

BHT Checklist ANW				
Reference no	Measurable Element	Compliance Y/N/NA	Obtained Marks	Maximum Marks
Area of Concern - B Patient Rights				
Standard B1	The facility/ward provides the information to care seekers, their families & community about the available services and their modalities			
ME B1.6	The ward ensures access to clinical records of patients to entitled personnel	2		
ME B1.6.1	Diagnosis cards are issued when necessary	3		
ME B1.6.2	Diagnosis cards are issued for patients left against medical advice			
ME B1.6.3	Discharge summary is filled in the pregnancy record card	3		
Standard B3	The facility/ward maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.			
ME B3.2	Confidentiality of patients records and clinical information is maintained	2		
ME B3.2.1	BHT pages are numbered			
Standard B4	The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making			
ME B4.1	There is established procedures for taking informed consent before treatment and procedures			
ME B4.1.1	Specific consent is obtained before diffrenet procedures (check the BHT)			
Area of Concern - E Clinical Services				
Standard E1	The facility has defined procedures for registration, consultation and admission of patients.			
ME E1.1	The ward has established procedure for registration of patients			
ME E1.1.1	Unique identification number (BHT) is given to each patient during process of registration			
ME E1.1.2	Patient demographic details are recorded in admission records			
ME E1.2	There is established procedure for admission of patients			
ME E1.2.1	There is no delay in treatment because of admission process			
Standard E2	The facility has defined and established procedures for clinical assessment and reassessment of the patients.			
ME E2.1	There is established procedure for initial assessment of patients			
	At the OPD/ETU			
ME E2.1.1	Initial assessment is done by a Medical officer at OPD/ETU			

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	Triage is carried out at the admitting medical officer			
	Initial management plan is provided by the admitting medical officer			
	At the admission to the ward:			
	Height			
	Weight			
	Temperature			
	Pulse			
	Respiratory rate			
	FHS			
	FM			
	Urine for sugar and protein			
	Admitting medical officer to the ward			
ME E2.1.2	ANC history of pregnant women is reviewed and recorded			
	Demographic details			
	History of present pregnancy			
	past obstetric history			
	Past medical/ surgical history			
	Family history			
	Drug history			
	Allergies			
	Blood group			
ME E2.1.3	Physical Examination is done and recorded wherever required			
	General examination			
	Blood pressure			
	Heart/ lung auscultation			
	Abormal examination			
	Dangers signs are identified and recorded			
	Risk conditions identified and recorded			
	Management plan given			
	Time, name and designation of the officer who conduct the assessment recorded			
ME E2.1.6	Initial assessment is documented preferably within 1/2 hours			
ME E2.2	There is established procedure for follow-up/ reassessment of Patients			
ME E2.2.1	There is fixed schedule for assessment of stable patients (Patients should be seen by a SHO three times a day (morning, afternoon and night)			
	Every examination, medical advice and procedure is accompanied with date , time and signature			

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ME E2.2.2	For critical patients admitted in the ward there is provision of reassessment as per need			
Standard E3	The facility has defined and established procedures for continuity of care of patient and referral			
ME E3.1	The ward has established procedure for continuity of care during interdepartmental transfer			
ME E3.1.1	Ward has established procedure for handing over of patients from antenatal ward to labour room			
	Facility has established procedure for handing over of patients from antenatal ward to OT			
ME E3.1.2	There is a procedure for obtaining consultation from other specialities regarding a patient with in the hospital			
ME E3.3	A person is identified for care during all steps of care			
ME E3.3.1	Duty Doctor is assigned for each patients			
	Duty nurse is assigned for each patients			
Standard E4	The facility has defined and established procedures for nursing care			
ME E4.4	Nursing records are maintained			
ME E4.4.1	Nursing notes are maintained adequately (BHT:FHS/3time, temp: 2times, BO/PU, FM, Diet			
ME E4.5.2	Critical patients are monitored continually			
Standard E5	The facility has a procedure to identify high risk and vulnerable patients.			
ME E5.1	The ward identifies high risk patients and ensure their care, as per their need			
ME E5.1.1	High Risk Pregnancies are identified and kept in intensive monitoring			
Standard E6	The facility follows standard treatment guidelines defined by government for prescribing the generic drugs & their rational use.			
ME E6.1	The facility ensured that drugs are prescribed in generic name only			
ME E6.1.1	Drugs are prescribed under generic name only			
ME E6.2	There is procedure of rational use of drugs			
ME E6.2.3	The drugs are prescribed as per STG			
Standard E7	The facility has defined procedures for safe drug administration			
ME E7.1	There is process for identifying and cautious administration of high alert drugs			
ME E7.1.3	There is process to ensure that right doses of high alert drugs are only given			
ME E7.2	Medication orders are written legibly and adequately			
ME E7.2.1	Every Medical advice and procedure is accompanied with date , time and signature			
ME E7.2.2	Check for the writing, It comprehensible by the clinical staff			

