists for at least one month to facilitate audit and review. Regular audits should be conducted by the Quality or Infection Control team to verify compliance and identify any gaps for corrective actions.

Scoring Criteria :

 2 Marks: The Housekeeping Checklist is properly displayed in all relevant patient care areas such as OPD, IPD, and Laboratory, and the housekeeping records show that the checklists have been updated daily without gaps for at least the last one month.

 1 Mark: The Housekeeping Checklist is displayed in most patient care areas, and housekeeping records show that checklists have been updated regularly but with occasional missing days within the last one month.

 0 Marks: The Housekeeping Checklist is not displayed in patient care areas, or housekeeping records do not demonstrate daily updates of the checklist for the last one month.

Reference : NA

B9.3	Use of Housekeeping Checklist in Procedure Areas

Interpretation

This checkpoint focuses on verifying two key aspects: the presence and visibility of the housekeeping checklist in critical procedure areas, and the consistency of its daily updates. Observers should confirm that the housekeeping checklist is physically displayed in the Labour room, OT Dressing room, and other procedure-related spaces to ensure that staff have a clear, accessible guide for their cleaning duties. Inquiry should be made into housekeeping records to check whether the checklist has been updated on a daily basis without gaps for at least the past month. This helps ascertain that cleaning activities are systematically documented, thereby supporting infection control and maintaining a safe environment. The emphasis is on both the availability of the checklist as a reference tool and the adherence to daily housekeeping routines

as recorded in the logs.
Means of verification : **OB / SI**

Observation (OB):

- Check if the Housekeeping Checklist is displayed in Labour Room, OT Dressing Room, and other procedure areas.
- Verify that the checklist is clearly visible and accessible in these locations.
- Review housekeeping records to ensure the checklist has been updated daily for at least the past one month.

Staff Interview (SI):

- Ask housekeeping staff or responsible personnel about the procedure for updating the checklist.
- Confirm whether the checklist is updated daily and maintained consistently.
- Enquire how they ensure the checklist is properly followed and documented every day.

Implementation plan :
To implement the use of the Housekeeping Checklist in procedure areas such as the Labour room and OT Dressing room, first ensure that a standardized housekeeping checklist is prepared according to the facility's protocols. The checklist should cover all critical cleaning and maintenance activities for these areas. The checklist must be clearly displayed in visible locations within the Labour room, OT Dressing room, and other relevant procedure areas to ensure easy access and regular use by the housekeeping staff. Training sessions should be conducted for housekeeping personnel and supervisors to emphasize the importance of daily updates on the checklist. Additionally, a system should be established for supervisors or quality managers to regularly review and verify that the housekeeping checklists are being updated daily. This review should cover at least the last one month to monitor consistency and compliance. Any deviations or gaps must be promptly addressed through corrective actions to maintain hygiene standards.
Scoring Criteria :

 2 Marks: The Housekeeping Checklist is clearly displayed in all key procedure areas such as the Labour room and OT dressing room. Additionally, housekeeping records show that the checklist has been consistently and correctly updated on a daily basis for at least the last one month.

 1 Mark: The Housekeeping Checklist is displayed in procedure areas, but the housekeeping records either show irregular updates or updates for less than one month.

 0 Marks: The Housekeeping Checklist is not displayed in the procedure areas, or there are no housekeeping records to verify daily updates, or the checklist has not been updated for the last one month.

Reference : NA

B9.4	**A person is designated for monitoring of Housekeeping Activities**

Interpretation

Checkpoint B9.4 requires that the hospital formally appoints a person to monitor housekeeping activities. It emphasizes accountability and verification by ensuring that this person not only checks the housekeeping work but also confirms it by countersigning the housekeeping checklist. The intent is to establish a clear line of responsibility for cleanliness and hygiene in the facility, and the SI (Self-Inspection) or RR (Record Review) method is used to verify this practice. The assessor will look for documentary evidence such as the housekeeping checklist with dual signatures—one from the housekeeping personnel and another from the designated monitoring staff—to confirm compliance.

Means of verification : **OB / SI**

Observation (OB):

- Observe the housekeeping checklist or monitoring register for the name of the designated staff responsible for housekeeping monitoring.
- Check if the checklist contains counter signatures or remarks from the designated person.
- Ensure that the entries are consistent, dated, and updated regularly.
- Look for signs of active monitoring, such as comments or notes indicating corrective actions.

Staff Interview (SI):

- Ask the designated staff to confirm their role in monitoring housekeeping activities.
- Enquire about the frequency of their monitoring and how they document their observations.
- Ask them to explain the process followed when they find any housekeeping deficiencies.
- Verify with housekeeping staff whether monitoring is being done regularly by the designated person.
- Confirm if any feedback or instructions are given by the designated staff during their rounds.

Implementation plan :
To implement checkpoint B9.4 effectively, the healthcare facility must designate a specific staff member responsible for monitoring housekeeping activities. This can be done through a formal appointment order or inclusion in their job responsibilities. The designated staff should be trained on the housekeeping checklist and standard operating procedures (SOPs). A daily or periodic schedule should be created to ensure timely inspections of all areas, including clinical, non-clinical, and common spaces. The designated person must verify the completion of housekeeping tasks and ensure that the housekeeping checklist is duly filled and signed by the housekeeping staff. Finally, the designated person must countersign the checklist to validate that monitoring has been performed and any deficiencies are corrected.

Scoring Criteria:

 2 Marks: A specific staff member from the hospital is formally designated to monitor housekeeping activities, and this is clearly documented. Additionally, the housekeeping checklist is consistently verified with the designated person's signature and a counter signature,

demonstrating active monitoring and accountability.

 1 Mark: A staff member is designated for monitoring housekeeping activities, but either the documentation is incomplete or inconsistent, or the housekeeping checklist lacks regular verification or counter signatures.

 0 Marks: No staff member is designated to monitor housekeeping activities, or there is no evidence of verification or counter signatures on the housekeeping checklist.

Reference : NA

B9.5	Monitoring of adequacy and quality of material used for cleaning

Interpretation

This checkpoint emphasizes the importance of ensuring that cleaning and disinfecting solutions used in the hospital are both adequate in quantity and effective in quality. It is not enough to simply use a disinfectant; the solution must be of the correct concentration to be effective. The standard requires the hospital to have a system in place to verify that the right concentrations are consistently being used. Additionally, the checkpoint highlights a participatory approach, where cleaning staff—being the frontline users—are encouraged to provide feedback on the efficacy of the solutions. This feedback must be taken seriously and acted upon if issues are noted. The underlying intent is to ensure a clean and safe environment for patients, staff, and visitors by maintaining high standards in cleaning practices.

Means of verification : **OB / SI**

What is to be observed (OB):

- Observe if disinfectant solutions are prepared as per defined dilution protocols.
- Check if containers used for cleaning solutions are properly labeled with concentration and date of preparation.
- Look for any displayed guidelines or charts related to the preparation and use of cleaning solutions.
- Observe if staff are using the correct amount and type of cleaning materials during cleaning activities.
- Check for any documentation or records showing monitoring of cleaning solution adequacy and quality.

What is to be enquired (SI):

- Ask cleaning staff if they are trained to prepare and use disinfectant solutions in the right concentration.
- Enquire whether staff are aware of the procedure for reporting ineffective cleaning agents.
- Ask if feedback is taken from cleaning staff about the effectiveness of cleaning solutions.
- Check with the hospital administration if they review feedback and take corrective actions based on staff input.
- Enquire about the system or protocol in place for monitoring the quality and adequacy of cleaning materials.

Implementation plan :

To implement checkpoint B9.5 effectively, the hospital should first establish a standard operating

procedure (SOP) for the preparation and use of cleaning and disinfectant solutions, clearly defining the recommended concentration levels for different areas (e.g., general areas, isolation zones). Designated staff must be trained on the correct dilution and usage of these materials. A monitoring mechanism should be introduced, which includes routine checks (using test strips, chemical indicators, or audits) to ensure that the solutions are prepared as per protocol. A feedback system must be developed where cleaning staff regularly report on the perceived effectiveness of the cleaning agents. Any concerns raised must be documented and reviewed by the hospital administration. If inadequacies are identified (e.g., insufficient disinfection or persistent odors), corrective actions such as changing the product, adjusting concentrations, or retraining staff should be promptly initiated.

Scoring Criteria :

 2 Marks: Award 2 marks if there is a well-established and documented system in place to monitor the adequacy and quality of cleaning materials, including verifying the correct concentration of disinfectant solutions. Additionally, feedback is regularly collected from cleaning staff regarding the efficacy of the cleaning solution, and appropriate corrective actions are taken if the solution is found to be ineffective.

 1 Mark: Award 1 mark if there is a partial system for monitoring disinfectant concentration or quality of cleaning materials, and feedback from cleaning staff is taken occasionally, but there is no consistent practice of taking corrective actions based on that feedback.

 0 Mark: Award 0 marks if there is no system to monitor the adequacy or concentration of disinfectant solutions used for cleaning, and no feedback mechanism or corrective action process is in place.

Reference : NA

B10	**Drainage and Sewage Management**
B10.1	**Availability of closed drainage system**

Interpretation

This checkpoint emphasizes the need for a closed drainage system within hospital premises to promote hygiene and prevent infection risks. A closed drainage system ensures that wastewater and other fluids are safely channeled away without exposure to patients, visitors, or staff. In cases where infrastructure limitations prevent the installation of a fully closed system, the critical requirement is that open drains are adequately covered to prevent contact with contaminants and to reduce odor and vector-borne disease risks. This flexibility recognizes infrastructural constraints while prioritizing patient safety and environmental cleanliness. Compliance with this checkpoint is essential for hospital sanitation and overall infection control.

Means of verification : **OB / SI**

Observation:

- Check the hospital premises for any open drains.
- Confirm that the hospital has a closed drainage system.
- If the hospital is old and closed drainage is not possible, verify that all open drains are properly covered.

Staff Interview:

- Ask staff if they know about any open drains on the hospital premises.
- Enquire how open drains, if any, are managed and maintained.
- Confirm if there have been any drainage-related issues reported.
- Check if any measures have been taken to cover or secure open drains.

Implementation plan :
To comply with checkpoint B10.1, the hospital must conduct a thorough survey of the entire hospital premises to identify any presence of open drainage systems. If the hospital infrastructure allows, all drainage should be converted into a closed drainage system using pipes and sealed channels to prevent exposure and contamination. For hospitals with older infrastructure where complete conversion is not feasible, the open drains must be securely and properly covered with durable materials to avoid any health hazards or environmental contamination. Regular maintenance schedules should be established to inspect and repair any damage to the closed or covered drainage systems, ensuring continuous effectiveness. Staff should be trained on the importance of maintaining drainage integrity, and periodic audits must be performed to monitor compliance.
Scoring Criteria :

 2 Marks: The hospital has a fully functional **closed drainage system** with no open drains visible anywhere within the premises. The system is well maintained, and there is no evidence of leakage, stagnation, or unhygienic conditions.

 1 Mark: The hospital has **some open drains**, but they are **properly covered and maintained**, especially in cases where infrastructure constraints prevent complete closure. The area is kept reasonably clean, and the drainage does not pose any hygiene or safety risks.

 0 Mark: The hospital has **open, uncovered drains** within the premises, which are poorly maintained, pose hygiene issues, or show signs of water stagnation or leakage, indicating non-compliance with the standard.

Reference : NA

B10.2	Gradient of Drains is conducive for adequate for maintaining flow

Interpretation

Checkpoint B10.2 requires verifying that the gradient or slope of the drainage system is sufficient to maintain effective drainage flow. This means the drains should be angled appropriately to avoid water or debris settling inside, which could cause blockages or flooding. Ensuring the gradient is "conducive" means it must be steep enough for water to flow naturally but not so steep

that it causes erosion or damage. The absence of water or debris accumulation indicates that the drainage system is functioning effectively and reduces risks related to hygiene and infrastructure damage.

Means of verification : **OB / SI**

Observation (OB):

- Observe that the drains have an adequate slope to ensure proper flow of water.
- Confirm there is no accumulation of water, debris, or stagnant areas in the drains.

Staff Interview (SI):

- Ask staff if they regularly inspect the drains for blockages or water pooling.
- Enquire about the frequency of cleaning and maintenance of the drainage system.
- Check if there have been any complaints or issues reported related to drainage flow.

Implementation plan :
To ensure that the drains have an adequate gradient conducive to maintaining proper flow, a detailed site inspection should be conducted. The process involves measuring the slope of all drain channels using appropriate tools such as a spirit level or digital inclinometer. The drains should be checked regularly to confirm that the slope is sufficient to prevent water stagnation. Maintenance schedules must be established to clear debris or blockages promptly. Any drains found with inadequate slope or signs of water accumulation should be redesigned or corrected immediately to maintain continuous flow.
Scoring Criteria :

 2 Marks: The drains have an adequate slope throughout, ensuring smooth and continuous flow of water without any accumulation of water or debris at any point.

 1 Mark: The drains mostly have an adequate slope, but there are minor areas where slight water or debris accumulation is observed, which does not significantly obstruct the flow.

 0 Marks: The drains lack adequate slope, leading to noticeable accumulation of water or debris that obstructs or significantly slows down the flow.

Reference : NA

B10.3	Availability of connection with Municipal Sewage System/ or Soak Pit

Interpretation

This checkpoint ensures that the hospital's wastewater is safely and effectively managed, preventing contamination of the environment and promoting public health. A proper sewage connection to the municipal drainage system is ideal as it allows centralized treatment of waste. However, if this option is not feasible, a well-maintained septic tank or soak pit on-site serves as an acceptable alternative. The focus is on compliance with environmental safety norms and

ensuring no raw sewage is released untreated, which can cause health hazards. The presence of these systems reflects the hospital's commitment to sanitation and environmental responsibility.
Means of verification : **OB / SI**

Observation (OB):

- Check if the hospital sewage system is physically connected to the municipal sewage or drainage system.
- Verify the presence of proper pipelines leading from the hospital to the municipal sewage system.
- If municipal sewage connection is not visible or accessible, observe whether the hospital has a septic tank or soak pit within the premises.
- Confirm that the septic tank or soak pit is well-maintained and appropriately located away from patient care areas.

Staff Interview (SI):

- Ask the staff responsible for facility management if the hospital sewage is connected to the municipal sewage system.
- Inquire about the alternative sewage treatment method used if municipal connection is not available (e.g., septic tank or soak pit).
- Verify how often the septic tank or soak pit is cleaned or maintained.
- Confirm if there have been any recent issues or complaints related to sewage disposal or drainage.

Implementation plan :
To implement checkpoint B10.3, the hospital management must first conduct an assessment of the existing sewage disposal system within the hospital premises. If the hospital is located in an area where municipal sewage connection is available, the hospital should ensure that its sewage system is properly connected to the municipal drainage network. This involves coordination with local municipal authorities to verify the connection and ensure it meets all regulatory standards. In cases where connection to the municipal sewage system is not available or accessible, the hospital must install and maintain a properly designed septic tank or soak pit within the hospital premises to safely treat and dispose of sewage waste. Regular maintenance schedules should be established to prevent system failure or environmental contamination.
Scoring Criteria :

 2 Marks: The hospital sewage system has a proper and functional connection with the municipal drainage system.

 1 Mark: If connection to the municipal sewage system is not accessible, the hospital has a well-maintained septic tank within the premises for sewage disposal.

 0 Mark: There is no connection to the municipal sewage system, and no septic tank or alternative sewage treatment system exists within the hospital premises.

Reference : NA

B10.4	No blocked/ over-flowing drains in the facility

Interpretation

This checkpoint requires verification that all drainage systems within the facility are functioning properly without any blockages or overflow. The objective is to ensure hygienic conditions by preventing water stagnation, which could lead to contamination, unpleasant odors, or even health hazards. Observers must physically check the drains to confirm they are clear and draining efficiently. The presence of any blocked or overflowing drains indicates non-compliance, reflecting poor maintenance and potential risks to sanitation and infection control within the facility.

Means of verification : **OB / SI**

Observation:

- Check all drains within the facility to confirm they are free-flowing.
- Look for any signs of water accumulation or stagnant water near drain areas.
- Verify that there is no visible debris or blockage inside or around the drains.
- Inspect the drainage covers and grates to ensure they are intact and not clogged.

Staff Interview:

- Ask the cleaning and maintenance staff about the frequency and method of drain cleaning.
- Inquire if there have been any recent complaints or issues related to drainage blockage.
- Confirm who is responsible for monitoring and maintaining the drains.
- Ask if there are any procedures in place to report and address blocked or overflowing drains.

Implementation plan :

To ensure that there are no blocked or overflowing drains within the facility, regular maintenance and monitoring protocols must be established. This includes scheduling routine inspections of all drainage points, particularly after heavy rainfall or periods of increased water usage. Staff should be trained to identify early signs of blockages such as slow drainage or unpleasant odors. Immediate corrective actions, like clearing debris or arranging professional plumbing services, must be taken as soon as any drainage issue is detected. Additionally, waste disposal policies should emphasize avoiding the disposal of solid waste or materials that could cause clogging in drains. Documentation of inspections, issues found, and remedial measures taken should be maintained to ensure accountability and continual improvement.

Scoring Criteria :

 2 Marks: The drains in the facility are completely clear, with no signs of blockage or overflow anywhere during observation.

 1 Mark: Minor signs of blockage or overflow are noticed, but these do not cause any significant water pooling or hygiene concerns.

 0 Marks: There are clearly blocked or overflowing drains causing water stagnation,

unhygienic conditions, or potential health hazards in the facility.

Reference : NA

B10.5	All the drains are cleaned once in a week

Interpretation

This checkpoint ensures that all drainage points within the facility are regularly cleaned at a minimum frequency of once per week. Regular drain cleaning is crucial for preventing the buildup of debris, avoiding foul odors, and minimizing the risk of pest infestations or infections. Compliance with this standard reflects good facility maintenance practices and contributes to a safe and hygienic environment for patients, staff, and visitors.
Means of verification : **OB / SI**

Observation (OB):

- Observe the drains to see if they are clean and free from dirt, blockages, or stagnant water.

Staff Interview (SI):

- Ask the cleaning staff how often they clean the drains and confirm if it is done once a week.
- Verify with the cleaning staff whether they follow a regular schedule for cleaning drains.
- Check the cleaning records to ensure that drain cleaning is documented at least once a week.
- Confirm that the records match the actual cleaning frequency reported by the staff.

Record Review (RR):

- Check the cleaning records to ensure that drain cleaning is documented at least once a week.
- Confirm that the records match the actual cleaning frequency reported by the cleaning staff.

Implementation plan :
The cleaning of all drains must be scheduled and carried out at least once every week to maintain hygiene and prevent any blockages or health hazards. The housekeeping or cleaning staff should have a clear timetable for drain cleaning, and the process should be monitored regularly by the supervisory team to ensure compliance. Proper records of each cleaning activity should be maintained and reviewed weekly to confirm that no drain is missed. Necessary training should be provided to the cleaning staff about the importance and correct procedure of drain cleaning.
Scoring Criteria :

 2 Marks: The drains are cleaned at least once every week consistently, verified through cleaning staff confirmation and supporting records.

 1 Mark: The drains are cleaned, but the frequency is irregular or less than once a week; partial records or inconsistent staff confirmation are available.

 0 Marks: The drains are not cleaned weekly, no reliable confirmation from staff, and no records of cleaning are available.

Reference : NA

C	**Waste Management**
C1	**Implementation of Biomedical Waste Rules 2016**
C1.1	**The Hospital leadership is aware of Biomedical Waste Rules 2016 including key changes as amendments.**

Interpretation

Interpretation of the Checkpoint (C1.1):
This checkpoint verifies that hospital leadership is not only aware of the Biomedical Waste Rules 2016 but also familiar with any amendments that have been introduced since the original enactment. The availability of a copy of the rules at the facility serves as evidence that the hospital prioritizes regulatory compliance and provides the leadership and staff with easy access to critical guidelines on biomedical waste management. This reflects the hospital's commitment to safe and environmentally responsible waste disposal practices, minimizing risks of contamination or legal non-compliance.
Means of verification: **OB / SI**

Observation (OB):

- Check if a copy of the Biomedical Waste Management Rules 2016 is physically available at the facility, preferably accessible to leadership or staff responsible for waste management.
- Observe if any updated documents, posters, or guidelines related to biomedical waste management are displayed in relevant areas such as the administration office or waste handling zones.

Staff Interview (SI):

- Enquire with hospital leadership or designated personnel about their knowledge of the Biomedical Waste Rules 2016.
- Ask specifically about their awareness of key changes or amendments made to the rules.
- Confirm if leadership understands their roles and responsibilities related to biomedical waste management under the updated rules.
- Check if leadership can explain any new procedures or compliance requirements resulting from the amendments.

Implementation plan :
To ensure compliance with the Biomedical Waste Rules 2016, hospital leadership will be

sensitized through regular training sessions and workshops focusing on the key provisions and recent amendments of the rules. A physical and digital copy of the Biomedical Waste Management Rules 2016 will be made readily available at the hospital facility, especially in key areas such as the hospital administration office, waste management department, and staff common rooms. The hospital quality team will conduct periodic audits to verify the availability and accessibility of the rules document and will update staff on any new amendments through internal communications such as memos or notice boards. Additionally, designated biomedical waste management officers will be assigned to oversee adherence to the rules and ensure leadership stays informed.

Scoring Criteria:

 2 Marks: The hospital leadership demonstrates clear awareness of the Biomedical Waste Rules 2016, including all key amendments and changes. They can explain the rules confidently and ensure compliance across the facility.

 1 Mark: A copy of the Biomedical Waste Management Rules 2016, including amendments, is available at the facility, and the hospital leadership shows partial or basic awareness of the rules.

 0 Marks: The hospital leadership is not aware of the Biomedical Waste Rules 2016 or its amendments, and no copy of the rules is available at the facility.

Reference : NA

C1.2	**The facility has implemented Biomedical Waste Rules**

Interpretation

This checkpoint verifies that the facility follows biomedical waste rules by using correct colour coding, having approved disposal methods (CBWTF linkage or deep burial pit), and pre-treating lab waste. This ensures safe handling and disposal of biomedical waste, protecting health and the environment.

Means of verification : **OB / SI**

 What is to be Observed (OB):

- Check if the biomedical waste bins have the correct color coding as per the updated biomedical waste rules.
- Observe the facility's biomedical waste disposal area to verify if waste segregation follows the color scheme.
- Look for documentation or evidence showing linkage with a Common Waste Treatment Facility (CWTF) if it is located within 75 kilometers.
- If no CWTF within 75 km, verify the existence and approval of a deep burial pit for waste disposal.
- Inspect the laboratory waste pre-treatment process to ensure it is done onsite before handing over to the Common Treatment Facility (CTF) operator.

 What is to be Enquired (Staff Interview - SI):

- Interview the personnel responsible for biomedical waste management to confirm their understanding of the color coding changes and implementation.

- Ask about the arrangements made for waste disposal, specifically whether they are linked with a CWTF within 75 km or if a deep burial pit is used, and whether it has proper approval.
- Enquire about the procedures followed for pre-treating laboratory waste onsite before handing it over to the CTF operator.
- Verify if they maintain records or logs related to biomedical waste segregation, treatment, and disposal.

Implementation plan :

The facility will train staff on the updated biomedical waste colour coding and ensure proper segregation. It will establish a link with a nearby CBWTF within 75 km or get approval for a deep burial pit if none is available. Laboratory waste will be pre-treated on-site before handing it over to the CBWTF. Regular checks and documentation will monitor compliance.

Scoring Criteria :

2 Marks:

- Correct change in colour coding scheme implemented.
- Linkage with CBWTF within 75 km OR approval for deep burial pit available.
- On-site pre-treatment of laboratory waste done before handing over to CBWTF operator.

1 Mark:

- At least two of the above actions are properly implemented and verified.
- Partial compliance but missing or incomplete in one area.

0 Marks:

- None or only one of the required actions implemented.
- No change in colour scheme, no linkage/approval, and no pre-treatment of lab waste.

Reference : NA

C1.3	The facility has started undertaking actions for bar coding system

Interpretation

This checkpoint requires verification that the hospital has initiated concrete actions towards implementing a bar coding system for bags and containers used within the facility. Compliance is demonstrated by reviewing documented evidence such as procurement records, purchase orders, and delivery notes of bar coded materials. Additionally, interviews with responsible personnel will confirm the ongoing efforts and understanding of the bar coding system implementation. This ensures traceability, enhances patient safety, and supports inventory management by reducing errors associated with manual handling. The checkpoint signifies a commitment towards modernizing hospital processes and improving overall quality management.

Means of verification : **OB / SI**

Observation:

- Look for the presence of bar coded bags and containers in relevant departments such as pharmacy, stores, or waste management.
- Check for any labels, tags, or equipment that indicate the use of a bar coding system.
- Review procurement records, purchase orders, or invoices related to bar coded bags and containers.
- Observe any ongoing activities that suggest implementation of the bar coding system (e.g., unpacking, labeling).

Staff Interview:

- Ask the procurement officer or store manager whether the facility has started procuring bar coded bags and containers.
- Enquire with nursing or housekeeping staff if they have received any bar coded materials or training on their use.
- Interview quality management or relevant supervisors about the progress and timeline for implementing the bar coding system.
- Confirm if staff are aware of any policies or procedures related to bar coding.
- Ask about challenges faced or support needed for full implementation.

Implementation plan :
The facility will initiate the implementation of a bar coding system by first conducting a needs assessment to identify the types and quantities of bags and containers that require bar coding. Procurement procedures will be established to source bar coded bags and containers from approved vendors. A dedicated team comprising quality and logistics personnel will be assigned to oversee the procurement process. Training sessions will be conducted for relevant staff on the use of bar coded materials to ensure smooth integration into daily operations. Documentation will be maintained to track the procurement progress, including purchase orders, delivery receipts, and inventory records. Regular reviews and feedback sessions will be held to address challenges and ensure timely completion of the implementation.
Scoring Criteria :

 2 Marks: The facility has fully started and documented actions for the procurement of bar-coded bags and containers. Records clearly show the initiation of procurement activities, and personnel confirm the ongoing process of implementing the bar coding system.

 1 Mark: The facility has taken some preliminary steps towards procurement of bar-coded bags and containers, but the actions are not fully documented or are in very early stages. Personnel acknowledge awareness and partial progress but evidence is incomplete or inconsistent.

 0 Marks: The facility has not started any action towards procurement of bar-coded bags and containers. There is no documented evidence or personnel awareness about initiating a bar coding system.

Reference : NA

C1.4	The facility has started undertaking actions, which are to be complied by March 2019

Interpretation

This checkpoint evaluates whether the hospital has actively commenced actions toward compliance with critical environmental and transparency standards by the specified deadline (March 2019). The focus is on three key areas: procurement of non-chlorinated bags to reduce environmental harm, development and publication of an annual report via the hospital website to enhance accountability and public communication, and implementation of measures to meet emission standards under the BMW Rules 2016 for safe biomedical waste management. Evidence for compliance includes procurement records, website progress and updates, and documented steps addressing emission controls. Interviews with responsible personnel verify awareness and active involvement in these initiatives, demonstrating the facility's commitment to regulatory adherence and sustainable practices.
Means of verification : **OB / SI**

Observation (OB):

- Check procurement records or stock for non-chlorinated bags.
- Verify if the hospital website is live and functioning.
- Look for the Annual Report uploaded on the hospital website.
- Review any documentation or records showing actions taken to meet emission standards according to BMW Rules 2016.

Staff Interview (SI):

- Ask procurement or store staff about the purchase and use of non-chlorinated bags.
- Interview IT or admin staff regarding the development and updating of the hospital website and Annual Report.
- Discuss with the biomedical waste management team about measures implemented to comply with emission standards under BMW Rules 2016.

Implementation plan :
The facility will initiate and document actions to comply with the specified requirements by March 2019. First, the procurement process for non-chlorinated bags will be started by coordinating with approved suppliers and updating inventory records accordingly. Simultaneously, the hospital's IT or communications department will begin the development of an official website, ensuring that it includes a dedicated section for the Annual Report, which will be uploaded upon completion. Finally, the hospital will conduct a thorough review of the biomedical waste (BMW) management systems to ensure compliance with the emission standards outlined in the BMW Rules 2016. This will involve identifying necessary equipment or procedural changes, engaging with environmental compliance experts if needed, and documenting all steps taken. Regular monitoring and follow-up audits will ensure timely progress and adherence to the deadline.

Scoring Criteria :

- **2 Marks:** The facility has fully started and documented actions for all three requirements:

procurement of non-chlorinated bags, development of a website with the annual report uploaded, and concrete actions underway to meet emission standards as per BMW Rules 2016. This is verified by records and personnel interviews.

- **1 Mark:** The facility has started actions for at least one or two of the requirements mentioned (procurement of non-chlorinated bags, website development with annual report, emission standards compliance), but not all three are fully in progress or documented.
- **0 Marks:** The facility has not started any actions or there is no evidence (records or personnel confirmation) to show initiation of procurement of non-chlorinated bags, website development, or actions to meet emission standards as per BMW Rules 2016.

Reference : NA

C1.5	**An existing committee or newly constituted committee for review and monitoring of BMW management at DH/SDH level**

Interpretation

Checkpoint C1.5 requires evidence that a committee responsible for overseeing Biomedical Waste management exists and functions effectively at the DH or SDH level. The primary focus is to verify that this committee convenes regularly — at a minimum, once every six months — and conducts a comprehensive review of the biomedical waste status. This ensures ongoing monitoring, accountability, and continuous improvement in BMW management practices. Auditors will check records such as meeting minutes and reports to confirm the frequency of meetings and the thoroughness of BMW status reviews.

Means of verification : **OB / SI**

What is to be observed (OB):

- Observe the records to confirm the committee for BMW management exists at the DH/SDH level.
- Check if the committee meetings are held at least once every six months.
- Verify that the committee reviews the status of biomedical waste management during these meeting.

What is to be enquired:

- Ask staff if they are aware of the committee responsible for BMW management.
- Enquire whether the committee meetings take place regularly.
- Enquire if the committee discusses the status of biomedical waste management during meetings.
-

Implementation plan :

To implement checkpoint C1.5, a committee dedicated to the review and monitoring of Biomedical Waste (BMW) management will either be identified from existing committees or newly constituted at the District Hospital (DH) or Sub-District Hospital (SDH) level. This committee should comprise key stakeholders such as the hospital's infection control team, housekeeping supervisors, nursing staff, and waste management officers. The committee will be scheduled to meet at least twice a year (every six months) to discuss and evaluate the current status of BMW management, address any challenges, and recommend improvements. Proper documentation of meeting dates, attendance, and minutes will be maintained as evidence of these periodic reviews.

Scoring Criteria :

 2 Marks: The committee (either existing or newly constituted) for review and monitoring of BMW management at DH/SDH level has met at least every six months, and there is clear documented evidence that the BMW status was reviewed during these meetings.

 1 Mark: The committee has met, but the meetings are either less frequent than every six months or the records show limited or incomplete review of BMW status.

 0 Marks: There is no evidence of the committee meetings or no record that the BMW status has been reviewed at all.

Reference : NA

C2	Segregated Collection and Transportation of Biomedical Waste
C2.1	Segregation of BMW is done as per BMW management rule,2016

Interpretation

This checkpoint mandates strict segregation of biomedical waste according to the BMW Management Rule, 2016. Anatomical waste and soiled dressing materials must be separated and collected only in yellow bins and bags, which are specifically designated for infectious waste. It is crucial that general waste and infectious waste remain segregated to prevent contamination and reduce health hazards. Proper segregation supports safe handling, treatment, and disposal of biomedical waste, thereby minimizing the risk of infection transmission and ensuring regulatory compliance.

Means of verification : **OB / SI**

Observation (OB):

- Check if anatomical waste and soiled dressing materials are segregated in yellow bins and yellow bags.
- Verify that general waste and infectious waste are not mixed together.
- Observe if segregation is done properly at the source or point of waste generation.

Staff Interview (SI):

- Ask staff if they know the segregation rules as per BMW Management Rule, 2016.
- Enquire whether they consistently segregate anatomical and soiled waste into yellow bins/bags.
- Confirm if staff follow the color coding for different categories of biomedical waste.
- Ask how they ensure segregation is maintained throughout their daily routine.

Implementation plan :

To ensure compliance with BMW Management Rule, 2016, segregation of biomedical waste (BMW) is carried out meticulously at the point of generation. Anatomical waste and soiled dressing materials are segregated and disposed of exclusively in designated yellow bins and bags.

The staff involved in waste handling are trained regularly on correct segregation procedures to avoid any mixing of general and infectious waste. Regular monitoring and supervision are conducted to verify that waste segregation protocols are strictly followed, and any deviations are immediately addressed through corrective actions.

Scoring Criteria :

2 Marks:
Segregation of Biomedical Waste (BMW) is fully compliant with the BMW Management Rule, 2016. Anatomical waste and soiled dressing materials are correctly segregated into yellow bins and bags. General waste and infectious waste are clearly separated and never mixed.

1 Mark:
Segregation of BMW is partially compliant. Anatomical waste and soiled dressing materials are mostly segregated into yellow bins and bags, but occasional mixing of general and infectious waste is observed or segregation is inconsistent.

0 Mark:
Segregation of BMW is not done as per the BMW Management Rule, 2016. Anatomical waste and soiled dressing materials are not segregated properly into yellow bins and bags. General and infectious waste are mixed.

Reference : NA

C2.2	**Work instructions for segregation and handling of Biomedical waste has been displayed prominently**

Interpretation

Checkpoint C2.2 requires that work instructions for the segregation and handling of biomedical waste are not only available but also clearly displayed at the locations where waste is generated. The presence of these instructions ensures that healthcare workers can easily refer to the correct procedures, thereby reducing the risk of improper segregation and enhancing compliance with biomedical waste management regulations. The instructions must cover the use of different color-coded bins, ensuring that staff segregate waste correctly at the source. The checkpoint is verified by observing these instructions physically displayed and confirming that they are accessible and visible to all relevant personnel at the point of use.

Means of verification : **OB / SI**

Observation (OB):

- Check whether work instructions for segregation and handling of biomedical waste are displayed at all points of waste generation (e.g., consultation rooms, dressing areas, laboratories).
- Verify if the instructions include clear guidance for segregation into different colour-coded bins (e.g., yellow, red, white, blue, black).
- Ensure the instructions are prominently placed, legible, and accessible to staff.
- Observe whether the actual segregation practice matches the displayed instructions.

Staff Interview (SI):

- Ask staff if they are aware of the biomedical waste segregation procedures.
- Enquire whether they can identify which type of waste goes into each colour-coded bin.
- Ask staff to explain what steps they follow for safe handling and disposal of biomedical waste.
- Confirm if the staff received any training related to biomedical waste management.

Implementation plan :
To comply with checkpoint C2.2, the healthcare facility will develop detailed work instructions outlining the segregation and handling of biomedical waste according to the prescribed color-coded system. These instructions will be designed in clear, simple language and accompanied by relevant visuals or diagrams to enhance understanding. The instructions will be printed on durable, weather-resistant material and displayed prominently at all points of use where biomedical waste is generated, such as wards, procedure rooms, laboratories, and waste collection areas. Regular training sessions will be conducted to ensure all staff understand and follow the segregation protocols. The facility will also assign responsibility to designated personnel for routine monitoring and maintenance of these displays to ensure continuous visibility and relevance.

Scoring Criteria :

 2 Marks: Work instructions for segregation and handling of biomedical waste are clearly available and prominently displayed at the point of use, including instructions for segregation into different color-coded bins.

 1 Mark: Work instructions are available but are either not prominently displayed or are incomplete, such as missing clear segregation instructions or not placed at the point of use.

 0 Marks: Work instructions for segregation and handling of biomedical waste are not available or not displayed at all at the relevant locations.

Reference : NA

C2.3	**The facility has linkage with a CWTF Operator or has deep burial pit (with prior approval of the prescribed authority)**

Interpretation

Checkpoint **C2.3** ensures that the facility is responsibly managing biomedical waste by either linking with a **Common Waste Treatment Facility (CWTF)** or using a **deep burial pit** as an alternative, but only with **official approval**. This is critical for protecting public health and the environment from hazardous waste exposure. During assessment, the NABH assessor will check for **documented proof** of this functional linkage — such as invoices, service agreements, transport manifests, or approval letters for burial pits. The terms **OB/RR/SI** indicate that assessors may observe (OB) the waste disposal system, review records (RR) for linkage or authorization, and speak to individuals (SI) responsible for waste management to confirm compliance.

Means of verification : **OB / SI**

What is to be Observed (OB):

- Presence of a valid agreement or MoU with a Common Waste Treatment Facility (CWTF) operator.
- Availability of an approved deep burial pit, if CWTF linkage is not present.
- Valid authorization from the Pollution Control Board (PCB) for the method of waste disposal being used.
- Proper segregation, labeling, and storage of biomedical waste as per the Biomedical Waste Management Rules.
- Maintenance of waste collection logs and records of waste disposal frequency.
- Display of appropriate signage in the biomedical waste storage area.
- Cleanliness and organization of the waste storage area and containers.

What is to be Enquired (Staff Interview - SI):

- Staff awareness about the existing method of biomedical waste disposal (CWTF linkage or deep burial).
- Knowledge of individual roles and responsibilities in the biomedical waste management process.
- Confirmation that staff have received training on biomedical waste handling and disposal procedures.
- Familiarity with emergency procedures in case of spills, leaks, or collection failures.
- Staff awareness of the contact details and expected response timelines of the CWTF operator.

Implementation plan :
To comply with checkpoint **C2.3**, the health facility must establish a clear and documented system for the safe and compliant disposal of biomedical waste. First, the facility should identify the availability of a **Common Waste Treatment Facility (CWTF)** in their region and initiate a formal agreement or contract with an authorized CWTF operator. If a CWTF is not accessible, the facility must construct a **deep burial pit** only after receiving **written prior approval from the prescribed authority** (such as the State Pollution Control Board or relevant environmental authority). The facility should maintain documentation such as the MoU or contract with CWTF, or approval letters for deep burial. Additionally, staff must be trained on waste segregation and disposal processes in line with Biomedical Waste Management Rules. Periodic audits should be conducted to ensure proper functioning of the linkage or pit usage.
Scoring Criteria :

 2 Marks: Awarded if the facility has a documented and verifiable functional linkage with a Common Biomedical Waste Treatment Facility (CBWTF) operator, or if it has a deep burial pit that is approved by the prescribed authority and is maintained as per the required guidelines. Records and evidence of compliance are readily available and up to date.

 1 Mark: Given if the facility has initiated steps toward establishing a linkage with a CBWTF operator or has constructed a deep burial pit, but the documentation is incomplete or the linkage is not yet fully functional. There may be minor gaps in records or approval documentation.

 0 Marks: Assigned if the facility has no functional linkage with a CBWTF operator and does

not have an approved deep burial pit. There is no documentation or evidence of compliance available.

Reference : NA

C2.4	**Biomedical waste bins are covered**

Interpretation
This checkpoint emphasizes that biomedical waste bins in the healthcare facility must have lids and remain covered to avoid exposure to infectious material. The presence of a lid alone is not sufficient; the lids must be appropriately closed. This practice is crucial for infection control and is part of the mandatory biomedical waste management protocol. It helps in minimizing health hazards to staff, patients, and the environment by reducing the chances of airborne transmission, accidental exposure, and pest infestations.
Means of verification : **OB / SI**

Observation:

- Observe whether all bins designated for biomedical waste in patient care, procedure, and laboratory areas are fitted with appropriate lids.
- Check that the lids are in place and remain closed when the bin is not being accessed.
- Ensure that the color coding of bins is not compromised by lid placement.
- Inspect whether damaged or lidless bins are being used in any area.

Staff Interview:

- Enquire from nursing and housekeeping staff about their understanding of why biomedical waste bins should remain covered.
- Ask staff what actions they take when they notice an uncovered or damaged bin.
- Confirm whether staff have received any training or orientation on this practice.

Implementation plan :
To implement this checkpoint effectively, the facility must ensure that all biomedical waste bins used within the premises are always equipped with appropriate lids and that these lids are kept securely closed when not in immediate use. The staff must be trained on the importance of keeping waste bins covered to prevent the spread of infections, control odor, and maintain overall hygiene. Regular monitoring should be done by housekeeping supervisors or designated personnel to ensure compliance in all clinical and support service areas. The facility should maintain records of such rounds and take corrective action where non-compliance is observed. Procurement processes should also ensure that only covered bins are purchased and used for biomedical waste disposal.
Scoring Criteria :

 2 Marks: All biomedical waste bins across the facility are covered with functional lids and are observed to be closed during the assessment, and staff are aware of the importance of keeping them covered.

