Patients For Patient Safety Foundation

CAHO
COMMITTED TO SAFER HEALTHCARE

PATIENT FRIENDLY HOSPITAL STANDARDS

Patients for Patient Safety Foundation

In Collaboration with CAHO

April 2026

PREFACE

The **Patient Friendly Hospital (PFH) Standards** developed by the **Patients for Patient Safety Foundation** in collaboration with **CAHO**, represent a structured effort to move healthcare **beyond safety towards truly patient-friendly care**. While patient safety remains foundational, it alone does not translate into patient satisfaction or trust. Patients today expect not only safe and clinically sound care, but also **clarity, respect, ease of access, communication, trust** and shared decision making throughout their medical journey.

These PFH Standards address the gap by translating patient expectations into **practical, measurable, and implementable structure** within hospital systems. They recognise that a hospital becomes truly patient-friendly when **care is person-centric**, not just disease-centric **responsive to individual needs**.

The PFH Standards have been **collaboratively developed with a multidisciplinary group of doctors and healthcare experts**, ensuring strong clinical relevance and real-world applicability. Each chapter has undergone a **rigorous review process—including intra-author, external peer reviews by** clinicians (both doctors and nurses), quality, operations, training, ethics experts and patient-centred perspective by Patients for Patient Safety Foundation.

The standards support hospitals in **integrating patient-friendly practices into existing care delivery**, strengthening communication, enabling patient participation, and addressing the **trust deficit in healthcare systems**. By embedding these practices, hospitals can improve patient experience, enhance clinical outcomes, and build long-term confidence and loyalty among patients and families.

The **PFH Standards** comprises 11 chapters, each including:

- **Statement of Value and Intent**
- **Specific Standards**
- **Assessment Tool and Scoring Matrix** with a checklist of parameters
- **CEO Dashboard with Key Impact Indicators (KIIs)**

Ensuring the standards are **actionable, measurable, and aligned with governance systems** without additional financial or manpower load.

These standards can be **used by** Hospital Leadership (CEO / Medical Superintendent), Clinical Heads, Nursing Leadership, Quality Team, HR & Training Team, Operations & Front Office and Patient Safety / Ethics Committee.

Ultimately, the PFH Standards enable hospitals to move from care that is **only safe** to care that is **safe, respectful, responsive, and truly patient-friendly** incorporating a continuous improvement cycle. CAHO will develop and conduct structured training programs to support and facilitate the effective implementation of these standards.

ACKNOWLEDGEMENT

The *Patient Friendly Hospital Standards* document is the result of a collaborative effort involving dedicated healthcare professionals and the team at the **Patients for Patient Safety Foundation**, who have collectively contributed their expertise, experience, and commitment to advancing patient-centred care.

We sincerely acknowledge and thank all contributors for their valuable inputs in developing this comprehensive framework. Their collective efforts have ensured that the content is practical, relevant, and aligned with real-world healthcare delivery, with a strong focus on enhancing patient safety, experience, and trust.

This work reflects a shared vision of embedding patient-friendly practices into routine healthcare systems, strengthening communication between patients and providers, and promoting dignity, respect, and participation at every stage of care.

We gratefully acknowledge the contributions of the following experts (listed in alphabetical order):

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Chapter 1: Access to Care and Patient Navigation (ACN)

Access to care is often the patient's first real experience of a hospital, and it strongly shapes trust, confidence, and comfort from the very beginning. A patient-friendly hospital must therefore ensure that patients and caregivers are able to enter, register, move through, and locate services easily, safely, and without confusion, delay, or unnecessary dependence on others. For many patients—especially the elderly, persons with disabilities, those who are frail, anxious, unlettered, or unfamiliar with the language—physical access and navigation are not convenience issues but essential conditions for receiving timely and equitable care. This chapter focuses on making the entry journey simpler, clearer, and more supportive so that patients feel guided, respected, and confident at every point of first contact with the hospital.

ACN 1: The hospital ensures easy and equitable physical access for all patients, including those with special needs

a. The hospital has clearly marked entry points and access routes for patients, including ramps, railings, and elevators.
b. The hospital ensures the availability of wheelchairs and stretchers at all major entry points.
c. Entry points and pathways are free of obstructions and accessible to patients
d. The hospital provides and helps priority access and physical assistance to patients who are frail, confused, elderly, or disabled.
e. The hospital minimises unnecessary patient movement between floors or buildings by ensuring care is delivered in the same location as far as possible.
f. Provide seating support to elderly or weak patients during waiting or registration.

