



# **DESKTOP SURVEILLANCE ASSESSMENT (ALLOPATHIC CLINIC)**



## PREFACE

For an accredited clinic to maintain its accreditation status, it is mandatory that the clinic continues to comply with the requirements of Accreditation Standards for Allopathic Clinics (1st edition: January 2011), for which NABH conducts mid cycle surveillance. The purpose of on-site surveillance is to verify the continued compliance to the accreditation standards.

Due to pandemic COVID-19 crises, the on-site assessments of NABH have also come to a halt. In view of the situation, NABH has decided to develop a methodology to verify the continued compliance of the accredited clinics to the applicable standards and the first step towards it is "Desktop Surveillance" wherein the clinics will be required to submit documents as required by NABH.

For the purpose of Desktop Surveillance, the clinics shall provide information as per this document and the same shall be considered for verifying the continued compliance. The information provided by clinic shall be evaluated at NABH secretariat and on the basis of this evaluation, decision regarding continuation of accreditation shall be taken.

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The clinics are therefore advised to provide the essential information accurately as per the format. Incorrect information provided may lead to adverse decision by National Accreditation Board for Hospitals & Healthcare Providers (NABH).

Note: The format provided for Desktop surveillance is in accordance with 1st Edition of standard. Clinics are advised to visit NABH website [www.nabh.co](http://www.nabh.co) regularly for recent updates.



**List of abbreviations:**

BMW- Bio-Medical Waste  
CAPA-Corrective action preventive action  
CQI-Continuous quality improvement  
DS- Desktop Surveillance  
FA-Final assessment  
FMEA- Failure Mode and Effects Analysis  
HAZMAT- Hazardous materials  
HCO- Healthcare organisation  
HIC-Hospital infection control  
HIRA- Hazard Identification and Risk Analysis  
ICN-Infection control nurse  
ICO-Infection control officer  
IMS-Information management system  
IPD- Inpatient department  
IT-Information technology  
KPI- Key performance indicators  
KRA- Key Result Area  
LASA-Look alike sound alike  
LSCS- Lower (uterine) segment Caesarean section  
MoU- Memorandum of understanding  
MRD-Medical record department  
MSDS- Material Safety Data Sheet  
NC -Non-Conformities  
OPD-Outpatient department  
PCB-Pollution control board  
PNDT- Pre-Natal Diagnostic Techniques Act, 1994  
PPE- Personal Protective Equipment  
QA-Quality assurance  
QIPs- Quality improvement program/ project  
RA-Renewal assessment  
RCA- Root cause analysis  
RSO- Radiation safety officer



## Information to be Furnished by Clinics for Desktop Surveillance Assessment

### 1. General Information

Information	Details
Reference Number	
Clinic name	
Address	
Accreditation Cycle – Accredited since (mention the year)	
Accreditation Validity Period:	
Previous assessment type: FA/ RA/ Verification/ Focus	
Date of Previous assessment	
Name of Owner/ CEO or equivalent	
Email of Owner/ CEO or equivalent	
Name of Accreditation Coordinator	
Email of Accreditation Coordinator	

### 2. Status of Non-Conformities (NCs) of previous on-site assessment:

Status of implementation and monitoring the effectiveness of corrective actions(s) taken on non-conformities raised during previous on-site assessment: *(please provide details in tabular format)*

Sl.	Non-conformities raised during previous on-site assessment	Relevant Standard and corresponding OE	Brief Summary of root cause analysis & corrective actions taken	Evidence of continued compliance of corrective actions to be attached (as on date)
1.				
2.				
3.				

**3. Committee Meeting Review: (Please mention NA for not applicable)**
*(Please provide details in tabular format & attach evidence in PDF)*

S. No	Name of Committee	Composition of committee  (Annexure to be attached)	No. of meetings since last assessment	Date of last meeting of the committee	Whether all the agenda points as required by the relevant standard were discussed  (Yes/No)	Whether minutes of the meeting and actions points thereon were recorded  (Yes/No)	Whether the action plan is implemented as targeted  (Yes/No)	Evidence of main improvement or action taken or the minutes of the last three meeting  (Annexure to be attached)
3.1.	Quality Improvement							
3.2.	Others, if any							

**4. Analysis of Quality Indicators:**

Summary of Quality Indicators reported and analysed  
*(Please provide details in tabular format & attach evidence in PDF)*

Note: It is desirable that the patient's name does not appear in any of the report / document submitted to NABH, only hospital unique ID will suffice.

	Indicator Name -	Indicator Name -	Indicator Name -	Indicator Name -
Month 1				
Month 2				
Month 3				
Month 4				
Month 5				
Month 6				
Average				

Root Cause Analysis (RCA) and Corrective and Preventive Action (CAPA) to be mentioned here



## 5. Mock Drills:

(Please provide details in tabular format & attach evidence in PDF)

Sl.	Mock drills	No. of drill conducted since last assessment	Findings and deviations observed	Root cause analysis & Corrective action taken (Yes/No)	Annexure to be attach (raw data, observations & reports)
5.1.	Fire				
5.2.	Cardiac/ medical Emergency (CPR)				
5.3.	Any other				

## 6. Details of Audits:

(Number of NCs not closed, number of NCs continuing from the previous internal audit and assessment/ OEs with the same NCs as the previous internal audit/assessment

Please provide details in tabular format & attach evidence in PDF)