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ME E7.3	There is a procedure to check drug before administration/ dispensing			
ME E7.3.4	Any adverse drug reaction is recorded and reported			
ME E7.4	There is a system to ensure right medicine is given to right patient			
ME E7.4.1	Administration of medicines done after ensuring right patient, right drugs , right route, right time			
ME E7.5	Patient is counselled for self drug administration			
ME E7.5.1	Patient is advice by doctor/nurse about the dosages and timings .			
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage			
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated			
ME E8.1.1	Day to day progress of patient is recorded in BHT			
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.			
ME E8.2.1	Treatment plan, first orders are written on BHT			
ME E8.3	Care provided to each patient is recorded in the patient records			
ME E8.3.1	Maintenance of treatment chart			
ME E8.4	Procedures performed are written on patients records			
ME E8.4.1	Any procedure performed written on BHT			
ME E8.5	Adequate form and formats are available at point of use			
ME E8.5.1	Standard Format for bed head ticketis available as national guidelines			
Standard E9	The facility has defined and established procedures for discharge of patient.			
ME E9.1	Discharge is done after assessing patient readiness			
ME E9.1.1	Assessment is done before discharging patient by a medical offier			
ME E9.1.2	Discharge is done by a responsible and qualified doctor			
ME E9.1.4	Treating doctor is consulted/ informed before discharge of patients			
ME E9.1.4	Diagnosis is written correctly in BHT before discharge			
ME E9.2	Case summary and follow-up instructions are provided at the discharge			
ME E9.2.1	Discharge summary is provided in pregnancy record			
ME E9.2.3	Discharge summary adequately mentions patients clinical condition, treatment given and follow up			
ME E9.2.4	Discharge summary is give to patients left against medical advice			
ME E9.3	Counselling services are provided as during discharges wherever required			
ME E9.3.1	Patient is counselled before discharge (Depend on whether its normal preganacy or high risk pregnancy information regarding plan for confinement)			
ME E9.3.2	Advice includes the information about:			
	The nearest hospital for further follow up			

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ME E9.3.3	Contact information of area PHM			
	Danger signs			
	Plan for confinement			
ME E9.3.4	Time of discharge is communicated to patient in prior			
ME E9.4	The facility has established procedure for patients leaving the facility against medical advice, absconding, etc			
ME E9.4.1	Declaration is taken from the patients left against medical advice.			
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.			
ME E13.9	There is established procedure for transfusion of blood			
ME E13.9.1	Consent is taken before transfusion			
ME E13.9.2	Patient's identification is verified before transfusion			
ME E13.9.3	Blood is kept on optimum temperature before transfusion			
ME E13.9.4	Blood transfusion is monitored and regulated by qualified person			
ME E13.9.5	Blood transfusion note is written in patient recorded			
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication			
ME E13.10.1	Any major or minor transfusion reaction is recorded and reported to responsible person			
Standard E14	The facility has established procedures for Anaesthetic Services			
ME E14.1	The facility has established procedures for Pre-anaesthetic Check up and maintenance of records			
ME E14.1.1	Pre anaesthesia check up is conducted for elective / Planned surgeries			
Standard E16	The facility has defined and established procedures for end of life care and death			
ME E16.1	Death of admitted patient/ intrauterine death is adequately recorded and communicated			
ME E16.1.1	Facility has a standard procedure to decent communicate death to relatives (most senior staff member available should deliver the message)			
ME E16.1.2	Death note is written on patient record			
ME E16.2	The facility has standard procedures for handling the death in the hospital			
ME E16.2.1	Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible			
ME E16.2.2	Death note including efforts done for resuscitation is noted in patient record			
Area of Concern - H Outcome				

Reference no	Measurable Element	Compliance Y/N/NA	Obtained Marks	Maximum Marks
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks			
ME H1.1	Facility measures productivity Indicators on monthly basis			
ME H1.1.1	Bed Occupancy Rate			
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark			
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis			
ME H3.1.1	Average length of stay for normal delivery			
ME H3.1.2	Average length of Stay for C-Section			
ME H3.1.3	Proportion of Newborns Breastfed within 1/2 hr of Birth			
ME H3.1.4	Maternal Death per 100,000 deliveries			
ME H3.1.5	No of adverse events per thousand patients (falls etc)			
ME H3.1.7	Time taken for initial assessment			

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1
2

Compliance Yes/No/Not Applicable