ACN 2: The hospital has effective signage and wayfinding systems to assist patients and visitors

a. The hospital displays pictorial and/or bilingual instructions to support illiterate patients and those who do not speak the local language.
b. The hospital ensures clear, prominently displayed signage in high-traffic areas, using large fonts and universal symbols to guide patients to departments, diagnostic/test areas, essential facilities, as well as emergency exits, lifts, and staircases.
c. Hospital directions are available at all entry points and major patient movement areas
d. The hospital provides wayfinding support through help desks, volunteers, floor maps, and directional signage to ensure patients and visitors can easily reach their destinations without confusion

ACN 3: The hospital facilitates patient registration and appointment processes to ensure timely access to services

a. Registration counters are adequate in number and operational during working hours. Atleast one desk should be operational beyond normal working hours to handle emergencies.

b. The hospital provides clear guidance on the registration process, expected waiting times, designated seating areas, and offers seating support or assistance to elderly or weak patients.
c. An appointment system is in place for both walk-in and scheduled patients
d. Waiting times for registration and consultation are monitored for process improvement and wait time information is clearly displayed in waiting area OPD, surgery etc.
e. Access to health care is prioritised based on patients' needs

ACN 4: The hospital provides support for navigation and coordination of care

a. Help desks are available at the main entrance and key service points
b. The hospital trains help-desk staff and volunteers to check if patients and caregivers have understood directions or instructions, and repeat or explain again if needed
c. The hospital ensures caregivers are given step-by-step guidance (verbal, visual, and/or written) about where to go and what to do next, and are not left to figure out the process on their own
d. The hospital assigns a single point person or coordinator to assist patients undergoing multiple tests or procedures, ensuring smooth coordination across departments
e. Real-time information about patient movement is available where applicable (eg, current patient location in HMS)

ACN 5: The hospital ensures clear communication of service information at the point of entry

a. The hospital clearly displays doctor availability schedules, OPD timings, and consultation charges at entry points, and informs patients whom to contact in case of cancellations or queries
b. The hospital provides clear information at the point of entry about available services such as emergency, ambulance, clinical specialities, teleconsultation, pharmacy, billing, insurance, diagnostics, help desks, and home care\
c. Functional digital/physical kiosks are available to provide service-related information
d. The hospital prominently displays helpline numbers for follow-up queries and post-discharge support

ACN 6: The hospital addresses communication and accessibility needs for patients with language or literacy barriers

a. The hospital uses pictorial signages, posters, and simple leaflets in bilingual language to help non-literate patients understand key steps such as registration, diagnostics, and follow-up
b. Interpreter services are available for patients speaking regional or foreign languages
c. Staff are sensitized and trained to assist patients with communication difficulties by speaking slowly, clearly, and repeating key points for unlettered, elderly, or vulnerable patients.
d. Audio-visual tools or leaflets, Television screens with multilingual audio and running text messages are used for conveying basic hospital navigation instructions

e. Provide simple bilingual leaflets explaining steps such as registration, diagnostics, and follow-up.
f. The hospital offers hand-holding assistance to patients who are confused, overwhelmed, or non-local to ensure they can navigate services smoothly

Chapter 2: Communication and Patient Education (CPE)

Clear communication is central to safe, compassionate, and patient-friendly care because patients can participate meaningfully only when they understand what is happening to them and what is expected of them. When information is explained in simple, respectful, and timely ways, it reduces fear, prevents misunderstanding, improves adherence, and helps patients and families make informed decisions. Communication is equally important within the care team, because gaps in handover, explanation, or documentation can directly affect continuity and safety. This chapter therefore highlights the importance of structured communication, understandable education, and responsive dialogue so that patients feel informed, heard, and supported throughout their care journey.

CPE 1: The organisation ensures structured and effective internal communication among care providers

a. Staff are required to use structured tools such as SBAR, SOAP, or checklists during handovers so that critical information is not missed.
   - SBAR- Situation Background Assessment and Recommendation
   - SOAP- Subjective, Objective, Assessment and Plan

b. Nurses summarise and communicate verbally in comprehensible language to incoming nurses during handover the three most important issues for each patient at the end of every shift before leaving.

c. Doctors and nurses record key goals of care on patient whiteboards so that the incoming team can continue seamlessly. Where whiteboards are not available, alternate means of documenting can be planned by the team, like documenting in the EMR

d. Interdisciplinary rounds are conducted with each team member clearly stating and documenting one assigned action item.

CPE 2: The hospital ensures timely and clear communication with patients and families

a. Staff are required to always introduce themselves with their name and role and purpose before starting a conversation. Example: “I am Dr. Anand, a consultant cardiologist. I have been directed by your attending physician to conduct a cardiac scan on you.”

b. Staff use simple, clear words and avoid medical jargon when speaking with patients and families. Speak in a language that patients understand. Use translations if facing difficulties.

c. Staff check patient understanding by using simple questions or, when appropriate, asking patients to explain instructions in their own words, use teach back method.

d. Families are proactively informed about delays, risks, or changes in prognosis in a timely manner and the same is documented.

e. Staff conduct sensitive conversations in a private, safe environment, while sitting at eye level with the patient rather than standing at the door.