 1 Mark: Most biomedical waste bins are covered and closed, but a few instances of

uncovered or lidless bins are observed; staff show partial awareness of the requirement.

 0 Mark: Multiple instances of uncovered biomedical waste bins are observed, or bins without lids are in use; staff are unaware or negligent about the practice.

Reference : NA

C2.5	Transportation of biomedical waste is done in closed container/trolley

Interpretation

Checkpoint C2.5 ensures that biomedical waste is transported within the healthcare facility in a safe and hygienic manner. The primary objective is to prevent any risk of infection, contamination, or exposure during the movement of biomedical waste from clinical areas to the designated storage site. This requires the use of **closed containers or covered trolleys** that are **specifically designated** for waste transport. Additionally, it is crucial that **trolleys used for transporting patients are not used for waste** to avoid cross-contamination and uphold patient safety standards.

Means of verification : **OB / SI**

 Observation:

- Observe whether biomedical waste is being transported in **covered containers or closed trolleys**.
- Check if the trolleys are **labeled for waste transport only**.
- Ensure **patient trolleys are not used** for transporting biomedical waste.
- Inspect the **cleanliness and integrity** of the waste transport trolleys.

 Staff Interview:

- Ask staff to explain the process they follow for transporting biomedical waste.
- Enquire if they are aware that **patient trolleys must not be used** for waste.
- Verify whether they have received **training** on biomedical waste transportation protocols.
- Ask how frequently the trolleys are **cleaned and disinfected**, and by whom.

Implementation plan :

The facility should begin by identifying and allocating **dedicated covered trolleys or containers** solely for biomedical waste transport. These trolleys should be **clearly labeled** and regularly inspected for cleanliness and functionality. A **Standard Operating Procedure (SOP)** should be developed to guide staff on proper waste transportation practices. Staff involved in waste handling, especially housekeeping personnel, must be **trained and oriented** on this SOP. Routine audits should be conducted to ensure that waste is never transported in open containers or patient-use trolleys. Additionally, a **cleaning and disinfection schedule** should be maintained for all biomedical waste trolleys.

Scoring Criteria :

 2 Marks: Biomedical waste is transported in **closed, dedicated trolleys or containers** that are never used for patient movement, and all staff involved are fully aware and compliant with

the protocol.

 1 Mark: Biomedical waste is generally transported in covered trolleys, but there are **occasional lapses** or some staff are **not fully aware** of the correct practices.

 0 Mark: Biomedical waste is transported in **open containers** or the same trolleys used for **patient movement**, indicating a **complete lack of compliance** with the standard.

Reference : NA

C3	Sharp Management
C3.1	Disinfection of Broken / Discarded Glassware is done as per recommended procedure

Interpretation

This checkpoint emphasizes the safe and effective disinfection of broken or discarded glass items to prevent injury and infection risks. It mandates that the disinfection must follow a scientifically validated method, ensuring biohazard safety. The focus is on ensuring that staff do not dispose of glass waste directly without proper disinfection, and that the procedure used aligns with prescribed biomedical waste management guidelines.
Means of verification : **OB / SI**

 Observation:

- Observe whether the disinfection process for broken glassware is actually taking place before disposal.
- Look for clearly labeled containers or areas for disinfecting sharp/infectious glass waste.
- Check whether sodium hypochlorite solution with the correct concentration and contact time is used.
- Inspect the availability and usage of autoclave, microwave, or hydroclave if these methods are employed.
- Check the usage of personal protective equipment (PPE) during the disinfection process.

 Staff Interview:

- Ask the staff to explain the steps they follow before discarding broken glassware.
- Enquire if they are aware of the concentration and required contact time for sodium hypochlorite.
- Verify whether they are aware of alternative methods like autoclaving and when they are used.
- Ask who is responsible for monitoring and verifying the disinfection process.

 Record Review:

- Review SOPs related to glassware disinfection.

- Check training records of staff on disinfection protocols.
- Review the logbooks or registers documenting disinfection procedures, if maintained.

Implementation plan :
To implement this checkpoint effectively, the healthcare facility must develop and institutionalize a standard operating procedure (SOP) for the disinfection of broken or discarded glassware. This SOP should specify that all such glassware is either treated with 1–2% sodium hypochlorite solution (with 30% residual chlorine) for at least 20 minutes or subjected to an approved sterilization method such as autoclaving, microwaving, or hydroclaving. Staff involved in waste management and housekeeping must be trained on these procedures, and necessary infrastructure such as designated disinfection areas, chemical solutions, and protective equipment must be ensured.
Scoring Criteria :

 2 Marks:
Full compliance is observed. Disinfection is done strictly as per the recommended procedure (1–2% sodium hypochlorite for 20 minutes or through approved equipment like autoclave). Staff are fully aware of the procedures, and proper documentation and observations support this.

 1 Mark:
Partial compliance is noted. Disinfection is done, but either the method, concentration, contact time, or documentation is inconsistent. Staff may have partial knowledge of the correct process.

 0 Mark:
No proper disinfection procedure is followed for broken or discarded glassware. Staff are unaware or incorrectly perform the process. SOPs are missing or not followed.

Reference : NA

C.3.2	**Disinfected Glassware is stored as per protocol given in Schedule I of the BMW Rules 2016 and amendments .**

Interpretation

This checkpoint ensures safe storage and management of disinfected glassware waste to prevent injury or contamination risks. Proper storage in puncture-proof and leak-proof containers reduces the chance of sharps injuries or environmental hazards. The blue marking as mandated by the BMW Rules helps in easy identification and proper segregation, supporting effective biomedical waste management. Compliance with this standard demonstrates adherence to legal requirements and promotes safe workplace practices within healthcare facilities.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether all disinfected glassware is stored in puncture-proof and leak-proof boxes or containers.
- Check if the containers have the required blue-colored marking as specified in Schedule I of the BMW Rules 2016.
- Inspect the condition of the containers to ensure they are intact, without punctures or

leaks.
- Verify that the containers are properly closed and stored safely until sent for recycling.
- Look for any evidence that the stored glassware is eventually sent for recycling through authorized channels.

Staff Interview (SI):

- Ask staff responsible for biomedical waste handling to describe the procedure for storing disinfected glassware.
- Enquire whether they are aware of the need for puncture-proof and leak-proof containers and the significance of the blue-colored marking.
- Confirm if they know how and when the glassware containers are sent for recycling.
- Assess their understanding of Schedule I of the BMW Rules 2016 concerning glassware storage.

Implementation plan :
To implement the checkpoint C.3.2, the hospital must ensure that all disinfected glassware is handled and stored according to the protocol outlined in Schedule I of the Biomedical Waste (BMW) Rules 2016 and its amendments. This involves procuring puncture-proof and leak-proof containers or boxes specifically designed for glassware disposal. These containers should have a clear blue-colored marking as per the rules. Staff must be trained to segregate glassware immediately after disinfection and store them securely to prevent breakage or contamination. The glassware stored in these containers must then be sent for recycling through authorized biomedical waste management vendors. Regular monitoring and audits should be conducted to ensure compliance with these protocols, including inspection of storage conditions and handling procedures.
Scoring Criteria :

 2 Marks: Full compliance with all aspects of the protocol is observed. All disinfected glassware is stored in puncture-proof, leak-proof containers with blue-colored marking, and there is evidence of timely recycling. Staff demonstrate clear understanding of the procedure.

 1 Mark: Partial compliance is observed. Most glassware is stored correctly with appropriate containers and markings, but there are minor lapses such as occasional damaged containers or incomplete recycling documentation. Staff knowledge is adequate but not comprehensive.

 0 Marks: Non-compliance is evident. Glassware is not stored in puncture-proof and leak-proof containers, or containers lack the required blue marking. Recycling of glassware is not documented or is absent. Staff are unaware of the correct protocol.

Reference : NA

C3.3	**The Staff uses needle cutters for cutting/burning the syringe hub**

Interpretation
The checkpoint interprets that the availability of needle cutters alone is not sufficient; their active use by staff at every waste generation point is essential. This practice demonstrates compliance with safety protocols and infection control standards, thereby reducing the risk of injury and environmental contamination from sharps waste.

Means of verification : **OB / SI**

Observation:

- Verify that needle cutters are physically available at every point where syringes are used or disposed.
- Watch staff while handling syringes to confirm they use needle cutters immediately after syringe use.
- Check that syringe hubs are properly cut or destroyed right at the waste generation site.

Staff Interview:

- Ask staff if they understand the purpose and procedure for using needle cutters.
- Inquire whether they consistently use needle cutters as required.
- Discuss any challenges or obstacles they face in using needle cutters regularly.
- Confirm if they have received training on safe syringe disposal practices.

Implementation plan :
To ensure safe handling and disposal of used syringes, the staff must consistently use needle cutters for cutting or burning the syringe hubs immediately after use. The implementation involves placing needle cutters at every point where medical waste, especially syringes, is generated, such as patient care areas, injection rooms, and disposal zones. Staff will be trained and reminded regularly on the importance of this practice to prevent needle-stick injuries and contamination. Supervisors will monitor adherence, and any non-compliance will be addressed promptly.
Scoring Criteria :

 2 Marks: Needle cutters are available at every waste generation point and are consistently used by all staff members without exception.

 1 Mark: Needle cutters are available at most waste generation points and are used by staff occasionally but not consistently.

 0 Marks: Needle cutters are not available at waste generation points, or staff do not use them at all.

Reference : NA

C.3.4	**Sharp Waste is stored in Puncture proof containers**

Interpretation
The interpretation of this checkpoint focuses on preventing injury and infection risks associated with improper handling of sharp biomedical waste. The presence and correct use of puncture-proof containers directly indicate adherence to safe waste management practices and regulatory compliance, reducing the risk to healthcare workers, patients, and the environment.
Means of verification : **OB / SI**

Observation:

- Check if puncture-proof and leak-proof white translucent containers are available at every point where sharp waste is generated.
- Observe whether needles, syringes with fixed needles, scalpel blades, and other sharps are immediately disposed into these containers after use.
- Verify that the containers are properly labeled and not overfilled.
- Confirm that containers are replaced or disposed of timely to avoid overflow or leakage.
- Look for any signs of improper disposal or unsafe handling of sharp waste.

Staff Interview:

- Ask staff members about their knowledge and practice regarding the use of puncture-proof containers for sharp waste disposal.
- Enquire if they have received training on handling and segregating sharp waste safely.
- Confirm whether staff understand the risks of improper sharp waste disposal and the importance of using the correct containers.
- Check if staff know the procedure for replacing containers when full and reporting any incidents of needle-stick injuries.
- Seek feedback on challenges they face in compliance with sharp waste storage protocols.

Implementation plan :
The implementation of checkpoint C.3.4 requires ensuring that all sharp waste such as needles, syringes with fixed needles, scalpel blades, and needles from cutters or burners are collected and stored immediately at the point of use in puncture-proof, leak-proof containers. These containers must be white translucent and designed specifically to prevent needle-stick injuries and contamination during handling and disposal. The staff involved in waste management and clinical care should be trained and sensitized on the proper segregation and storage of sharp waste, following infection control protocols. Regular monitoring and supervision should be scheduled to verify compliance, and any gaps identified should be addressed through corrective actions and re-training if necessary.
Scoring Criteria :

 2 Marks: Puncture-proof, leak-proof white translucent containers are available and consistently used at every point of sharp waste generation. Staff demonstrate clear knowledge and adherence to the correct handling and storage procedure, with no evidence of overfilled or missing containers.

 1 Mark: Containers are available but inconsistently used or not at every point of use. Some staff are aware of the procedure but others show gaps in knowledge or occasional improper storage practices.

 0 Marks: No puncture-proof containers are available at points of use, or they are not used for sharp waste storage. Staff lack knowledge regarding safe sharp waste handling, resulting in unsafe practices and potential hazards.

Reference : NA

C3.4	Staff is aware of needle stick injury Protocol and PEP is available to the staff

Interpretation

Interpretation of this checkpoint means verifying that the staff understands the immediate management steps after exposure to needle stick injuries, that PEP is accessible without delay, and that reporting and follow-up are well documented. The emphasis is on both knowledge and practice, as well as the availability of necessary treatment to prevent occupational infections.

Means of verification : **OB / SI**

Observation (OB):

- Check if Post-Exposure Prophylaxis (PEP) medication is available and accessible in the facility.
- Verify presence of documented records for reporting needle stick injury cases.
- Review records related to administration of PEP and follow-up for exposed staff.
- Observe if any signage or protocol instructions regarding needle stick injury management are displayed in relevant areas.

Staff Interview (SI):

- Ask staff to describe the immediate management steps they should take following a needle stick injury.
- Enquire if the Medical Officer knows the criteria for initiating PEP.
- Confirm staff awareness of the availability of PEP and the reporting procedure for needle stick injuries.
- Check if staff understand the importance of timely reporting and follow-up after exposure.

Implementation plan

The implementation plan for checkpoint C3.4 focuses on ensuring that all staff members are knowledgeable about the needle stick injury protocol and have timely access to Post-Exposure Prophylaxis (PEP). The facility must establish and communicate a clear protocol for managing needle stick injuries, including immediate first aid measures and reporting procedures. The Medical Officer should be well-versed with the criteria for initiating PEP and ensure its availability to staff at risk. Regular training sessions and refresher programs should be conducted to maintain staff awareness. Documentation of needle stick injury incidents, timely administration of PEP, and proper follow-up care must be systematically recorded and reviewed for compliance and quality improvement.

Scoring Criteria :

 2 Marks: Staff clearly explains immediate management of exposure, Medical Officer demonstrates knowledge of PEP criteria, PEP is available and accessible, and records of reporting, treatment, and follow-up of needle stick injuries are complete and up-to-date.

 1 Mark: Staff has some knowledge of needle stick injury management and PEP, but some

gaps exist in protocol understanding or documentation is incomplete or delayed.

 0 Mark: Staff is unaware of needle stick injury management protocol, PEP is not available, or there are no records of injury reporting, treatment, or follow-up.

Reference : NA

C4	Storage of Biomedical Waste
C4.1	**Dedicated Storage facility is available for biomedical waste and its has biohazard symbol displayed**

Interpretation
This checkpoint verifies whether the health facility has a physically separate and clearly identifiable space reserved for biomedical waste storage. The presence of the biohazard symbol confirms that the facility recognizes the hazardous nature of the waste and is committed to maintaining safety standards. Proper storage before disposal or transfer is crucial for infection control, environmental safety, and regulatory compliance. This measure helps prevent accidental exposure, cross-contamination, and unauthorized access to biomedical waste.
Means of verification : **OB / SI**

Observation:

- Check if the health facility has a dedicated room or clearly demarcated area exclusively used for storing biomedical waste before disposal or transfer.
- Look for the biohazard symbol prominently displayed at the entrance and inside the storage facility.
- Verify if the storage area is secure and access is restricted to authorized personnel only.
- Observe the cleanliness and maintenance of the storage facility to ensure it meets safety and hygiene standards.

Staff Interview / Enquiry:

- Ask the staff responsible for biomedical waste management about the location and use of the dedicated storage area.
- Enquire whether they are aware of the significance and presence of the biohazard symbol.
- Check their understanding of the protocols related to storage duration and handling before handing over waste to the Common Treatment Facility.
- Confirm if they follow procedures to maintain the security and hygiene of the biomedical waste storage facility.

Implementation plan :
The health facility must establish a dedicated storage area specifically for biomedical waste before it is disposed of or handed over to the Common Treatment Facility (CTF). This storage area should be secure, accessible only to authorized personnel, and comply with relevant safety and environmental regulations. The facility should ensure that the storage room is well-maintained, clean, and equipped to prevent contamination or exposure. Importantly, the storage

facility must clearly display the internationally recognized biohazard symbol to warn all personnel and visitors about the presence of hazardous waste. Staff responsible for waste management should be trained on proper storage protocols and the significance of biohazard labeling.

Scoring Criteria :

 2 Marks: The health facility has a dedicated, secure biomedical waste storage room that is clearly marked with a biohazard symbol, well-maintained, and staff demonstrate clear knowledge of storage protocols.

 1 Mark: The facility has a designated biomedical waste storage area, but the biohazard symbol is missing or inadequately displayed, or staff knowledge about protocols is limited.

 0 Mark: There is no dedicated storage facility for biomedical waste, or the storage area is unsecured, unmarked, and staff are unaware of proper waste storage procedures.

Reference : NA

C4.2	**The Storage facility is located away from the patient area and has connectivity of a motor able road.**

Interpretation

This checkpoint verifies that the storage area is strategically placed to avoid any potential risks to patients, whether they are indoors or outdoors. Being away from patient areas reduces noise, contamination, and safety risks. The connectivity through a motorable road ensures logistical efficiency and smooth supply chain management by allowing necessary vehicles to reach the storage facility without hindrance. It highlights the facility's commitment to patient safety and operational effectiveness.

Means of verification : **OB / SI**

Observation (OB):

- Observe the location of the storage facility to confirm it is away from patient areas.
- Observe the access route to verify there is a motorable road for vehicles.
- Check that the road is clear and allows unhindered movement of CWTF vehicles.

Staff Interview (SI):

- Enquire with staff responsible for facility maintenance or transport about the condition and regular maintenance of the road.
- Ask if there have been any issues or complaints regarding vehicle access or patient safety related to the storage area.

Implementation plan :

To implement the requirement that the storage facility is located away from the patient area and has connectivity via a motorable road, first identify a suitable storage site that is physically separated from the main patient treatment zones to minimize any risk or disturbance to patients. Ensure that the chosen location is accessible through a motorable road, facilitating unhindered vehicle movement, especially for CWTF (Cold Water Treatment Facility) vehicles or any other

supply and transport vehicles. Conduct a site inspection and map out routes to confirm ease of access and safety. Coordinate with facility management and transport departments to maintain this access route regularly and keep it free from obstructions or hazards.

Scoring Criteria :

 Award **2 marks** if the storage facility is clearly located away from patient areas and has well-maintained motorable road connectivity with no hindrance for vehicle access, ensuring no risk to patients.

 Award **1 mark** if the storage facility is located away from patient areas but the motorable road connectivity has minor issues or occasional hindrances that do not significantly affect access or patient safety.

 Award **0 marks** if the storage facility is located near patient areas or if there is no motorable road connectivity, causing risk to patients or obstructing vehicle access.

Reference : NA

C4.3	**The Storage facility is secured against pilferage and reach of animal and rodents.**

Interpretation

This checkpoint focuses on ensuring that the storage areas in the healthcare facility are physically secured to prevent unauthorized access (pilferage) and are adequately protected from contamination or damage by animals and rodents. A well-secured storage space ensures the safety and integrity of medicines and consumables, which is critical for patient care and facility operations. Rodent proofing is vital to prevent infestation and contamination, which can lead to wastage and serious health hazards.

Means of verification : **OB / SI**

 Observation (OB):

- Observe whether the storage area has functional locking systems (lock and key, latch, or any other security mechanism).
- Check if the storage area is physically enclosed and inaccessible to stray animals.
- Look for signs of rodent-proofing measures like wire meshes, sealed doors/windows, or use of rodent traps.
- Observe the general cleanliness and presence or absence of rodent droppings or animal intrusion signs.

 Staff Interview:

- Enquire if staff regularly check the integrity of the locks and report any malfunctions.
- Ask whether pest control activities are conducted periodically and documented.
- Check if staff are aware of the protocol to follow in case of suspected pilferage or rodent intrusion.
- Ask how the facility ensures rodents do not enter the storage area (e.g., maintenance checks, use of traps, etc.).

Implementation plan :
To ensure compliance with C4.3, the healthcare facility must identify all storage areas where medicines, consumables, or important records are kept. These areas should be assessed for their current level of physical security and protection against animal and rodent intrusion. Steps should be taken to ensure all storage units and rooms have functioning locking systems (such as padlocks, door latches, or digital locks). The facility should install rodent-proof materials (such as mesh or sealed containers) and apply pest control measures. The staff responsible for storage management must be trained on maintaining security protocols and reporting any evidence of rodent activity or attempted theft.
Scoring Criteria :

- **2 Marks:** The storage facility is fully secured with a reliable lock-and-key mechanism and shows clear evidence of rodent-proofing. There are no signs of animal or rodent entry. Staff are well aware of the security and pest control protocols.
- **1 Mark:** The storage facility has basic security (such as a lock), but rodent-proofing measures are either minimal or not consistently implemented. Minor lapses are observed, or staff awareness is partial.
- **0 Mark:** The storage facility lacks proper locks or shows signs of animal or rodent intrusion. There are no clear pest control or security measures, and staff are unaware of the required protocols.

Reference : NA

C4.4	**No Biomedical waste is stored for more than 48 Hours**

Interpretation
This checkpoint emphasizes that biomedical waste poses significant health and environmental risks if stored beyond a specific time limit. The 48-hour threshold is critical for preventing infection, foul odor, pest infestation, and contamination. The expectation is that no biomedical waste — regardless of category — should remain on-site for more than 48 hours from the time of its generation. This includes proactive planning for holidays or operational downtimes. Compliance with this standard reflects the facility's commitment to safe, hygienic, and responsible biomedical waste management.
Means of verification : **OB / SI**

 Observation (OB):

- Observe the color-coded bins and waste containers for appropriate labeling with date and time of waste generation.
- Check storage areas for biomedical waste to ensure they are not overloaded and waste is not older than 48 hours.
- Inspect the daily waste handover log to verify timely disposal, especially around weekends and holidays.
- Look for the presence of sealed and barcoded waste bags ready for collection by CTF.

 Staff Interview (SI):

- Ask staff to explain the process followed for recording and handing over biomedical waste.

- Enquire how waste disposal is managed during public holidays or weekends.
- Confirm whether staff are aware of the 48-hour limit for waste storage.
- Ask who is responsible for ensuring waste is not retained beyond the permissible time.

Implementation plan :
To meet the requirement that biomedical waste is not stored for more than 48 hours, the healthcare facility must establish a clear, documented protocol for waste collection, storage, and timely handover to the Common Treatment Facility (CTF). The waste management team should track the date and time of waste generation and ensure disposal arrangements are in place every 48 hours or less. Adequate infrastructure such as labeled bins, temporary storage rooms, and a logbook for waste handover should be maintained. Special attention should be given to arrangements during weekends and public holidays, such as scheduling extra pickups or arranging temporary storage that complies with safety norms. Staff must be trained and designated to oversee this process daily to ensure compliance.
Scoring Criteria :

 2 Marks:
The facility consistently ensures that all biomedical waste is disposed of or handed over to the CTF within 48 hours of generation, including weekends and holidays. Records are well-maintained and updated, and staff are fully aware of the process.

 1 Mark:
The facility generally disposes of biomedical waste within 48 hours, but there are occasional lapses or incomplete records, especially during holidays. Staff awareness is partial or inconsistent.

 0 Marks:
The facility does not ensure timely disposal of biomedical waste. Waste is often stored for more than 48 hours, especially during weekends/holidays. Documentation is lacking or inaccurate, and staff are unaware of the requirement.

Reference : NA

C4.5	The storage facility has hand-washing facilities for the workers

Interpretation
This checkpoint emphasizes the importance of providing hand hygiene facilities specifically for workers in the storage area. Hand-washing infrastructure is crucial in preventing contamination of medical and non-medical supplies. The proximity of these facilities to the storage area allows workers to maintain hygiene before and after handling materials, thereby supporting infection control and overall cleanliness in the facility.
Means of verification : **OB / SI**

Observation (OB)

- Observe whether a hand-washing station is present in or near the storage facility.
- Check if the station has a steady supply of clean running water.
- Verify the availability of liquid soap or a functioning soap dispenser.
- Confirm the presence of hygienic hand-drying options such as paper towels or an air

dryer.
- Assess the cleanliness and usability of the hand-washing facility.

Staff Interview (SI)

- Enquire whether staff routinely use the hand-washing facility before and after handling supplies.
- Ask staff if they have been instructed or trained on hand hygiene practices specific to the storage area.
- Confirm whether staff report any issues or breakdowns in the facility and if these are addressed promptly.
- Verify if the staff are aware of the importance of hand hygiene in preventing contamination of supplies.

Implementation plan :
To comply with this checkpoint, the healthcare facility must ensure that proper hand-washing facilities are installed in or near the storage areas where workers frequently handle supplies or materials. This involves installing a sink with continuous access to clean running water, liquid soap, and hygienic hand-drying options such as disposable paper towels or air dryers. Regular maintenance schedules should be established to keep the facility functional and clean. Staff should be trained on the importance of hand hygiene, especially in storage areas, to prevent contamination. The facility's quality team should monitor this checkpoint during internal audits and report any deficiencies for prompt correction.
Scoring Criteria :

 2 Marks: The hand-washing station is functional, located in close proximity to the storage area, and equipped with running water, soap, and hand-drying provisions. Staff confirm regular use and awareness of hygiene practices.

 1 Mark: The hand-washing station exists but is partially functional (e.g., water supply or soap is missing), or staff are not fully aware or consistent in using it.

 0 Mark: There is no hand-washing facility available near the storage area, or the facility is completely non-functional.

Reference : NA

C5	**Disposal of Biomedical waste**
C5.1	**The Health Facility has adequate arrangements for disposal of Biomedical waste**

Interpretation
This checkpoint emphasizes the necessity of a legal and environmentally safe mechanism for disposing of biomedical waste. The facility must demonstrate either a formal arrangement with a CTF if within a 75 km radius or maintain in-house infrastructure (deep burial and sharp pits) for safe disposal. The prescribed authority's approval is essential for in-house facilities to ensure

compliance with regulatory standards and environmental safety.
Means of verification : **OB / SI**

 Observation (OB):

- Verify the presence of a valid contract with the Common Treatment Facility (if applicable).
- Check for the presence and condition of deep burial pit and sharp pit within the facility premises.
- Inspect signage and labeling indicating proper waste segregation and disposal areas.
- Look for physical records or logbooks documenting biomedical waste disposal.
- Confirm that pits are covered, fenced, and appropriately maintained.

 Staff Interview (SI):

- Ask staff if they are aware of how and where biomedical waste is disposed of.
- Enquire if they have received any training regarding biomedical waste management.
- Ask about the frequency and method of biomedical waste collection.
- Verify whether staff can differentiate between different categories of biomedical waste.

Implementation plan :
To ensure compliance with C5.1, the health facility must assess its current biomedical waste disposal system. If located within 75 km of a Common Treatment Facility (CTF), the facility should establish a valid contract with the CTF for regular collection and disposal of biomedical waste. In the absence of access to a CTF, the facility must construct and maintain an approved deep burial pit and sharp pit within its premises. The deep burial pit must be constructed as per guidelines and approved by the prescribed authority. Regular staff training and monitoring mechanisms should be instituted to ensure proper segregation, storage, and disposal of biomedical waste.
Scoring Criteria :

 2 Marks:
The facility has a valid contract with a CTF within 75 km *or* has an approved deep burial pit and sharp pit within premises; infrastructure is compliant with guidelines and staff are aware of the process.

 1 Mark:
Partial compliance – either infrastructure is available but lacks formal approval/documentation, or the contract with the CTF exists but implementation is inconsistent or not understood by staff.

 0 Marks:
No valid CTF contract despite proximity *and* no approved infrastructure for waste disposal; staff are unaware of the biomedical waste disposal mechanism.

Reference : NA

C5.2	**Recyclable waste is disposed as per procedure given in the BMW Rules 2016**

Interpretation
This checkpoint focuses on ensuring recyclable biomedical waste is managed according to BMW Rules 2016. The aim is to treat and destroy the waste to prevent reuse and ensure it is disposed of through environmentally safe methods like recycling or energy recovery. It prohibits incineration and landfill disposal. Proper segregation, treatment, documentation, and staff awareness are key indicators of compliance.
Means of verification : **OB / SI**

Observation (OB):

- Observe if recyclable waste items are being collected in color-coded bins according to BMW Rules.
- Confirm that these items are being treated using autoclave, microwave, or hydroclave before mutilation/shredding.
- Check whether the treated and shredded waste is stored in a designated area for dispatch to registered recyclers or authorized agencies.
- Verify signage, labels, and condition of equipment used for waste treatment.

Staff Interview (SI):

- Ask staff to explain the process of treating and disposing recyclable waste.
- Enquire if they are aware that recyclable waste should not be incinerated or sent to landfills.
- Ask about the agencies or recyclers with whom the facility has tie-ups for waste disposal.
- Enquire about any training they received related to biomedical waste management and the specific handling of recyclable waste.

Record Review (RR):

- Review logs of waste treatment processes including autoclaving or hydroclaving records.
- Examine waste disposal records, including name and license of the recycler or agency.
- Check for monthly reports or manifests as per local pollution control board requirements.
- Review training records of staff involved in waste handling.

Implementation plan :
The healthcare facility should establish a clear protocol for the safe disposal of recyclable biomedical waste such as catheters, IV tubes, gloves, and syringes (without needles). This waste must be segregated correctly, treated using autoclaving, microwaving, or hydroclaving, and then shredded or mutilated to prevent reuse. Treated waste should be handed over only to registered recyclers or sent for energy recovery or road construction. It must never be incinerated or dumped in landfills. Staff handling waste should be properly trained, and records of treatment and disposal must be maintained. Regular audits should be conducted to ensure ongoing compliance.
Scoring Criteria :

 2 Marks: If the facility follows the prescribed method of treating recyclable waste using autoclaving/microwaving/hydroclaving followed by mutilation or shredding, and disposes it only through registered recyclers or authorized agencies (energy recovery/road construction) with

documented evidence; and staff are fully aware of the procedure and confirm it during interviews.

 1 Mark: If the procedure is partially implemented — for instance, waste is treated but not always mutilated before dispatch, or there is incomplete documentation or occasional non-compliance noted; or staff awareness is inconsistent.

 0 Mark: If recyclable waste is either not treated/mutilated before disposal, or is being incinerated or sent to landfill; or if the staff is unaware of the disposal procedure, and there is no evidence of compliance.

Reference : NA

C5.3	**Disposal of Expired or discarded medicine is done as per protocol given in Schedule I of BMW Rules 2016**

Interpretation
This checkpoint emphasizes the legal and safe disposal of expired or unused medicines to avoid misuse and environmental contamination. The facility must not treat expired medicines as general waste. Instead, they must follow the correct biomedical waste disposal pathway—either returning the drugs to the manufacturer (take-back programs) or sending them for incineration through an authorized agency. Proper documentation and adherence to the procedure outlined in Schedule I of the BMW Rules are critical indicators of compliance.
Means of verification : **OB / SI**

- **Observation (OB):**
  - Check for the presence of clearly labeled bins/containers marked for expired or discarded medicines.
  - Observe if the expired medicines are stored separately from usable stock.
  - Check for any indication that expired medicines are being mixed with general waste (a non-compliance).
  - Verify the presence of Schedule I guidelines displayed near the storage/disposal area.
  - Observe any handover or documentation process involving waste pickup.
- **Staff Interview (SI):**
  - Ask pharmacy or clinical staff to explain the process of disposing of expired medicines.
  - Enquire if they are aware of the authorized agency responsible for the disposal.
  - Ask if they have received training on BMW Rules 2016, particularly Schedule I.
  - Verify whether staff can distinguish between hazardous and non-hazardous pharmaceutical waste.
- **Record Review (RR):**
  - Check disposal records of expired medicines—dates, quantity, method of disposal, and agency name.
  - Verify acknowledgement slips from the authorized waste handler or manufacturer.
  - Review training records to ensure staff awareness and understanding of the protocol.

Implementation plan :
To ensure compliance with C5.3, the healthcare facility must establish a clear, written protocol

for the disposal of expired or discarded medicines in alignment with Schedule I of the Bio-Medical Waste Management (BMW) Rules, 2016. The protocol should specify the method of segregation, labeling, storage, and final disposal. Staff must be trained on the procedures, and appropriate coordination with the authorized waste disposal agencies or pharmaceutical manufacturers should be in place. A designated person should be responsible for monitoring the process, maintaining records, and ensuring timely disposal to prevent accumulation.

Scoring Criteria :

 2 Marks:

The facility has a documented protocol for disposal as per Schedule I of BMW Rules 2016. Expired medicines are clearly segregated, stored, and either returned to the manufacturer or incinerated through an authorized agency. Staff are trained and records are properly maintained.

 1 Mark:

Partial implementation observed. The system exists but lacks complete adherence—for example, irregular record-keeping, inconsistent segregation, or lack of staff awareness.

 0 Mark:

No system in place or significant non-compliance with the Schedule I protocol. Expired medicines are not disposed of properly or are mixed with general waste.

Reference : NA

C5.4	**Discarded / contaminated linen is disposed as per procedure given in the BMW Rules 2016**

Interpretation

This checkpoint emphasizes the importance of managing infectious linen waste in a manner that prevents environmental contamination and protects healthcare workers and the community. Contaminated linen containing blood or body fluids is classified as biohazardous and must be treated with utmost care. The requirement to use non-chlorinated disinfectants ensures the minimization of harmful by-products. Proper disinfection followed by incineration or destruction renders the waste non-infectious and unrecognizable, thereby aligning with the objectives of safe and sustainable biomedical waste management as outlined in the BMW Rules 2016.

Means of verification : **OB / SI**

 Observation:

- Observe whether contaminated linen is collected in color-coded bags as per BMW Rules.
- Check for the presence and use of non-chlorinated disinfectants like Hydrogen Peroxide.
- Ensure that disinfection and disposal equipment (e.g., incinerator or shredder) is available and functional.
- Look for signage or SOPs describing the linen disposal procedure near relevant areas.
- Verify that the linen disposal area is separate and not used for any other purpose.

 Staff Interview:

- Ask staff to explain the procedure for handling and disposing of contaminated linen.
- Enquire whether they use non-chlorinated disinfectants and why.
- Ask if they have received training on BMW Rules 2016 related to linen disposal.

- Verify their knowledge on segregation, disinfection, and final disposal methods.
- Check their understanding of the health hazards associated with improper handling of contaminated linen.

Implementation plan :
To comply with the Bio-Medical Waste (BMW) Rules 2016, the healthcare facility must establish a written protocol for handling and disposing of contaminated linen, mattresses, and bedding. This includes clear guidelines for identifying contaminated materials, segregating them at the source, disinfecting them using approved non-chlorinated disinfectants such as Hydrogen Peroxide, and finally, ensuring their disposal through incineration or mutilation (e.g., shredding). Staff involved in the handling of such waste must be trained and sensitized to follow the procedure strictly. Regular audits and supervision should be conducted to ensure adherence to the protocol, and any deviation should be corrected through immediate retraining or corrective action.
Scoring Criteria :

 2 Marks:
The healthcare facility fully complies with BMW Rules 2016. Contaminated linen is properly segregated, disinfected using non-chlorinated agents, and disposed of by incineration or shredding. All relevant staff are trained and demonstrate correct knowledge and practice.

 1 Mark:
The facility has a procedure in place, but implementation is partial. Either disinfection or disposal is not fully compliant, or staff have only partial awareness or training.

 0 Mark:
No proper procedure is in place. Contaminated linen is not disinfected or disposed of correctly. Staff lack awareness of the rules and the risks involved.

Reference : NA

C6	Management Hazardous Waste
C6.1	The Staff is aware of Mercury Spill management

Interpretation
This checkpoint assesses whether the staff is aware of the risks associated with mercury spills and the proper steps to manage such incidents safely. It emphasizes the importance of knowledge and readiness in handling hazardous material incidents to ensure the safety of both patients and staff, as well as environmental protection
Means of verification : **OB / SI**

 What is to be observed (OB):

- Availability and accessibility of mercury spill kits in areas where mercury-containing equipment is used.

- Display of protocols or emergency contact numbers for mercury spill management.
- Proper labelling and segregation of mercury waste.

 What is to be enquired (SI):

- Ask staff to explain the steps they would take in the event of a mercury spill.
- Enquire if they have received any formal training or orientation on mercury spill management.
- Ask staff to identify the contents of a mercury spill kit and how to use them.
- Enquire about whom to inform or contact in case of a spill.

Implementation plan :
The healthcare facility should develop and implement a clear policy and procedure for mercury spill management. This policy must be based on applicable regulations and safety protocols. Training sessions should be conducted for all staff, especially those handling equipment that may contain mercury (e.g., thermometers, sphygmomanometers). Visual aids like posters or quick reference charts on mercury spill management can be displayed in relevant areas. Spill kits specific to mercury should be available, and staff should be trained on their use. Periodic mock drills or scenario-based discussions may be conducted to reinforce learning.
Scoring Criteria :

 2 Marks: Staff correctly explains the mercury spill management process, identifies the location of the spill kit, and demonstrates familiarity with its use. Training records are available and relevant signage/protocols are displayed.

 1 Mark: Staff has partial knowledge of the process but is unsure of some steps or kit usage. Training may have been conducted, but documentation is incomplete.

 0 Mark: Staff is unaware of mercury spill management protocols and/or spill kits are not available or accessible.

Reference : NA

C6.2	Availability of Mercury Spill Management Kit

Interpretation

This checkpoint ensures the facility's preparedness to safely manage mercury spills, which are hazardous to both health and the environment. The expectation is that all departments with potential mercury exposure are equipped with a Mercury Spill Kit and that staff are trained to use it. The checkpoint reflects both compliance with safety regulations and a proactive approach to patient and staff safety in case of a mercury spill incident.

Means of verification : **OB / SI**

 Observation:

- Check for the **physical presence** of a Mercury Spill Management Kit in departments

functional on a 24x7 basis, such as the Emergency Department and Wards.

- Verify that the **kit is complete and intact**, containing necessary items like gloves, mask, mercury aspirator/scoop, waste disposal bags, etc.
- Ensure that the **location of the kit is clearly labeled** and easily accessible during an emergency.

 Staff Interview:

- Ask nursing or housekeeping staff whether they are **aware of the presence and location** of the Mercury Spill Kit in their department.
- Enquire whether the staff has been **trained in handling mercury spills** and can describe the basic steps of the procedure.
- Confirm whether there is any **protocol or guideline available** for mercury spill management and if the staff knows how to access it.

Implementation plan :

To implement this checkpoint effectively, the facility must first identify all areas where mercury-based devices are or were previously in use—especially departments operating round the clock, such as the Emergency Department and Inpatient Wards. The next step is to procure standard Mercury Spill Management Kits and place them in these high-risk areas. These kits must be placed in clearly marked, easily accessible locations.

Alongside physical placement, training sessions should be conducted for clinical and housekeeping staff to ensure they understand the correct procedures for handling mercury spills. Periodic mock drills or demonstrations can help reinforce the training. A checklist or inventory log should be maintained to ensure the kits are regularly inspected and replenished if required.

Scoring Criteria :

 2 Marks:
The Mercury Spill Management Kit is physically available, complete, and properly maintained in all required 24x7 functional areas such as the Emergency Department and Wards. Additionally, the concerned staff are fully aware of its location and have been adequately trained in its use.

 1 Mark:
The Mercury Spill Management Kit is available but may be incomplete or not present in all required areas. Staff awareness or training regarding the use of the kit is either partial or inconsistent across departments.

 0 Mark:
The Mercury Spill Management Kit is not available in required departments, or the staff are unaware of its existence or have not received any training on mercury spill handling.

Reference : NA

C6.3	Disposal of Radiographic Developer and Fixer

Interpretation
The interpretation of this checkpoint is to ensure that the facility does not discharge radiographic developer and fixer solutions into regular drainage systems, which can cause pollution and violate environmental regulations. Compliance with this checkpoint reflects the organisation's commitment to safe biomedical and chemical waste management practices.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether there is any evidence of direct discharge of developer/fixer into sinks or drains.
- Look for labelled storage containers in the radiology department for used developer and fixer.
- Check for any signage or SOPs displayed about hazardous chemical disposal.
- Verify the presence of secondary containment measures to prevent spillage or leakage.
- Review records showing disposal dates and agency details.

Staff Interview:

- Enquire whether staff can describe the correct method for disposing of developer and fixer.
- Ask who is responsible for collecting and handing over the waste to the authorised agency.
- Ask about training received on hazardous chemical handling and disposal procedures.
- Check whether staff are aware of the consequences of improper disposal.