### a. Internal Audits:

Sl.	Audits	Dates	Root cause analysis & Corrective action taken (Yes/No)	Annexure to be attach (raw data, observations &
6.1.	Internal Audit			
6.2.	Any Other			

**7. Details of Manpower:**

(Please provide details in tabular format & attach evidence in excel format as given)

**Table 7.1**

S I .	Manpower	Total number	Attach evidences as per S.No.7	Timings
7.1.	Doctors/ Consultants (Both visiting and full time with OPD timings)			
7.2.	Resident Medical Officers (RMO)/ Duty doctors			
7.3.	Nurses			
7.4.	Paramedical Staff(Including Pharmacists & Technicians)			

**8. Details of Training provided to CLINIC staff since last assessment:**

(Please provide details in tabular format)

S. No		Yes/No	Remarks if any & attach evidence
8.1.	<p>Training record for training imparted in past 1 year:</p> <p>Training record must include name of training imparted, trainer and feedback obtained.</p> <p>Scanned copies of common training sheets also can be submitted after highlighting the name of the afore mentioned employees.</p> <ul style="list-style-type: none"> <li>- Records pertaining to All categories of employees e.g. consultants/RMO/Junior doctor / Nursing Staff, Paramedical staff, Non Clinical staff etc. may be included in annex.</li> </ul>		Clinic is required to enlist the trainings done in last 1 year

**09. Has there been a change in the following aspects of the CLINIC operations since last assessment?**

*(Please provide details in tabular format & attach evidence in PDF if any)*

Sl.		Yes/No	(If yes, give details thereof)
10.1.	CLINIC Premises		
10.2.	Key CLINIC Personnel		
10.3.	Legal Status		
10.4.	Ownership		
10.5.	Policies		
10.6.	Scope of services		
10.7.	Top Management		
10.8.	Organogram		

**10. Statutory Compliances**

*(Furnish details of applicable Statutory/ Regulatory requirements the organization is governed by law of land)*

*(Please provide details in tabular format & attach evidence in PDF format. Kindly mention NA for Not Applicable)*

Sl.	Name of legal document	Certifying Authority	Authorization / Invoice No	Valid from	Valid upto	Attach (Yes/ No/ Not applicable)	Remarks Lapsed / applied for
	General:						
11.1.	Registration from State Health Authority/Clinical Establishment Act						
11.2.	Registration under Shops and Commercial Establishment Act						
11.3.	PCB Consent to generate BMW						

11.4.	MoU with the BMW collecting agency					
11.5.	PCB License for Air Pollution					
11.6.	PCB License for Water Pollution					
	<b>Facility management:</b>					
11.7.	Fire NOC					
	<b>Imaging:</b>					
11.8.	Registration under PNDT					
11.9.	License to Operate X-Ray (Fixed)					
11.10.	License to Operate X-Ray (Mobile)					
11.11.	License to Operate CT Scan					
11.12.	License to Operate C-Arm					
11.13.	RSO Level I					
11.14.	License to Operate Nuclear Medicine Lab					
11.15.	License to procure Radioactive Material (Diagnostic/The rapy)					
11.16	Pharmacy license					
	<b>Clinical departments:</b>					
11.17.	License for MTP					

**11. CLINIC is required to enclose geotagged photographs with timestamp of the following:**

Sl.	Areas	Photographs
12.1	Entrance of the clinic showing name of the clinic	
12.2	Display of Scope of services	
12.3	Display of patient rights & responsibilities	
12.4	COVID waste segregation	
12.5	Firefighting equipment availability, fire signage's, exit plans	

**12. Documents/Manuals:**

**Table 17.1**

Sl.	Name of Manual	List of changes in manuals/SOPs (If applicable, else mention NA)
1	HIC-Infection Control	
2	Quality Improvement manual Nursing quality improvement included in CQI manual	
3	Safety and/ or patient safety	

### **13. Outsourced Services**

**13.1. Provide the list of all outsourced services**

**13.2. Declaration on letter head, duly signed by authorised person of CLINIC to be submitted**

I, clinics' authorized person's name & designation hereby state that Name of clinic has formal valid (as on date) documented agreement (specifying the service parameters & incorporating quality assurance by frequent monitoring) for all the outsourced services listed.

**13.3. Sample of three MOUs including MOUs (if any) for Clinical & Diagnostic Services, Emergency services (including ambulance and advance care) – the purpose is to assess if quality parameters are enlisted in the MOUs.**



**14. Litigation**

1. Has clinic faced any litigations from the last onsite assessment? Yes/No
2. If yes, provide list and present status of the same.

**15. Self-Declarations (to be submitted on the letter head of clinic, duly signed by Head of the clinic)**

1. I hereby declare that the clinic (name) is in continued compliance of 1st Edition of NABH standards for Allopathic Clinic since last on-site assessment.
2. I also declare that each statement and/or contents and /or documents, certificates submitted as Desktop Surveillance documents are true, correct and authentic. I am aware that any wrong information / declaration given therein may lead to adverse actions by NABH.

**16. Details of 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> year Annual Accreditation Fee payment by clinic:**

**Amount of Fee paid:**

**Date of payment;**

**Mode of payment along with complete details**

Signature of Head/ Director/ CEO of clinic

Name & Designation

Date & Place

**NATIONAL ACCREDITATION BOARD FOR HOSPITALS  
& HEALTHCARE PROVIDERS (NABH)  
Quality Council of India**

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