Implementation plan :
To implement this checkpoint, the healthcare facility must ensure a structured and compliant system is in place for the safe disposal of radiographic developer and fixer solutions. These chemicals are hazardous and can cause environmental damage if not handled properly. The radiology department must follow a clearly documented protocol that involves the collection, storage, and final disposal of these solutions through an authorised waste disposal agency. This process should be supported by records of handover, contracts with authorised vendors, and regular training of staff involved in the handling of these materials.
Scoring Criteria :

 2 Marks: The radiographic developer and fixer are **always disposed of through an authorised agency**, supported by documented SOPs, regular staff training, and verifiable records of disposal. There is **no evidence of direct discharge** into drains, and staff are well-informed about the procedure.

 1 Mark: The disposal is **usually done through an authorised agency**, but documentation is **partial or inconsistent**, or **not all staff are fully aware** of the procedure. Minor lapses in the process or evidence of occasional non-compliance may be observed.

 0 Mark: There is **no defined procedure** or **evidence of direct discharge** of developer/fixer

into drains. Staff are **unaware** of the correct disposal method, and there are **no records or contracts** with an authorised agency.

Reference : NA

C6.4	**Disposal of Disinfectant solution like Glutaraldehyde**

Interpretation
Interpretation of this checkpoint means verifying that Glutaraldehyde and similar disinfectants are never released directly into the sewage system untreated, as this can lead to serious environmental harm and regulatory violations. The presence of a safe, controlled disposal mechanism confirms adherence to safety standards and responsible environmental practices.
Means of verification : **OB / SI**

Observation:

- Observe the area where disinfectant solutions like Glutaraldehyde are disposed of.
- Check for designated containers or systems specifically for collecting used Glutaraldehyde.
- Look for any signs of untreated disinfectant being drained directly into the sewage.
- Verify presence of proper labeling and disposal instructions near disposal points.
- Review any disposal records or logs maintained by the facility.

Staff Interview:

- Ask staff responsible for cleaning and waste disposal to describe the disposal procedure for Glutaraldehyde.
- Enquire if staff have received formal training on safe disposal of disinfectants.
- Question how frequently and by what method the disinfectant solutions are disposed of.
- Check staff understanding of risks associated with improper disposal of Glutaraldehyde.
- Confirm if staff are aware of environmental safety policies related to disinfectant disposal.

Implementation plan :
The implementation plan for this checkpoint involves establishing a clear protocol for the disposal of disinfectant solutions such as Glutaraldehyde to ensure they are not drained untreated into the sewage system. The hospital or health center must set up a designated disposal method that neutralizes or safely contains these chemicals before disposal, complying with environmental safety norms and local regulations. Staff must be trained and made aware of these protocols, including the use of appropriate containers and handling procedures to prevent environmental contamination and occupational hazards. Regular monitoring and documentation of disposal practices should be integrated into the facility's waste management system to maintain compliance and ensure safety.
Scoring Criteria :

 2 Marks: The facility has a clearly defined, implemented, and consistently followed method for the safe disposal of Glutaraldehyde that prevents untreated discharge into sewage; staff are

trained and knowledgeable; documentation and observation confirm compliance.

 1 Mark: There is a disposal method in place but it is inconsistently followed or only partially prevents untreated discharge; some staff are aware but training is incomplete or irregular.

 0 Mark: No proper disposal system exists; Glutaraldehyde is observed or reported to be discharged untreated into the sewage; staff lack awareness or training on disposal protocols.

Reference : NA

C6.5	**Disposal of Lab reagents**

Interpretation
This checkpoint ensures that laboratory reagents are disposed of safely and in compliance with the manufacturer's instructions. Proper disposal minimizes risks of contamination, environmental pollution, and potential harm to personnel. It also aligns with regulatory and safety standards. The interpretation is that following the manufacturer's disposal instructions is critical to maintaining lab safety, protecting the environment, and demonstrating responsible laboratory management.
Means of verification : **OB / SI**

Observation:

- Observe whether the disposal containers and methods in the lab match the manufacturer's recommended disposal instructions.
- Check if lab staff are following proper procedures while discarding reagents.
- Verify the presence of manufacturer's disposal instructions physically displayed or readily accessible in the lab.
- Look for proper segregation of reagents for disposal as per instructions.
- Confirm proper labeling of disposal containers.

Staff Interview:

- Enquire if the staff are aware of and understand the disposal instructions provided by manufacturers.
- Ask staff how they dispose of different types of lab reagents.
- Question whether staff have received training or guidance regarding reagent disposal.
- Check if staff know where to find disposal instructions and what to do in case of uncertainty.
- Confirm if staff report or document disposal activities as per lab protocol.

Implementation plan :
To implement the disposal of lab reagents as per the manufacturer's instructions, the laboratory will first collect and maintain up-to-date disposal guidelines provided by the reagent manufacturers. Staff members will be trained regularly on these disposal procedures to ensure they understand and follow them precisely. The lab will provide clearly labeled disposal containers that meet the manufacturer's requirements and ensure proper segregation of reagents for safe disposal. Routine observations and audits will be conducted to verify compliance, and any deviations will be addressed immediately. Documentation of disposal activities will be

maintained to demonstrate adherence. Communication channels will be established so staff can clarify doubts about disposal practices promptly.

Scoring Criteria :

 2 Marks: Disposal of lab reagents is consistently done strictly according to the manufacturer's instructions, with clear evidence of staff awareness, proper procedures followed, and documentation maintained.

 1 Mark: Disposal is mostly in line with manufacturer's instructions, but minor deviations or occasional lapses in staff adherence or documentation are observed.

 0 Marks: Disposal of lab reagents is not done according to manufacturer's instructions, staff are unaware of proper disposal procedures, and there is no evidence of compliance or documentation.

Reference : NA

C7	Solid General Waste Management
C7.1	Recyclable and Biodegradable Wastes have segregated collection

Interpretation

This checkpoint evaluates whether the healthcare facility actively segregates recyclable and biodegradable waste to promote effective waste management and environmental sustainability. It assesses the availability and strategic placement of separate bins for different waste types, as well as staff awareness and adherence to segregation protocols. Successful implementation indicates that the facility minimizes contamination between waste streams, facilitates recycling efforts, and reduces environmental impact, thus demonstrating responsible and compliant waste disposal practices.

Means of verification : **OB / SI**

Observation:

- Check if two types of bins (for recyclable and biodegradable waste) are available at kerb collection points.
- Observe the presence and correct placement of segregated bins in wards.
- Verify availability of separate bins in OPD areas.
- Look for distinct bins in patient waiting areas, pharmacy, office, and cafeteria.
- Confirm that bins are clearly marked or color-coded to differentiate recyclable and biodegradable waste.

Staff Interview:

- Ask staff if they are aware of the waste segregation policy and know what waste goes into each bin.
- Enquire about the procedures followed for emptying and handling segregated waste.
- Check if staff have received any training or instructions related to waste segregation.

- Discuss any challenges faced by staff in maintaining proper segregation at their work areas.

Implementation plan :
To implement this checkpoint, the facility must ensure the placement of two distinct bins—one for recyclable waste and another for biodegradable waste—at all critical points including kerb collection points, wards, outpatient departments (OPD), patient waiting areas, pharmacies, offices, and cafeterias. These bins should be clearly marked or color-coded for easy identification. Staff members need to be trained on the importance of waste segregation and the correct disposal method for each type of waste. Regular monitoring and supervision should be scheduled to verify proper use and maintenance of the bins. Additionally, the facility should establish a routine for emptying and handling the segregated waste to maintain hygiene and compliance.
Scoring Criteria :

 2 Marks: Two types of bins (for recyclable and biodegradable waste) are available and clearly placed at all designated locations including kerb collection points, wards, OPD, patient waiting areas, pharmacy, office, and cafeteria. Staff demonstrate good understanding and compliance with segregation practices.

 1 Mark: Two types of bins are available in most, but not all, designated areas. Some locations may lack proper segregation bins or staff awareness on segregation is partial.

 0 Marks: There are no distinct bins for recyclable and biodegradable waste, or bins are poorly placed, missing at key locations, and staff lack awareness about segregation practices.

Reference : NA

C7.2	**The Facility Undertakes efforts to educate patients and visitors about segregation of recyclable and biodegradable wastes**

Interpretation
This checkpoint assesses whether the facility actively promotes and facilitates the segregation of waste by educating patients and visitors. The presence of posters and clear work instructions, combined with the availability of two separate bins for recyclable and biodegradable wastes, reflects the facility's commitment to sustainable waste management practices. It is not enough to just have bins; proper communication and signage are critical to ensure correct usage and compliance.
Means of verification : **OB / SI**

Observation

- Check if posters or work instructions about waste segregation are displayed near the bins.
- Confirm the presence of two separate bins labeled for recyclable and biodegradable waste at relevant locations.
- Verify that bins are clean, properly maintained, and not overflowing.
- Observe whether patients and visitors are correctly segregating their waste into the appropriate bins.

- Note the positioning and accessibility of the bins to ensure they are easy to use.

Staff Interview

- Ask staff if they routinely educate patients and visitors about the segregation of recyclable and biodegradable waste.
- Inquire how often staff check that posters and work instructions are in place and visible.
- Question staff on their role in maintaining the bins and ensuring they are labeled correctly.
- Ask if staff have observed any issues with compliance among patients or visitors and how they handle such situations.
- Confirm whether staff receive training or guidance on waste segregation communication.

Implementation plan :

Implementation Plan:

The facility will ensure that clear, visible posters and work instructions regarding waste segregation are displayed at strategic locations where waste bins are placed. These instructions will guide patients and visitors to separate recyclable and biodegradable waste correctly. Two distinct bins, one for recyclable waste and another for biodegradable waste, will be installed in common areas such as waiting rooms, corridors, and near cafeterias. Staff will be trained to educate and remind patients and visitors about proper segregation practices. Regular checks will be conducted to confirm that posters are intact and bins are appropriately labeled and functional.

Scoring Criteria :

- **2 Marks:** Posters/work instructions are prominently displayed at all bin locations, two types of bins (recyclable and biodegradable) are available and clearly labeled, and staff actively educate and monitor patients and visitors on waste segregation.
- **1 Mark:** Posters/work instructions are displayed but only in some locations; bins are available but not always clearly labeled or maintained; staff occasionally educate patients and visitors.
- **0 Mark:** No visible posters or work instructions; bins are not segregated or missing; no evidence of staff educating patients or visitors about waste segregation.

Reference : NA

C7.3	General Waste is not mixed with infected waste

Interpretation

This checkpoint requires that general waste must be strictly separated from infected waste to prevent contamination and reduce health risks. The mixing of these wastes compromises infection control measures, endangers staff and patients, and violates biomedical waste management regulations. Compliance indicates effective implementation of waste segregation protocols and proper staff awareness and behavior.

Means of verification : **OB / SI**

Observation:

- Check bins in various areas to confirm separate bins for general waste and infected waste.

- Verify that no general waste is found mixed in infected waste bins and vice versa.
- Observe if bins are clearly labeled with the appropriate waste category.
- Look for proper placement of bins to facilitate segregation at the point of waste generation.
- Check the condition and cleanliness of the bins to ensure regular disposal.

Staff Interview:

- Ask housekeeping and clinical staff about their understanding of waste segregation rules.
- Enquire if staff have received training on the importance and procedures of segregating general and infected waste.
- Question staff about challenges faced during waste segregation and how they manage them.
- Verify if staff are aware of the risks associated with mixing general and infected waste.
- Check if staff can explain the color coding system and disposal protocol for different types of waste.

Implementation plan :
To ensure that general waste is not mixed with infected waste, the facility will establish clear protocols for waste segregation at the point of generation. All staff will be trained on the importance of segregating waste and identifying the different categories. Color-coded bins will be placed strategically in all areas to facilitate easy segregation. Regular monitoring will be conducted by supervisory staff to ensure compliance. Any deviations will be addressed promptly through corrective actions and refresher training sessions.
Scoring Criteria :

 2 Marks: No mixing of general and infected waste is observed; all bins are properly labeled and used correctly; staff demonstrate clear knowledge of segregation procedures.

 1 Mark: Occasional minor mixing found but mostly segregated correctly; bins are mostly labeled; staff show partial understanding of segregation.

 0 Mark: Frequent mixing of general and infected waste; bins not labeled or used properly; staff lack knowledge or have not been trained on segregation.

Reference : NA

C7.4	Availability of Compost Pit within the premises

Interpretation
This checkpoint evaluates whether the facility responsibly manages organic waste either by having an on-site compost pit or by collaborating with the municipal waste management system. Presence of a compost pit signifies direct effort to recycle and reduce organic waste on-site. However, if the facility has an effective and documented arrangement with municipal waste collectors that includes regular removal of general waste, this is considered equally compliant. The key objective is sustainable waste management that prevents environmental pollution and supports health and hygiene within the premises.
Means of verification : **OB / SI**

Observation:

- Check if a compost pit is physically present within the facility premises.
- Assess the location and condition of the compost pit to see if it is functional and well-maintained.
- Look for any signage, labels, or instructions related to composting or waste segregation near the compost pit.
- Verify if there is any documentation displayed or available regarding waste management practices.
- If no compost pit is present, observe any evidence of municipal waste collection arrangements, such as bins labeled for general waste, collection schedules posted, or receipts from municipal waste services.

Staff Interview:

- Ask housekeeping or waste management staff if a compost pit exists and how it is managed.
- Enquire how biodegradable waste is segregated and disposed of within the facility.
- Confirm whether there is a formal linkage or contract with the municipal waste management system for collecting general waste.
- Question staff on the frequency and reliability of waste collection by municipal services if no compost pit is available.
- Assess staff awareness regarding the environmental importance of composting and waste disposal practices.
- Ask who is responsible for monitoring the compost pit or coordinating with municipal waste services.

Implementation plan :
To implement the requirement for having a compost pit within the premises, the facility must first conduct a site assessment to identify a suitable location that complies with environmental and operational guidelines. The compost pit should be constructed following standard specifications to allow effective decomposition of biodegradable waste. Staff should be trained on segregation of waste at source to ensure only appropriate organic waste is sent to the compost pit. If the facility opts not to maintain an on-site compost pit, it must establish a formal linkage or contract with the local municipal waste management system to ensure regular collection and proper disposal of general waste. Periodic monitoring should be done to ensure the compost pit is maintained properly or that the municipal waste collection system is functioning reliably.
Scoring Criteria :

 Award **2 Marks** if the facility has a well-maintained compost pit within the premises **or** has an active, documented linkage with the municipal waste management system for regular general waste collection.

 Award **1 Mark** if the facility has a compost pit present but it is poorly maintained or only partially functional, or if there is a linkage with municipal waste system but it lacks formal documentation or is irregular.

 Award **0 Marks** if there is no compost pit, and no linkage or arrangement with the municipal

waste management system for general waste collection, or if the waste management process is completely absent or dysfunctional.

Reference : NA

C7.5	The facility has introduced innovations in managing General Waste

Interpretation

This checkpoint evaluates whether the facility has proactively introduced innovative and sustainable practices for managing general waste beyond conventional disposal methods. Innovations could include techniques such as vermicomposting for organic waste, recycling programs for paper and other materials, implementation of waste-to-energy technologies, or use of compost activators to accelerate decomposition. The presence of such initiatives indicates the facility's commitment to environmental sustainability, resource optimization, and compliance with best practices in waste management. Successful implementation not only reduces waste volume but also minimizes environmental impact and may contribute to cost savings or resource recovery.

Means of verification : **OB / SI**

What to observe (OB):

- Presence of vermicomposting units or compost pits within the facility premises.
- Designated recycling bins or paper recycling processes visibly implemented.
- Equipment or infrastructure related to waste-to-energy conversion, if applicable.
- Labels or signage indicating innovative waste management practices.
- Documentation or records showing the use of compost activators or other novel methods.

What to enquire (Staff Interview):

- Ask staff if they have received training on innovative waste management techniques.
- Enquire whether the staff understand the procedures involved in vermicomposting or recycling.
- Check if staff can explain the benefits of innovations introduced and how they contribute to waste reduction.
- Inquire about challenges faced during implementation and how they are addressed.
- Ask if there is a team or individual responsible for overseeing waste management innovations.

Implementation plan :

To implement innovative practices in managing general waste, the facility will first conduct a baseline assessment of existing waste management procedures. Next, the team will research and select suitable innovative methods such as vermicomposting, recycling of papers, waste-to-energy conversion, and use of compost activators. Training sessions will be conducted for the staff to ensure proper understanding and adoption of these methods. A waste management committee will be formed to oversee the application of these innovations and regularly monitor their effectiveness. The facility will also establish partnerships with external vendors or experts if necessary, to support technologies like waste-to-energy. Documentation of procedures and outcomes will be maintained to track progress and improvements. Finally, periodic reviews and

feedback sessions will be held to refine the waste management strategy, ensuring continuous innovation and compliance.

Scoring Criteria :

- **2 Marks:** The facility has fully implemented one or more innovative general waste management practices such as vermicomposting, paper recycling, waste-to-energy, or compost activators. Staff are well-trained, and proper infrastructure and documentation are available and maintained.
- **1 Mark:** The facility has introduced some innovative practices but implementation is partial or limited to a small section. Staff awareness or infrastructure may be inconsistent, and documentation may be incomplete.
- **0 Marks:** No evidence of any innovative general waste management practices; the facility relies only on conventional waste disposal methods without attempts at innovation or staff training.

Reference : NA

C8	Liquid Waste Management
C8.1	The laboratory has a functional protocol for managing discarded samples

Interpretation

This checkpoint ensures that the laboratory follows safe and standardized practices for discarded sample management, thereby minimizing risks to laboratory personnel and the environment. A functional protocol is essential for consistent and safe disposal, and staff awareness of the protocol reflects effective implementation. The safe treatment of discarded samples before disposal is critical to avoid contamination or infection risks, and proper segregation from other waste streams safeguards overall laboratory hygiene and environmental safety.

Means of verification : **OB / SI**

What is to be observed (OB):

- Presence of a written and accessible protocol document for discarded sample management in the laboratory.
- Actual disposal practices of discarded samples and verification that discarded samples are treated or made safe before disposal.
- Waste segregation practices specifically related to discarded laboratory samples.

What is to be enquired during staff interview (SI):

- Awareness and understanding of the protocol for managing discarded samples among laboratory staff.
- Training received on the protocol and frequency of refresher sessions.
- Procedures followed by staff when handling and discarding laboratory samples.
- Measures taken to ensure discarded samples are safe before disposal.

Implementation plan :

The laboratory must develop and maintain a written, functional protocol for the management of discarded samples. This protocol should detail how discarded samples are handled, treated, and safely disposed of to prevent contamination and hazards. All laboratory staff must be trained on this protocol and updated regularly to ensure proper understanding and adherence. Regular monitoring and audits should be conducted to verify that discarded samples are treated appropriately and never mixed with other wastewater or general waste. The protocol document should be readily accessible within the laboratory for easy reference by staff at all times.

Scoring Criteria :

 2 Marks:
The laboratory has a documented, functional protocol available on-site; staff demonstrate clear awareness and understanding of the protocol; discarded samples are consistently treated or made safe before disposal, with direct observation confirming compliance.

 1 Mark:
A protocol exists but may not be fully functional or consistently followed; some staff have limited awareness; discarded samples are sometimes made safe but there are lapses observed in the disposal process.

 0 Mark:
No documented protocol available or protocol is not functional; staff are unaware of any such protocol; discarded samples are disposed of without any treatment or safety measures, posing risks.

Reference : NA

C8.2	**Body fluids, Secretions in suction apparatus, blood and other exudates in OT, Labour room, minor OT, Dressing room are disposed only after treatment**

Interpretation
This checkpoint ensures that all potentially infectious biological waste like body fluids, secretions collected in suction apparatus, blood, and other exudates from critical areas such as Operation Theatres (OT), Labour Rooms, minor OTs, and Dressing Rooms are disposed of only after undergoing proper treatment. The objective is to prevent the risk of infection transmission and environmental contamination by mandating the treatment of these fluids as per prescribed infection control protocols before their final disposal.
Means of verification : **OB / SI**

- **Observation (OB):**
  - Observe the presence of a designated area or equipment used for treating body fluids and secretions before disposal.
  - Check that suction apparatus and containers in OT, Labour Room, minor OT, and Dressing Room are properly labeled and regularly cleaned.
  - Confirm that body fluids, blood, and exudates are visibly treated (e.g., chemical disinfection, autoclaving) before disposal.
  - Look for records or logs documenting treatment procedures and disposal timings.

- **Staff Interview (SI):**
  - Enquire with staff if they are trained on the protocol for treatment and disposal of body fluids and secretions.
  - Ask about the steps they follow before disposing of such waste.
  - Confirm whether they understand the importance of treating these materials before disposal.
  - Verify if staff can explain the method of treatment used for different types of secretions or blood.

Implementation plan :
To implement checkpoint C8.2 effectively, first establish and communicate a standard operating procedure (SOP) that clearly outlines the treatment methods for body fluids, secretions in suction apparatus, blood, and other exudates generated in the OT, Labour Room, minor OT, and Dressing Room. Train all relevant staff on these protocols, emphasizing the importance of treating such waste before disposal to prevent infection and contamination. Assign responsibility to designated personnel to monitor adherence daily and maintain records of the treatment processes. Periodic audits should be scheduled to verify compliance, and corrective actions must be promptly implemented if deviations are identified.
Scoring Criteria :

 2 Marks: The facility consistently treats all body fluids, secretions, blood, and exudates from OT, Labour Room, minor OT, and Dressing Room before disposal as per the protocol, supported by clear documentation and demonstrated staff awareness.

 1 Mark: Treatment is done for most cases but may lack consistency or documentation; staff demonstrate partial understanding of the protocols.

 0 Marks: No evidence of treatment before disposal or lack of staff knowledge about the treatment protocols; unsafe disposal practices observed.

Reference : NA

C8.3	The Facility has treatment facility for managing infectious liquid waste

Interpretation
This checkpoint aims to ensure that the healthcare facility responsibly manages infectious liquid waste, which poses a significant risk to public health and the environment if not handled correctly. The standard requires that infectious liquid waste is not discharged untreated or mixed with general wastewater. Instead, it must be routed through a dedicated collection system leading to a treatment mechanism such as an ETP. This reflects the facility's commitment to infection control, environmental safety, and compliance with statutory regulations. Staff awareness and procedural clarity are also critical to ensuring the effective functioning of the system.
Means of verification : **OB / SI**

 Observation (OB):

- Observe the presence of a separate drainage or collection line specifically designated for infectious liquid waste.

- Check for physical connection to an Effluent Treatment Plant (ETP) or any appropriate liquid waste treatment facility.
- Verify that signs or color-coded labels indicate the waste path or source.
- Ensure the area is well maintained and there is no leakage or overflow of untreated waste.

 Staff Interview (SI):

- Ask staff to explain the procedure for disposing of infectious liquid waste.
- Enquire if they have received training on how to handle liquid waste.
- Ask if there is any specific protocol for accidental spillage or malfunction of the waste treatment system.
- Confirm whether staff are aware of the system used for treatment and the department responsible for its upkeep.

Implementation plan :
To implement this checkpoint, the healthcare facility must install a dedicated system for the safe collection and treatment of infectious liquid waste. This involves creating a separate drainage or pipeline system that prevents the mixing of infectious waste with general liquid waste. The infectious liquid waste should be channeled directly to an Effluent Treatment Plant (ETP) or an equivalent system capable of neutralizing infectious agents. The plan should include infrastructural modifications, procurement of necessary equipment, and assignment of responsibilities for system operation and maintenance. Staff should be trained in waste handling protocols, and periodic audits must be conducted to ensure compliance. Visual indicators and SOPs (Standard Operating Procedures) must be made accessible to all relevant personnel.
Scoring Criteria :

 2 Marks:
The facility has a clearly defined and functional separate collection system for infectious liquid waste that leads directly to an operational effluent treatment system. Staff are aware of the procedures, and evidence of regular use and maintenance is present.

 1 Mark:
The collection system exists but is either not properly separated or not consistently functional. Some staff have partial awareness, or the treatment system has minor issues requiring corrective action.

 0 Mark:
There is no separate collection or treatment system for infectious liquid waste. Staff are unaware of any specific procedures, and the existing practice poses a risk of contamination.

Reference : NA

C8.4	

Interpretation
Means of verification : **OB / SI**

Observation (OB):

- Observe the premises, especially the bathroom and kitchen areas, to confirm there is no water stagnation.
- Check the sullage outlets and drainage paths for continuous flow and connectivity.
- Verify if the sullage is connected to the municipal drainage system.
- If there is no municipal system, check for the presence and condition of a soakage pit or equivalent system.
- Ensure there are no signs of fly or mosquito breeding around sullage discharge areas.

Staff Interview (SI):

- Enquire with housekeeping or maintenance staff about the regularity of drain cleaning.
- Ask if there is a system in place to manage sullage in case of a blockage or overflow.
- Enquire about actions taken in the absence of a municipal drainage system.

Implementation plan :
The facility shall assess all areas generating sullage (bathrooms and kitchen) and map the current drainage system. Where a municipal drainage system is available, the sullage outlets must be connected securely and checked for blockages regularly. In facilities without municipal drainage access, soakage pits must be constructed as per standard environmental norms. Regular maintenance schedules will be instituted, and staff will be trained to report and address any signs of stagnation or vector breeding immediately. Documentation and periodic internal audits will support compliance.
Scoring Criteria :

 2 Marks: Sullage is properly connected to the municipal drainage system or a well-maintained soakage pit is present. No stagnation or signs of fly/mosquito breeding observed.

 1 Mark: Sullage is mostly managed, but minor signs of stagnation or lack of maintenance exist, or soakage pit is present but not well maintained.

 0 Mark: Sullage is not managed properly, stagnation is evident, and no proper drainage or soakage system is in place, leading to a high risk of vector breeding.

Reference : NA

C8.5	Runoff is drained into the municipal drain

Interpretation
The intent of this checkpoint is to ensure that the healthcare facility has an effective system for managing rainwater and surface water runoff. This includes having a proper drainage infrastructure that prevents water stagnation, flooding, or damage to the building and its surroundings. The system must be designed in such a way that it allows surface water to flow smoothly, using an appropriate gradient, into an external drainage system like a municipal drain or any other approved outlet.
Means of verification : **OB / SI**

Observation / Staff Interview:

- **Observation:**
  - Check for physical presence of a drainage system around the premises.
  - Observe the slope or gradient of the facility surroundings to ensure proper runoff flow.
  - Look for signs of water stagnation, blockage, or damage in the drainage lines.
  - Check for connection points between facility drains and municipal drainage systems.
- **Staff Interview:**
  - Enquire about the routine maintenance schedule for the drainage system.
  - Ask staff if there have been any incidents of water stagnation or drainage overflow in the past.
  - Verify staff awareness about the importance of maintaining an effective drainage system.

Implementation plan :
The facility should ensure that surface water runoff is properly managed to prevent water stagnation and associated risks. This involves assessing the current drainage infrastructure and identifying whether a system is in place that effectively channels rainwater or wash water to a designated outlet, such as a municipal drain or soak pit. The team should physically inspect the area surrounding the building to confirm the presence and condition of the drainage system. Staff responsible for facility maintenance must be trained on the importance of keeping the drainage pathways clear of obstructions. Records of regular inspection and maintenance of the drainage system should also be maintained.

Scoring Criteria : **2 Marks:** A functional and well-maintained drainage system is present with proper gradient and documented maintenance. Staff are aware of the procedure.

 1 Mark: A drainage system exists but may lack proper gradient or has minor maintenance issues. Staff have partial awareness.

 0 Mark: No proper drainage system or evidence of water stagnation; staff are unaware of the maintenance procedure.

Reference : NA

C9	Equipment and Supplies for Bio Medical Waste Management
C9.1	Availability of Bins and liners for segregated collection of waste at point of use

Interpretation

This checkpoint emphasizes the requirement for a proper system to collect biomedical and general waste separately at the point of generation. According to the Biomedical Waste Management Rules, 2016 and its amendments, healthcare facilities must have appropriate color-coded bins and liners to ensure waste is segregated correctly right at the source. Each waste generation point (e.g., OPDs, IPDs, dressing rooms, laboratories) should have at least one set of clearly labeled and color-coded bins for both general and biomedical waste. This setup minimizes the risk of infection and promotes compliance with legal and environmental regulations.

Means of verification : **OB / SI**

Observation (OB):

- Check the physical presence of color-coded bins and liners at each waste generation point.
- Confirm the condition and cleanliness of the bins.
- Ensure liners are appropriately fitted and match the bin color.

Staff Interview (SI):

- Ask staff to explain the purpose of each bin and the correct method of waste segregation.
- Enquire about the frequency of liner replacement and whether they face shortages.
- Verify whether they received formal training in waste segregation.

Record Review (RR):

- Examine stock registers to confirm regular supply and distribution of bins and liners.
- Review maintenance and replenishment logs for the waste management system.

Implementation plan :

To implement this checkpoint, the facility should first identify all points of waste generation. Based on this, the required number and type of bins and liners must be procured and placed accordingly. The bins should be color-coded as per the prescribed standards (e.g., yellow for infectious waste, red for contaminated plastic, black or green for general waste, etc.). Liners matching the color codes should be inserted into the bins. A stock monitoring system must be put in place to ensure continuous availability of bins and liners. Periodic checks and training sessions should be conducted to ensure staff compliance. All purchases and distributions of bins and liners should be documented and reviewed regularly.

Scoring Criteria :

2 Marks: All points of generation have appropriate, color-coded bins with liners. Staff are knowledgeable, and stock records are complete and regularly updated.

1 Mark: Most waste generation points have appropriate bins and liners. Staff have partial knowledge, and some inconsistencies exist in stock records.

 0 Marks: Bins and liners are inadequately placed or missing. Staff are unaware of segregation protocols, and records are absent or poorly maintained.

Reference : NA

C9.2	Availability of Needle/ Hub cutter and puncture proof boxes

Interpretation
This checkpoint emphasizes the critical importance of having safety devices like needle/hub cutters and puncture-proof sharps boxes readily accessible at the exact points where sharps are used or disposed of. The intent is to prevent injuries and infections due to improper handling or disposal of sharps. The availability should not be centralized or limited to select areas but must cover **each** point of generation.
Means of verification : **OB / SI**

Observation (OB):

- Check whether needle/hub cutters are available and functional at all points of sharp waste generation.
- Verify the presence of puncture-proof boxes that are appropriately labeled and in use.
- Observe whether the containers are not overfilled and are replaced when three-fourths full.
- Confirm that the containers are placed as close as possible to the point of use.

Staff Interview (SI):

- Ask staff if they are aware of the correct process for disposing of used needles and sharps.
- Enquire whether staff have received training on biomedical waste management, specifically on sharps disposal.
- Ask staff to explain what action they take when a container is full or if a cutter is not functioning.

Implementation plan :
To ensure compliance with checkpoint C9.2, the healthcare facility must procure and install needle/hub cutters and puncture-proof sharps containers at every location where sharp waste is generated, such as consultation rooms, treatment areas, injection rooms, dressing stations, and laboratories. Staff should be trained on the proper usage and disposal protocols to minimize needle-stick injuries and enhance occupational safety. Regular monitoring must be implemented to ensure continued availability and proper utilization of these safety devices.

Scoring Criteria :

 2 Marks: Needle/hub cutters and puncture-proof boxes are available and functional at **all** points of sharp waste generation, and staff are fully aware of the usage and replacement protocols.

 1 Mark: Safety devices are available at **most** points of sharp waste generation, but there are one or two minor gaps either in placement or staff awareness.

 0 Mark: Needle/hub cutters and/or puncture-proof boxes are **not available** at most sharp waste generation points or are non-functional, and staff are unaware of proper usage or protocols.

Reference : NA

C9.3	**Availability and supply of personal protective equipment**

Interpretation
This checkpoint emphasizes the critical role of PPE in ensuring the safety of waste handlers from infections, injuries, and hazardous exposure. Compliance indicates that the facility prioritizes occupational health and safety. It reflects an organized and preventive approach to infection control and staff protection. If PPE is consistently available and used appropriately, it reduces the risk of health hazards and ensures the facility's adherence to safety norms under the NABH standards.
Means of verification : **OB / SI**

Observation (OB):

- Look for the physical presence of PPE (caps, masks, gloves, boots, goggles) in relevant storage or work areas.
- Observe whether waste handlers are using PPE correctly while performing their duties.
- Check that PPE items are not expired, damaged, or poorly stored.

Staff Interview (SI):

- Ask waste handlers if PPE is provided to them regularly and in adequate quantity.
- Enquire whether they have received training on the usage and importance of PPE.
- Verify whether they understand the risks associated with not using PPE.

Record Review (RR):

- Examine stock and issue registers to verify timely procurement and distribution of PPE.
- Review training records for waste handlers on PPE use.
- Look for incident reports or complaints regarding PPE shortages or non-compliance.

Implementation plan :

To ensure compliance with the checkpoint C9.3, the facility must develop a structured system for the procurement, storage, distribution, and monitoring of personal protective equipment (PPE) for all waste handlers. This includes items such as caps, masks, gloves, boots, and goggles. A dedicated storage area should be maintained for PPE, and inventory must be checked regularly to avoid stockouts. A register/logbook should be maintained to record the issue and usage of PPE by waste handlers. Staff must be trained periodically on the correct usage, importance, and disposal of PPE. The facility should also assign responsibility to specific personnel for monitoring PPE availability and ensuring that waste handlers are supplied with appropriate protective gear at all times.

Scoring Criteria :

2 Marks:
All required PPE is consistently available and used by waste handlers. Records are well-maintained, and staff are trained and aware of PPE protocols.

1 Mark:
PPE is available but occasionally insufficient or inconsistently used. Records or staff awareness may be partial or incomplete.

0 Mark:
PPE is not adequately available or used. Records are absent or poorly maintained, and staff are unaware or untrained regarding PPE usage.

Reference : NA

C9.4	Availability of Sodium Hypochlorite Solution

Interpretation
Checkpoint C9.4 pertains to the consistent availability and proper documentation of Sodium Hypochlorite solution, which is a key disinfectant used in healthcare facilities. This checkpoint ensures that the facility maintains adequate stocks of the solution for routine disinfection practices and that records are maintained regarding its procurement, preparation (if applicable), and usage.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether Sodium Hypochlorite solution is physically available in clinical and cleaning areas.
- Check for correct labeling (date of preparation, concentration).
- Verify storage conditions and placement of the solution as per safety guidelines.
- Observe any expired or improperly stored solution.

Staff Interview (SI):

- Enquire whether the staff knows the purpose of using Sodium Hypochlorite and its correct dilution ratios.
- Ask the responsible staff how and when the solution is replenished.
- Enquire about the frequency of stock monitoring and who is accountable for it.

Record Review (RR):

- Review stock and usage records of Sodium Hypochlorite.
- Verify the presence of daily or weekly logs indicating preparation and usage.
- Check for consistency between the physical availability and the documented records.

Implementation plan :

To implement this standard, the healthcare facility should designate a responsible staff member for monitoring the inventory and replenishment of Sodium Hypochlorite solution. The solution should be readily available in designated areas like procedure rooms, cleaning stations, and areas of high infection risk. A logbook or record should be maintained showing the date of procurement or preparation, the strength of the solution (as per standard guidelines), and daily usage. Periodic internal audits should be conducted to verify availability and usage patterns. Staff should be trained on the importance of this solution and its role in infection control.

- **Scoring Criteria : 2 Marks:**
  Sodium Hypochlorite solution is available in required areas, properly labeled and stored. Staff are knowledgeable about its use and records of availability and usage are up to date and complete.
- **1 Mark:**
  Sodium Hypochlorite is available but may have minor gaps such as incomplete labeling, partial staff awareness, or sporadic record maintenance.
- **0 Mark:**
  Sodium Hypochlorite is not available, poorly maintained, improperly labeled, or no documentation is available. Staff are unaware of its use or handling procedures.

Reference : NA

C9.5	Availability of trolleys for waste collection and transportation

Interpretation

Interpretation of this checkpoint includes understanding that the trolleys are a critical component of waste management infrastructure. They must be color-coded or labeled to support waste segregation practices and must not be used for any other purpose. Their availability ensures that waste is collected and moved hygienically, reducing the risk of infection and ensuring compliance with waste handling norms.

Means of verification : **OB / SI**

 Observation (OB):

- Observe whether trolleys are present in sufficient numbers in all critical waste generation areas such as OPD, IPD, procedure rooms, and pharmacy.
- Check if the trolleys are clean, intact, and appropriately labeled or color-coded for different waste categories.
- Observe whether the trolleys are used exclusively for biomedical waste and not for any other purpose.
- Verify whether the trolleys are stored in designated places and not blocking pathways.

 Staff Interview (SI):

- Ask staff about the number of trolleys available and whether they are sufficient for daily waste collection needs.
- Enquire about the frequency of trolley cleaning and who is responsible for it.

- Ask whether the staff is aware of the waste categories and which trolley is used for which category.
- Check whether staff are trained on safe waste handling and trolley usage procedures.

Implementation plan :
To implement this checkpoint, the facility must ensure the availability of trolleys specifically designed for the collection and internal transportation of various categories of biomedical waste. The number and size of the trolleys should be proportionate to the facility's size, patient load, and the quantity of waste generated. These trolleys should be made of materials that are easy to clean and disinfect, and their design should support safe handling and segregation of waste as per applicable BMW rules.
Scoring Criteria :

 2 Marks: The facility has an adequate number of clean, color-coded or labeled trolleys as per waste category, appropriate to the facility size and waste load. Trolleys are observed in proper condition and correctly used, and staff are aware of their purpose and usage protocols.

 1 Mark: The facility has trolleys for waste transportation, but they are either insufficient in number, not properly labeled/color-coded, or not uniformly used across all areas. Minor gaps are observed in maintenance or staff awareness.

 0 Mark: Trolleys are not available or are grossly inadequate. The available trolleys are either damaged, unclean, or used for multiple purposes. Staff are unaware or poorly trained in their usage.

Reference : NA

C10	Statuary Compliances

C10.1	The Health Facility has a valid authorization for Bio Medical waste Management from the prescribed authority

Interpretation
This checkpoint requires that the health facility must not only possess the authorization certificate for BMW management but also ensure that it is currently valid. It reflects the facility's compliance with legal and environmental norms related to biomedical waste. The absence of such authorization or an expired certificate indicates non-compliance, which is a critical deviation from regulatory and accreditation requirements.
Means of verification : **OB / SI**

 Observation (OB):

- Observe the BMW authorization certificate displayed or filed in the administrative office or quality department.
- Check whether the certificate clearly mentions the name and address of the health facility,

authorization number, and the validity period.
- Verify that the dates on the certificate are current and that it has not expired.

 Staff Interview / Enquiry:

- Enquire who is responsible for maintaining and renewing the BMW authorization.
- Ask the staff to explain the procedure followed for applying or renewing the certificate.
- Confirm if they are aware of the validity period and if any reminders or monitoring mechanisms are in place.

Implementation plan :
The health facility must ensure it obtains a valid authorization for Bio Medical Waste (BMW) management from the prescribed authority, typically the State Pollution Control Board. This authorization must be renewed as per the validity period specified. A responsible staff member, preferably from the administrative or quality team, should be assigned to monitor the validity and initiate the renewal process in a timely manner. The facility should maintain a dedicated file or digital record for all environmental clearances, including the BMW authorization certificate, and keep it readily accessible for inspection and audit.
Scoring Criteria :

 2 Marks:
The health facility possesses a valid authorization certificate for biomedical waste management from the prescribed authority, and the certificate is current and readily available for review.

 1 Mark:
The health facility has an authorization certificate, but it has either recently expired (within a short duration) or is not readily accessible at the time of assessment.

 0 Mark:
The health facility does not have a biomedical waste management authorization certificate, or the certificate has been expired for a long duration, indicating a lack of compliance with regulatory requirements.

Reference : NA

C10.2	The Health Facility submits Annual report to pollution control board

Interpretation
This checkpoint ensures that the health facility is complying with regulatory requirements under the Biomedical Waste Management Rules. Submitting the annual report to the Pollution Control Board is a statutory obligation and reflects the facility's commitment to environmental safety and legal compliance. This also serves as documentation that the facility monitors and manages biomedical waste properly throughout the year.
Means of verification : **OB / SI**

 What is to be observed (OB):

- Check for a copy of the submitted annual report for the previous year.

- Observe the acknowledgment or receipt issued by the Pollution Control Board.
- Verify the submission date on the document (should be on or before 30th June).
- Check if the report includes complete and accurate biomedical waste data as per prescribed formats.

 What is to be enquired:

- Ask the responsible staff (e.g., Biomedical Waste Officer) about the process of preparing and submitting the report.
- Enquire whether any reminders or internal checks are conducted to ensure timely submission.
- Ask who is responsible for submission and what actions are taken in case of delay.
- Enquire if any feedback or communication is received from the Pollution Control Board after submission.

Implementation plan :
The facility shall establish a systematic process to ensure timely submission of the Annual Report to the State Pollution Control Board (SPCB) or other designated authority. The responsibility of compiling and submitting the report must be assigned to a designated staff member (e.g., Quality Manager or Biomedical Waste Officer). The report must include data related to biomedical waste generation, segregation, handling, and disposal in the prescribed format. An internal deadline (e.g., by 15th June) should be set to complete the report and submit it by or before the 30th of June each year. Records of submission, including acknowledgment receipts or email confirmation from the SPCB, should be maintained for verification during audits.
Scoring Criteria :

 2 Marks:
The facility has submitted the annual report to the Pollution Control Board on or before 30th June, and documentary evidence (submission receipt or acknowledgment) is available and complete.

 1 Mark:
The report was submitted after the due date (30th June) but submission was eventually made, with supporting evidence available.

 0 Mark:
The report was not submitted, or there is no evidence available to verify submission, or the report is incomplete/incorrect.

Reference : NA

C10.3	**The Health Facility has a system of review and monitoring of BMW Management through an existing committee or by forming a new committee**

Interpretation

This checkpoint emphasizes the need for a structured approach to overseeing BMW management within the health facility. It suggests that accountability and continual quality improvement are essential, and this can only be achieved through a formal committee-based review process. The review system not only ensures regulatory compliance but also promotes safety and awareness among staff regarding proper BMW handling and disposal.

Means of verification : **OB / SI**

- **Observation (OB):**
  - Check for the presence of an official office order indicating the constitution of a committee responsible for BMW management.
  - Verify the availability of committee meeting records (hard copy or digital).
  - Look for documentation of meetings conducted at least once every six months.
  - Review minutes of meetings to ensure BMW management is a part of the agenda and discussed adequately.
- **Staff Interview (SI):**
  - Ask committee members about the roles and responsibilities of the committee related to BMW management.
  - Enquire about the frequency of committee meetings and the typical issues discussed.
  - Check whether staff are aware of any recent changes or decisions made by the committee to improve BMW practices.
  - Ask staff if they have received any training or updates as a result of these committee meetings.

Implementation plan :

To ensure effective monitoring and review of Biomedical Waste (BMW) Management, the health facility should establish a dedicated system under an existing committee such as the Infection Control Committee or Quality Committee. If no such committee exists, a new committee should be constituted specifically for this purpose. The formation of the committee should be officially documented through an office order. This committee should meet at least once every six months to review the processes, compliance, and improvements related to BMW management. The agenda of the meetings must include a review of current practices, discussion of non-compliance or incidents, staff training needs, and opportunities for improvement. Minutes of each meeting should be recorded and maintained for review and audit purposes.

Scoring Criteria :

 2 Marks:

The facility has constituted a dedicated or existing committee for BMW management with documented office order, conducts meetings at least every six months, and maintains well-documented minutes that include discussion on BMW management.

 1 Mark:

The facility has formed a committee and conducts meetings, but either the frequency is irregular or the documentation (minutes or agenda) does not consistently reflect discussion on BMW

management.

 0 Marks:
There is no committee constituted for BMW management, or there is no evidence of regular meetings or documentation related to BMW review and monitoring.

Reference : NA

C10.4	The Health facility maintains its website and annual report is uploaded

Interpretation
This checkpoint assesses whether the health facility complies with regulatory requirements by maintaining a website that publicly displays its annual biomedical waste management report. Uploading the annual report ensures transparency and accountability regarding the facility's environmental and safety practices. It demonstrates that the facility adheres to BMW Rules 2016 and facilitates easy access for regulatory authorities and the public to review compliance information. A lack of an updated annual report or absence of a website indicates non-compliance with these important standards.
Means of verification : **OB / SI**

Observation:

- Check if the health facility has an official, functional website.
- Look for a dedicated section on the website for reports or regulatory compliance.
- Verify that the latest annual report related to BMW Rules 2016 is uploaded and accessible.
- Confirm the date of the uploaded annual report to ensure it is current and relevant.

Staff Interview:

- Ask the staff responsible for website management about the frequency and process of updating the website.
- Enquire who is responsible for preparing, approving, and uploading the annual report.
- Discuss how often the annual report is reviewed and when it is published online.
- Ask if there is any mechanism to ensure the website content remains up to date and compliant.

Implementation plan :
The health facility must develop and maintain an official, functional website that is regularly updated to reflect current and accurate information. The designated team should ensure the website includes a dedicated section for regulatory documents and reports. As per the BMW Rules 2016, the facility must prepare an annual report on biomedical waste management and upload the latest version on the website in a timely manner. Regular reviews and updates should be scheduled to keep the website content relevant and compliant. Responsibility for managing and uploading these reports should be clearly assigned, with a process in place for report preparation, approval, and publication.
Scoring Criteria :

 2 Marks: The health facility has a functional official website, and the latest annual report related to BMW Rules 2016 is uploaded and easily accessible to the public.

 1 Mark: The facility has a website, but the annual report is either not uploaded or the latest report is missing or outdated.

 0 Marks: The facility does not have an official website or does not upload the annual report on the website.

Reference : NA

C10.5	**The Health Facility maintains records, as required under the Biomedical Waste Rules 2016**

Interpretation

This checkpoint emphasizes the importance of thorough documentation as evidence of compliance with biomedical waste management regulations. Maintaining yearly health check-up records ensures that waste handlers are medically fit and safeguarded against occupational hazards. Annual training records reflect the facility's commitment to educating staff about safe waste handling practices and regulatory updates. Immunisation records confirm that handlers are protected against vaccine-preventable diseases, reducing health risks. Long-term records of autoclave and equipment operation indicate ongoing functionality and adherence to safety protocols. Together, these records form a comprehensive system of accountability, helping the facility to demonstrate compliance during audits and minimize health and environmental risks associated with biomedical waste.

Means of verification : **OB / SI**

Observation

- Observe if the health facility has well-organized records for biomedical waste management.
- Check for yearly health check-up records of all biomedical waste handlers.
- Verify if annual biomedical waste training records for staff are available and updated.
- Look for immunisation records of all waste handlers.
- Inspect operational logs of autoclaves and other equipment covering the last five years.
- Confirm records are accessible and securely stored.

Staff Interview

- Ask staff responsible for biomedical waste management about their record-keeping practices.
- Enquire with waste handlers if they undergo regular health check-ups.
- Question staff about the frequency and content of biomedical waste training sessions.
- Ask about immunisation status and record maintenance for waste handlers.
- Discuss with technical staff how autoclave and equipment operation records are maintained.

Implementation plan :
The health facility should establish a clear system to maintain comprehensive records in line with the Biomedical Waste Rules 2016. This involves scheduling and documenting yearly health check-ups for all biomedical waste handlers to monitor their health status. The facility must organize annual training sessions for all staff involved in biomedical waste handling and maintain records of attendance and training content. Immunisation records for waste handlers should be updated and securely stored to ensure protection against relevant infections. Additionally, operational logs for autoclaves and other waste treatment equipment must be maintained for a minimum of five years to demonstrate continuous equipment functionality and compliance. A designated staff member or quality team should be responsible for regularly reviewing these records, conducting internal audits to verify completeness, and ensuring timely updates. This structured approach will help the facility remain compliant and promote safe biomedical waste management.
Scoring Criteria :

- **2 Marks:** All required records (yearly health check-ups, annual training, immunisation, and five years of equipment operation logs) are complete, up to date, properly maintained, and readily available during verification.
- **1 Mark:** Some records are maintained but either incomplete, outdated, or partially available, indicating partial compliance with the Biomedical Waste Rules 2016.
- **0 Mark:** Records related to health check-ups, training, immunisation, and equipment operation are missing or poorly maintained, reflecting non-compliance with the rules.

Reference : NA

D	**Infection Control**

D1	**Hand Hygiene**

D1.1	**Availability of sink and running water at point of use**

Interpretation
Interpretation of this checkpoint means confirming that handwashing facilities are not only present but also functional and accessible at all necessary points of care. The presence of a sink alone is insufficient if taps are not working or if soap is unavailable. The key focus is to ensure hand hygiene infrastructure supports infection control by enabling healthcare workers and patients to perform hand hygiene easily and effectively wherever required.
Means of verification : **OB / SI**

Observation:

- Check for washbasins with functional taps at all points of use including nursing stations, OPD clinics, operation theatres, labour rooms, etc.

- Confirm the presence of running water at these sinks.
- Verify that soap or liquid hand wash is available at every sink.
- Inspect cleanliness and accessibility of the sinks without any obstruction.

Staff Interview:

- Ask staff if they are aware of the locations of all handwashing points.
- Enquire if they have experienced any issues with non-functional taps or interruptions in water supply.
- Confirm how frequently handwashing facilities are checked and maintained.
- Ask if staff regularly use these sinks for hand hygiene and if any problems are reported to maintenance teams.

Implementation plan :
The implementation plan for ensuring the availability of sinks and running water at points of use involves identifying all critical areas within the healthcare facility where hand hygiene is essential. These areas include nursing stations, outpatient department (OPD) clinics, operation theatres (OT), labour rooms, and other patient care areas. The facility management must ensure that functional washbasins with running taps are installed at these locations and are maintained regularly to avoid downtime. In addition to physical availability, supplies such as soap or liquid hand wash must be consistently stocked to support proper hand hygiene practices. Staff should be made aware of the importance of these facilities through ongoing training and monitoring.
Scoring Criteria :

- **2 Marks:** All points of use have functional washbasins with running water and soap available consistently, and staff confirm regular maintenance and usage of these facilities.
- **1 Mark:** Most points of use have functional sinks and running water with soap available; occasional minor issues with availability or maintenance are reported but promptly addressed.
- **0 Marks:** Significant gaps exist such as absence of sinks, non-functional taps, lack of running water or soap at multiple points of use, or staff report poor maintenance and irregular use of handwashing facilities.

Reference : NA

D1.2	**Display of Hand washing Instructions**

Interpretation
Interpretation of this checkpoint involves verifying that the instructions are prominently displayed and accessible to all healthcare workers and visitors at every relevant hand hygiene point. This is crucial as it serves as a continuous visual reminder and educational tool to promote proper hand hygiene practices, which are fundamental to patient safety and infection control.
Means of verification : **OB / SI**

Observation:

- Check if hand washing instructions are displayed at all designated hand hygiene points such as sinks, washbasins, and sanitizer dispensers.

- Verify that the instructions are clear, legible, and standardized across the facility.
- Observe whether the instructions are positioned at eye level and are not obstructed, faded, or damaged.

Staff Interview:

- Ask staff if they know where the hand washing instructions are displayed.
- Enquire if they regularly refer to these instructions when performing hand hygiene.
- Ask staff about the importance of following the displayed hand washing instructions for infection control.

Implementation plan :
To implement the checkpoint on the display of hand washing instructions, the healthcare facility should first identify all critical points of use where hand hygiene is essential, such as near sinks, washbasins, and hand sanitizer stations. The facility should ensure that clear, visible, and standardized hand washing instructions are displayed at these locations. Staff must be trained and oriented on the importance of these instructions to encourage compliance and reduce infection risks. Regular checks should be scheduled to maintain the visibility and condition of the instructions, replacing any damaged or missing posters immediately.
Scoring Criteria :

 2 Marks: Hand washing instructions are displayed clearly and legibly at all points of use throughout the facility, and staff confirm awareness and regular reference to these instructions.

 1 Mark: Instructions are displayed at most critical points but some locations are missing or instructions are partially damaged/illegible; staff awareness is moderate.

 0 Mark: Instructions are not displayed or are missing at most points of use; staff are unaware or do not refer to any displayed instructions.

Reference : NA

D1.3	Adherence to 6 steps of Hand washing	SI	Ask facility staff to demonstrate 6 steps of normal hand wash

Interpretation
This checkpoint assesses whether healthcare staff correctly perform the six steps of hand washing as per the recommended guidelines. Proper hand hygiene is critical to prevent healthcare-associated infections and ensure patient safety. Demonstration of all six steps in the correct order indicates good compliance and understanding of infection control practices. Failure to adhere to these steps reflects a risk for cross-contamination and lower quality of care.
Means of verification : **OB / SI**

Observation (OB):

- Watch the staff member perform the hand washing procedure.
- Check if the staff follow all six steps in the correct sequence.

- Ensure no steps are missed or performed incorrectly.

Staff Interview (SI):

- Ask the staff to describe the six steps of hand washing.
- Enquire about why each step is important for infection control.
- Confirm when and how often they perform hand washing during their work.

Implementation plan : The facility should ensure that all healthcare staff are trained on the six standard steps of hand washing through formal training sessions and periodic refresher courses. Visual aids such as posters displaying the six steps should be placed near all hand washing stations. Supervisors should encourage regular practice and monitor compliance. During audits, staff will be asked to demonstrate the hand washing procedure to verify their knowledge and skill. Any gaps identified should be addressed immediately with additional training or coaching.

Scoring Criteria :

- **2 Marks:** The staff correctly demonstrate all six steps of hand washing in the proper sequence without any omission or error.
- **1 Mark:** The staff demonstrate most steps correctly but miss one or two minor steps or perform steps out of sequence.
- **0 Marks:** The staff are unable to correctly demonstrate the six steps of hand washing or show significant gaps in knowledge or technique.

Reference : NA

D1.4	Availability of Alcohol Based hand rub	SI/OB	Check for availability alcohol based hand-rub. Ask staff about its regular supply

Interpretation

This checkpoint assesses whether alcohol-based hand rub is consistently available at the point of care for staff to use. Availability is crucial to ensure effective hand hygiene, which prevents the spread of infections within the healthcare setting. Regular supply indicates good inventory management and commitment to infection control practices. Lack of ABHR availability may reflect poor logistics, procurement, or staff awareness, posing a risk to patient safety and care quality.

Means of verification : **OB / SI**

 Observation:

- Verify if alcohol-based hand rub dispensers are present and accessible at all designated locations.
- Check if dispensers are filled and functional, with no signs of being empty or broken.
- Observe whether staff are using ABHR appropriately during routine patient care activities.

 Staff Interview:

- Ask staff if they receive regular and timely supplies of alcohol-based hand rub.
- Enquire whether they have ever faced a shortage and how quickly it was addressed.
- Confirm their understanding of the importance of ABHR in infection control.

Implementation plan :
To implement the availability of alcohol-based hand rub (ABHR), the hospital or healthcare facility must ensure that ABHR dispensers are installed at key points such as patient care areas, nursing stations, and entry/exit points of wards. The supply chain must be monitored regularly to maintain continuous availability without stockouts. The procurement team should establish contracts with reliable suppliers and maintain buffer stock to avoid interruptions. Staff should be educated on the importance of using ABHR for hand hygiene and be encouraged to report shortages immediately. Periodic audits should be planned to verify availability and functionality of dispensers.
Scoring Criteria :

 2 Marks: Alcohol-based hand rub is readily available at all patient care points, dispensers are filled and functional, and staff confirm regular, uninterrupted supply. Staff demonstrate awareness of its importance and usage.

 1 Mark: Alcohol-based hand rub is mostly available with occasional short periods of shortage; dispensers are generally functional, and staff report some delays in supply but overall availability.

 0 Marks: Alcohol-based hand rub is frequently unavailable or dispensers are often empty/non-functional; staff report irregular or no supply, indicating poor implementation of hand hygiene support.

Reference : NA

D1.5	**Staff is aware of when to hand wash**

Interpretation

Interpretation of the Checkpoint:
This checkpoint evaluates whether staff members can identify specific situations that require handwashing to prevent healthcare-associated infections. It is not only about performing hand hygiene but understanding the critical moments when it must be done. Awareness indicates that the staff recognizes the essential role of hand hygiene in patient safety and infection control, which directly impacts quality of care and reduces cross-contamination.

Means of verification : **OB / SI**

 Observation (OB):

- Observe staff performing hand hygiene at critical moments during patient care.
- Check for presence and visibility of hand hygiene posters around the workplace.

- Observe availability and accessibility of handwashing facilities and hand sanitizers.

 Staff Interview (SI):

- Ask staff to list situations when handwashing is mandatory.
- Enquire about their knowledge of the “5 Moments of Hand Washing.”
- Question staff on the importance of hand hygiene in infection prevention.
- Ask about any challenges they face in performing hand hygiene consistently.

Implementation plan :
Implementation Plan:
To ensure compliance with the checkpoint D1.5, training sessions will be conducted for all healthcare staff emphasizing the importance of hand hygiene. Staff will be educated about the "5 Moments of Hand Washing" — before touching a patient, before aseptic procedures, after body fluid exposure risk, after touching a patient, and after touching patient surroundings. Regular reminders through posters and visual aids will be displayed near handwashing stations. Supervisors will monitor compliance and provide immediate feedback. Refresher training will be scheduled quarterly to maintain awareness.
Scoring Criteria :

 2 Marks: Staff correctly identifies all 5 moments of handwashing and explains the importance of hand hygiene clearly. Demonstrates strong understanding without hesitation.

 1 Mark: Staff identifies 3 to 4 moments correctly and shows basic understanding of hand hygiene importance but misses some details.

 0 Mark: Staff cannot correctly identify key moments of handwashing or shows lack of awareness regarding when hand hygiene is necessary.

Reference : NA

D2	Personal Protective Equipment (PPE)

D2.1	Use of Gloves during procedures and examination

Interpretation
This checkpoint assesses whether gloves are used consistently and correctly by healthcare personnel during patient examinations and procedures that pose a risk of contamination or infection transmission. The use of gloves acts as a barrier to protect both the patient and healthcare worker from cross-infection. Failure to use gloves appropriately indicates a lapse in infection control practices and can increase the risk of healthcare-associated infections. Therefore, this checkpoint measures adherence to essential infection prevention protocols critical for maintaining patient safety and quality of care.
Means of verification : **OB / SI**

Observation

- Observe if staff wear gloves during all examinations and procedures that require contact with bodily fluids or mucous membranes.
- Check whether gloves are changed between patients.
- Verify proper disposal of used gloves immediately after the procedure.
- Observe if gloves are put on before starting the procedure and removed right after completion.
- Confirm the availability and accessibility of gloves at the point of care.

Staff Interview

- Ask staff when and why they use gloves during procedures and examinations.
- Enquire about their knowledge of glove use protocols and infection control guidelines.
- Ask what steps they take if gloves become torn or contaminated during a procedure.
- Check if staff understand the importance of hand hygiene before and after glove use.
- Confirm awareness of the facility's policies on glove use and disposal.

Implementation plan :
To ensure proper use of gloves during procedures and examinations, all healthcare staff must be trained on the importance of glove use in infection prevention. Clear guidelines should be established, communicated, and displayed at points of care outlining when gloves must be worn. Adequate stock and easy accessibility of gloves must be maintained throughout the facility. Supervisors should conduct regular direct observations and staff interviews to monitor compliance. Any non-compliance should be addressed immediately through feedback and retraining. Additionally, staff should be educated about correct glove donning and removal techniques, proper disposal methods, and hand hygiene before and after glove use to maintain patient and staff safety.
Scoring Criteria :

 2 Marks: Staff consistently use gloves during all applicable procedures and examinations, change gloves appropriately between patients, and demonstrate clear knowledge of glove use protocols.

 1 Mark: Staff usually use gloves but occasional lapses are observed or reported, or some gaps exist in knowledge or practice regarding glove use.

 0 Marks: Staff do not use gloves consistently during procedures and examinations, or there is poor understanding of glove use requirements and protocols.

Reference : NA

D2.2	Use of Masks and Head cap

Interpretation

This checkpoint emphasizes the importance of infection prevention by ensuring that all staff wear masks and head caps while delivering patient care or conducting procedures. This is particularly relevant in areas where sterility and hygiene are critical. The requirement aims to reduce the risk of cross-contamination and protect both healthcare providers and patients from infections. Compliance with this standard is a visible indicator of the facility's commitment to maintaining a hygienic environment.

Means of verification : **OB / SI**

Observation (OB):

- Observe if clinical and support staff are wearing face masks and head caps correctly in patient care areas.
- Check for visible signboards or instructions regarding the mandatory use of personal protective equipment (PPE) in these areas.
- Observe whether the PPE used is clean, intact, and appropriately worn (e.g., mask covers nose and mouth, head cap fully covers hair).

Staff Interview (SI):

- Ask staff to explain why using masks and head caps is necessary during patient care and procedures.
- Enquire whether staff have received any formal training or orientation on PPE usage.
- Ask how often they change or dispose of the mask/head cap and who monitors compliance in their department.

Implementation plan :

To implement the standard D2.2, all staff involved in patient care and procedures shall be instructed and trained to use face masks and head caps appropriately. The healthcare facility must identify all procedure and patient care areas, and ensure that a sufficient supply of disposable or reusable masks and head caps is available. Display signage in relevant areas reminding staff to use protective gear. Supervisory staff must be assigned to monitor compliance regularly and reinforce adherence. Training programs and refresher courses should be conducted periodically to ensure staff understand the rationale and importance of this practice in infection control.

Scoring Criteria :

2 Marks: All staff consistently use masks and head caps correctly in designated patient care and procedure areas. Staff are aware of the rationale and demonstrate good understanding and compliance.

1 Mark: Most staff use masks and head caps, but a few instances of non-compliance or improper usage are noted. Staff awareness is partial or inconsistent.

0 Mark: Masks and head caps are not used by staff in patient care or procedure areas. Staff are

unaware of the need for or rationale behind their use.

Reference : NA

D2.3	Use of Heavy Duty Gloves and gumboot by waste handlers

Interpretation

This checkpoint ensures that the health and safety of waste handlers and housekeeping staff are protected by enforcing the use of appropriate PPE — specifically heavy duty gloves and gumboots. These items provide necessary protection against exposure to infectious waste, hazardous substances, and physical injury. The checkpoint reflects the organization's commitment to occupational safety and infection control, and helps in reducing workplace-related health risks among support staff.

Means of verification : **OB / SI**

Observation (OB):

- Observe whether the waste handlers and housekeeping staff are wearing heavy duty gloves and gumboots while performing waste handling or cleaning duties.
- Check the physical condition of the gloves and gumboots being used — they should be intact, clean, and appropriate for use.
- Look for visible signage in waste collection areas reminding staff to wear PPE.

Staff Interview (SI):

- Ask the housekeeping and waste management staff if they have received training on the use and importance of gloves and gumboots.
- Enquire about the process they follow when PPE is damaged or worn out — do they know how to request replacements?
- Ask if they face any challenges in using the PPE or if they feel it protects them during waste handling.

Implementation plan :

To implement this standard, the healthcare facility must ensure that all housekeeping staff and waste handlers are provided with heavy duty gloves and gumboots as part of their personal protective equipment (PPE). A policy must be established mandating the use of these items during waste handling activities, particularly while managing biomedical waste, cleaning contaminated areas, or working in wet or potentially hazardous environments. Adequate stock and proper sizing should be maintained, and the PPE must be cleaned or replaced regularly. Training programs should be conducted to educate staff about the health hazards of non-compliance and the correct usage of protective gear. Supervisory checks and audits should be carried out to monitor adherence.

Scoring Criteria :

2 Marks: All waste handlers and housekeeping staff consistently use heavy duty gloves and gumboots while performing relevant duties, and demonstrate clear awareness of their importance.

1 Mark: Most staff use gloves and gumboots, but occasional lapses are noted. Some staff show

partial awareness or incorrect usage.

0 Mark: Staff are not using heavy duty gloves and/or gumboots while handling waste. No understanding or training on PPE usage is evident.

Reference : NA

D2.4	Use of aprons/ Lab coat by the clinical staff

Interpretation

This checkpoint is intended to verify whether clinical staff are complying with the dress code standards appropriate to their roles within the healthcare setting. It reflects the hospital's commitment to maintaining hygiene, infection control, and safety for patients and staff alike. The consistent use of protective attire is a basic yet essential component of professional healthcare delivery. Non-compliance can indicate gaps in awareness, enforcement, or organizational discipline. Evaluators will look for visible use of appropriate attire and verify staff understanding of its purpose and importance.

Means of verification: **OB / SI**

Observation (OB):

- Observe if doctors are wearing aprons during patient consultation or clinical duties.
- Observe nurses in their clinical areas for use of aprons or designated uniforms.
- Check whether lab technicians are wearing lab coats in laboratory sections.
- In operation theatres, observe the usage of sterile gowns, caps, masks, and other protective gear.
- Ensure that all attire is clean, well-maintained, and suitable for the work environment.

Staff Interview (SI):

- Ask staff if they know which protective clothing is required for their role.
- Enquire whether they understand why protective attire is necessary.
- Ask if they have received training or instructions regarding the use of aprons, lab coats, or gowns.
- Verify whether there are any challenges in accessing or maintaining these garments.

Implementation plan :

To implement this standard effectively, the healthcare facility must establish a clear policy mandating the use of appropriate protective attire for all clinical staff. This includes aprons for doctors and nurses, lab coats for laboratory personnel, and sterile gowns for OT staff. The policy should specify when and where each type of attire is to be worn. The hospital should ensure availability of these garments in sufficient numbers and sizes. Training sessions and regular briefings should be conducted to orient staff on the importance of wearing protective attire for infection control and professionalism. Monitoring mechanisms, such as supervisory checks and peer accountability, should be introduced to ensure adherence to the dress code policy.

Scoring Criteria :

2 Marks:

All relevant clinical staff consistently wear clean and appropriate protective attire as per their roles. They are fully aware of the policy and understand its importance in infection control and professional conduct.

1 Mark:
Protective attire is worn by most clinical staff, but minor lapses are observed. Staff show partial understanding or awareness of the policy, and compliance may vary slightly across departments.

0 Mark:
Significant non-compliance with protective attire usage is observed. Staff are either unaware of the policy or do not follow it regularly. There is no system for monitoring or enforcement in place.

Reference : NA

D2.5	**Adequate supply of Personal Protective Equipment (PPE)**

Interpretation

This checkpoint emphasizes that PPE must be readily available and adequately stocked to ensure the safety of staff and patients. The assessor is expected to verify both physical availability and staff awareness. It does not suffice to have PPE available at one point in time; there should be no records of frequent stock-outs. Staff members should confidently confirm the regular availability of PPE and its appropriate use. Records such as purchase logs, stock registers, and issue registers provide documentary evidence.

Means of verification : **OB / SI**

- **Observation:**
  - Observe the storage areas (store room, procedure rooms, dressing room) to check if different PPE items are physically available.
  - Check if PPEs are accessible to the staff at the point of care.
  - Look for any posters or charts that indicate appropriate PPE usage.
- **Staff Interview:**
  - Ask staff if PPE is regularly available when needed, especially during patient care or dressing procedures.
  - Enquire if there have been any incidents of PPE unavailability or stock-outs in the recent past.
  - Ask staff whether they have received any instructions or training regarding PPE use.

Implementation plan :
To implement this checkpoint, the facility must ensure a systematic and consistent supply of personal protective equipment (PPE) such as gloves, masks, aprons, gowns, face shields, etc., depending on the services rendered and the infection control risks. The procurement department should maintain a stock register and minimum stock levels for each type of PPE. Periodic inventory reviews should be scheduled to avoid stock-outs. All staff should be sensitized on the

types and correct usage of PPE based on their roles. PPE usage guidelines must be available and displayed in key areas like consultation rooms, dressing rooms, and procedure areas.
Scoring Criteria :

 2 Marks: PPE is available in adequate quantity without any recent history of stock-outs. Staff confirms consistent availability and correct usage practices. Records are complete and up to date.

 1 Mark: PPE is mostly available but there have been occasional short-term shortages. Staff report general satisfaction with availability. Records may show minor gaps or delays in replenishment.

 0 Mark: PPE is often unavailable or insufficient in quantity. Staff report frequent stock-outs or have to manage without PPE at times. Records show poor inventory management or significant stock-out periods.

Reference : NA

D3	**Personal Protective Practices**
D3.1	**The staff is aware of use of gloves, when to use (occasion) and its type**

Interpretation
This checkpoint evaluates whether staff members are knowledgeable about glove use, specifically understanding when gloves are necessary, when they are not, and the difference between clean and sterile gloves. Staff should be able to articulate scenarios requiring glove use (e.g., during patient contact with non-intact skin or bodily fluids) and differentiate between clean gloves (used for standard contact precautions) and sterile gloves (used for invasive procedures). The objective is not only compliance with glove use but also rational and appropriate use to prevent misuse and cross-contamination.
Means of verification : **OB / SI**

 Observation (OB):

- Observe if staff wear gloves during appropriate clinical tasks such as wound dressing, handling body fluids, or invasive procedures.
- Check if sterile gloves are used when required, especially in procedures involving sterile fields.
- Notice if gloves are changed between patients and tasks and if hand hygiene is performed after glove removal.

 Staff Interview (SI):

- Ask staff to explain when gloves are necessary and when they are not needed.
- Enquire about the difference between clean and sterile gloves.
- Ask for examples of procedures where sterile gloves are mandatory and others where clean gloves suffice.
- Clarify whether they understand the risks of overuse or misuse of gloves.

Implementation plan :
To ensure that staff are fully aware of glove usage, the hospital shall conduct structured training sessions during induction and at regular intervals thereafter. The training should cover the types of gloves (clean and sterile), their purpose, and appropriate occasions for use, including donning and doffing techniques. Posters and visual aids will be displayed in clinical areas to reinforce key messages. Supervisors will demonstrate proper glove use during rounds and provide real-time feedback to staff. Periodic audits and staff interviews will be used to assess compliance and understanding. Emphasis will be placed on rational glove use to prevent overuse and ensure patient safety.
Scoring Criteria :

 2 Marks:
The staff correctly explains when gloves are needed and when they are not. They clearly distinguish between clean and sterile gloves and provide appropriate examples. Observed practices fully comply with the standard.

 1 Mark:
The staff demonstrates partial knowledge—knows when to use gloves but has limited understanding of the type of gloves or gives incomplete examples. Observed practices show minor deviations from expected standards.

 0 Mark:
The staff is unaware or provides incorrect information about glove usage or glove types. Observed practices show non-compliance or misuse of gloves.

Reference : NA

D3.2	Correct method of wearing and removing gloves

Interpretation
The checkpoint emphasizes that staff must not only know but also **demonstrate** the correct technique for wearing (donning) and removing (doffing) gloves to prevent cross-contamination and maintain infection control. The correct method includes hand hygiene before and after glove use, ensuring the gloves fit properly, and removing them in a manner that avoids contact with the contaminated exterior surface.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether the staff washes or sanitizes their hands before donning gloves.
- Check if gloves are worn covering the wrist properly without contamination.
- Observe if the staff avoids touching non-sterile surfaces with gloved hands.
- During glove removal, observe whether the staff peels the glove from the wrist and folds it inside-out, avoiding contact with skin.
- After glove removal, confirm if hand hygiene is performed immediately.

Staff Interview (SI):

- Ask the staff to explain when gloves should be used in a clinical setting.

- Inquire if they know the steps to properly wear and remove gloves.
- Ask about the importance of hand hygiene before and after glove use.
- Verify if the staff can explain situations where glove usage is mandatory and when it is inappropriate.

Implementation plan :
To ensure compliance with standard D3.2, all clinical and support staff involved in patient care or handling potentially contaminated materials must be trained in the correct method of donning and doffing gloves. This training should be conducted during induction and periodically thereafter. Visual job aids such as posters or videos should be displayed in appropriate areas (e.g., treatment rooms, procedure areas). Supervisors must regularly monitor staff during routine duties and provide corrective feedback as needed. Competency assessments should be documented and updated periodically to ensure ongoing adherence to proper glove usage protocols.
Scoring Criteria :

2 Marks: The staff **demonstrates all steps correctly** in wearing and removing gloves, including hand hygiene before and after, and follows aseptic technique. They also **confidently answer all interview questions correctly**.

1 Mark: The staff **misses one or two steps** in demonstration (e.g., hand hygiene not done) or is **partially correct in responses** during the interview.

0 Mark: The staff **fails to demonstrate the correct technique**, or **provides incorrect or no response** when asked about the correct procedure.

Reference : NA

D3.3	Correct Method of wearing mask and cap

Interpretation
This checkpoint evaluates whether healthcare staff correctly wear masks and caps as per infection prevention guidelines. It assesses both knowledge and practice—whether the staff understand and follow the correct procedure consistently. This includes proper coverage, correct handling of protective items, and timely replacement when required. The objective is to reduce the risk of infection transmission within the healthcare setting by ensuring compliance with basic protective measures.
Means of verification : **OB / SI**

 Observation (OB):

- Observe if the mask covers both nose and mouth snugly without gaps.
- Check if the cap fully covers the hair, including the sides and back.
- Ensure the staff use ear loops or ties to wear/remove the mask without touching the mask surface.
- Observe whether staff change masks when wet, soiled, or after a certain period.

 Staff Interview (SI):

- Ask the staff to describe the steps for properly wearing a mask and cap.

- Enquire how often they change masks and under what circumstances.
- Check if they understand why correct usage is important for infection control.
- Verify if the staff have received formal training on this topic.

Implementation plan :
To ensure adherence to infection control protocols, a structured implementation plan must be followed. All healthcare staff should undergo training sessions on the correct method of wearing masks and caps, with demonstrations during orientation and periodic refresher courses. Visual aids such as posters and infographics must be displayed in strategic locations like changing rooms, nursing stations, and near entry points to clinical areas. Infection control nurses or designated quality personnel should conduct regular audits and on-the-spot corrections. Supervisors should reinforce the correct practices during routine rounds and briefings.
Scoring Criteria :

 2 Marks:

- All staff observed wear the mask and cap correctly, and confidently explain the correct method and rationale for use.

 1 Mark:

- Majority of staff follow the correct method, with minor deviations or gaps in explanation.

 0 Mark:

- Several staff either wear the mask/cap incorrectly or lack understanding of proper usage and purpose.

Reference : NA

D3.4	No re-use of disposable personal protective equipment

Interpretation
This checkpoint emphasizes that disposable PPE, such as gloves and masks intended for single-use, should **not** be reused under any circumstance. If reusable PPE items such as certain masks or gloves are used, it must be ensured that they undergo adequate cleaning, disinfection, or sterilization as per infection control protocols. The intent is to reduce the risk of cross-contamination and maintain patient and staff safety. The checkpoint applies to all clinical and non-clinical staff who may use PPE in the course of patient care or facility operations.
Means of verification : **OB / SI**

 Observation (OB):

- Observe whether used disposable gloves and masks are being discarded immediately after a single use.

- Check bins and PPE stations to see if there are any signs of re-used disposable PPE.
- Verify if reusable PPE, if used, is being collected and sent for sterilization through proper channels.
- Observe staff during procedures to ensure they don't use the same gloves or mask between patients.

 Staff Interview (SI):

- Ask staff to explain the difference between disposable and reusable PPE.
- Enquire if they have received training on PPE use and infection control practices.
- Ask how and where they discard used PPE.
- Verify their knowledge of protocols for reusable PPE, if applicable.

Implementation plan :
To ensure compliance with the standard D3.4, the healthcare facility must develop a policy that clearly prohibits the re-use of disposable personal protective equipment (PPE) such as gloves and masks. The policy should outline the distinction between disposable and reusable PPE and the protocols for the safe handling and disposal of used items. All staff must be trained on this policy during induction and through periodic refresher sessions. Waste bins should be made available at all patient care points for immediate disposal. Clear signage must be displayed in critical areas like OPD, IPD, treatment rooms, and laboratories to reinforce the one-time use of disposable PPE. Supervisory staff must be instructed to regularly monitor compliance through direct observation and periodic audits.
Scoring Criteria :

 2 Marks: The facility has a clear policy in place, and all staff adhere to the practice of not re-using disposable PPE. There is no evidence of non-compliance during observations or interviews. Reusable PPE, if used, is sterilized adequately before re-use.

 1 Mark: The policy exists and is partially implemented. Occasional lapses are noticed in observation or staff interviews indicate partial awareness or non-uniform compliance.

 0 Mark: No policy exists or it is not implemented. There is frequent or evident re-use of disposable PPE, and staff are unaware or negligent regarding the correct protocol.

Reference : NA

D3.5	The Staff is aware of Standard Precautions

Interpretation
This checkpoint assesses whether clinical and support staff are knowledgeable about Standard Precautions, which are essential practices to prevent transmission of infections in healthcare settings. The staff should be able to correctly identify and explain key elements such as hand hygiene, use of personal protective equipment (PPE), respiratory hygiene, safe injection practices, and handling of potentially contaminated equipment or surfaces. This indicator checks awareness rather than actual practice.
Means of verification : **OB / SI**

 Observation (OB):

- Observe if posters or job aids depicting Standard Precautions are displayed in staff areas.
- Observe if staff correctly demonstrate or mention practices like hand hygiene or use of PPE during patient care.
- Look for availability and accessibility of hand sanitizers, gloves, masks, and sharps disposal containers.

 Staff Interview (SI):

Ask the staff to list five Standard Precautions they are aware of.

- Enquire when they last received training on infection control or Standard Precautions.
- Ask staff how they ensure protection against infection in routine procedures.

Implementation plan :
To implement this checkpoint, all staff members involved in patient care should be educated and trained on Standard Precautions as part of their induction and ongoing infection control training. Posters or visual aids should be displayed in clinical areas to reinforce awareness. Periodic refresher sessions must be conducted, and infection control policies should be readily available to staff for reference. The hospital should ensure that appropriate protective equipment and hygiene resources are consistently provided to support adherence to Standard Precautions.
Scoring Criteria :

- **2 Marks:** Staff confidently and correctly explain at least five Standard Precautions and demonstrate clear understanding of each.
- **1 Mark:** Staff are aware of only some (less than five) Standard Precautions or are able to recall them with partial correctness or hesitation.
- **0 Mark:** Staff are not aware of or are unable to explain Standard Precautions.

Reference : NA

D4	**Decontamination and Cleaning of Instruments**
D4.1	**Staff knows how to make Chlorine solution**

Interpretation
This checkpoint verifies whether the staff is adequately trained and knowledgeable in preparing disinfectant solutions. The focus is on their ability to explain and, if needed, demonstrate the correct method for preparing a **1% chlorine solution** using both **bleaching powder** and **sodium hypochlorite solution**. This is a critical component of infection prevention and control, particularly for managing spills and high-risk contamination.
Means of verification : **OB / SI**

 Observation (OB):

- Observe whether the staff is preparing the chlorine solution correctly.
- Check if the required measuring equipment (like measuring cups, spoons, weighing scale) is available and used correctly.
- Verify whether the preparation area has a displayed SOP or instruction chart for chlorine solution preparation.

 Staff Interview (SI):

- Ask the staff to explain the procedure for preparing a 1% chlorine solution from bleaching powder (e.g., required grams per liter of water).
- Ask how to prepare a 1% chlorine solution from a 5% sodium hypochlorite stock solution (e.g., dilution ratio).
- Inquire about how long the prepared solution remains effective and how it should be stored.

Implementation plan :
To ensure effective disinfection practices, the healthcare facility must train all relevant staff, especially housekeeping and nursing personnel, on the preparation of chlorine solutions using both bleaching powder and sodium hypochlorite. Practical demonstration sessions should be conducted regularly, and posters or job aids outlining the preparation steps should be displayed in cleaning areas. The infection control nurse or quality manager should periodically validate staff knowledge and practice through random interviews and observation during cleaning procedures.
Scoring Criteria :

 2 Marks:
Staff can clearly explain and/or demonstrate how to prepare a 1% chlorine solution from both bleaching powder and sodium hypochlorite with correct quantities and methods. Staff is aware of storage, shelf-life, and safety precautions.

 1 Mark:
Staff can explain the preparation method for either bleaching powder or hypochlorite solution correctly but is unsure about the other. Minor errors or confusion are noted, but basic understanding is present.

 0 Mark:
Staff is unable to explain or demonstrate the correct preparation method for either bleaching powder or sodium hypochlorite. Lack of awareness or incorrect practices are observed.

Reference : NA

D4.2	**Decontamination of operating and Surface examination table, dressing tables etc. after every procedures**

Interpretation
This checkpoint evaluates whether the operating surfaces and related tables are properly cleaned after every patient procedure, ensuring a safe and hygienic environment. It is important that the cleaning process uses effective disinfectants and is carried out consistently and immediately after use to prevent cross-contamination and infection risks. The staff should be aware of both the frequency and the specific cleaning methods applied. This ensures compliance with infection control standards and patient safety norms.
Means of verification : **OB / SI**

Observation (OB):

- Observe the cleaning of operating tables, surface examination tables, and dressing tables immediately after each procedure.
- Check whether the surfaces appear visibly clean and free from contamination.
- Verify the presence and use of disinfectants such as chlorine solution or carbolic acid near the cleaning area.
- Look for any cleaning equipment or materials used by staff after procedures.
- Review any cleaning logs or records if maintained and accessible during the observation.

Staff Interview (SI):

- Ask staff when the operating and surface examination tables are cleaned (expected: after every procedure).
- Enquire about the cleaning agents used (should include chlorine solution or disinfectant like carbolic acid).
- Ask how the cleaning is performed (the method or procedure followed).
- Confirm if the staff are trained and aware of the importance of cleaning after every procedure.
- Ask if there are any records or checklists maintained for cleaning activities and who is responsible for updating them.

Implementation plan :
To ensure proper decontamination of operating tables, surface examination tables, dressing tables, and other related surfaces after every procedure, a standard protocol will be established and followed by all staff involved in the clinical and surgical areas. The cleaning agents to be used, such as chlorine solution or disinfectants like carbolic acid, will be clearly specified and readily available at the point of use. Training sessions will be conducted to educate the staff on the correct timing and method of cleaning these surfaces immediately after each procedure. Regular supervision and monitoring will be put in place to ensure adherence to the decontamination protocol. A checklist or logbook may be maintained for documentation purposes.
Scoring Criteria :

- **2 Marks:** Operating and surface examination tables, dressing tables, etc., are consistently cleaned after every procedure using the appropriate disinfectant (chlorine solution or carbolic acid). Staff demonstrate clear knowledge and adherence to the cleaning protocol, and cleaning logs are maintained.
- **1 Mark:** Cleaning is done most of the time but inconsistently after every procedure; disinfectants are available but occasionally not used correctly; staff have partial

knowledge of the procedure.

- **0 Marks:** Cleaning is rarely or never performed after procedures; disinfectants are unavailable or not used; staff are unaware of cleaning requirements; no records are maintained.

Reference : NA

D4.3	**Decontamination of instruments after use**

Interpretation

This checkpoint assesses whether the facility follows the prescribed method for effective instrument decontamination to minimize infection risks. Proper decontamination using a 0.5% chlorine solution for at least 10 minutes ensures that infectious agents on instruments are neutralized. Failure to comply with this procedure could lead to cross-contamination and infection transmission. Therefore, this checkpoint confirms both the presence of the process and the staff's adherence to critical infection control practices, contributing directly to patient safety and quality assurance.

Means of verification : **OB / SI**

Observation

- Observe whether instruments are immersed in a 0.5% chlorine solution immediately after use.
- Check if the chlorine solution is prepared at the correct concentration (0.5%).
- Verify that instruments remain submerged in the solution for at least 10 minutes without interruption.
- Inspect the decontamination area for availability of required materials and proper maintenance.
- Observe the condition of instruments before and after the decontamination process to assess thoroughness.

Staff Interview

- Enquire whether staff are aware of the procedure for decontaminating instruments after use.
- Ask how the 0.5% chlorine solution is prepared and how they ensure the concentration is accurate.
- Question how staff monitor the timing to ensure instruments stay in the solution for the full 10 minutes.
- Discuss any challenges faced in implementing the decontamination procedure consistently.
- Confirm if staff have received training on the importance and methods of instrument decontamination.

Implementation plan :

Ensure that every reusable instrument used in patient care is immediately subjected to

decontamination after use. This involves immersing the instruments in a freshly prepared 0.5% chlorine solution for a minimum of 10 minutes. Train the staff responsible for handling instruments on the correct preparation of the chlorine solution, the importance of maintaining the right concentration, and adhering strictly to the minimum exposure time. Establish a standard operating procedure (SOP) and monitoring mechanism to routinely check compliance with this process. Make sure that the necessary materials for decontamination are always available and that the area for decontamination is properly maintained to support consistent implementation.

Scoring Criteria :

 Award 2 marks if all instruments are consistently decontaminated using 0.5% chlorine solution for at least 10 minutes, and staff demonstrate clear understanding and adherence to the procedure.

 Award 1 mark if decontamination is done but with occasional lapses in timing, concentration, or staff knowledge is limited but instruments are generally safe.

 Award 0 marks if instruments are not decontaminated properly or if the chlorine solution is not used at the correct concentration or time, indicating poor compliance and potential risk.

Reference : NA

D4.4	**Cleaning of instruments done after decontamination**

Interpretation

This checkpoint ensures that instruments are not only decontaminated but also physically cleaned to remove all residual contaminants before sterilization. Proper cleaning with water and soap is essential to prevent sterilization failures and reduce the risk of infection transmission. It reflects the facility's commitment to high standards of patient safety and infection control. The checkpoint evaluates both the effectiveness of the cleaning process and the staff's understanding and consistency in performing this critical task.

Means of verification : **OB / SI**

Observation

- Observe whether instruments are visibly clean after the decontamination process.
- Check if cleaning is done thoroughly using water and soap, not just rinsing.
- Confirm that all parts of the instruments are cleaned properly.
- Look for cleaning supplies and materials being used appropriately.
- Verify if cleaning logs or checklists are maintained and filled out correctly.

Staff Interview

- Ask staff to explain the steps they follow for cleaning instruments after decontamination.
- Inquire about their understanding of why thorough cleaning is important before sterilization.
- Check if they are aware of the protocols or SOPs related to instrument cleaning.
- Ask how often their cleaning practices are monitored or supervised.
- Verify if they have received training on cleaning instruments and infection control

measures.

Implementation plan :
The cleaning of instruments after decontamination should be systematically integrated into the infection control workflow. Staff must be trained and regularly reminded to clean all instruments thoroughly using water and soap immediately after decontamination and before sterilization. Standard operating procedures (SOPs) must be established and accessible, detailing the cleaning steps, appropriate materials, and responsibilities. Regular supervision through direct observation and periodic staff interviews should be conducted to ensure adherence. Maintenance of cleaning logs or checklists will help monitor compliance and identify any deviations promptly for corrective action.
Scoring Criteria :

 2 Marks: Instruments are consistently and thoroughly cleaned with water and soap after decontamination, and staff demonstrate clear knowledge of the process with proper documentation maintained.

 1 Mark: Instruments are generally cleaned after decontamination, but occasional lapses in thoroughness or staff understanding are observed; documentation may be incomplete.

 0 Mark: Instruments are not cleaned properly after decontamination; staff show poor knowledge of the procedure, and no documentation or monitoring is in place.

Reference : NA

D4.5	Adequate Contact Time for decontamination

Interpretation
The interpretation of this checkpoint involves confirming that instruments are exposed to the disinfectant or cleaning agent for the full required time (minimum 10 minutes) to ensure effective decontamination. Adequate contact time helps in preventing infection transmission and maintaining patient safety. Failure to meet this criterion can compromise instrument sterility and increase the risk of healthcare-associated infections.
Means of verification : **OB / SI**

Observation

- Observe the instrument decontamination area to see if instruments remain immersed in the disinfectant or cleaning solution for at least 10 minutes.
- Check if staff use timers, clocks, or any time-tracking devices to monitor the contact time during the decontamination process.
- Look for visible SOPs or instructions displayed near the decontamination area regarding the required contact time.
- Verify if supervisors or quality team members conduct regular checks to ensure the contact time is adhered to and documented.

Means of Verification: Staff Interview

- Ask staff how long instruments are kept in the disinfectant during the decontamination process.
- Enquire if staff are aware of the required contact time of 10 minutes for effective decontamination.
- Question staff about the procedure they follow to ensure instruments meet the contact time standard.
- Confirm whether staff have received training or instructions regarding the importance of contact time in preventing infections.
- Ask if there is any regular monitoring or supervision of this activity.

Implementation plan :
To implement this checkpoint, healthcare staff must be trained and made aware of the required contact time for decontamination of instruments, which is 10 minutes. Clear Standard Operating Procedures (SOPs) should be established and displayed in the instrument decontamination area. Supervisors must monitor the decontamination process regularly to ensure compliance with the contact time. Adequate resources, such as timers or clocks, should be provided to staff to help them adhere to the timing. Periodic refresher training and audits can reinforce the importance of this standard and maintain quality assurance in instrument reprocessing.
Scoring Criteria :

- **2 Marks:** Staff consistently adhere to the 10-minute contact time for instrument decontamination as confirmed by both observation and staff interviews. Proper monitoring and documentation are maintained.
- **1 Mark:** Staff sometimes adhere to the 10-minute contact time, but there may be occasional lapses or lack of consistent monitoring and documentation.
- **0 Marks:** Staff do not follow the required contact time or there is no evidence of adherence, monitoring, or understanding of the contact time requirement.

Reference : NA

D5	Disinfection & Sterilization of Instruments

D5.1	Adherence to Protocols for autoclaving

Interpretation
Interpretation of this checkpoint focuses on confirming that the autoclaving process is performed consistently according to the standard recommended conditions: 121°C, 15 pounds per square inch pressure for 20 minutes for instruments (30 minutes if wrapped), and 30 minutes for linen. Staff must be aware of these parameters and able to explain them accurately. Any deviation from these conditions may risk ineffective sterilization, potentially compromising patient safety and infection control.

Means of verification : **OB / SI**

What is to be observed (OB):

- The autoclave machine's settings during operation (temperature, pressure, and duration)
- Documentation or logbooks recording each autoclaving cycle
- Physical condition and maintenance status of the autoclave
- Handling and packaging of instruments and linen before autoclaving

What is to be enquired during staff interview (SI):

- Staff awareness of the correct autoclaving temperature, pressure, and duration
- Understanding of differences in autoclaving time between wrapped and unwrapped instruments
- Knowledge of sterilization protocols specific to instruments and linen
- Steps taken when autoclave parameters fall outside recommended ranges
- Training frequency and access to protocol guidelines

Implementation plan :
The implementation plan for ensuring adherence to protocols for autoclaving involves systematic monitoring and staff training. First, all personnel responsible for sterilization must be trained and periodically refreshed on the recommended autoclaving parameters, including temperature, pressure, and duration for different items such as instruments and linen. The sterilization process must be standardized with clear written protocols accessible near the autoclave units. Regular checks should be conducted to verify the calibration and proper functioning of autoclave machines. Additionally, documentation of each autoclaving cycle should be maintained to ensure traceability and accountability.
Scoring Criteria :

 2 Marks: Staff demonstrate clear and accurate knowledge of recommended autoclaving parameters (121°C, 15 psi, 20 minutes for instruments, 30 minutes if wrapped, and 30 minutes for linen). Observation confirms autoclave machine settings and records fully comply with protocols.

 1 Mark: Staff show partial knowledge of autoclaving parameters or there is minor inconsistency in documentation or observations of autoclave settings, but overall the process is mostly followed.

 0 Marks: Staff are unaware or provide incorrect information regarding autoclaving parameters. Observations reveal non-compliance with recommended temperature, pressure, or duration protocols, and documentation is missing or inadequate.

Reference : NA

D5.2	Adherence to Protocol for High Level disinfection

Interpretation
The checkpoint interpretation focuses on whether the staff correctly follows the established disinfection protocols consistently and effectively. If the high-level disinfection process is

performed accurately using the recommended agents and methods, it indicates compliance with infection control norms. Any deviation or incomplete adherence can pose risks for cross-contamination and requires immediate corrective action.
Means of verification : **OB / SI**

Observation:

- Observe the process of high-level disinfection being performed on instruments.
- Check if boiling or chlorine solution is used as the disinfecting agent.
- Verify the correct time duration and concentration of the disinfectant during the procedure.
- Confirm the use of appropriate equipment and safety measures while performing disinfection.

Staff Interview:

- Ask staff to explain the steps they follow for high-level disinfection.
- Enquire if staff are aware of the correct protocol including the type of disinfectant, concentration, and duration.
- Check if staff understand the importance of following the protocol strictly.
- Discuss whether there is a schedule or checklist for high-level disinfection.
- Identify any challenges staff face in implementing the protocol.
- Confirm if staff have received training related to high-level disinfection procedures.

Implementation plan :
To ensure adherence to the protocol for high-level disinfection, the process involves direct observation and staff interviews at the healthcare facility. The responsible team will monitor the actual practice of disinfecting critical equipment and instruments using the prescribed methods such as boiling or chlorine solutions. Staff will be interviewed to verify their knowledge and routine compliance with the disinfection protocols. This dual approach helps identify gaps between documented procedures and actual practice, ensuring patient safety and infection control standards are maintained.
Scoring Criteria :

 2 Marks: The staff consistently follow the high-level disinfection protocol correctly using boiling or chlorine solutions, demonstrated by observation and confirmed by staff interviews, including correct concentration, timing, and method.

 1 Mark: The staff mostly follow the protocol, but there are minor lapses such as inconsistent timing or partial understanding in interviews, though overall the disinfection process is mostly adequate.

 0 Marks: The protocol for high-level disinfection is not followed, either observed or confirmed through staff interviews, with incorrect or missing use of boiling/chlorine solutions or significant knowledge gaps.

Reference : NA

D5.3	Use of Signal Locks for sterilization

Interpretation
This checkpoint verifies that the sterilization process is reliable and safe by confirming the use of signal locks as an objective measure. The presence and correct use of these indicators in autoclaving cycles ensure that instruments and materials have undergone proper sterilization, thus preventing infection risks. The checkpoint helps in assessing adherence to sterilization protocols and the reliability of documentation maintained by the staff.
Means of verification : **OB / SI**

Observation:

- Observe the autoclave during sterilization cycles to confirm the use of chemical or biological signal locks.
- Check autoclaving records to ensure signal locks are documented for every sterilization batch.
- Verify if corrective actions are recorded when signal locks indicate sterilization failure.
- Inspect the completeness and consistency of sterilization logs concerning signal locks.

Staff Interview:

- Ask staff to explain the process of using signal locks during sterilization.
- Enquire about their understanding of how to interpret the results of signal locks.
- Question how staff respond when signal locks indicate sterilization failure.
- Confirm whether staff are aware of the importance of documenting signal lock results in the autoclaving records.

Implementation plan :
To ensure effective sterilization processes, the facility must implement the use of signal locks (chemical or biological indicators) during autoclaving cycles. This requires staff training on proper placement and interpretation of these indicators. Autoclaving records should consistently include documentation of these signal locks to confirm that sterilization parameters have been met. Regular monitoring and review of these records should be integrated into the quality management process, with immediate corrective actions if any deviation is found.
Scoring Criteria :

 2 Marks: Signal locks are consistently used for all sterilization cycles, correctly recorded in autoclaving logs, and staff demonstrate clear understanding and correct interpretation of the indicators. Any failures are promptly addressed.

 1 Mark: Signal locks are used in most sterilization cycles and mostly documented, but some records may be incomplete or staff knowledge may be partial. Minor lapses in follow-up actions exist.

 0 Marks: Signal locks are rarely or never used, records do not contain documentation of indicators, and staff lack knowledge of the importance or use of signal locks in sterilization.

Reference : NA

D5.4	**Chemical Sterilization of instruments done as per protocol**

Interpretation

This checkpoint assesses whether the chemical sterilization process of delicate instruments like laparoscopes is carried out according to the prescribed protocol. Proper soaking in 2% Glutaraldehyde for the specified duration is critical to eliminate all microbial contamination and prevent infections. Staff knowledge of the protocol reflects the center's commitment to patient safety and quality assurance. Successful implementation indicates adherence to infection control guidelines, whereas failure to comply may increase the risk of postoperative infections and compromise patient care.

Means of verification : **OB / SI**

Observation (OB):

- Observe the sterilization area to confirm that the laparoscope is soaked in 2% Glutaraldehyde solution.
- Check that the instrument remains immersed for the full 10-hour duration as per protocol.
- Verify that the sterilization setup is clean, organized, and that the chemical solution is properly labeled and stored.
- Look for records or logs documenting the sterilization cycles and solution changes.

Staff Interview (SI):

- Enquire if the staff can clearly explain the protocol for chemical sterilization of laparoscopes.
- Ask about the concentration of Glutaraldehyde used and the required soaking time.
- Check if the staff are aware of safety precautions when handling the chemical solution.
- Confirm whether the staff understand how to maintain documentation and monitor the sterilization process.

Implementation plan :

The chemical sterilization of laparoscopic instruments must be carried out by soaking them in a 2% Glutaraldehyde solution for a minimum of 10 hours, following the standard operating protocol. Staff responsible for this procedure should receive thorough training on the preparation of the solution, correct soaking time, and safety precautions during handling. The sterilization area must be properly equipped and maintained to ensure the effectiveness of the process. Regular monitoring and documentation of each sterilization cycle should be enforced to maintain quality control and ensure compliance with infection control standards.

Scoring Criteria :

 Award 2 marks if the staff demonstrates full knowledge of the chemical sterilization protocol, the soaking time of 10 hours in 2% Glutaraldehyde is strictly followed, and observation confirms correct implementation with proper documentation.

 Award 1 mark if the staff has partial knowledge or if the protocol is generally followed but

minor deviations or incomplete documentation are noted.

 Award 0 marks if the staff lacks knowledge of the protocol, the sterilization is not performed as per the required procedure, or there is no proper documentation or observation of the process.

Reference : NA

D5.5	Sterility of autoclaved pack maintained during storage

Interpretation
This checkpoint verifies that sterilized instrument packs remain sterile during storage until they are used. It requires confirmation that packs are stored in a designated clean area to prevent contamination, that expiry dates are visibly marked on the packaging, and that packs are discarded after opening, not reused. Maintaining sterility during storage is critical for patient safety and infection control in the healthcare setting.
Means of verification : **OB / SI**

Means of Verification: Observation

- Observe whether autoclaved instrument packs are stored in a designated clean and dry area.
- Check that the expiry date is clearly mentioned on the instrument packs.
- Verify that opened instrument packs are discarded and not kept for later use.

Means of Verification: Staff Interview

- Ask staff how they ensure that autoclaved packs remain sterile during storage.
- Enquire if they check the expiry dates before using instrument packs.
- Confirm their procedure when an instrument pack is opened — whether it is discarded or reused.

Implementation plan :
To ensure the sterility of autoclaved instrument packs is maintained during storage, designate a clean, dry, and dust-free area specifically for storing these packs. Staff must be trained on the importance of proper storage practices, including handling without contaminating the packs. Label each autoclaved pack clearly with the date of sterilization and an expiry date based on standard validity (e.g., 30 days). A process must be in place to check the expiry date before using any pack. Once an instrument pack is opened, it should be discarded or reprocessed immediately to prevent contamination.
Scoring Criteria :

 Award 2 marks if autoclaved instruments are stored in a designated clean area, expiry dates are clearly mentioned on all packs, and opened packs are not reused.

 Award 1 mark if autoclaved instruments are stored properly but expiry dates are inconsistently marked or not clearly visible, or if some packs are occasionally reused after opening.

 Award 0 marks if autoclaved instruments are stored in an unclean or non-designated area,

expiry dates are not mentioned, or opened packs are regularly reused.

Reference : NA

D6	Spill Management

D6.1	Staff is aware of how manage small spills

Interpretation

This checkpoint assesses whether staff members have the necessary knowledge and understanding to safely and effectively manage small spills, minimizing risk to patients, staff, and the environment. Proper management includes knowing the appropriate materials to use, the steps to contain and clean the spill, and how to dispose of contaminated materials safely. Staff awareness reflects the effectiveness of training programs and the organization's commitment to maintaining a safe environment.

Means of verification : **OB / SI**

Observation (OB):

- Observe staff during routine work or simulated spill scenarios to check if they follow spill management protocols correctly.
- Check if staff use appropriate cleaning agents and wear the correct personal protective equipment (PPE).
- Verify availability and accessibility of spill kits and cleaning materials in the work area.
- Look for visible signage or posted protocols related to spill management in relevant areas.

Staff Interview (SI):

- Ask staff about the steps they would take to manage a small spill.
- Verify their understanding of materials required and disposal procedures.
- Confirm if they know when and how to report spills.

Record Review (RR):

- Review training records to confirm that staff have received training on spill management.
- Check logs or incident reports for documentation of spill events and actions taken.
- Verify maintenance records to ensure spill kits are stocked and inspected regularly.

Implementation plan :

To implement this checkpoint, the hospital will conduct regular training sessions for all relevant staff on the correct procedures for managing small spills. This will include demonstrations, distribution of written protocols, and refresher sessions at periodic intervals. Supervisors will ensure that the protocols are accessible and clearly displayed in relevant work areas. Practical

drills or mock spill scenarios may be used to reinforce learning and confidence. Additionally, there will be routine monitoring by quality assurance teams to check adherence and identify any gaps in knowledge or practice.

Scoring Criteria :

 2 Marks: Staff demonstrate full knowledge and consistently follow the correct spill management procedures during observation and interview, including correct use of PPE, spill containment, cleaning, and disposal as per protocol.

 1 Mark: Staff show partial understanding or inconsistent adherence to the protocols. They may miss some steps or require occasional reminders.

 0 Mark: Staff are unaware or unable to demonstrate proper spill management procedures during observation or interview, posing a risk to safety and environment.

Reference : NA

D6.2	Availability of spill management Kit

Interpretation

This checkpoint requires that spill management kits are readily available in areas prone to spills or contamination risks to facilitate prompt and effective response to any spills. The presence of these kits is crucial to maintain hygiene, prevent accidents, and protect staff and patients. The audit will focus on verifying not only the physical presence but also the adequacy and accessibility of the spill kits during normal operations.

Means of verification : **OB / SI**

Observation (OB):

- Check the physical presence of spill management kits in all designated areas such as treatment rooms, laboratories, and storage spaces.
- Verify that the spill kits are complete with all necessary components like absorbents, protective gloves, disposal bags, and disinfectants.
- Confirm that the kits are placed in accessible locations and are not obstructed or locked away.
- Review records or checklists showing periodic inspections and replenishment of spill kits.

Staff Interview (SI):

- Ask housekeeping and nursing staff about the location of spill management kits in their work areas.
- Enquire if staff know how to use the spill kits correctly in case of a spill.
- Confirm whether staff have received training or instructions regarding spill management and kit usage.
- Check if staff are aware of the process to report when kits are used or need replenishment.

Implementation plan :

To ensure compliance with checkpoint D6.2, the facility will establish a clear procedure for the

availability and accessibility of spill management kits in relevant areas. The housekeeping and safety teams will be assigned responsibility for regular inspection and replenishment of these kits. Staff will be trained on the location and use of spill kits as part of safety and emergency preparedness sessions. A periodic checklist will be maintained to document inspections and actions taken to ensure continuous availability.

Scoring Criteria :

 Award 2 marks if spill management kits are available in all required areas, are complete, easily accessible, and staff demonstrate clear knowledge of their use.

 Award 1 mark if kits are available but may be incomplete, partially accessible, or staff have limited knowledge of their use.

 Award 0 marks if spill management kits are missing, inaccessible, or staff are unaware of their location and usage

Reference : NA

D6.3	Staff has been trained for spill management

Interpretation

This checkpoint verifies whether staff have been adequately trained to manage spills safely and effectively. The presence of documented training records and staff knowledge indicates compliance with safety protocols and preparedness to respond to spill incidents. Proper training reduces the risk of injury, contamination, and operational disruptions, ensuring a safe environment for patients, staff, and visitors.

Means of verification : **OB / SI**

Observation

- Verify the availability of documented training records on spill management for all relevant staff.
- Check that training records include details such as dates, trainer's name, and content covered.
- Observe if spill management materials, such as spill kits and protective equipment, are accessible and properly maintained.

Means of Verification: Staff Interview

- Ask staff if they have undergone training on spill management.
- Enquire about the procedures they would follow in the event of a spill.
- Confirm their knowledge of the proper use of spill kits and personal protective equipment during spill incidents.
- Assess their understanding of reporting requirements after managing a spill.

Implementation plan :

To implement checkpoint D6.3, the organization must identify all staff members involved in handling or working near potential spill areas and provide them with comprehensive spill

management training. This includes scheduling regular training sessions, developing or sourcing training materials, and documenting attendance and training content accurately. Supervisors should ensure that training is repeated periodically to keep staff updated. Additionally, spill kits and protective equipment must be made readily available to support effective spill management.

Scoring Criteria :

 Award 2 marks if all relevant staff have documented, up-to-date training records on spill management and can clearly explain spill management procedures during the interview.

 Award 1 mark if some staff have training records, or staff provide partial or unclear answers during the interview regarding spill management.

 Award 0 marks if there are no training records available and staff cannot demonstrate any knowledge of spill management procedures.

Reference : NA

D6.4	Spill management protocols are displayed at points if use

Interpretation

This checkpoint assesses whether the facility has taken proactive steps to promote safety by displaying spill management protocols at critical points of use. The presence of these protocols indicates that the facility prioritizes quick and proper response to spills, reducing potential hazards to patients, staff, and visitors. It reflects a structured approach to environmental safety and staff readiness to handle spill incidents efficiently.

Means of verification : **OB / SI**

Observation

- Check if spill management protocols are displayed at all points where spills may occur.
- Verify that the protocols are clear and easy to read.
- Ensure the displayed protocols are placed in visible and accessible locations.
- Confirm the protocols are up-to-date and in good condition.

Staff Interview

- Ask staff if they know about the spill management protocols.
- Enquire if staff can explain the basic steps to manage spills.
- Confirm whether staff have received training on spill management.
- Ask how often refresher training on spill management is conducted.
- Verify if staff know the location of spill kits or materials needed for spill cleanup.

Implementation plan :

To implement the spill management protocols effectively, the facility must develop and approve clear guidelines for managing spills. These protocols should be printed and displayed prominently at all points where spills are likely to occur, such as patient care areas, laboratories, housekeeping zones, and waste disposal sites. The displayed protocols must be easily visible and legible to staff and visitors. Regular monitoring and audits should be conducted to ensure the

protocols remain in place, are up-to-date, and staff are familiar with their content. Training sessions should be held periodically to reinforce staff understanding and preparedness in spill management.

Scoring Criteria :

 Award 2 marks if spill management protocols are displayed clearly at all required points and staff demonstrate good awareness of the procedures.

 Award 1 mark if the protocols are displayed at some, but not all, relevant points and staff have partial awareness of the procedures.

 Award 0 marks if the protocols are not displayed at required points and staff show little or no knowledge of spill management procedures.

Reference : NA

D6.5	**Staff is aware of management of large spills**

Interpretation

The interpretation of this checkpoint focuses on verifying staff awareness and proper execution of spill management protocols. It ensures that employees not only know the protocol but also apply it correctly in practice to maintain safety and hygiene standards. The effectiveness of this measure is critical for minimizing risk to patients, staff, and the environment, and compliance reflects good safety culture within the institution.

Means of verification : **OB / SI**

Observation:

- Observe if staff promptly and correctly respond to large spill incidents.
- Check for proper use of personal protective equipment during spill management.
- Observe if the spill area is appropriately isolated and contained.
- Verify that the cleaning and disposal procedures are followed according to protocol.
- Monitor if the spill is reported timely to the designated authority.
- Look for any breaches or unsafe practices during spill cleanup.

Staff Interview:

- Ask staff to explain the steps they take when managing a large spill.
- Enquire if staff are aware of the personal protective equipment required during spill handling.
- Check if staff know how and when to report spills to supervisors or safety officers.
- Confirm staff understanding of disposal methods for contaminated materials.
- Discuss the frequency and content of training sessions on spill management.
- Assess staff confidence in managing spills safely and effectively.

Implementation plan :

To implement the checkpoint D6.5 effectively, a clear protocol for managing large spills must be established and communicated to all relevant staff members. This involves training sessions to ensure that the staff understand the steps involved in identifying, containing, and cleaning spills

safely and promptly. The protocol should include the use of appropriate personal protective equipment (PPE), notification procedures, and methods for spill disposal. Regular drills or refresher sessions can help reinforce knowledge and readiness. Management should monitor adherence to the protocol through routine observations and staff feedback to ensure the process is consistently followed.

Scoring Criteria :

 2 Marks: Staff demonstrate complete awareness of spill management protocols and consistently follow them during observations and interviews.

 1 Mark: Staff show partial understanding or inconsistent adherence to spill management procedures.

 0 Marks: Staff lack awareness or fail to follow the protocol during observations and interviews.

Reference : NA

D7	Isolation and Barrier Nursing

D7.1	Provision of Isolation ward

Interpretation

This checkpoint evaluates whether the hospital has a functional isolation ward available for isolating patients to minimize infection risk. The presence of an isolation ward is crucial for infection control and patient safety, especially during outbreaks or when managing contagious diseases. It reflects the hospital's preparedness and adherence to standard infection prevention practices. Lack of an isolation ward or inadequate facilities could lead to increased risk of hospital-acquired infections and compromise patient care quality.

Means of verification : **OB / SI**

Observation

- Observe if a designated isolation ward is physically present within the hospital.
- Check for clear and visible signage indicating the isolation ward.
- Verify that the isolation ward is separated from general patient areas.
- Look for availability of essential equipment and infection control supplies in the ward.
- Assess the cleanliness and maintenance status of the isolation ward.
- Confirm that the ward has proper ventilation and access control measures.

Staff Interview

- Ask staff if an isolation ward is available and regularly used for isolating patients.
- Inquire about staff training related to isolation protocols and infection control.
- Confirm staff awareness of procedures for admitting patients to the isolation ward.
- Ask how often the isolation ward is checked and maintained.
- Verify if staff know the purpose and importance of the isolation ward in infection prevention.

Implementation plan :
The hospital must designate a dedicated isolation ward to manage patients with infectious diseases or conditions requiring isolation. This ward should be clearly identified, appropriately equipped, and separated from general patient areas to prevent cross-contamination. The hospital administration will ensure the availability of adequate space, ventilation, and infection control measures in the isolation ward. Staff must be trained on isolation protocols and the ward must be regularly maintained and monitored for readiness. The implementation includes signage, access controls, and periodic audits to confirm the ward's functionality and compliance with infection prevention guidelines.

Reference : NA

D7.2	**Infectious patients are not mixed for general patients**

Interpretation
This checkpoint aims to minimize cross-infection risks by ensuring that infectious patients are not accommodated with general patients. It implies that the healthcare facility must have a designated infectious ward or an isolation facility, and that patients with confirmed or suspected infectious conditions are not mixed with non-infectious patients in wards or treatment areas.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether the facility has a separate, well-identified infectious ward or isolation area.
- Check if infectious patients are placed in the designated area and not in general wards.
- Look for clear signage indicating infection control zones.
- Observe whether standard precautions (e.g., PPE usage, dedicated equipment) are followed in the infectious ward.
- Inspect patient movement records to confirm infectious patients are not transferred to general areas.

Staff Interview (SI):

- Ask clinical staff how they identify and manage infectious patients upon admission.
- Enquire about the process followed when an existing general patient turns infectious.
- Ask staff to explain the infection control protocol and isolation procedures.
- Check if the staff are aware of the designated areas for infectious patients and the rationale behind segregation.

Implementation plan :
The healthcare facility shall ensure that all infectious patients are identified promptly at the point of entry or during assessment and are isolated or admitted to a designated infectious ward or isolation area. Clear protocols must be developed and implemented for triage, admission, and segregation of patients based on their infection status. Staff must be trained on infection control protocols, and signage should be placed to indicate isolation areas. Periodic audits should be conducted to ensure compliance.
Scoring Criteria :

2 Marks:
The facility has a clearly designated infectious ward; all infectious patients are appropriately admitted to this area without any mixing with general patients. Staff are fully aware of and comply with the segregation and infection control protocol.

1 Mark:
The facility has a designated infectious ward or isolation area, but occasional lapses are noted in segregation or staff knowledge is partial/inconsistent.

0 Mark:
There is no proper segregation of infectious patients; they are admitted with general patients, and staff are unaware or do not follow the infection control protocols.

Reference : NA

D7.3	Maintenance of adequate bed to bed distance in wards

Interpretation
This checkpoint ensures patient privacy, infection control, and ease of movement for both patients and healthcare staff. A bed-to-bed distance of 3.5 feet is considered adequate to prevent overcrowding and maintain safety. The measurement should be taken from the edge of one bed to the edge of the next. This standard applies to all wards and is not optional. Temporary arrangements that compromise this distance will be considered non-compliant.
Means of verification : **OB / SI**

- **Observation (OB):**
  - Observe the physical layout of the wards to check the spacing between two adjacent beds using a measuring tape or scale.
  - Confirm that the distance between beds is at least 3.5 feet in all directions where patient beds are placed.
  - Check for uniformity in spacing throughout the ward.
- **Staff Interview:**
  - Enquire with the ward in-charge or staff nurse about the standard spacing requirement.
  - Ask how they ensure this spacing is maintained during admission or shifting of beds.
  - Verify if they are aware of the rationale behind maintaining 3.5 feet distance between beds.

Implementation plan :
To comply with D7.3, the healthcare facility must ensure that the spatial arrangement of beds in all inpatient wards allows for a minimum distance of 3.5 feet between the edges of adjacent beds.

The facility administrator and maintenance team should jointly assess the ward layout, measuring the distances between beds using a measuring tape. Any necessary reorganization should be carried out to ensure compliance. This standard should be included in the facility layout review checklist and be reassessed periodically, especially when beds are rearranged or patient load increases. Staff responsible for ward management must be oriented about the standard and trained to maintain this spacing during routine operations and admission processes.

Scoring Criteria :

 2 Marks: The bed-to-bed distance is consistently 3.5 feet or more in all wards, and the staff is aware of the standard and its importance.

 1 Mark: The distance is maintained in most areas, with minor deviations in a few beds; staff has partial awareness or inconsistent practice.

 0 Marks: The spacing is not maintained in significant portions of the ward; no evidence of staff awareness or active monitoring of bed distances.

Reference : NA

D7.4	Restriction of external foot wear in critical areas

Interpretation
This checkpoint ensures that external footwear, which may carry contaminants from outside, is not permitted within critical areas of the facility where sterility or high cleanliness standards are essential. The intent is to minimize the risk of infection or contamination by enforcing a barrier between the external environment and the clinical zones. This practice reflects the facility's commitment to infection prevention and control.
Means of verification : **OB / SI**

Observation (OB):

- Observe if external footwear is restricted in areas such as the lab, therapy room, and OT.
- Check for visible signage or indicators at entry points restricting the use of external footwear.
- Look for designated internal-use-only footwear or shoe covers available at entry points.
- Inspect whether the flooring and environment of critical areas appear clean and free from dust or outdoor debris.

Staff Interview:

- Ask staff to explain the policy on external footwear in critical areas.
- Enquire if they have been trained regarding this restriction and how they enforce it.
- Verify if there is a designated cleaning or maintenance schedule related to footwear hygiene.
- Confirm whether staff ensure patient and visitor compliance with the no external footwear rule.

Implementation plan :

To implement the restriction of external footwear in critical areas, the healthcare facility must

first identify all the critical zones such as the laboratory, therapy rooms, operation theatres (OT), and similar sterile or semi-sterile environments. Proper signage indicating "No External Footwear" must be displayed at the entry points of these areas. The facility must arrange for footwear changing areas with clean, internal-use-only footwear such as slippers or shoe covers, preferably color-coded for easy identification. Staff, patients, and visitors should be educated about this protocol through verbal instructions, posters, and periodic training. Compliance must be monitored regularly by the infection control team or designated personnel.

Scoring Criteria :

2 Marks:
The facility has clearly implemented and enforced the restriction of external footwear in all identified critical areas. Signage, internal-use-only footwear, and staff compliance are evident and consistent.

1 Mark:
The facility has partially implemented the restriction. It may be observed in some critical areas, or staff awareness and compliance are inconsistent.

0 Mark:
There is no restriction of external footwear in critical areas, or there is no evidence of implementation or awareness among staff.

Reference : NA

D7.5	Restriction of visitors to Isolation Area

Interpretation

This checkpoint ensures that the healthcare facility has strict controls to prevent unauthorized access of visitors to critical zones like the isolation area and OT, which are high-risk areas for infection transmission. The focus is on safeguarding patients, staff, and visitors by minimizing cross-contamination and exposure. Restricting visitors in such areas is an essential infection control measure and reflects adherence to patient safety norms.

Means of verification : **OB / SI**

 Observation:

- Check for clearly visible signage outside the isolation area stating visitor restrictions.
- Observe whether unauthorized persons are entering or exiting the isolation area.
- Look for physical barriers (e.g., doors with access control or restricted entry boards).
- Verify that PPE is appropriately used when there are exceptions (if allowed).

 Staff Interview:

- Ask nursing staff or security personnel if they are aware of the visitor restriction policy.
- Enquire about how they handle situations where visitors insist on entering the isolation

area.

- Check if there is a documented protocol for exceptions and whether staff are trained on it.

Implementation plan :
To implement the restriction of visitors in isolation areas effectively, the healthcare facility should first develop and enforce a clear policy that outlines which areas are restricted and who qualifies as essential personnel. Signages indicating "No Visitor Entry" must be displayed prominently outside the isolation area and other critical zones such as the Operation Theatre (OT). Staff must be trained on the rationale and procedures for visitor restriction. Security and nursing personnel should be briefed to ensure compliance. Exceptions, if any, such as for terminally ill patients, must be documented with defined protocols for PPE usage and time limits.
Scoring Criteria :

 2 Marks: Visitor restriction policy is in place and fully implemented. Clear signage is displayed. Staff are aware of the policy, and no unauthorized visitors are seen entering isolation areas.

 1 Mark: Visitor restriction policy is available, but either signage is missing or some staff are unaware of the implementation process.

 0 Mark: No evidence of visitor restriction practices in isolation areas. Staff are unaware, and unauthorized entry is not prevented.

Reference : NA

D8	Infection Control Program

D8.1	Infection Control Committee is constituted and functional in the Hospital

Interpretation
This checkpoint emphasizes not only the formal establishment of an Infection Control Committee but also its functionality. A functional committee is one that actively meets, discusses relevant IPC issues, and implements decisions. The existence of an enabling order alone is not sufficient; evidence of regular meetings and documented action points are needed to confirm functionality. It also implies that the committee has an active role in improving infection control standards within the hospital.
Means of verification : **OB / SI**

 Observation (OB):

- Look for the enabling order or official document that constitutes the Infection Control Committee.
- Observe the availability of minutes of meetings with attendance records, agendas, and documented decisions.

- Check for displayed IPC policies or guidelines developed or reviewed by the ICC.

 Staff Interview (SI):

- Ask committee members about the frequency of meetings and major decisions taken recently.
- Enquire how the committee identifies infection control issues and what actions are taken.
- Interview nursing or housekeeping staff to confirm awareness and involvement in the initiatives taken by the ICC.

Implementation plan :
To implement this standard, the hospital management should issue an enabling order formally constituting the Infection Control Committee (ICC), clearly defining its structure, roles, and responsibilities. The committee should be multidisciplinary, including representatives from key departments like clinical services, nursing, housekeeping, and administration. Regular meetings should be scheduled (e.g., monthly or quarterly) and documented with clear agendas and minutes. The ICC should take responsibility for guiding infection prevention and control (IPC) practices in the hospital, developing policies, monitoring infection rates, conducting surveillance, and initiating corrective actions.
Scoring Criteria :

 2 Marks:

- The ICC is formally constituted with an enabling order, and there is documented evidence of regular meetings (minimum two in the last six months) with clearly recorded minutes and follow-up actions. Staff are aware of ICC activities.

 1 Mark:

- The ICC is constituted with an enabling order, but meetings are irregular or inadequately documented. Staff awareness or involvement is partial.

 0 Mark:

- The ICC is not constituted or only exists on paper with no documented meetings or functionality. Staff are unaware of any ICC-related activities.

Reference : NA

D8.2	Regular Monitoring of infection control practices

Interpretation
This checkpoint verifies whether the institution consistently implements and documents the monitoring of infection control practices. The emphasis is on regular (preferably daily) checks of critical aspects like hand hygiene compliance and the proper use of PPE among staff. It assesses not just policy existence but its practical application and continuous monitoring on the ground to minimize infection risks.
Means of verification : **OB / SI**

- **Observation (OB):**
  - Observe whether any infection control monitoring checklist or logbook is maintained and updated daily.
  - Check if staff are performing hand hygiene at appropriate moments (before and after patient contact, after glove removal, etc.).
  - Observe staff usage of personal protective equipment like gloves, aprons, and masks during patient care.
  - Look for infection control posters, hand rub stations, and PPE availability in patient care areas.
- **Staff Interview (SI):**
  - Ask staff if infection control rounds are conducted daily and by whom.
  - Inquire whether they have received training or guidance on daily infection control monitoring.
  - Ask staff to describe the hand hygiene protocol and situations when PPE must be used.
  - Enquire if there is any feedback mechanism on compliance with infection control practices.

Implementation plan :
To ensure regular monitoring of infection control practices, the healthcare facility should establish a structured infection control surveillance system. A designated staff member or infection control officer (ICO) should be assigned the responsibility of overseeing and documenting daily compliance with infection control protocols, such as hand hygiene, use of personal protective equipment (PPE), and safe waste disposal. Daily checklists, observation rounds, and audit tools should be utilized to monitor and record adherence. The ICO should also conduct briefings or huddles to sensitize staff and discuss any lapses or improvements needed.
Scoring Criteria :

 2 Marks:
The facility has a system in place for daily monitoring of infection control practices, which is consistently implemented and documented. Staff are aware of this practice and actively follow hand hygiene and PPE protocols.

 1 Mark:
The facility has initiated infection control monitoring, but it is not done daily or lacks consistent documentation. Staff are partially aware or practice is irregular.

 0 Mark:
There is no system or evidence of daily monitoring of infection control practices. Staff are unaware or do not follow established hand hygiene or PPE protocols.

Reference : NA

D8.3	Immunization of Service Providers

Interpretation
This checkpoint verifies whether the institution consistently implements and documents the

monitoring of infection control practices. The emphasis is on regular (preferably daily) checks of critical aspects like hand hygiene compliance and the proper use of PPE among staff. It assesses not just policy existence but its practical application and continuous monitoring on the ground to minimize infection risks.

Means of verification : **OB / SI**

 Observation (OB):

- Look for the presence of documented vaccination records in staff files.
- Check for a formal policy or guideline on staff immunization against Hepatitis B.
- Observe any visible educational material or instructions displayed in staff areas regarding Hepatitis B immunization.
- Verify the availability of cold chain equipment and vaccine storage conditions if vaccination is carried out on-site.

 Staff Interview:

- Ask staff whether they have received Hepatitis B immunization and whether the hospital facilitated it.
- Enquire if staff are aware of the risks of Hepatitis B transmission and the benefits of immunization.
- Ask about the process followed in the hospital for ensuring new joiners receive the Hepatitis B vaccine.
- Inquire whether follow-up and reminder systems are in place for completing the vaccine schedule.

Implementation plan :

To ensure regular monitoring of infection control practices, the healthcare facility should establish a structured infection control surveillance system. A designated staff member or infection control officer (ICO) should be assigned the responsibility of overseeing and documenting daily compliance with infection control protocols, such as hand hygiene, use of personal protective equipment (PPE), and safe waste disposal. Daily checklists, observation rounds, and audit tools should be utilized to monitor and record adherence. The ICO should also conduct briefings or huddles to sensitize staff and discuss any lapses or improvements needed.

Scoring Criteria :

 2 Marks: Awarded if all at-risk staff have been fully immunized against Hepatitis B, records are complete and up to date, and staff demonstrate awareness of the immunization policy.

 1 Mark: Awarded if immunization has been initiated for staff but is either partially complete or records are incomplete; there may be limited staff awareness or implementation gaps.

 0 Mark: Awarded if there is no evidence of Hepatitis B immunization for staff, no policy exists, or the staff are unaware of the need or provision for such immunization.

Reference : NA

D8.4	Regular Medical check- ups of food handlers and housekeeping staff

Interpretation

This checkpoint emphasizes the importance of safeguarding food safety and environmental hygiene through the health monitoring of food handlers and housekeeping personnel. Regular medical examinations help in the early detection and management of communicable diseases that may pose a risk to patients, staff, and visitors. The intent is to create a system that minimizes the potential for contamination and infection transmission from these high-risk groups. Compliance with this standard reflects the organization's commitment to infection prevention, patient safety, and a safe working environment.

Means of verification : **OB / SI**

Observation (OB):

- Observe whether there are individual health records for food handlers and housekeeping staff.
- Look for evidence of periodic medical check-ups such as dates, test reports (e.g., stool, CBC), and doctor's remarks.
- Check for institutional policy or SOP regarding periodic health screening of food handlers and housekeeping staff.
- Observe whether the staff in the kitchen and housekeeping departments are wearing clean uniforms and practice good personal hygiene.

Staff Interview (SI):

- Ask food handlers and housekeeping staff when their last medical check-up was conducted.
- Enquire whether they were informed about the purpose and frequency of the medical tests.
- Ask them if they have ever been asked to refrain from work due to medical issues identified during a check-up.
- Interview HR or administrative personnel about the schedule, documentation, and follow-up of these check-ups.

Implementation plan :

To implement this checkpoint effectively, the healthcare facility should develop and document a clear policy for conducting regular medical check-ups of food handlers and housekeeping staff. This includes identifying all staff under these categories and scheduling their medical examinations at predefined intervals, preferably at least once a year. The medical check-up should include clinical assessments and relevant laboratory investigations such as stool examination, complete blood count (CBC), and any other tests based on potential occupational exposure or risk. A designated person or department, such as HR or infection control, should be made responsible for organizing the check-ups, maintaining individual health records, ensuring follow-up for abnormal findings, and restricting work duties when necessary until fitness is confirmed. Awareness and training sessions should also be conducted to educate the staff on the importance of these check-ups.

Scoring Criteria :

 2 Marks:
If medical check-up records of all food handlers and housekeeping staff are available, up-to-date, and include relevant lab investigations (e.g., stool test, CBC), and the staff are aware of the periodic screening policy.

 1 Mark:
If medical check-up records exist but are incomplete (e.g., missing investigations or not covering all staff), or if the frequency of check-ups is not consistently maintained.

 0 Mark:
If no records are available or no evidence of regular medical check-ups and investigations for food handlers and housekeeping staff is found.

Reference : NA

D9	Hospital Acquired Infection Surveillance

D9.1	Regular microbiological surveillance of Critical areas

Interpretation
This checkpoint ensures that the healthcare facility takes proactive steps to monitor and control the microbial load in critical areas to prevent healthcare-associated infections (HAIs). Regular surveillance reflects the organization's commitment to infection control and patient safety. The standard requires both documentation (records/reports of microbiological surveillance) and awareness (staff knowledge of surveillance protocols).
Means of verification : **OB / SI**

Observation (OB):

- Look for labeled samples or evidence of recent microbial testing in critical areas.
- Check for maintained environmental cleanliness and use of infection control protocols.
- Observe if results of microbial surveillance are displayed or available in the department for review.
- Inspect the logs or registers documenting the date, area sampled, method used, and results.

Staff Interview (SI):

- Ask staff about the frequency and method of microbiological surveillance in their area.
- Enquire whether they are aware of what actions are taken if microbial levels exceed acceptable limits.
- Confirm whether they are trained on infection control measures and understand the

significance of the surveillance.
- Ask how the facility uses the surveillance results to improve infection control practices.

Implementation plan :
To implement D9.1 effectively, the healthcare organization must establish a structured and periodic microbiological surveillance program in all critical areas such as the Operation Theatre (OT), therapy rooms, and other areas where invasive procedures or high-risk treatments are carried out. The plan should outline responsibilities, frequency of sampling (e.g., weekly, monthly), the method of sampling (air sampling, surface swabs, etc.), parameters to be tested (bacterial count, fungal spores, etc.), acceptable limits, corrective actions for deviations, and documentation protocols.
Scoring Criteria :

 2 Marks: The facility has a documented microbiological surveillance program for all critical areas, surveillance is done at defined intervals, records are available and complete, and staff are aware of the process and its importance.

 1 Mark: Microbiological surveillance is done occasionally or partially (some critical areas covered), records are available but not consistently maintained or updated, or staff have partial knowledge of the procedure.

 0 Mark: No evidence of microbiological surveillance, no records available, or staff are unaware of any surveillance process in critical areas.

Reference : NA

D9.2	**Hospital measures Surgical Site Infection Rates**

Interpretation
This checkpoint evaluates whether the hospital effectively monitors surgical site infections by maintaining accurate and timely records of SSI rates. It reflects the hospital's commitment to infection control by ensuring that surgical outcomes are tracked systematically. The presence of regular data analysis and management review indicates a proactive approach to identifying potential issues and taking corrective measures. A well-implemented SSI measurement system signifies that the hospital prioritizes patient safety and quality care through continuous monitoring and improvement of surgical infection control practices.
Means of verification : **OB / SI**

Observation (OB):

- Verify if records of Surgical Site Infection (SSI) rates are maintained and accessible.
- Check whether SSI data is regularly updated and documented.
- Observe if there is a clear format or system used for recording SSI incidents.
- Look for evidence of reports or analysis of SSI data shared with hospital management.
- Confirm if there are documented actions or interventions based on the SSI data.

Staff Interview (SI):

- Ask infection control or quality team staff how SSI data is collected and recorded.
- Enquire about the frequency of SSI data review and reporting.
- Confirm whether staff are aware of the importance of tracking SSI rates.
- Ask how SSI data influences infection control practices and staff training.
- Inquire about the follow-up process when an SSI is identified.

Implementation plan :
The hospital should develop and maintain a structured system to measure Surgical Site Infection (SSI) rates. This includes setting up a standardized process for recording and tracking infections following surgical procedures. The infection control team, along with quality assurance personnel, must collect data consistently, ensuring all relevant surgical cases are monitored for infections within a defined postoperative period. The data should be regularly analyzed to identify trends or spikes in infection rates. Based on this analysis, the hospital should implement targeted interventions such as staff training, infection prevention protocols, and process improvements. Documentation of all activities related to SSI measurement and prevention must be maintained and regularly reviewed by hospital management to support continuous quality improvement.
Scoring Criteria :

- **2 Marks:** The hospital maintains comprehensive, up-to-date, and accurate records of SSI rates, which are regularly analyzed and reviewed by management with documented evidence of corrective actions or quality improvements based on the data.
- **1 Mark:** The hospital has records of SSI rates, but they are incomplete, irregularly updated, or there is limited evidence of regular review or follow-up actions.
- **0 Mark:** The hospital does not maintain any records of surgical site infection rates or there is no evidence of monitoring or using this data for quality improvement.

Reference : NA

D9.3	Hospital measures Device Related HAI rates

Interpretation
This checkpoint verifies whether the hospital actively monitors and documents device-related HAI rates through reliable records and surveillance systems. It checks if the hospital uses these data to assess infection trends and take timely corrective measures to enhance patient safety. A compliant hospital demonstrates evidence of regular review, staff involvement, and sustained efforts to minimize device-associated infections. Lack of documentation or inconsistent surveillance indicates poor infection control practices and non-compliance with this standard.
Means of verification : **OB / SI**

What is to be Observed (OB):

- Availability of documented records or reports on device-related HAI rates.
- Presence of a surveillance log or database tracking infections related to devices.
- Display or summary reports on infection rates accessible to infection control teams.
- Evidence of regular infection control meetings discussing device-related HAIs.
- Compliance with protocols related to device insertion and maintenance to prevent

infections.

What is to be Enquired (Staff Interview):

- How often are device-related HAI rates measured and recorded?
- What is the process for collecting and reporting device-related infection data?
- Who is responsible for monitoring and analyzing these infection rates?
- What actions are taken if infection rates exceed acceptable levels?
- How are staff trained and updated on infection prevention related to devices?

Implementation plan :

The hospital must establish a systematic process to measure device-related Healthcare-Associated Infection (HAI) rates such as Respiratory Rate (RR) and Surgical Site Infection (SI). This includes creating a surveillance system for regular data collection and documentation of infections linked to medical devices like catheters and ventilators. The infection control team should conduct routine audits and maintain updated records of these infection rates. Staff must be trained on proper device handling, infection identification, and reporting procedures. Regular meetings should be held to review data, identify trends, and implement corrective actions to reduce infection rates. The hospital management should ensure resources and support are available for effective monitoring and infection prevention.

Scoring Criteria :

 2 Marks: The hospital maintains comprehensive, up-to-date records of device-related HAI rates; data is regularly reviewed and used for improving infection control practices, with clear evidence of staff awareness and corrective actions.

 1 Mark: The hospital has partial or inconsistent records of device-related HAI rates; surveillance is done occasionally but lacks systematic review or follow-up actions. Staff have some knowledge but procedures are not fully implemented.

 0 Marks: The hospital lacks documented records of device-related HAI rates; no regular monitoring or analysis is evident, and staff are unaware or not involved in infection rate surveillance or prevention activities.

Reference : NA

D9.4	Hospital takes corrective Action on occurrence of HAIs

Interpretation

This checkpoint requires the hospital to demonstrate that it actively identifies HAIs and takes timely corrective actions to control and reduce such infections. Corrective actions must be documented and should show a clear link between the identification of an infection and the steps taken to resolve or prevent further occurrences. The presence of an effective feedback loop indicates a proactive infection control environment focused on patient safety and compliance with best practices.

Means of verification : **OB / SI**

- **What is to be observed:**
  - Review of infection control records and logs related to HAIs.
  - Documentation of corrective action plans and follow-up reports.
  - Visual confirmation of infection control measures being implemented (e.g., isolation procedures, hand hygiene practices).
  - Availability and use of infection control protocols in clinical areas.
- **What is to be enquired (Staff interview):**
  - Ask infection control staff or nurses about procedures followed after identifying an HAI case.
  - Enquire how corrective actions are decided, documented, and communicated.
  - Question the staff on training received about infection prevention and corrective action procedures.
  - Confirm if feedback or audit results related to HAIs are shared with the clinical teams.

Implementation plan :
The hospital will establish a systematic process to monitor and identify occurrences of hospital-acquired infections (HAIs). Upon detection of any HAI event, a corrective action plan will be initiated promptly. This includes investigating the source and cause of the infection, analyzing existing infection control practices, and implementing targeted interventions to prevent recurrence. Staff involved in patient care will be trained regularly on infection control protocols. The infection control team will maintain detailed documentation of all incidents and corrective actions taken, ensuring continuous quality improvement through periodic review and feedback mechanisms.
Scoring Criteria :

 2 Marks: The hospital consistently identifies HAIs, promptly initiates and documents corrective actions, and demonstrates evidence of effective implementation and follow-up that reduces infection rates. Staff interviews confirm good knowledge and active involvement in corrective processes.

 1 Mark: The hospital identifies HAIs and takes corrective actions but documentation or implementation is incomplete or inconsistent. Staff awareness of the corrective action process is limited or partial.

 0 Mark: There is no evidence of corrective action taken on HAIs, no proper documentation, or the hospital fails to identify or respond to infection occurrences adequately. Staff are unaware of procedures related to HAIs.

Reference : NA

E	SUPPORT SERVICES

E1	Laundry Services & Linen Management

E1.1	The facility has adequate stock (including reserve) of linen

Interpretation
The interpretation of this checkpoint is to verify that the facility maintains an adequate supply of linen to meet its operational needs without interruption. Adequate stock includes not just the linen currently in use but also a reserve to handle unexpected increases in demand or supply delays. This ensures hygiene, comfort, and smooth functioning of the facility.
Means of verification : **OB / SI**

Observation:

- Check the physical stock of linen in the storage area to see if it is adequate and properly organized.
- Verify if the linen stock is labeled and segregated according to type and usage.
- Review stock records and turnover reports for the last 12 months to confirm regular availability.
- Look for any signs of stock shortages or overstocking.

Staff Interview:

- Ask the storekeeper or responsible staff about the process of monitoring linen stock and maintaining reserve levels.
- Enquire how frequently stock counts are conducted and documented.
- Inquire if there have been any shortages or delays in linen supply during the past year.
- Ask if there is a defined minimum stock level and how replenishment orders are placed and managed.
- Discuss how they handle unexpected demand surges or supply disruptions.

Implementation plan :
To implement this checkpoint effectively, the facility must establish a reliable inventory management system that tracks the stock levels of linen regularly, including reserve stock. This involves maintaining updated records of linen received, issued, and current stock status. The facility should ensure timely replenishment to avoid shortages by analyzing past demand patterns and usage trends over the last year. Staff responsible for linen management need to be trained on proper stock monitoring and documentation procedures.
Scoring Criteria :

- **2 Marks:** The facility maintains an adequate stock including reserve, with proper documented evidence of stock levels and turnover over the past year. There are no shortages reported, and stock management procedures are consistently followed.

- **1 Mark:** The facility has linen stock but occasional shortages or delays were reported. Documentation and monitoring exist but may be incomplete or irregular.
- **0 Mark:** The facility does not maintain adequate linen stock or reserve. Records are missing or inconsistent, and stockouts frequently occur affecting operations.

Reference : NA

E1.2	**Bed-sheets and pillow cover are stain free and clean**

Interpretation
This checkpoint emphasizes maintaining hygiene and infection control by ensuring all bed-sheets and pillow covers used in patient areas are free from stains and visibly clean. It reflects on the effectiveness of linen management and housekeeping practices. Failure to meet this standard can compromise patient safety and comfort and indicate lapses in routine cleaning or handling procedures. This checkpoint indirectly measures the vigilance of staff and the efficiency of laundry and linen distribution systems in healthcare settings.
Means of verification : **OB / SI**

Observation (OB):

- Observe the condition of bed-sheets and pillow covers currently in use in wards, Accident & Emergency Department, and other patient care areas.
- Check for visible stains, dirt, or discoloration on the linen.
- Note whether the linens appear clean, properly maintained, and replaced timely.

Staff Interview (SI):

- Ask housekeeping staff about their routine procedures for inspecting and replacing bed-sheets and pillow covers.
- Inquire about the frequency and criteria for linen checks during their shifts.
- Discuss the reporting process for stained or damaged linens.
- Confirm whether staff receive training on linen hygiene standards and protocols.

Implementation plan :
To ensure bed-sheets and pillow covers remain stain-free and clean, regular linen inspection protocols will be established in all patient care areas including wards and Accident & Emergency Department. Housekeeping and nursing staff will be trained to routinely check linen condition during shift changes and report any soiled or stained items immediately. The laundry services will follow strict quality control processes for washing and handling linens. Supervisory staff will conduct random checks daily to monitor cleanliness standards, and any non-compliance will trigger corrective actions. Continuous feedback loops will be maintained through staff meetings and patient feedback to reinforce cleanliness standards.
Scoring Criteria :

 2 Marks: All bed-sheets and pillow covers observed are completely stain-free and clean across all patient care areas; staff demonstrate clear knowledge and adherence to linen inspection and replacement protocols.

 1 Mark: Most linens are clean with minimal stains found; staff show partial awareness of linen management but occasional lapses are evident.

 0 Marks: Significant number of bed-sheets and pillow covers are stained or visibly unclean; staff are unaware or do not follow linen hygiene practices properly.

Reference : NA

E1.3	**Bed-sheets and linen are changed daily**

Interpretation
This checkpoint verifies the hygiene standard related to patient comfort and infection control by ensuring that bed-sheets and linen are replaced every day. Clean linen reduces the risk of infections and improves patient satisfaction. Both physical observation of the linen condition and confirmation from patients about the frequency of changes are necessary to validate compliance. Regular linen changes reflect a hospital's commitment to cleanliness and patient care.
Means of verification : **OB / SI**

Observation:

- Observe if the bedsheets and pillow covers on patient beds look clean and appear to have been changed on the day of the visit.
- Check for any stains, dirt, or signs that linen has not been replaced recently.

Staff Interview:

- Ask housekeeping staff about their routine for changing bedsheets and pillow covers.
- Inquire how often linen is changed and how they document this activity.
- Ask nursing or patient care staff if they monitor linen changes regularly.

Implementation plan :
To ensure that bed-sheets and linen are changed daily, the housekeeping staff will be assigned the responsibility of replacing all bedsheets and pillow covers each day. Supervisors will conduct daily rounds to verify compliance. Patient care staff will be trained on the importance of hygiene and timely linen changes. A checklist will be maintained to document daily linen changes for each bed. Feedback from patients will be actively sought to ensure their comfort and confirm that linen is changed as per the standard. Any lapses will be immediately addressed through corrective actions.
Scoring Criteria :

2 Marks:

- Bedsheets and pillow covers are visibly clean and changed daily.
- Staff confirm daily linen changes and maintain proper documentation.
- Patients confirm that linen is changed every day and express satisfaction with hygiene.

1 Mark:

- Linen is changed most days but with occasional lapses.

- Staff provide inconsistent answers or documentation is incomplete.
- Some patients report that linen is not always changed daily.

0 Marks:

- Bedsheets and pillow covers are visibly unclean or unchanged for multiple days.
- Staff deny or are unsure about daily linen changes.
- Patients report linen is rarely changed or express dissatisfaction with linen hygiene.

Reference : NA

E1.4	Soiled linen is removed, segregated and disinfected, as per procedure

Interpretation
This checkpoint ensures that soiled linen, which can be a potential source of infection, is handled carefully to prevent the spread of pathogens. Immediate removal, proper segregation, and prompt disinfection reduce contamination risk and protect patients, staff, and the environment. The process reflects good infection control practices and adherence to hygiene standards in the healthcare setting.
Means of verification : **OB / SI**

Observation:

- Watch how soiled linen is removed from patient care areas.
- Check if soiled linen is segregated properly from clean linen and other waste.
- Verify the use of designated containers or bags specifically for soiled linen.
- Observe the process used to disinfect or sluice the soiled linen immediately after removal.
- Look for any delays or lapses in handling or disinfection during the process.

Staff Interview:

- Ask staff to explain the procedure for removing soiled linen.
- Inquire how soon after removal the linen is disinfected or sluiced.
- Confirm if they understand the importance of segregating soiled linen.
- Ask if they have received training on linen handling and disinfection procedures.
- Check their awareness of the facility's SOP regarding soiled linen management.

Implementation plan :
The facility must establish and strictly follow a standard operating procedure (SOP) for the handling of soiled linen. This includes immediate removal of soiled linen from patient care areas to prevent contamination. Staff must be trained on segregation protocols to separate soiled linen from clean linen and other waste materials. Appropriate disinfecting procedures, such as sluicing or using disinfectant solutions, should be done immediately after removal. Regular monitoring and supervision should be implemented to ensure compliance. The facility should also maintain records of linen handling and disinfection activities.
Scoring Criteria :

 2 Marks: Soiled linen is removed immediately, segregated properly, and disinfected or sluiced

without delay according to the procedure, with clear evidence from observation and staff confirmation.

 1 Mark: Soiled linen is removed and segregated properly but there is a delay or inconsistency in the disinfection process or staff knowledge is partial.

 0 Marks: Soiled linen is not removed promptly, segregation is poor or not done, and disinfection procedures are not followed or unknown to staff.

Reference : NA

E1.5	**Patients' dress are clean and not torn**

Interpretation
This checkpoint assesses whether patients' clothing is maintained in a clean and undamaged state, which is an important indicator of patient hygiene, comfort, and overall quality of care. Clean and intact clothing reduces the risk of infection, promotes patient dignity, and reflects positively on the healthcare environment. Observing patients' attire helps to identify any lapses in hygiene practices or inadequate support for patient needs, which must be addressed promptly.
Means of verification : **OB / SI**

 Observation:

- Visually inspect the clothes worn by patients to check for visible dirt, stains, or tears.
- Note the overall appearance of the clothing – whether it appears fresh, clean, and properly worn.

 Staff Interview:

- Ask nursing or ward staff about the process of assisting patients in maintaining clean attire.
- Enquire if there are any provisions or procedures in place for changing or laundering patients' clothes during their stay.
- Confirm if staff receive any training or guidelines related to patient hygiene and clothing maintenance.

Implementation plan :
To implement this checkpoint effectively, the healthcare facility should establish a routine monitoring system where staff periodically check patients' attire for cleanliness and physical condition. Training sessions should be conducted to sensitize staff about the importance of patients' hygiene and dignity reflected through their clothing. Additionally, patients should be encouraged and supported, if needed, to maintain clean and intact clothing during their stay. Supplies such as clean gowns or assistance with laundry should be made available when required. Documentation of observations should be maintained to track compliance and identify areas for improvement.
Scoring Criteria :

 2 Marks: Patients' clothes are consistently clean and without any tears or damage across all

observed areas. Staff demonstrate clear processes and support mechanisms for maintaining patient clothing hygiene.

 1 Mark: Most patients' clothes are clean and intact, but occasional minor issues like small stains or slight wear may be present. Staff show some awareness and efforts but lack consistent procedures.

 0 Mark: Patients' clothes are frequently dirty, stained, or torn. There is no clear system or support from staff to maintain or assist with patients' clothing hygiene.

Reference : NA

E2	**Water Sanitation**

E2.1	**The facility receives adequate quantity of water as per requirement**

Interpretation
This checkpoint evaluates whether the healthcare facility consistently receives an adequate quantity of water to meet daily operational and patient care needs. The criterion specifically requires a minimum of 200 litres of water per bed per day if the water source is municipal, or an equivalent supply that is continuously available (24x7) at every water usage point within the facility. Adequate water supply is critical for hygiene, cleaning, patient care, and infection control. Failure to meet these requirements could compromise patient safety and the overall quality of healthcare services. The facility's ability to demonstrate uninterrupted water availability confirms compliance with this standard.
Means of verification : **OB / SI**

Observation

- Observe water storage tanks and their capacity to ensure sufficient volume relative to the number of beds.
- Check water supply points across the facility—wards, operation theaters, labs, restrooms—to verify water availability.
- Inspect water meters, consumption logs, or records showing daily water usage per bed.
- Monitor if water supply is continuous throughout the day at all points of use.
- Look for any visible signs of water shortage or disruption such as dry taps or alternate water sources in use.

Staff Interview

- Ask facility staff responsible for water management about the regularity and adequacy of water supply.
- Enquire if staff have encountered any water shortages or interruptions recently.
- Discuss procedures followed when water supply disruptions occur and how they are managed.

- Confirm whether there are contingency plans in place for water shortages.
- Interview housekeeping and nursing staff to understand if water availability ever affected their work or patient care.

Implementation plan :

The facility must establish a reliable system to ensure the availability of an adequate quantity of water as per the required standards. This involves securing a continuous water supply of at least 200 litres per bed per day if the source is municipal water. The facility should monitor daily water consumption and storage levels regularly to prevent shortages. Maintenance of water supply infrastructure, including pumps, storage tanks, and pipelines, is essential to ensure uninterrupted service. Staff should be trained to promptly report any water supply issues. Contingency plans, such as alternative water sources or backup storage, must be in place to manage potential disruptions effectively. Regular audits and documentation of water availability should be conducted to maintain compliance.

Scoring Criteria :

 2 Marks: The facility consistently receives at least 200 litres of water per bed per day from municipal supply, or water is available 24x7 at all usage points without interruption.

 1 Mark: The facility generally meets water quantity requirements, but occasional short interruptions or minor deficiencies in availability at some points are observed or reported.

 0 Mark: The facility fails to provide adequate water quantity per bed per day or experiences frequent interruptions in water supply at multiple usage points affecting care or hygiene.

Reference : NA

E2.2	**There is storage tank for the water and tank is cleaned periodically**

Interpretation
This checkpoint ensures that the hospital has a reliable water supply system by requiring a storage tank with sufficient capacity to meet water needs for 48 hours. Periodic cleaning of the tank is critical to prevent bacterial growth and contamination, which can impact patient safety and hospital operations. Maintaining records of cleaning activities provides evidence of compliance and helps in tracking maintenance activities. Together, these measures reduce the risk of waterborne infections and interruptions in hospital water supply.
Means of verification : **OB / SI**

Observation:

- Check if a water storage tank is physically present on site.
- Verify the tank's capacity to ensure it can hold 48 hours of water supply.
- Inspect the condition and cleanliness of the water storage tank.
- Review records and logs of tank cleaning and maintenance.
- Confirm that cleaning has been done at six-month intervals as per the records.

Staff Interview:

- Ask staff responsible for maintenance about the schedule and frequency of tank cleaning.
- Enquire how the hospital ensures there is always sufficient water stored for 48 hours.
- Question about procedures followed in case of water supply interruptions.
- Confirm if documentation of cleaning and maintenance activities is properly maintained and updated.

Record Review:

- Examine cleaning and maintenance logs to verify six-monthly cleaning.
- Check if records are complete, accurate, and up-to-date.
- Review any reports or audit documents related to water tank maintenance.

Implementation plan :
The hospital must install and maintain a water storage tank with enough capacity to store water for at least 48 hours of the hospital's consumption. A maintenance schedule should be established to clean the water tank every six months to prevent contamination and ensure safe water supply. The cleaning process must be documented, and records should be maintained and made available for review. Staff responsible for maintenance must be trained on the cleaning procedures and record-keeping requirements. Regular audits or inspections should be planned to ensure compliance with the cleaning schedule and storage capacity standards.
Scoring Criteria :

 2 Marks: The hospital has a water storage tank with capacity for at least 48 hours of supply, and the tank is cleaned every six months with complete and up-to-date cleaning records maintained.

 1 Mark: The hospital has the water storage tank of required capacity, but either the cleaning is not done regularly every six months or the cleaning records are incomplete or not properly maintained.

 0 Marks: The hospital lacks a water storage tank of adequate capacity or does not maintain periodic cleaning of the tank, or there are no records available to verify the cleaning and maintenance.

Reference : NA

E2.3	Drinking Water is chlorinated

Interpretation
This checkpoint ensures that drinking water within the healthcare facility is safe from microbial contamination through adequate chlorination. Maintaining a free chlorine residual of at least 0.2 ppm is critical for preventing waterborne infections among patients, staff, and visitors. The presence of free chlorine at the specified concentration indicates effective disinfection, which is a basic requirement for infection control in healthcare settings. Failure to maintain this standard reflects lapses in water safety management and increases the risk of disease transmission, compromising patient safety and overall hygiene.

Means of verification : **OB / SI**

Observation (OB):

- Observe the process of collecting water samples from potable water points such as taps and storage tanks.
- Check if the water samples are tested on-site using chlorine testing kits or instruments.
- Verify the presence and condition of chlorine testing equipment.
- Review the records or logbooks documenting the chlorine testing results for free chlorine residual levels.
- Inspect the water chlorination system and equipment to confirm they are functional and properly maintained.

Staff Interview:

- Enquire about the frequency of water sampling and chlorine testing carried out for potable water.
- Ask about the procedure followed for testing free chlorine levels and what actions are taken if chlorine is below 0.2 ppm.
- Check the staff's knowledge regarding the importance of maintaining chlorine residual at 0.2 ppm in drinking water.
- Inquire who is responsible for maintaining the water chlorination system and recording the test results.
- Discuss the corrective measures applied when chlorine levels are found to be inadequate.

Implementation plan :

To implement the checkpoint E2.3, the healthcare facility must establish a systematic procedure to ensure all drinking water supplied to the facility is adequately chlorinated. This involves regular sampling of potable water from various points within the facility, including storage tanks and dispensing taps. The water samples should be tested daily or at a predetermined frequency using reliable chlorine testing kits to detect free chlorine levels. A record of each test result must be maintained meticulously. In case the chlorine levels are found to be below the required threshold of 0.2 ppm, immediate corrective actions should be taken, such as adjusting the chlorine dosage or inspecting the water treatment system for faults. Staff responsible for water quality management should be trained on testing methods, safety protocols, and documentation practices. Additionally, maintenance of the water chlorination system must be scheduled routinely to ensure consistent disinfectant levels.

Scoring Criteria :

 2 Marks: Free chlorine residual of 0.2 ppm or above is consistently detected in all potable water samples, with proper documentation and evidence of routine monitoring and maintenance.

 1 Mark: Free chlorine residual is detected in most samples but with occasional readings below 0.2 ppm; records are available but monitoring or corrective actions are inconsistently applied.

 0 Mark: Free chlorine residual is not detected or is consistently below 0.2 ppm; no regular monitoring or documentation is available; corrective actions and equipment maintenance are not evident.

Reference : NA

E2.4	**Quality of Water is tested periodically**

Interpretation

This checkpoint verifies that the healthcare facility consistently monitors water quality by conducting bacteriological tests at defined intervals. It ensures that water used within the facility meets safety standards and does not pose a risk of infection to patients or staff. Periodic testing helps in early detection of microbial contamination and supports timely intervention. Compliance with this standard demonstrates the facility's commitment to maintaining hygiene and safety as part of its overall quality management system.

Means of verification : **OB / SI**

Observation (OB):

- Observe if water samples are being collected regularly from designated points.
- Check whether the collected water samples are properly labeled and stored before dispatch.
- Verify that water samples are sent periodically to an accredited laboratory for bacteriological examination.
- Review records and reports of water quality tests for dates, laboratory details, test results, and follow-up actions.
- Observe if corrective actions (like water treatment) are carried out when test results indicate contamination.

Staff Interview:

- Enquire how often water samples are collected and sent for testing.
- Ask who is responsible for collecting and dispatching water samples.
- Enquire if staff are aware of the procedure for collecting water samples and maintaining the schedule.
- Ask if staff understand the importance of bacteriological testing of water in infection control.
- Enquire about the actions taken if test results show contamination in the water supply.

Implementation plan :

The quality of water used in the facility must be tested at regular intervals to ensure it is safe and free from contamination. A schedule should be established to send water samples periodically for bacteriological examination through a certified laboratory. The responsibility for collecting and dispatching water samples should be assigned to designated staff, with proper documentation maintained for each test. Any findings of contamination must be addressed immediately by taking corrective action, such as water treatment or source protection, to maintain patient and staff safety. The plan should include training for staff on the importance of water quality and protocols for sample handling.

Scoring Criteria :

 2 Marks: Water quality is tested periodically as per schedule, with documented reports

available for review and evidence of corrective actions taken when needed. Staff demonstrate clear knowledge of the sampling and testing process.

 1 Mark: Water quality testing is done, but either the schedule is irregular, documentation is incomplete, or corrective actions are inconsistently implemented. Staff have partial understanding.

 0 Mark: No evidence of periodic water quality testing, absence of documentation, and lack of staff awareness about the testing process.

Reference : NA

E2.5	**Water is available at all points of use**

Interpretation
This checkpoint evaluates whether water is consistently accessible at all essential points of care and patient interaction within the facility. Availability of water at hand-washing stations is critical for infection control, while sufficient water supply in OT, labour room, wards, and patient toilets ensures hygiene and patient comfort. Lack of water at any point can compromise patient safety and quality of care, making this a fundamental standard for accreditation.
Means of verification : **OB / SI**

Observation:

- Check if water is physically available and flowing at hand-washing points across all critical areas such as the OT, labour room, wards, patients' toilets and baths, and waiting areas.
- Verify that taps, faucets, or other water outlets are functional at each point of use.
- Look for the presence and condition of water storage tanks or backup water supplies where applicable.
- Observe any visible signs of water shortage, leakage, or plumbing issues.

Staff Interview:

- Ask staff if they experience any interruptions or shortages in the water supply at these points of use.
- Enquire how frequently the water supply is monitored and who is responsible for maintaining it.
- Question staff about the procedures followed when water supply issues occur, including reporting and corrective actions.
- Confirm whether patients or visitors have raised concerns about water availability in waiting areas or patient care zones.

Implementation plan :
To ensure water availability at all points of use, a detailed assessment of all critical areas such as hand-washing stations, operation theatre (OT), labour room, wards, patients' toilets and baths, and waiting areas will be conducted. Infrastructure checks and maintenance schedules will be established to regularly monitor water supply systems. Staff will be trained to report any

interruptions or issues promptly. Contingency plans like backup water storage or alternative supply lines will be implemented to avoid any disruption. Regular audits will be carried out to ensure compliance and address gaps immediately.

Scoring Criteria :

 Award **2 marks** if water is available and accessible at all points of use consistently, with documented monitoring and no recent interruptions reported.

 Award **1 mark** if water is available at most points but occasional interruptions or minor issues have been noted and are being addressed.

 Award **0 marks** if water is unavailable at multiple points, or frequent interruptions occur with no effective corrective actions in place.

Reference : NA

E3	**Kitchen Services**

E3.1	**Hospital kitchen is located in a separate building, away from patient care area and functions meticulously**

Interpretation

This checkpoint ensures that the hospital kitchen functions in an environment that supports food safety and infection control by being physically separated from patient care areas. The use of LPG or PNG for cooking reflects the hospital's commitment to safe and clean fuel use, minimizing smoke and environmental pollution. Proper segregation of kitchen waste from biomedical waste helps prevent cross-contamination and aligns with waste management regulations. Overall, meeting this checkpoint demonstrates that the hospital has effective systems in place for kitchen hygiene, safety, and environmental responsibility.

Means of verification : **OB / SI**

Observation:

- Confirm that the hospital kitchen is located in a separate building away from patient care areas.
- Check that the kitchen has a proper layout supporting hygienic and efficient operation.
- Verify that cooking is done using LPG or PNG and that no firewood is used.
- Observe the method of kitchen waste collection and ensure it is collected separately from biomedical waste.
- Look for any signs of mixing kitchen waste with biomedical waste.

Staff Interview:

- Ask kitchen staff about the type of fuel used for cooking and confirm that firewood is not used.
- Enquire how kitchen waste is handled and whether it is segregated from biomedical waste.
- Interview housekeeping or infection control staff about any challenges faced in maintaining kitchen location and waste segregation standards.
- Confirm awareness among staff about the importance of the kitchen being separate from patient care areas.

Implementation plan :
The hospital must ensure that the kitchen is located in a completely separate building, physically distant from all patient care areas to reduce contamination risks. The kitchen should have a well-organized layout to facilitate hygienic and efficient food preparation and handling. Cooking should strictly use clean fuel sources such as LPG or PNG; the use of firewood or any other polluting fuels must be avoided. Waste management procedures must be established to ensure that kitchen waste is collected separately from biomedical waste, following proper segregation and disposal protocols. Regular monitoring and staff training should be conducted to maintain compliance with these requirements.
Scoring Criteria :

 2 Marks: The hospital kitchen is fully functional in a separate building with a proper layout; cooking uses only LPG/PNG fuel, and kitchen waste is always collected separately without mixing with biomedical waste.

 1 Mark: The kitchen is located separately but has minor lapses either in fuel usage (e.g., occasional use of firewood) or kitchen waste segregation practices.

 0 Marks: The kitchen is not located separately or is within patient care areas; firewood is used for cooking; kitchen waste is mixed with biomedical waste, indicating non-compliance with the standard.

Reference : NA

E3.2	**The Kitchen has provision to store dry ration and fresh ration separately.**

Interpretation

This checkpoint ensures that food safety and hygiene standards are maintained by preventing cross-contamination between dry and fresh rations. Proper storage on pallets and in closed containers protects dry rations from moisture and pests. Temperature control for fresh ration and perishables like dairy products prevents spoilage and bacterial growth. Regular cleaning and defrosting of refrigeration equipment is critical to avoid contamination. Meeting this checkpoint indicates that the kitchen maintains good food handling practices and supports overall food safety management.

Means of verification : **OB / SI**

Observation:

- Check if dry ration is stored on pallets and kept away from walls.
- Verify that dry ration is stored in closed containers.
- Observe whether vegetables are stored at appropriate temperatures.
- Inspect the refrigerator used for perishable items like milk and curd to ensure it is clean and regularly defrosted.
- Look for documentation or evidence of regular cleaning and maintenance of storage areas and refrigeration.

Staff Interview:

- Ask staff how they separate dry and fresh rations during storage.
- Inquire about the frequency and procedure of cleaning and defrosting the refrigerator.
- Question staff on how they monitor the temperature of fresh ration storage areas.
- Ask what actions are taken if spoilage or contamination is detected.
- Verify staff understanding of protocols related to food storage and hygiene practices.

Implementation plan :
The kitchen must establish clear and designated storage areas to separate dry ration from fresh ration. Dry rations should be placed on pallets and kept away from walls to avoid moisture and pest contamination. All dry items must be stored in closed containers to maintain hygiene and prevent spoilage. Fresh ration, including vegetables, must be stored at appropriate temperatures to preserve freshness. Perishable items such as milk and curd need to be kept in a refrigerator that is cleaned and defrosted regularly. Staff should be trained on proper storage procedures and responsible for regular monitoring and maintenance of storage conditions to ensure ongoing compliance.
Scoring Criteria :

 2 Marks: Dry ration is stored properly on pallets away from walls in closed containers; vegetables are kept at correct temperature; perishable items are stored in a clean, regularly defrosted refrigerator with documented maintenance.

 1 Mark: Partial compliance, such as dry ration stored correctly but refrigerator cleaning or temperature control not fully documented or consistent.

 0 Mark: Dry and fresh rations are mixed or improperly stored; refrigerators are not cleaned or defrosted regularly; poor maintenance of storage areas leading to potential contamination.

Reference : NA

E3.3	The Kitchen is smoke-free and fly-proofed

Interpretation
This checkpoint requires that the kitchen environment remains free from smoke and flying insects, which are critical factors in maintaining food hygiene and staff safety. Proper ventilation ensures that cooking smoke does not accumulate, thereby reducing health risks and discomfort.

Fly-proofing prevents contamination from flies that can carry pathogens. The absence of smoke and flies inside the kitchen indicates that the kitchen environment is safe, hygienic, and compliant with food safety standards. Failure to maintain these conditions suggests lapses in infrastructure or housekeeping practices that need urgent attention.

Means of verification : **OB / SI**

- **Observation:**
  - Check that the kitchen has functional ventilation systems such as exhaust fans, chimneys, or windows allowing proper air circulation.
  - Verify that all doors and windows have intact and clean fly-proof screens or meshes.
  - Observe if there is any visible smoke accumulation inside the kitchen area.
  - Look for the presence or absence of flies or other flying insects within the kitchen premises.
  - Check the overall cleanliness and maintenance of ventilation and fly-proofing equipment.
- **Staff Interview:**
  - Ask staff if they experience any smoke buildup while cooking or during kitchen operations.
  - Inquire about the frequency of maintenance or cleaning of ventilation and fly-proof screens.
  - Ask if they have noticed any fly nuisance or issues with flies inside the kitchen recently.
  - Check if staff report any problems with doors or windows not closing properly or damaged fly-proofing.

Implementation plan :

To implement this checkpoint, ensure that the kitchen is equipped with adequate ventilation systems such as exhaust fans, chimneys, or windows that facilitate proper air flow and prevent smoke accumulation. Install fly-proof screens or meshes on all kitchen doors and windows to stop flies and other insects from entering. Conduct regular cleaning and maintenance of ventilation equipment and fly-proof screens to ensure their effectiveness. Train kitchen staff to promptly report any smoke buildup or fly nuisance. Schedule periodic inspections to verify the condition of ventilation and fly-proofing measures, and take corrective actions immediately if any issues are detected.

Scoring Criteria :

 2 Marks: The kitchen is well ventilated with all doors and windows fitted with intact fly-proof screens, no smoke or fly nuisance is noticed inside at any time, and staff confirm regular maintenance and no issues.

 1 Mark: The kitchen has ventilation and fly-proofing mostly intact, with minor issues such as occasional fly presence or minor smoke but no significant nuisance; some maintenance activities are irregular.

 0 Marks: The kitchen lacks proper ventilation or fly-proofing, visible smoke or flies are regularly noticed inside, and staff report frequent issues or lack of maintenance.

Reference : NA

E3.4	Staff observes meticulous personal hygiene

Interpretation

This checkpoint focuses on the importance of personal hygiene among staff, particularly those involved in cooking and food handling, to prevent contamination and ensure safe food preparation. The use of caps and kitchen dresses helps minimize hair and clothing contamination, while trimmed nails and hair reduce the risk of harboring bacteria. Restricting kitchen access only to authorized staff prevents unnecessary exposure to food preparation areas. Availability of toilet facilities and nail brushes supports proper hand hygiene and cleanliness, all of which contribute to overall food safety and infection control.

Means of verification : **OB / SI**

Observation (OB):

- Check if staff wear caps while cooking.
- Observe if staff wear the designated kitchen dress.
- Inspect if nails and hair of staff are trimmed and clean.
- Verify that only authorized staff are working in the kitchen area.
- Confirm availability and cleanliness of toilet facilities for staff.
- Check presence and accessibility of nail brushes near handwashing areas.

Staff Interview (SI):

- Ask staff about the importance of wearing caps and kitchen dresses during food preparation.
- Enquire how staff maintain personal hygiene, including nail and hair grooming.
- Confirm staff understanding of restrictions on kitchen access for unauthorized personnel.
- Ask about the use and availability of toilet facilities and nail brushes for hygiene purposes.

Implementation plan :

To ensure staff maintains meticulous personal hygiene, the hospital management will develop clear policies and protocols outlining hygiene expectations, especially for staff involved in food preparation. Regular training sessions and refresher courses will be conducted to educate staff on hygiene standards including appropriate kitchen attire, grooming, and hand hygiene. Supervisors will monitor daily practices, ensuring only authorized personnel enter kitchen areas. Facilities such as toilets and handwashing stations will be maintained in good condition with adequate supplies, including nail brushes. Periodic audits and spot checks will be scheduled to reinforce compliance and identify areas for improvement.

Scoring Criteria :

- Award 2 marks if all staff strictly adhere to wearing caps and kitchen dresses, have trimmed nails and hair, unauthorized personnel are restricted from the kitchen, and toilet facilities and nail brushes are available and used properly.
- Award 1 mark if some staff comply with the hygiene practices but there are minor lapses such as occasional unauthorized personnel in the kitchen or inconsistent use of caps and dresses.
- Award 0 marks if there is poor compliance with personal hygiene standards, lack of

proper attire, unrestricted kitchen access, or inadequate facilities for hygiene maintenance.

Reference : NA

E3.5	**Food to patients is distributed through covered trolleys and patients utensils are not dented or chipped - off**

Interpretation

This checkpoint emphasizes the importance of hygienic food delivery and the safety of patient utensils. Covered trolleys prevent exposure of food to environmental contaminants during transportation. Utensils that are dented or chipped can harbor bacteria and pose a risk of injury to patients, therefore must be discarded or replaced promptly. Meeting this standard reflects good infection control practices and patient safety measures within the hospital.

Means of verification : **OB / SI**

Observation (OB):

- Check if an adequate number of covered food trolleys are available in the food distribution area.
- Observe whether these trolleys are being used during meal rounds.
- Inspect patient utensils such as plates, bowls, cups, and cutlery to see if they are free from dents, chips, or damage.

Staff Interview (SI):

- Enquire about the process for using covered trolleys during food distribution.
- Ask about the frequency and responsibility for inspecting and replacing damaged patient utensils.
- Check staff understanding of the importance of using covered trolleys and maintaining utensil quality for patient safety.

Implementation plan :
To ensure that food is distributed to patients using covered trolleys and that patient utensils are free from dents or chips, the hospital must procure and maintain an adequate number of covered food trolleys. These trolleys should be routinely inspected for cleanliness and functionality. Staff involved in food distribution should be trained on hygienic practices and the importance of using covered trolleys to prevent contamination. Additionally, a system should be in place for regular inspection and replacement of patient utensils to ensure they are intact and safe for use.
Scoring Criteria :

 2 Marks: Covered food trolleys are adequate in number and consistently used, and all patient utensils are intact without dents or chips.

 1 Mark: Covered trolleys are available but not consistently used, or minor issues are found

with some utensils (few dents/chips).

 0 Mark: Covered trolleys are not available or not used, and patient utensils are frequently found dented or chipped.

Reference : NA

E4	Security Services

E4.1	The main gate of premises, Hospital building, wards, OT and Labour room are secured

Interpretation

This checkpoint focuses on physical security to protect patients, staff, and hospital assets. Securing critical areas like the main gate, wards, OT, and labour room ensures that only authorized personnel and visitors can enter sensitive zones, reducing risks of theft, violence, or unauthorized access. Presence of security personnel at these strategic locations acts as a deterrent and ensures prompt response to any suspicious activities. Maintaining this security is essential for patient safety and smooth hospital operations.

Means of verification : **OB / SI**

Observation (OB):

- Observe if security personnel are physically present at the main gate, hospital building entrances, wards, OT, and labour room.
- Check that these critical locations have controlled access points monitored by security staff.
- Verify that security personnel are actively observing and managing entry and exit.

Staff Interview (SI):

- Enquire security staff about their duties and shifts related to securing critical locations.
- Ask security personnel how they monitor and control access at the main gate, wards, OT, and labour room.
- Discuss with hospital supervisors or management about the deployment and adequacy of security personnel at these locations.

Implementation plan :

The implementation of checkpoint E4.1 requires ensuring that all critical entry points of the hospital premises, including the main gate, hospital building, wards, operation theatre (OT), and labour room, are secured effectively. This involves deploying trained security personnel at these locations during all operating hours. Security staff must be oriented about their roles and responsibilities to monitor access and prevent unauthorized entry. Regular rounds and monitoring systems such as CCTV should be used to enhance security coverage. The hospital management should conduct periodic audits to confirm that security arrangements meet required standards

consistently.
Scoring Criteria :

 2 Marks: Security personnel are present at all critical locations (main gate, hospital building, wards, OT, and labour room) during all shifts, with evidence of active monitoring and control.

 1 Mark: Security personnel are present at most critical locations but not consistently at all required points or during all shifts. Some lapses in active monitoring observed or reported.

 0 Marks: Security personnel are absent or inadequately deployed at critical locations, with no proper monitoring or control of access points.

Reference : NA

E4.2	**The security personal are meticulously dressed and smartly turned-out.**

Interpretation

Interpretation of this checkpoint involves assessing both the physical appearance and conduct of the security personnel. The staff should be impeccably dressed in the prescribed uniform, with attention to cleanliness and grooming. Additionally, their behaviour must reflect discipline — they should not engage in any acts that compromise the institution's image, such as spitting, tobacco chewing, or smoking. Compliance indicates a well-managed security team that respects institutional policies and promotes a safe environment.

Means of verification : **OB / SI**

Observation (OB):

- Check the security personnel's uniform for neatness, cleanliness, and proper wearing of all uniform components.
- Observe the grooming of security staff, including clean shoes, tidy hair, and overall well-maintained appearance.
- Watch for any inappropriate behaviours such as spitting, chewing tobacco, or smoking while on duty.
- Note the body language and attentiveness of security personnel during their shift.

Staff Interview (SI):

- Ask security personnel if they understand the importance of maintaining a smart and professional appearance.
- Enquire whether they are aware of the rules against spitting, chewing tobacco, and smoking while on duty.
- Discuss how they ensure compliance with grooming and behavioural standards.
- Check if they have received any training or guidance related to professional conduct and appearance.

Implementation plan :
The implementation plan for checkpoint E4.2 focuses on ensuring that security personnel maintain a professional and neat appearance, which reflects discipline and sets a positive image for the institution. Supervisors will conduct regular inspections during various shifts to observe the personal grooming and attire of security staff. Training sessions will be held to reinforce the importance of professional behaviour, including personal hygiene, dress code, and conduct such as refraining from spitting, chewing tobacco, and smoking within the premises. Any non-compliance will be addressed immediately through counseling or disciplinary action. The objective is to maintain high standards of decorum among security personnel, contributing to overall institutional safety and professionalism.

Reference : NA

E4.3	**There is a robust crowd management system.**

Interpretation
This checkpoint evaluates how effectively the healthcare facility manages patient crowds in the OPD to ensure safety, comfort, and hygiene. A robust crowd management system means the waiting area is sufficient and well-maintained, dustbins are available to control waste, and ventilation supports a healthy environment. It also reflects how well the facility organizes patient movement to avoid overcrowding, which is critical for infection control and patient satisfaction. Achieving this standard indicates the facility's commitment to quality care and operational efficiency.
Means of verification : **OB / SI**

What is to be observed (OB):

- Presence of a designated waiting area in the OPD with sufficient seats for patients and attendants.
- Availability and proper placement of dustbins within the OPD and waiting areas.
- Adequate ventilation in the OPD, such as open windows, exhaust fans, or air circulation systems.
- Organization of patient flow and crowd movement in the OPD (signage, barriers, queue management).

What is to be enquired during staff interview:

- How is the seating capacity decided and maintained for the waiting area?
- What measures are taken to ensure cleanliness and timely emptying of dustbins?
- How is ventilation maintained and monitored regularly?
- What protocols are followed during peak hours to manage patient crowding effectively?

Implementation plan :
To implement a robust crowd management system in the OPD, the facility must ensure there is a designated waiting area with enough seating to comfortably accommodate patients and their attendants, minimizing overcrowding. Dustbins should be strategically placed in accessible locations and regularly emptied to maintain cleanliness. Adequate ventilation must be provided

through natural or mechanical means to ensure a fresh and healthy environment for everyone in the OPD. Staff should be trained and assigned to manage patient flow efficiently, especially during peak hours, with clear signage to guide patients and prevent confusion or congestion. Regular monitoring and feedback mechanisms should be in place to continuously improve the crowd management system.

Scoring Criteria :

 2 Marks: The OPD has a clearly designated waiting area with ample seating; dustbins are available and regularly maintained; ventilation is adequate and functional; crowd flow is effectively managed through signage and staff intervention during busy hours.

 1 Mark: The OPD has a waiting area with some seating; dustbins are present but may not be optimally placed or maintained; ventilation is partially adequate; crowd management is informal and sometimes effective.

 0 Marks: No proper waiting area or insufficient seating; dustbins are absent or poorly maintained; ventilation is inadequate; no crowd management system in place, leading to overcrowding and discomfort.

Reference : NA

E4.4	**Security personal reprimands attendants, who found indulging into unhygienic behaviour - spitting, open field urination & defecation, etc.**

Interpretation

This checkpoint focuses on the active role of security personnel in upholding hygiene and sanitation standards by addressing inappropriate behaviors promptly. It is interpreted as a measure to ensure that the environment remains clean and safe for all patients, attendants, and staff. The presence of security staff who are vigilant and willing to intervene is essential for preventing unhygienic practices that could compromise the health environment. This checkpoint indicates not only observation but also the timely corrective action taken by security personnel.

Means of verification : **OB / SI**

Observation (OB):

- Check if security personnel are actively watching the behavior of patients and their attendants, especially for unhygienic practices like spitting, open field urination, and defecation.
- Observe whether security personnel take immediate action by reprimanding those found indulging in such behavior.
- Look for visible signs of monitoring, such as security staff patrolling or stationed at strategic locations prone to unhygienic behavior.
- Verify if there is any documentation or incident report related to reprimanding of attendants by security staff during your observation.

Staff Interview (SI):

- Enquire from security personnel if they understand their responsibility to monitor and control unhygienic behavior among patients and attendants.
- Ask security staff how they handle situations when they witness such unhygienic

practices.

- Confirm whether they have been trained or briefed about the importance of reprimanding such behavior.
- Inquire if there is any protocol or documentation process they follow when reprimanding attendants.
- Find out if they feel empowered and supported by the administration to take such actions.

Implementation plan :

To implement this checkpoint effectively, the security personnel must be clearly briefed and trained on the importance of maintaining hygiene and sanitation within the facility. They should be instructed to actively monitor the behavior of patients and their attendants, specifically looking for unhygienic actions such as spitting, open field urination, and defecation. There must be a clear protocol empowering security staff to reprimand individuals engaging in such behaviors immediately and firmly. Regular supervision and refresher sessions should be held to reinforce these responsibilities. Additionally, a system to document and report any incidents and actions taken should be established to ensure accountability and follow-up.

Scoring Criteria :

- **2 Marks:** Security personnel consistently monitor patient and attendant behavior and promptly reprimand unhygienic actions, with documented evidence of such interventions.
- **1 Mark:** Security personnel occasionally monitor and reprimand but lack consistency or documentation of actions taken.
- **0 Marks:** Security personnel do not monitor or reprimand unhygienic behavior, or there is no evidence of such enforcement.

Reference : NA

E4.5	**Un-authorized vendors are not present inside the campus. Waste storage is secured and there is no plastic items, card board etc.**

Interpretation

This checkpoint requires that no unauthorized vendors, such as rag-pickers, are present within the campus boundaries at any time. It highlights the importance of maintaining a secure and well-managed waste storage area that does not contain plastic, cardboard, or other inappropriate materials. The checkpoint ensures that waste handling and vendor access protocols protect the campus environment and uphold hygiene and safety standards. Essentially, it reflects the facility's commitment to controlled access and proper waste management practices.

Means of verification : **OB / SI**

Observation:

- Observe the entry points to see if vendor access is actively controlled and monitored.
- Check for any unauthorized individuals, such as rag-pickers, inside the campus premises.
- Inspect the waste storage area to confirm it is secured with locks, fences, or other barriers.
- Look for the presence of plastic items, cardboard, or any other unauthorized waste materials in the waste storage area.

Staff Interview:

- Ask security or reception staff about the procedures followed to verify and control vendor entry.
- Enquire if they have noticed any unauthorized vendors or rag-pickers entering or attempting to enter the campus recently.
- Interview housekeeping or waste management staff about waste segregation and storage practices.
- Check if staff have received training on controlling vendor entry and maintaining secured waste storage.

Implementation plan :

To implement checkpoint E4.5 effectively, the facility must establish a robust system to control and monitor the entry of vendors into the campus. This includes having security personnel or reception staff verify the identity and authorization of all vendors before allowing access. Entry points should be equipped with proper documentation and visitor logs to track vendor movements. The waste storage area should be physically secured using locks, fencing, or barriers to prevent unauthorized access. Regular inspections must be scheduled to ensure no plastic items, cardboard, or other unauthorized materials are stored with the waste. Staff training on waste management and vendor control protocols is essential to maintain consistent compliance.

Scoring Criteria :

 2 Marks: Vendor entry is strictly controlled with documented verification procedures, no unauthorized vendors or rag-pickers are present, and the waste storage area is fully secured and free from plastic, cardboard, or other prohibited waste items.

 1 Mark: Vendor entry control exists but with occasional lapses; minor presence of unauthorized vendors or some unsecured waste items detected, but overall waste storage is mostly secured.

 0 Mark: No control over vendor entry, frequent presence of unauthorized vendors inside the campus, waste storage is unsecured with visible plastic, cardboard, or other non-permitted waste materials.

Reference : NA

E5	Out-sourced Services Management

E5.1	There is valid contract for out-sourced services, like house-keeping, BMW management, security, etc.

Interpretation

This checkpoint ensures that the hospital has formal, legally binding agreements in place with external vendors providing essential support services. Valid contracts demonstrate that the hospital is accountable for maintaining service quality, safety, and compliance with regulatory requirements. The presence of these contracts protects the hospital legally and ensures that outsourced services meet the expected standards consistently.

Means of verification : **OB / SI**

 What is to be observed (OB):

- Review the physical or digital copies of all contracts related to outsourced services such as housekeeping, BMW management, and security.
- Check if the contracts are current, signed, and contain necessary details like terms of service, duration, and responsibilities.
- Observe any contract renewal records or correspondence related to contract management.

 What is to be enquired (Staff interview):

- Ask administrative or contract management staff about the process of contract renewal and monitoring.
- Enquire if there have been any lapses or delays in renewing contracts for outsourced services.
- Confirm whether the staff is aware of the service providers and if there are any quality or compliance issues linked to outsourced services.

Implementation plan :

To implement this checkpoint effectively, the hospital management must ensure that all outsourced services such as housekeeping, biomedical waste (BMW) management, security, and other contracted services have valid and up-to-date contracts. This involves periodically reviewing the contracts to verify their validity and ensuring compliance with the terms. The contracts should clearly define the scope of services, duration, responsibilities, and performance standards. The quality and timely renewal of these contracts must be monitored by the quality or administrative department to avoid any lapse in service delivery.

Scoring Criteria :

 2 Marks: Valid contracts for all outsourced services (housekeeping, BMW management, security, etc.) are available, up-to-date, signed by authorized persons, and monitored regularly for renewal and compliance.

 1 Mark: Contracts are available for most outsourced services but some are either expired or not regularly reviewed.

 0 Mark: Contracts are missing, invalid, or not maintained for outsourced services, leading to non-compliance or risk of service disruption.

Reference : NA

E5.2	The Contract has well defined measurable deliverables

Interpretation
This checkpoint emphasizes the importance of clarity and accountability in outsourcing arrangements. A "well-defined measurable deliverable" means the contract should not just state the service to be provided, but also define the quality, frequency, and standards to be met. For instance, if housekeeping is outsourced, the deliverables may include cleaning frequency, cleaning agents to be used, timelines, and cleanliness benchmarks. This enables both parties to have a clear understanding of expectations and provides a basis for performance evaluation and corrective action if required.
Means of verification : **OB / SI**

 Observation:

- Observe the physical contract files or digital copies maintained in the administrative office.
- Check if the contract mentions specific, quantifiable outputs and methods for verification.
- Look for evidence of periodic review reports or performance evaluations based on contract terms.

 Staff Interview:

- Enquire with the hospital administrator or quality manager about the process of defining and reviewing deliverables in outsourced contracts.
- Ask how the hospital monitors outsourced service quality and what action is taken if deliverables are not met.
- Confirm with staff if they are aware of the measurable criteria against which vendor performance is evaluated.

Implementation plan :
The hospital must ensure that all outsourced services are governed by a formal contract that clearly defines the scope of services, expected outcomes, and measurable deliverables. The deliverables must be specific, time-bound, and verifiable either through performance indicators or qualitative standards. This includes services such as housekeeping, laundry, biomedical waste management, security, and maintenance. The contract should also specify the monitoring mechanism and the methods by which the deliverables will be reviewed periodically.
Scoring Criteria :

 2 Marks:
The contract clearly defines measurable deliverables, including how each will be verified, and the hospital has evidence of regular monitoring and review based on these parameters.

 1 Mark:

The contract mentions deliverables but lacks specificity or clarity in measurability; verification methods are present but inconsistently applied or documented.

 0 Mark:
The contract does not define measurable deliverables, or there is no evidence of monitoring or verification related to service performance.

Reference : NA

E5.3	**The contract has penalty clause and it has been evoked in the event of non-performance or sub-standard performance**

Interpretation
This checkpoint aims to verify whether the healthcare organization is not only including a penalty clause in vendor contracts but also ensuring its enforcement when necessary. The intention is to ensure accountability and high-quality service from external vendors. Mere presence of the clause is not sufficient; evidence of its usage when appropriate is necessary to demonstrate the hospital's commitment to quality and contract compliance.
Means of verification : **OB / SI**

- **Observation (OB):**
  - Observe the contract documents of outsourced services and verify the inclusion of penalty clauses.
  - Check documentation related to vendor performance evaluation and related penalties applied.
  - Look for copies of letters or notes highlighting invocation of penalty clauses or deductions made.
- **Staff Interview (SI):**
  - Ask administrative or quality in-charge staff how they monitor vendor performance.
  - Enquire if the penalty clause has ever been enforced and request an example.
  - Ask how non-compliance by vendors is documented and managed.

Implementation plan :
To effectively implement this standard, the facility should ensure that all service contracts with external vendors (e.g., housekeeping, security, waste management, laundry, etc.) include a clearly defined penalty clause. This clause should specify consequences in case of non-performance or substandard service delivery. Administrative or quality personnel responsible for vendor management should regularly review vendor performance as per agreed terms and document any deviations. In instances of repeated non-compliance, the penalty clause should be enforced, and evidence of such enforcement (e.g., penalty letters, reduced payments, or corrective action notices) should be maintained.
Scoring Criteria :

 2 Marks: The contract includes a clear penalty clause, and there is documented evidence that the clause has been invoked in case of non-performance or sub-standard service delivery.

 1 Mark: The contract includes a penalty clause, but there is no evidence that it has ever been invoked despite instances where it may have been necessary.

 0 Mark: The contract does not include any penalty clause or such clause is included but never monitored or invoked, regardless of vendor performance issues.

Reference : NA

E5.4	**Services provided by the out-sourced organization are measured periodically and performance evaluation is formally recorded.**

Interpretation
This checkpoint emphasizes that the hospital must **periodically measure the performance of outsourced service providers** and **formally record** the evaluation results. It is not sufficient to have informal feedback or verbal complaints; there should be documented evidence such as filled evaluation forms, summary reports, or meeting minutes. The evaluation should assess parameters like timeliness, compliance with contractual terms, quality of service, and staff behavior. The documentation should be accessible and updated as per the defined frequency.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether vendor evaluation forms or performance records are maintained and accessible.
- Check if evaluation formats include measurable parameters and rating criteria.
- Verify the dates on evaluation forms to ensure periodicity is followed (e.g., every 6 months).

Staff Interview:

- Ask the responsible staff whether vendor performance is assessed regularly and what parameters are used.
- Enquire if any actions or corrective steps have been taken based on vendor performance evaluations.
- Check if staff are aware of the frequency and documentation process for such evaluations.

Record Review (RR):

- Review vendor evaluation forms or performance appraisal records for at least the past two cycles.
- Check if the records mention specific service parameters and include performance ratings or scores.
- Look for evidence of follow-up actions or meeting minutes discussing vendor performance.
- Verify whether evaluation dates align with the stated frequency in the facility's policy.

Implementation plan :
To implement this standard, the healthcare facility must develop a structured system for evaluating the performance of outsourced services. This includes identifying all outsourced services (e.g., housekeeping, laundry, biomedical waste management, security), defining key performance indicators (KPIs) for each service, and conducting evaluations at regular intervals—

preferably quarterly or biannually. A responsible staff member or committee must be assigned to oversee the evaluation process, document the findings, and initiate corrective actions if required. Vendor evaluation forms or performance rating tools must be developed and stored as evidence for audit purposes.

Scoring Criteria :

2 Marks:

- The hospital evaluates all outsourced services periodically (as defined in policy) using a documented, structured format.
- Evaluation results are formally recorded and available for all vendors.
- The process is consistent and includes follow-up actions where needed.

1 Mark:

- Vendor performance is evaluated, but the process is informal or not done consistently for all outsourced services.
- Some records are available but incomplete or lacking proper documentation.

0 Mark:

- No evidence of periodic performance evaluation for outsourced services.
- Either evaluations are not conducted at all or are done verbally without documentation.

Reference : NA

E5.5	**There is defined time-line for release of payment to the contractors for the services delivered by the organisation.**

Interpretation

This checkpoint evaluates whether the organization honors its financial commitments to outsourced service providers in a timely manner. A defined payment timeline reflects the institution's professionalism, credibility, and operational discipline. Timely payment ensures continuity of services and helps maintain positive relationships with vendors. The absence of such a timeline or frequent delays can lead to service disruption or legal/financial issues. The standard is not only about having a policy in place but also about demonstrating consistent adherence to it through records and interactions with vendors.

Means of verification : **OB / SI**

 Observation (OB):

- Observe whether there is a written policy or SOP available that defines the timeline for releasing payments to contractors.
- Observe the payment records (e.g., payment register or software reports) to check whether payments were released within the specified time frame.

 Staff Interview:

- Interview the finance/accounts staff to confirm their awareness of the defined payment timeline and how it is implemented.

- Interview the vendor (if available) to check their experience regarding the timeliness of payments from the organization.

 Record Review:

- Review past payment records to compare the invoice date, approval date, and actual payment date for a sample of vendors.
- Check whether delays, if any, are documented with valid reasons and if they are exceptions rather than a regular occurrence.

Implementation plan :
To comply with E5.5, the organization must formulate a clear, written policy outlining the timeline for releasing payments to contractors or outsourced service providers. This timeline should be practical, based on internal administrative processes, and aligned with any contractual obligations. The accounts or finance department should be oriented about this policy and trained to adhere to the specified deadlines. It is essential to document each step of the payment process, including invoice receipt, verification, approval, and final payment, with timestamps. The organization should maintain a register or software log that captures all contractor payments, showing actual release dates versus due dates. A monitoring mechanism must be put in place to periodically review payment timelines and ensure consistent compliance.
Scoring Criteria :

 2 Marks:
The organization has a clearly defined and documented payment timeline; records consistently show that payments are released within the defined time; finance staff and vendors confirm adherence to timelines.

 1 Mark:
The organization has a defined timeline, but there are occasional delays in payment releases; records show some inconsistencies; staff are aware, but vendors report mixed experiences.

 0 Mark:
There is no defined payment timeline; payment records show frequent delays; staff are unaware of any defined process; vendors report dissatisfaction or delays in receiving payments.

Reference : NA

F	Hygiene Promotion

F1	Community Monitoring & Patient Participation

F1.1	Members of Hospital management committee and Local Governance bodies monitor the cleanliness of the hospital at pre-defined intervals

Interpretation
This checkpoint emphasizes active participation of both internal (HMC) and external (LGBs) stakeholders in maintaining hygiene and cleanliness within the hospital. The monitoring must not be an ad-hoc activity but should occur at clearly defined intervals—minimum once a month. This reflects community involvement and ensures accountability, transparency, and a culture of shared responsibility for infection prevention and hospital hygiene.

Means of verification : **OB / SI**

Observation (OB):

- Check the presence of a cleanliness monitoring schedule.
- Verify records of monthly visits with dates, observations, and actions taken.
- Look for evidence of committee meeting minutes, attendance records, and sign-off sheets.
- Inspect for visible cleanliness in high-traffic patient areas, toilets, and OPD zones post-visit.

Staff Interview:

- Enquire with the hospital in-charge or quality officer about the frequency and process of cleanliness monitoring.
- Ask committee members or administrative staff about their role in cleanliness monitoring and the mechanism for reporting deficiencies.
- Confirm involvement of local governance representatives and whether their feedback is documented and acted upon.

Implementation plan :
To implement the standard F1.1, the hospital shall constitute or identify the Hospital Management Committee (HMC) and include representatives from the Local Governance Bodies (LGBs). A schedule for cleanliness monitoring will be developed in consultation with these members, ensuring that inspections are planned at least once every month. The committee will be oriented on the NABH cleanliness standards and provided with a checklist to assess hospital cleanliness during their visits. Documentation of each monitoring visit—including observations, corrective actions taken, and signatures of committee members—will be maintained for verification. A responsible staff member shall coordinate the meetings and maintain communication with local governance representatives.

Scoring Criteria :

 2 Marks: The hospital demonstrates that members of both the Hospital Management Committee and Local Governance Bodies have monitored cleanliness at least once every month with documented evidence (e.g., checklists, meeting minutes, corrective actions).

 1 Mark: Monitoring of cleanliness is done, but either the frequency is inconsistent (less than once a month) or involvement of local governance representatives is irregular or not clearly documented.

 0 Mark: There is no evidence of cleanliness monitoring by HMC or local governance members, or the process is informal and undocumented.

Reference : NA

F1.2	**Patients are counselled on benefits of Hygiene**

Interpretation
This checkpoint ensures that the facility actively promotes health education by making hygiene counselling a routine practice. It is not enough to simply display posters; direct verbal counselling or structured education is expected. The aim is to empower patients with knowledge that can improve their health outcomes and prevent infections. The counselling must be meaningful and tailored to the patient's understanding and context.
Means of verification : **OB / SI**

 What is to be observed (OB):

- Observe whether hygiene-related educational materials (posters, charts) are displayed in patient care areas.
- Observe staff interactions to see if they are actually providing hygiene counselling to patients.
- Observe if there is a structured protocol or checklist for hygiene counselling in patient care processes.

 What is to be enquired (Staff Interview):

- Ask staff members (e.g., nurse or doctor) to describe how and when they counsel patients on hygiene.
- Ask staff if they have received any training or instructions on hygiene counselling.
- Ask if any records or documentation are maintained for the hygiene counselling provided.

Implementation plan :
The healthcare institution shall develop and implement a structured counselling process where all patients are made aware of the importance of personal and environmental hygiene. Designated staff, such as nurses, health educators, or medical officers, should be trained to deliver consistent and culturally appropriate hygiene counselling to patients. The counselling can be done during admission, outpatient consultation, or discharge, and should cover aspects such as handwashing, sanitation, personal cleanliness, and hygienic practices in daily life. Educational materials like

posters or leaflets may also be used to reinforce the message.

Scoring Criteria :

- **2 Marks:**
  Patients confirm that they have been counselled on hygiene practices, and staff are able to clearly explain the process. Observation confirms that counselling is routinely practiced and documented where applicable.
- **1 Mark:**
  Counselling on hygiene is done inconsistently or only by a few staff members. Some patients report being counselled, while others do not. Observations and interviews show partial implementation.
- **0 Mark:**
  There is no evidence that hygiene counselling is provided to patients. Staff are unaware of the requirement, and no patients recall receiving any counselling related to hygiene.

Reference : NA

F1.3	**Patients are made aware of their responsibility of keeping the health facility clean**

Interpretation

This checkpoint emphasizes the **involvement of patients** in maintaining hygiene and cleanliness within the facility. It is not just about facility housekeeping but also about instilling a shared responsibility among patients and caregivers. The displayed content must clearly inform patients about expected behaviors such as using dustbins, avoiding littering, not spitting, maintaining toilet hygiene, and cooperating with facility staff. The goal is to build a participatory culture where cleanliness is seen as a joint responsibility between the staff and patients.

Means of verification : **OB / SI**

Observation (OB):

- Observe whether patient responsibilities regarding cleanliness are displayed clearly and prominently in waiting areas, OPDs, or common spaces.
- Check if the language used is local and understandable by the target population.
- Look for the presence of visual aids or symbols that support understanding of patient roles in cleanliness.

Staff Interview / Patient Interview:

- Ask patients if they are aware of their responsibilities related to cleanliness.
- Inquire if any staff members educate or remind them about keeping the premises clean.
- Ask registration or nursing staff how and when they communicate patient responsibilities.
- Enquire whether any incidents of patient involvement in cleanliness practices have been noted or appreciated.

Implementation plan :

To implement this standard, the facility should develop and disseminate a clear message to patients about their responsibilities in maintaining cleanliness within the health centre. This can be done by displaying patient responsibilities in visible areas such as the entrance, waiting area,

and consultation rooms. The content should be simple, in local language, and may include visual cues. The staff should be trained to sensitize and remind patients periodically about their role in keeping the facility clean. Additionally, patient education materials (like leaflets or posters) may be used to reinforce the message during registration or consultation.

Scoring Criteria :

2 Marks:

- Patient responsibilities are prominently displayed in multiple key areas in a clear and local language.
- Patients are aware of their roles and confirm being informed or reminded by staff.
- Visual or written IEC materials are in active use.
- Staff members can explain how patient responsibilities are communicated.

1 Mark:

- Patient responsibilities are displayed but may not be very prominent or understandable to all patients.
- Some patients are aware while others are not.
- Staff communication regarding cleanliness is inconsistent or informal.

0 Mark:

- No display of patient responsibilities related to cleanliness is present.
- Patients are unaware of any such responsibilities.
- Staff do not educate or inform patients on their role in maintaining cleanliness.

Reference : NA

F1.4	**The Health facility has a system to take feed-back from patients and visitors for maintaining the cleanliness of the facility**

Interpretation

This standard emphasizes the importance of involving patients and visitors in maintaining cleanliness within the health facility. It is not only about having a feedback mechanism in place but also ensuring that the feedback collected is reviewed and acted upon to improve environmental hygiene. The system should be functional, visible to patients, and capable of recording inputs consistently. It also reflects the hospital's commitment to participatory cleanliness and infection control practices.

Means of verification : **OB / SI**

 What is to be observed (OB):

- Presence of a visible and accessible feedback system such as suggestion boxes or digital kiosks.
- Display boards or signage inviting patients and visitors to give feedback regarding cleanliness.
- Availability of filled feedback forms or entries showing that feedback is being collected.
- Records of feedback analysis and actions taken based on the feedback.

 What is to be enquired (Staff Interview):

- Ask staff if they are aware of the feedback mechanism and how it is used to assess cleanliness.
- Enquire whether feedback collected is reviewed and whether any actions are taken based on recurring concerns.
- Ask staff about the frequency of feedback review meetings and any recent initiatives taken to improve cleanliness based on patient suggestions.

Implementation plan :
To implement this checkpoint, the health facility must develop and operationalize a structured feedback mechanism specifically aimed at assessing cleanliness. Suggestion boxes, physical feedback forms, or digital platforms such as tablets or QR codes linked to online forms can be used to collect inputs from patients and visitors. Staff should be assigned to monitor and analyze feedback regularly. Periodic meetings should be held to review the feedback and initiate corrective actions wherever necessary. The system should ensure anonymity and ease of access for users to provide honest feedback without hesitation.
Scoring Criteria :

 2 Marks: The facility has a clearly defined and functioning feedback mechanism that is actively used by patients and visitors. Feedback is regularly reviewed, documented, and corrective actions are taken to improve cleanliness.

 1 Mark: The facility has a feedback mechanism, but it is either not well-publicized or inconsistently used. Some feedback is reviewed, but documentation and follow-up actions are partial or irregular.

 0 Mark: There is no feedback system for cleanliness, or it exists only on paper without actual implementation. No evidence of feedback being collected or acted upon.

Reference : NA

F2	Information Education and Communication

F2.1	IEC regarding importance of maintaining hand hygiene is displayed in hospital premises

Interpretation
This checkpoint emphasizes the role of visual communication in promoting hand hygiene, a fundamental aspect of infection control. It is not sufficient to merely have policies or training; the hospital must actively create awareness through visual reminders. These IECs must be easily visible, culturally appropriate, and preferably in the local language to ensure maximum impact and accessibility for all stakeholders.
Means of verification : **OB / SI**

- **Observation (OB):**
  - Check for the presence of posters or IEC materials related to hand hygiene in all patient care and common areas.
  - Observe whether the displayed materials are prominently placed and not obscured by other notices or objects.
  - Ensure that the IECs are in the local language and are legible and well-maintained (not torn or faded).
- **Staff Interview:**
  - Ask staff if they have seen hand hygiene-related IECs in the hospital.
  - Inquire if they can describe the key messages from the posters and whether these materials influence their hand hygiene practices.
  - Confirm whether the staff know who is responsible for placing or updating the IEC materials.

Implementation plan :
To implement this standard, the facility must ensure that Information, Education, and Communication (IEC) materials such as posters, standees, or digital screens that emphasize the importance of hand hygiene are prepared and displayed across the hospital premises. These should be strategically placed in high-traffic areas including OPDs, IPDs, nursing stations, patient waiting areas, toilets, and near handwashing stations. The materials must be in the local language and understandable by all categories of staff, patients, and visitors. The facility's Quality Team or Infection Control Committee should take responsibility for designing, placing, and periodically auditing these IEC materials.
Scoring Criteria :

 2 Marks:
IEC materials related to hand hygiene are prominently displayed in all relevant areas of the hospital in the local language, clearly visible to patients, visitors, and staff.

 1 Mark:
IEC materials are displayed but either not in all required locations or not in the local language.

 0 Marks:
No IEC materials regarding hand hygiene are displayed in the hospital premises, or those present are not visible, outdated, or irrelevant.

Reference : NA

F2.2	IEC regarding Swachhata Abhiyan is displayed within the facilities' premises

Interpretation
This checkpoint evaluates whether the healthcare facility actively promotes the Swachhata Abhiyan initiative through visible and understandable communication within its premises. The presence of IEC materials in the local language serves as a reminder and motivation for everyone to maintain cleanliness and hygiene. It reflects the facility's commitment to creating a clean, safe, and healthy environment and helps foster awareness and behavioral change in both staff and

visitors regarding sanitation practices.
Means of verification : **OB / SI**

 Observation:

- Check for the presence of IEC materials related to Swachhata Abhiyan in the facility.
- Ensure the materials are displayed prominently at key locations like entrance gates, waiting rooms, and near washrooms.
- Confirm that the displayed IEC materials are in the local language and easily readable.
- Verify that the IEC materials are maintained well, without damage or fading.

 Staff Interview:

- Ask staff if they are aware of the Swachhata Abhiyan campaign and the role of IEC materials.
- Inquire whether staff receive regular updates or training related to Swachhata Abhiyan and hygiene practices.
- Confirm if staff encourage visitors and patients to follow cleanliness practices promoted by the IEC materials.
- Ask if there is a schedule or person responsible for updating or maintaining the IEC displays.

Implementation plan :
The facility will develop and procure IEC materials specifically focused on the Swachhata Abhiyan campaign. These materials will be translated into the local language to ensure easy comprehension by all patients, visitors, and staff. The IEC posters or boards will be strategically placed at prominent locations such as the main entrance, waiting areas, corridors, and near restrooms. Facility staff will be assigned the responsibility to regularly inspect these displays to ensure they are intact, clean, and legible. Periodic refresher sessions may be conducted to sensitize staff about the importance of these IEC materials and their role in promoting cleanliness.
Scoring Criteria :

 2 Marks: IEC materials related to Swachhata Abhiyan are prominently displayed in multiple strategic locations within the facility, in the local language, and are well-maintained. Staff demonstrate clear awareness of the campaign and actively support its promotion.

 1 Mark: IEC materials are displayed but only in a few locations or some are not prominently visible. Materials may not be fully in the local language, or staff have limited awareness of the campaign.

 0 Marks: IEC materials related to Swachhata Abhiyan are missing, not visible, or not displayed in the local language. Staff show little or no awareness of the campaign and do not promote cleanliness initiatives.

Reference : NA

F2.3	IEC regarding use of toilets is displayed within hospital premises

Interpretation

This checkpoint verifies whether educational signage about the proper use of toilets is clearly displayed within the hospital premises. The objective is to promote hygiene, prevent misuse or damage, and facilitate easy access for all users. The IEC materials should be easy to read, culturally appropriate, and placed where they can be seen by patients and visitors. Ensuring these displays exist helps reinforce behavioral change towards better sanitation practices within the hospital.

Means of verification : **OB / SI**

- **What is to be observed (OB):**
  - The IEC regarding the use of toilets must be prominently displayed in multiple visible areas within the hospital, such as near toilet entrances, waiting areas, corridors, and reception.
  - The signage should be in the local language and clearly legible.
  - The condition of the display should be intact without any damage or fading.
  - The placement should be accessible and not blocked by other objects or furniture.
- **What is to be enquired (Staff Interview):**
  - Ask staff whether they are aware of the IEC displays about toilet use.
  - Enquire if they have received any training or instructions related to maintaining or explaining the IEC content to visitors.
  - Check if staff know the importance of the IEC materials and how to direct patients or visitors to the toilets appropriately.
  - Confirm whether there are any routine checks conducted to ensure the IEC displays are maintained properly.

Implementation plan :

To implement the IEC (Information, Education, and Communication) regarding the use of toilets within hospital premises, the hospital management will ensure that clear and visible signage is designed and placed in strategic locations across the facility. The IEC material will be prepared in the local language for better comprehension by patients, visitors, and staff. The housekeeping and maintenance teams will coordinate to regularly check the condition and visibility of these displays, ensuring that they are not damaged, faded, or obstructed. Staff training sessions will include awareness about the importance of the IEC displays and encourage staff to guide visitors towards proper toilet usage. Regular audits will be conducted to monitor the presence and effectiveness of the IEC signs.

Scoring Criteria :

 2 Marks: IEC regarding the use of toilets is prominently displayed in the local language at multiple appropriate locations within the hospital, in good condition, easily visible, and staff are aware and supportive of its importance.

 1 Mark: IEC is displayed but only in limited locations, or it is somewhat visible but may have minor issues such as fading or partial obstruction; staff awareness is partial.

 0 Marks: No IEC signage is displayed regarding toilet use, or the signage is not in the local language, not visible, or staff are unaware of its presence or importance.

Reference : NA

F2.4	IEC regarding water sanitation is displayed in the hospital premises

Interpretation

This checkpoint aims to ensure that awareness about water sanitation is effectively communicated within the hospital through visible IEC materials. Displaying IEC materials in the local language promotes understanding among all hospital users, contributing to better hygiene practices and infection prevention. The presence of these materials in strategic locations helps reinforce the importance of water sanitation and supports behavior change. Regular monitoring by staff ensures that the IEC materials remain accessible, legible, and up-to-date, reflecting the hospital's commitment to maintaining a safe and clean environment for patients and visitors.

Means of verification : **OB / SI**

Observation (OB):

- Check that IEC materials regarding water sanitation are prominently displayed in key areas of the hospital such as waiting rooms, entrances, drinking water points, and near washrooms.
- Verify that the IEC materials are written clearly in the local language.
- Observe the condition and visibility of the IEC displays to ensure they are well-maintained and legible.

Staff Interview (SI):

- Ask housekeeping or infection control staff if they are aware of the IEC materials related to water sanitation displayed in the hospital.
- Enquire whether staff members monitor the IEC displays regularly and how often they update or replace these materials.
- Question staff about the role of IEC materials in promoting water sanitation practices within the hospital.

Implementation plan :

To implement checkpoint F2.4, the hospital must ensure that IEC (Information, Education, and Communication) materials related to water sanitation are prominently displayed throughout the hospital premises. These materials should be placed in key areas such as waiting rooms, entrances, near drinking water sources, and washrooms where patients, visitors, and staff can easily see them. The content of the IEC materials must be in the local language to ensure it is understood by all users. The hospital should assign responsibility to the quality assurance or infection control team to regularly check these displays for visibility, relevance, and condition. Periodic updates and replacements of IEC materials should be planned to keep the information current and effective. Staff should be trained on the importance of these displays and involved in monitoring them.

Scoring Criteria

- **2 Marks:** IEC materials regarding water sanitation are prominently displayed in multiple appropriate locations within the hospital premises, clearly written in the local language,

and staff demonstrate awareness and regular monitoring of these displays.

- **1 Mark:** IEC materials are displayed in some areas but may be limited in number or placement, or staff awareness/monitoring is inconsistent.
- **0 Marks:** IEC materials are absent, not displayed prominently, not in the local language, or staff are unaware of the IEC displays and do not monitor them.

Reference : NA

F2.5	**Hospital disseminates hygiene messages through other innovative manners**

Interpretation

This checkpoint assesses whether the hospital employs diverse and creative channels beyond traditional means to promote hygiene awareness. The use of kiosks, videos, leaflets, and IEC corners indicates a proactive approach to ensuring hygiene messages reach a wider audience in an engaging manner. Effective dissemination through these innovative methods reflects the hospital's commitment to fostering a hygienic environment and encouraging good hygiene practices among patients, visitors, and staff alike.

Means of verification : **OB / SI**

What is to be observed (OB):

- Presence of hygiene kiosks in common areas such as entrances, corridors, and waiting rooms.
- Display and functionality of video messages related to hygiene on screens in patient and visitor areas.
- Availability and distribution of leaflets or pamphlets focusing on hygiene practices.
- Existence and maintenance of IEC corners or dedicated information boards with hygiene messages.

What is to be enquired during staff interview:

- How frequently hygiene messages are updated or rotated in kiosks and IEC corners.
- Whether staff are trained or designated to manage these innovative hygiene communication tools.
- The hospital's strategy or approach to ensuring all patients and visitors receive hygiene information.
- Feedback mechanisms, if any, to assess the effectiveness of these communication channels.

Implementation plan :

The hospital should adopt various innovative communication methods to disseminate hygiene messages effectively. This includes setting up hygiene kiosks in key locations like entrances and waiting areas, displaying hygiene-related video messages on screens throughout the hospital, distributing informative leaflets to patients and visitors, and establishing IEC (Information,

Education, and Communication) corners that continuously provide hygiene awareness. Staff members should be trained to manage, update, and monitor these communication tools regularly to ensure that the messages remain relevant, visible, and engaging for all hospital stakeholders.
Scoring Criteria :

 2 Marks: The hospital effectively uses multiple innovative methods (hygiene kiosks, video messages, leaflets, IEC corners) consistently, with evidence of regular updates and staff involvement in managing these tools.

 1 Mark: The hospital uses some innovative methods to disseminate hygiene messages but not all, or the methods are not consistently maintained or updated.

 0 Marks: The hospital does not use any innovative methods to disseminate hygiene messages beyond basic or traditional means.

Reference : NA

F3	Leadership and Team work

F3.1	Cleanliness and Infection control committee is constituted at the facility

Interpretation
This checkpoint assesses whether the facility has a dedicated committee responsible for monitoring and managing cleanliness and infection control activities. The presence of such a committee signifies an organized approach to maintaining hygiene standards and reducing infection risks. The committee's constitution and active functioning reflect the facility's commitment to patient safety and quality care through structured oversight and continuous improvement in infection prevention.
Means of verification : **OB / SI**

Observation:

- Verify official documents establishing the Cleanliness and Infection Control Committee (e.g., formation orders, terms of reference).
- Check the committee's membership list for appropriate representation from key departments.
- Review records of committee meetings, including minutes and attendance sheets.
- Observe notice boards or internal communications displaying infection control updates or activities.
- Look for evidence of policies or protocols developed or monitored by the committee.

Staff Interview:

- Ask committee members about the committee's roles, composition, and meeting frequency.

- Enquire how infection control policies are implemented and monitored.
- Discuss with housekeeping and nursing staff their awareness of the committee and its activities.
- Verify if staff have received training or updates related to infection control through the committee.
- Confirm whether staff know whom to approach regarding infection control concerns or suggestions.

Implementation plan :
To implement checkpoint F3.1, the facility must formally establish a Cleanliness and Infection Control Committee by clearly defining its composition, roles, and responsibilities. The committee should include representatives from various departments such as nursing, housekeeping, infection control staff, and administration to ensure comprehensive oversight. Regular meetings must be scheduled with documented minutes to review infection control practices and cleanliness standards. The committee should also develop and oversee implementation of policies, procedures, and protocols related to infection prevention and environmental hygiene. Training and awareness programs should be organized for all staff to reinforce compliance with infection control measures.
Scoring Criteria :

 2 Marks: The facility has a formally constituted Cleanliness and Infection Control Committee with documented membership, regular meetings held, documented minutes available, and evidence of active functioning and follow-up actions. Staff demonstrate awareness of the committee's role.

 1 Mark: The committee is constituted, but meetings are irregular or documentation is incomplete. Some evidence of functioning is present but not consistent or well documented. Staff awareness is partial.

 0 Marks: No evidence of a constituted committee or no proof of its functioning. Staff are unaware of any such committee or infection control oversight mechanism.

Reference : NA

F3.2	**Cleanliness and infection control committee has representation of all cadre of staff including Group 'D' and cleanings staff**

Interpretation
This checkpoint assesses whether the infection control committee truly represents the entire workforce, emphasizing inclusivity of all staff levels, particularly Group 'D' employees who play a crucial role in cleanliness and infection control. The presence of all cadres in the committee ensures that practical insights from frontline workers are included in decision-making, thereby improving the effectiveness of infection control measures. It reflects the organization's commitment to a collaborative approach and recognizes the importance of every staff category in maintaining hygiene standards.
Means of verification : **OB / SI**

 What is to be observed (OB):

- Review the committee's official list or records showing members from all staff cadres, including Group 'D' and cleaning staff.
- Check attendance registers or minutes of committee meetings to confirm participation of all cadres.
- Observe if the committee meeting notice or agenda mentions inclusion of cleaning staff.
- Verify visible records like appointment letters or nomination letters for committee membership.

 What is to be enquired (Staff interview):

- Ask cleaning and Group 'D' staff if they are aware of their representation on the infection control committee.
- Enquire if the cleaning staff have ever participated in infection control meetings or given input.
- Check if staff feel their concerns related to cleanliness and infection control are addressed through the committee.
- Interview committee members to confirm the presence and role of Group 'D' representatives.

Implementation plan :
To implement this checkpoint, the hospital or health facility must ensure the formation of a cleanliness and infection control committee that includes representatives from all staff categories. This specifically includes clinical, administrative, nursing, technical staff, and importantly, Group 'D' employees such as cleaning and housekeeping staff. The committee should be officially constituted with documented evidence such as meeting minutes, attendance registers, and appointment letters. Regular meetings should be conducted, and the active participation of all cadres must be encouraged to address infection control and cleanliness issues effectively. Training and awareness programs can be arranged to empower all staff, especially Group 'D', to contribute meaningfully.
Scoring Criteria :

 2 Marks: The infection control committee includes documented representation from all cadres of staff, including Group 'D' and cleaning staff, with evidence of regular attendance and active participation. Cleaning staff confirm their involvement and input is visibly considered in meetings.

 1 Mark: The committee has some representation from various cadres, but documentation or evidence of Group 'D' staff participation is limited or irregular. Participation of cleaning staff is occasional or unclear.

 0 Marks: There is no evidence of representation of Group 'D' or cleaning staff in the infection control committee, or such representation is absent in records and staff feedback.

Reference : NA

F3.3	**Roles and responsibility of different staff members have been assigned and communicated**

Interpretation

This checkpoint verifies whether the organization has clearly assigned and effectively communicated the roles and responsibilities of its staff members. It ensures that each staff member understands their specific duties and what is expected of them. Proper assignment and communication help avoid confusion, overlap, or neglect of tasks, which contributes to smooth operational workflow and accountability. The presence of clearly defined roles also facilitates better coordination and teamwork within the hospital.

Means of verification : **OB / SI**

Observation:

- Check if job descriptions or responsibility charts are displayed in relevant departments.
- Verify the presence of documents such as staff duty rosters, organizational charts, or responsibility matrices.
- Observe if supervisors regularly conduct briefings or meetings where roles and responsibilities are discussed.

Staff Interview:

- Ask different staff members to describe their specific roles and responsibilities.
- Enquire how they were informed about their roles—whether through formal communication, training sessions, or written documents.
- Confirm if staff members can explain their duties clearly and confidently.
- Ask supervisors or team leads about the methods used to communicate and reinforce role assignments.

Implementation plan :

To implement this checkpoint, the hospital management must clearly define the roles and responsibilities for each category of staff. Job descriptions or responsibility matrices should be developed or updated to reflect current tasks and expectations. These documents must then be communicated to all relevant staff members through formal meetings, induction sessions, or written circulars. Regular refresher sessions and updates should be conducted to ensure ongoing awareness and clarity. Supervisors should monitor the adherence to assigned roles and provide feedback or corrective actions when deviations occur.

Scoring Criteria :

 Award **2 marks** if all interviewed staff clearly demonstrate an understanding of their roles and responsibilities, and there is documented evidence of role assignment and communication.

 Award **1 mark** if some staff members can describe their roles, but others are unclear or if the documentation exists but communication appears inconsistent.

 Award **0 marks** if staff members are unable to state their roles, and no formal documentation

or communication regarding roles and responsibilities is evident.

Reference : NA

F3.4	**Hospital leadership review the progress of the cleanliness drive on weekly basis**

Interpretation

This checkpoint requires evidence that hospital leadership actively monitors and reviews the cleanliness drive on a weekly basis. It means that leadership is not only aware of the ongoing cleaning activities but also plays a proactive role in assessing their effectiveness, addressing challenges, and driving improvements. Regular documented meetings and follow-ups indicate strong leadership commitment, which is essential for maintaining high standards of hygiene and ensuring a safe hospital environment. The presence of systematic reviews reflects accountability and a continuous improvement approach toward cleanliness management.

Means of verification : **OB / SI**

What is to be observed (OB):

- Presence of a documented schedule of weekly meetings specifically focused on the cleanliness drive.
- Records or minutes of meetings showing discussions on cleanliness progress, challenges, and action plans.
- Evidence of monitoring tools used during the review (checklists, audit reports).
- Visible improvements or corrective actions taken following these meetings (e.g., cleaning logs updated, areas cleaned more frequently).
- Participation of hospital leadership or designated officials in the meetings.

What is to be enquired (Staff Interview):

- Frequency of the leadership review meetings for the cleanliness drive.
- The agenda and outcomes typically discussed during these meetings.
- How feedback from cleaning staff or other hospital personnel is incorporated.
- Examples of actions taken based on review discussions.
- Staff perception of leadership commitment to maintaining cleanliness standards.

Implementation plan :

Hospital leadership must establish a structured process to review the progress of the cleanliness drive on a weekly basis. This includes scheduling and conducting regular meetings focused specifically on cleanliness activities. During these meetings, leadership should evaluate ongoing cleaning efforts, monitor compliance with cleaning schedules, identify any gaps or challenges, and ensure appropriate corrective actions are planned and implemented promptly. Documentation such as meeting minutes and monitoring reports should be maintained to track progress and demonstrate leadership engagement. Leadership should also ensure effective communication with cleaning staff and other relevant departments to sustain motivation and accountability.

Scoring Criteria :

2 Marks: The hospital leadership holds documented weekly meetings on the cleanliness drive

consistently, with evidence of active monitoring, discussion of progress, challenges, and follow-up actions. Staff confirm leadership involvement and timely corrective measures.

1 Mark: The hospital leadership conducts reviews irregularly (less than weekly or inconsistently documented), with some evidence of monitoring and occasional follow-up actions. Staff acknowledge leadership reviews but indicate gaps in regularity or effectiveness.

0 Marks: No evidence of leadership reviews or meetings specifically related to the cleanliness drive. Monitoring and follow-up actions are absent or very minimal. Staff report no leadership involvement in cleanliness progress review.

Reference : NA

F3.5	**Hospitals leadership identifies good performing staff members and departments**

Interpretation
This checkpoint ensures that hospital leadership proactively identifies and acknowledges staff members and departments demonstrating exemplary performance. It reflects a culture of positive reinforcement and continuous quality improvement within the hospital. Recognition of good performers contributes to motivation, employee satisfaction, and overall service excellence. The focus is not only on formal awards but also on the existence of a structured practice where leadership systematically monitors and appreciates good performance, which is crucial for sustaining high standards of care.
Means of verification : **OB / SI**

Observation:

- Look for documented procedures or policies regarding staff and department recognition.
- Observe records of awards, certificates, or appreciation letters issued to staff or departments.
- Check minutes of meetings where performance reviews and recognitions are discussed.
- Note any visible recognition boards or announcements highlighting good performers.

Staff Interview:

- Ask staff if they are aware of any recognition practices in the hospital.
- Enquire whether leadership communicates about good performance regularly.
- Find out if staff members feel motivated by any formal or informal recognition initiatives.
- Check if staff know the criteria or process by which good performance is identified and rewarded.

Implementation plan :
The hospital leadership will establish a formal system to recognize and identify good performing staff members and departments. This includes setting clear performance criteria, collecting regular feedback, and reviewing staff achievements during management meetings. The leadership team will communicate the importance of acknowledging excellence and motivate all departments to participate in the recognition process. Mechanisms such as monthly or quarterly

performance reviews, awards, or appreciation letters will be implemented to ensure consistent identification of high performers. Documentation and transparency will be maintained to promote fairness and boost staff morale.

Scoring Criteria :

 2 Marks: The hospital leadership has a well-documented, systematic, and regularly practiced method to identify and recognize good performing staff and departments. Evidence of consistent recognition activities and clear communication is present. Staff are aware and motivated by these practices.

 1 Mark: There is some recognition of good performers, but the process is irregular or informal, with limited documentation or communication. Staff have partial awareness.

 0 Marks: There is no evidence or practice of identifying or recognizing good performing staff or departments. Staff are unaware of any such initiatives.

Reference : NA

F4	Training and Capacity Building and Standardization

F4.1	Hospital conducts are training need assessment regarding cleanliness and infection control in hospital

Interpretation

This checkpoint verifies whether the hospital has taken proactive steps to assess and address staff training needs related to cleanliness and infection control. It indicates the hospital's commitment to maintaining a safe and hygienic environment by ensuring that staff are adequately trained and updated on infection prevention measures. Successful implementation reflects a structured approach to minimizing infection risks and improving patient safety through continuous staff development.

Means of verification : **OB / SI**

 Observation:

- Check for documented records of training needs assessments related to cleanliness and infection control.
- Observe if any schedules or action plans derived from the assessment are visible or implemented.

 Staff Interview:

- Ask staff if they are aware of any recent assessments conducted on their training needs for infection control and cleanliness.
- Enquire how the results of such assessments have influenced their training or work practices.
- Confirm whether staff feel their training needs in this area have been adequately identified

and addressed.

Implementation plan :
The hospital must conduct a training needs assessment specifically focused on cleanliness and infection control. This involves systematically identifying gaps in staff knowledge and skills related to infection prevention and environmental hygiene. The assessment should be documented and updated regularly to ensure targeted training programs are developed and implemented effectively. Interpreting this checkpoint means verifying whether the hospital has proactively evaluated the training requirements to maintain high standards of cleanliness and infection control, which are critical to patient safety and reducing hospital-acquired infections.
Scoring Criteria :

 2 Marks: The hospital has clear, documented evidence that a training needs assessment regarding cleanliness and infection control has been conducted recently, and results have been used to plan staff training effectively.

 1 Mark: There is some evidence or indication that a training needs assessment was carried out, but documentation is incomplete or outdated, or training plans are not fully aligned with assessment results.

 0 Marks: No evidence of any training needs assessment related to cleanliness and infection control is available, or no training has been planned or conducted based on such an assessment.

Reference : NA

F4.2	**Bio medical waste Management training has been provided to the staff**

Interpretation

This checkpoint assesses whether the healthcare facility has taken necessary actions to educate its staff on biomedical waste management. It is not enough to have policies in place—the staff must be adequately trained to understand and follow correct procedures in their daily tasks. The intent is to ensure all personnel involved in waste handling are competent to segregate, handle, store, and dispose of biomedical waste in accordance with prescribed norms. Evidence of training and staff awareness reflects the facility's commitment to safety, hygiene, and regulatory compliance.

Means of verification : **OB / SI**

Observation

- Observe whether training records for biomedical waste management are available and up to date.
- Check if the training records include essential details such as date, duration, trainer's name, topics covered, and participant list.
- Look for physical evidence of recent training activities (e.g., certificates, signed attendance sheets).
- Observe if posters or visual aids related to biomedical waste segregation and disposal are displayed in work areas.
- Check if waste is being properly segregated and disposed of according to training

(indicating application of learning).

Staff Interview

- Ask staff whether they have attended biomedical waste management training and when it was last conducted.
- Enquire what topics were covered during the training session.
- Ask staff to explain the color coding system used for waste segregation.
- Ask how they handle accidental spills or injuries involving biomedical waste.
- Enquire whether they feel confident in their knowledge and skills related to biomedical waste handling.

Implementation plan :
To implement this checkpoint effectively, the healthcare facility must develop a systematic approach to provide biomedical waste management training to all relevant staff members, including clinical, housekeeping, and support staff. This involves identifying training needs, preparing content based on current Biomedical Waste Management Rules, and organizing regular training sessions. Qualified internal trainers or external experts should conduct the sessions, ensuring that the topics cover waste segregation, color-coded bin usage, handling precautions, and disposal protocols. Training should also be included as part of the induction program for new employees. All sessions must be documented with attendance records, training materials, and feedback forms. Refresher trainings should be conducted at regular intervals to reinforce knowledge and address gaps. The Infection Control Officer or Quality Manager should oversee the entire process, maintain records, and ensure compliance with the standard.
Scoring Criteria :

 2 Marks: Comprehensive training records are available showing all relevant staff have been trained recently; staff interviewed demonstrate clear understanding of biomedical waste management procedures.

 1 Mark: Partial training records exist, but not all staff are covered or records are incomplete; staff show some awareness but with gaps in knowledge.

 0 Marks: No training records found or training was not conducted; staff are unable to explain biomedical waste management processes clearly.

Reference : NA

F4.3	**Infection control Training has been provided to the staff**

Interpretation
This checkpoint verifies whether structured and documented infection control training has been imparted to staff. It implies that there is a systematic approach to training, not just one-time sensitization. The focus is on ensuring that staff are aware of infection control practices and are competent in applying them in their routine activities. The aim is to promote a culture of safety and hygiene within the facility to minimize healthcare-associated infections.

Means of verification : **OB / SI**

 Observation (OB):

- Check for the presence of a documented training schedule or plan related to infection control.
- Review training attendance registers or certificates issued post-training.
- Inspect notice boards or staff rooms for training posters, reminders, or schedules.
- Look for practical demonstration areas (e.g., hand hygiene technique display) used during training.

 Staff Interview:

- Ask staff about the last infection control training they attended and what topics were covered.
- Enquire whether they feel confident in applying infection control practices in their work.
- Verify if new staff received training during induction.
- Assess whether the staff can recall key elements like proper handwashing steps or biomedical waste segregation.

Implementation plan :
To implement F4.3 effectively, the hospital should schedule periodic infection control training sessions for all categories of staff, including clinical, housekeeping, and support personnel. A comprehensive infection control training module needs to be developed covering key areas like hand hygiene, biomedical waste management, use of personal protective equipment (PPE), needle stick injury prevention, and standard precautions. These sessions can be conducted in-house by the infection control nurse or a designated trainer. Attendance records must be maintained, and staff must be encouraged to actively participate. Refresher training should be conducted at regular intervals (e.g., annually or bi-annually), and newly joined staff should be trained during their induction.
Scoring Criteria :

 2 Marks: Infection control training is conducted regularly with proper documentation (schedules, attendance, and content). All staff categories have been covered, and interviews confirm understanding and participation.

 1 Mark: Infection control training has been conducted but lacks comprehensiveness or regularity. Documentation is partial, or only some staff categories have been covered.

 0 Mark: No documented evidence of infection control training. Staff interviews reveal no awareness or recall of any such training being conducted.

Reference : NA

F4.4	Hospital has documented Standard Operating procedures for Cleanliness and Upkeep of Facility

Interpretation

This checkpoint expects the hospital to have **written and accessible SOPs** related to cleanliness and maintenance of the hospital environment. The SOPs should not just exist but must be **functionally known and used** by the staff responsible for cleaning and housekeeping. This includes ensuring that cleaning routines are consistent, standardized, and monitored across departments. The intent is to promote hygiene, reduce infection risks, and improve the patient experience by maintaining a clean and well-kept facility.

Means of verification : **OB / SI**

Observation (OB):

- Check if the cleaning and maintenance SOPs are visibly available at relevant locations.
- Observe if the hospital premises, including patient areas, toilets, and common areas, are maintained in a clean and orderly condition.
- Look for evidence of compliance with SOPs such as displayed cleaning schedules, logs, or use of recommended cleaning materials.

Staff Interview:

- Ask cleaning and housekeeping staff if they are aware of the SOPs and whether they have received any training or orientation.
- Enquire how frequently cleaning activities are performed and documented.
- Ask if they know what materials and disinfectants are used, and whether any checklist or log is maintained.

Implementation plan :

To ensure systematic cleanliness and upkeep of the facility, the hospital shall develop and document Standard Operating Procedures (SOPs) that cover all critical areas such as patient care zones, toilets, administrative areas, outpatient departments, consultation rooms, and external surroundings. These SOPs must clearly define the frequency, cleaning agents used, responsible personnel, safety precautions, and waste disposal protocols. The SOPs should be shared with all relevant staff through orientation or training sessions. Displaying summarized cleaning schedules in key areas is also recommended for better compliance.

Scoring Criteria :

2 Marks:

If the hospital has well-documented SOPs for cleanliness and upkeep that are readily available with users; staff are aware of the SOP content and demonstrate consistent adherence through observation and interviews.

1 Mark:

If the SOPs are available but either not updated or not fully known/implemented by all relevant staff; partial compliance observed in practice.

0 Mark:

If SOPs are not documented or available; staff are unaware of procedures, or no evidence of

consistent cleaning practices is found during observation.

Reference : NA

F4.5	**Hospital has documented Standard Operating procedures for Bio-Medical waste management and Infection Control**

Interpretation
This checkpoint emphasizes the requirement for documented SOPs that guide the hospital's biomedical waste management and infection control activities. The presence of such SOPs ensures that practices are standardized, safe, and in line with regulatory expectations. Documentation helps in accountability, training, and auditing of practices. It reflects the hospital's commitment to patient and staff safety, as well as environmental responsibility. Merely having SOPs is not enough—their implementation, staff awareness, and alignment with actual practices are essential to meet this standard effectively.
Means of verification : **OB / SI**

Observation (OB):

- Check if the SOPs are physically available in relevant departments.
- Observe if waste segregation is done as per the color coding mentioned in the SOP.
- Look for instruction boards/posters on infection control and waste handling.
- Observe whether staff are using PPE appropriately.
- Check for availability of hand hygiene stations and disinfection supplies.

Staff Interview:

- Ask staff if they are aware of the SOPs for waste management and infection control.
- Inquire if they have undergone relevant training.
- Ask what steps they would take in case of a needle stick injury or waste spill.
- Inquire if the SOPs are regularly updated and how they are informed of updates.
- Ask staff to explain the process they follow for disinfection or handling infectious waste.

Implementation plan :
To implement this standard, the hospital must prepare separate and detailed Standard Operating Procedures (SOPs) for both biomedical waste management and infection control. These SOPs must be based on applicable national laws such as the Biomedical Waste Management Rules, 2016 (and amendments), and guidelines from credible authorities like CPCB, NABH, or the Ministry of Health. The SOP for biomedical waste should clearly define the categorization of waste, segregation practices using color-coded bins, internal transportation, storage, and final disposal. For infection control, the SOP should address hand hygiene, sterilization and disinfection, use of personal protective equipment (PPE), needle stick injury protocol, and outbreak response. The SOPs must be accessible in all departments, communicated to relevant staff, and periodically reviewed and updated. Training programs should be conducted to ensure all staff are aware of and follow the SOPs.
Scoring Criteria :

 2 Marks: The hospital has complete and up-to-date SOPs for both biomedical waste management and infection control, aligned with regulatory guidelines. Staff are well-informed,

and actual practices are consistent with the SOPs.

 1 Mark: SOPs exist but may not be fully updated or implemented across all areas. Staff have partial awareness, and compliance is inconsistent.

 0 Mark: SOPs are missing, incomplete, or not implemented. Staff are unaware of procedures, and observed practices are not in compliance with standard protocols.

Reference : NA

F5	Staff Hygiene and Dress Code

F5.1	Hospital has dress code policy for all cadre of staff

Interpretation
This checkpoint ensures that nursing staff maintain a professional and uniform appearance as per the hospital's designated dress code. Adhering to the dress code not only promotes hygiene and safety but also enhances the professional image of the healthcare team. It reflects discipline and commitment to institutional standards, which can influence patient confidence and satisfaction. Any deviations from the dress code may indicate laxity in policy enforcement or staff awareness and need to be addressed promptly.
Means of verification : **OB / SI**

Observation (OB):

- Observe if all nursing staff are wearing the prescribed uniform during their shifts.
- Check for neatness and cleanliness of the uniforms.
- Look for proper wearing of identification badges and adherence to any specific dress code elements (e.g., no unauthorized accessories, correct footwear).
- Notice if there are any deviations such as torn uniforms, incorrect dress color, or lack of personal grooming standards.

Staff Interview (SI):

- Ask nursing staff if they are aware of the designated dress code policy.
- Enquire about the training or instructions they have received regarding the dress code.
- Question how they ensure compliance with the dress code during their duties.
- Ask supervisors how they monitor and enforce adherence to the dress code among nursing staff.

Implementation plan :
To implement the adherence to the designated dress code by nursing staff, the hospital management will first communicate the dress code policy clearly to all nursing personnel through

meetings and written guidelines. Regular training sessions and reminders will be conducted to reinforce the importance of maintaining the professional appearance. Supervisors and nursing leaders will monitor compliance daily during shifts, and corrective feedback will be given promptly when deviations are observed. The dress code policy will also be incorporated into staff appraisals and performance reviews to encourage consistent adherence. Additionally, clear signage or notices about the dress code will be displayed in staff changing areas.

Scoring Criteria :

 2 Marks: All nursing staff strictly adhere to the designated dress code consistently, including uniform, identification badges, and personal grooming, with visible supervision and awareness among staff.

 1 Mark: Majority of nursing staff follow the dress code, but occasional minor lapses are noticed; some staff may lack full awareness or supervision is inconsistent.

 0 Mark: Nursing staff frequently do not comply with the dress code, with multiple lapses observed and no evidence of enforcement or awareness among staff.

Reference : NA

F5.2	Nursing staff adhere to designated dress code

Interpretation

This checkpoint verifies whether nursing staff consistently follow the established dress code, which includes proper uniform, identification badges, and personal hygiene standards as prescribed by the hospital policy. Adherence to the dress code reflects professionalism, promotes a uniform appearance, and supports infection control practices. Non-compliance may indicate gaps in policy communication, staff awareness, or supervision, which can affect patient trust and safety.

Means of verification : **OB / SI**

Observation (OB):

- Observe if nursing staff are wearing the complete designated uniform including proper attire, identification badges, and appropriate footwear.
- Check if uniforms are clean, well-maintained, and worn as per hospital standards during duty hours.
- Look for compliance with hair grooming and minimal jewelry as per policy.
- Observe if nursing staff refrain from wearing unauthorized items like casual clothes or accessories.

Staff Interview:

- Ask nursing staff if they are aware of the hospital dress code policy and its importance.
- Inquire about the frequency of reminders or training related to dress code.
- Question if they have faced any difficulties or exceptions in following the dress code.
- Discuss the role of supervisors in monitoring dress code adherence.

Implementation plan :
To ensure nursing staff adhere to the designated dress code, a clear policy will be communicated and displayed prominently in the nursing stations and staff rooms. Regular training sessions and reminders will be conducted to reinforce the importance of the dress code as part of professional conduct and infection control. Supervisors and ward in-charges will be assigned to conduct routine spot checks during shifts to monitor compliance. Non-compliance will be addressed promptly through counseling and corrective measures, with documentation maintained for audit purposes. Feedback from staff will be collected periodically to identify challenges or suggestions related to the dress code policy.
Scoring Criteria :

 2 Marks: Nursing staff consistently adhere to the complete designated dress code without exceptions, and there is clear evidence of regular monitoring and reinforcement by supervisors. Staff demonstrate awareness of the dress code policy and its importance.

 1 Mark: Nursing staff mostly adhere to the dress code but occasional minor lapses are observed. There is some monitoring, but enforcement and staff awareness need improvement.

 0 Mark: Nursing staff frequently do not follow the designated dress code, with little or no supervision or enforcement. Staff show lack of awareness or disregard for the dress code policy.

Reference : NA

F5.3	**Support and Housekeeping staff adhere to their designated dress code**

Interpretation
The interpretation of this checkpoint is that support and housekeeping staff must consistently wear the designated uniforms as per hospital policy during their duty hours. Proper adherence reflects the staff's commitment to maintaining hygiene standards and the hospital's overall professional image. Non-compliance indicates potential lapses in staff discipline, training effectiveness, or uniform availability, which can compromise infection control and the facility's credibility.
Means of verification : **OB / SI**

Observation (OB):

- Observe whether support and housekeeping staff are wearing the correct designated uniform during their work shifts.
- Check if the uniforms are clean, neat, and properly worn without unauthorized modifications.
- Note if staff maintain the dress code consistently throughout their duties.
- Verify presence of any required accessories like ID badges or caps as per policy.

Staff Interview (SI):

- Ask staff if they are aware of the hospital's designated dress code policy for their roles.
- Enquire how frequently the dress code is communicated or reinforced by supervisors.
- Ask if they face any difficulties in adhering to the dress code, such as uniform availability or comfort issues.

- Check if they understand the reasons and importance behind following the dress code, including hygiene and professionalism.

Implementation plan :
To implement checkpoint F5.3, the hospital management must ensure that all support and housekeeping staff are clearly informed about the designated dress code applicable to their roles. This includes providing the appropriate uniforms and accessories and conducting training sessions or briefings that emphasize the importance of adhering to the dress code for infection control, professionalism, and safety. Supervisors should monitor compliance regularly through routine walk rounds and audits. Any deviations must be addressed promptly with corrective actions and continuous reinforcement.
Scoring Criteria :

 Award 2 marks if all support and housekeeping staff consistently wear the designated dress code properly, uniforms are clean and well-maintained, and staff demonstrate clear awareness and understanding of the dress code during interviews.

 Award 1 mark if most staff follow the dress code with minor lapses such as occasional improper wearing or uniforms not always clean, or if some staff show limited understanding during interviews.

 Award 0 marks if a significant number of staff do not adhere to the dress code, uniforms are often dirty or worn incorrectly, or if staff show poor awareness or disregard of the dress code policy during interviews.

Reference : NA

F5.4	**There is a regular monitoring of hygiene practices of food handlers and housekeeping staff**

Interpretation
The interpretation of this checkpoint is that the hospital must demonstrate active and ongoing oversight of hygiene practices among staff directly involved with food handling and cleaning. This ensures infection control and patient safety by reducing the risk of contamination and hospital-acquired infections. It indicates a proactive approach rather than reactive measures, emphasizing the importance of regular monitoring rather than one-time assessments.
Means of verification : **OB / SI**

Observation (OB):

- Observe food handlers washing hands before and during food preparation.
- Check if food handlers use gloves, hairnets, and clean uniforms properly.
- Observe housekeeping staff following cleaning protocols, using appropriate disinfectants.
- Look for proper disposal of waste and cleanliness of food preparation and storage areas.
- Review records/logbooks of hygiene monitoring activities maintained by hospital administration.

Staff Interview (Enquiry):

- Ask food handlers about their understanding of hygiene practices and hand hygiene

protocols.
- Inquire how often their hygiene practices are monitored by supervisors.
- Question housekeeping staff on their cleaning schedules and use of disinfectants.
- Confirm with supervisors how monitoring results are documented and actions taken on non-compliance.

Implementation plan :
The implementation plan for F5.4 involves establishing a routine and systematic process to monitor the hygiene practices of food handlers and housekeeping staff. This includes scheduling regular inspections and audits to observe the adherence to hygiene protocols, such as proper handwashing, use of personal protective equipment (PPE), and cleanliness of uniforms. The hospital administration should designate responsible personnel or a hygiene monitoring team to carry out these checks consistently. Records of these observations and any corrective actions taken must be maintained for accountability and continuous improvement.
Scoring Criteria :

 2 Marks: The hospital demonstrates regular, documented monitoring of hygiene practices for both food handlers and housekeeping staff, with evidence of corrective actions for any non-compliance. Staff interviews confirm awareness and adherence to hygiene protocols.

 1 Mark: Monitoring is done but irregular or partially documented; some staff are aware of hygiene practices but monitoring is inconsistent.

 0 Marks: There is no evidence of regular monitoring or documentation, and staff are unaware or non-compliant with hygiene practices.

Reference : NA

F5.5	**Identity cards and name plates have been provided to all staff**

Interpretation
This checkpoint verifies that every staff member in the healthcare facility is easily identifiable through official identity cards and visible name plates. It ensures transparency and helps patients and colleagues quickly recognize staff roles and responsibilities. Providing identity cards and name plates is also a security measure that prevents unauthorized personnel from accessing restricted areas. The presence of these identifiers reflects professionalism and contributes to an organized and safe environment.
Means of verification : **OB / SI**

Observation:

- Observe whether all staff members are wearing or carrying their identity cards correctly.
- Check that name plates are displayed visibly on uniforms or workstations.
- Verify that the identity cards and name plates have a consistent format and contain correct information.
- Look around in different departments to ensure there are no staff members without identity cards or name plates.

Staff Interview:

- Ask staff members if they have been provided with identity cards and name plates.
- Enquire whether they understand the importance of displaying identity cards and name plates at all times.
- Confirm if staff face any issues or delays in receiving or using their identity cards or name plates.
- Ask about the process followed when new staff join or when replacements are needed for lost/damaged cards or plates.

Scoring Criteria :

 2 Marks: All staff members have properly issued identity cards and visible name plates without exception.

 1 Mark: Majority of staff members have identity cards and name plates, but a few are missing or not properly displayed.

 0 Marks: Identity cards and name plates are not provided to staff or are rarely visible and inconsistently used.

Implementation plan :
To implement this checkpoint, the hospital administration must ensure that all staff members are issued identity cards and have name plates displayed at their workstations or uniforms. The process involves preparing and printing identity cards with clear photographs, names, and designations, and distributing them to every employee. Similarly, standardized name plates should be designed and installed where applicable. The hospital should establish a timeline and designate responsible personnel to oversee the issuance and proper display of these items. Regular follow-up and updates must be scheduled to account for new hires or replacements.
Reference : NA

KERALA AYUSH KAYAKALP

TRANSFORMING AYUSH HEALTHCARE FACILITIES

NATIONAL AYUSH MISSION KERALA

National AYUSH Mission, Kerala
1st Floor, Bliss Haven, Convent Road
Thiruvananthapuram, Kerala– 695035

Phone: 0471-2 474 550, Email: namkerala@gmail.com
www.nam.kerala.gov.in