CPE 3: The organisation provides structured patient education tailored to individual needs

a. Each patient and/or family receives disease-specific and need-based education, including general health tips provided in their preferred language.
b. Staff provide simple, practical instructions for home care in three to four key points that patients can easily follow at home.
c. Education provided is documented in the patient's file and assessed for effectiveness.
d. Bedside education boards are used in wards where nurses tick off completed education topics.
e. Patients are encouraged to participate and ask questions about care.
f. High-risk patients, such as those with heart failure, are shown short videos or digital content for better comprehension before discharge.

CPE 4: Patient and family education materials are accurate, culturally appropriate, and accessible

a. All education materials are written in simple language, supported with pictures or icons for low-literacy or other language-speaking patients.
b. Resources are made available in local languages such as Kannada, Tamil, Urdu, Marathi, Bengali, Punjabi, Gujarati, Telugu, Malayalam, Hindi, and English. Where possible, consider special needs, like Braille writing for differently abled individuals
c. Dietary advice and examples are linked to local foods affordability, preference and cultural so that patients can relate to recommendations. Where possible, pictorial lists are also used to support patient's understanding.
d. Staff ensure that information provided across departments is consistent and does not contradict other care instructions.
e. In case of comorbidities, clearance is taken from chief treating doctor.

CPE 5: The communication needs of patients with disabilities or language barriers are proactively addressed

a. Interpreters or video translation services are made available for patients who do not understand the local language.
b. Visual aids, flash cards, or pictorial charts are used to support patients with hearing difficulties.
c. Staff speak slowly, with compassion, face the patient directly, and use gestures to improve comprehension.
d. Hospital signage is multilingual and includes clear symbols for persons with disabilities. Where possible, consider special needs, like Braille writing for differently abled individuals
e. Patients with visual impairment are supported with large print documents or speech-to-text applications where possible.

CPE 6: Communication during emergencies and critical situations is standardised

a. Staff follow established protocols during resuscitation, critical illness, or sudden deterioration of patients.

b. Families are promptly updated and supported during and after emergency events.
c. Staff are trained to deliver difficult news with empathy and professionalism.
d. Signags for taxonomy of emergencies/ dangers are clearly displayed and marked with explanation.

CPE 7: Staff are trained and evaluated in communication and health education skills

a. All clinical and non-clinical staff undergo mandatory training in empathetic communication. This should be repeated periodically.
b. Simulation exercises and role-play sessions are conducted periodically to strengthen communication practices.
c. Staff communication performance is included in appraisals and clinical audits.
d. Advanced tools such as virtual reality or AI-assisted simulations are used to enhance training effectiveness.

CPE 8: The effectiveness of communication and education is monitored and improved continuously

a. Patient and family feedback is routinely collected to assess the clarity and effectiveness of communication. Feedback from patients should include these parameters.
b. Staff develop playbooks or documents to learn communication techniques in different scenarios.
c. Key indicators, such as the percentage of patients with documented education, are tracked monthly.
d. Corrective actions are taken whenever communication gaps are identified.
e. Patient Reported Experience Measures (PREMs) on communication are tracked quarterly and acted upon.

Chapter 3: Respect, Privacy and Cultural Sensitivity (RPC)

Every patient has the right to be treated with dignity, respect, privacy, and sensitivity to personal beliefs, values, and preferences. A hospital becomes truly patient-friendly when care is not only clinically appropriate but also emotionally safe, culturally aware, and respectful of individuality, modesty, autonomy, and choice. Patients are more likely to trust care providers, share important information, and participate openly in treatment when they feel protected from embarrassment, discrimination, coercion, or disregard. This chapter emphasises that respect is not an optional courtesy but a core component of quality care, and that privacy, consent, cultural understanding, and ethical conduct are essential to preserving the patient's dignity at every stage of care.

RPC 1: The hospital demonstrates respect for patient dignity, autonomy, and individual rights

a. A documented charter of rights is communicated and displayed visibly.
b. The hospital culture promotes respect irrespective of background, gender, or socio-economic status.
c. Consent is obtained before examinations, procedures, and care decisions. Explanation, videos & discussion regarding procedural pros, cons, risks should be explained.
d. Consent is an ongoing process. Patients are given sufficient autonomy and informed about their ability to withdraw consent at any time.
e. Shared decision-making tools are used in clinical pathways to reinforce patient autonomy.
f. Shared decision-making is promoted so that patients feel they are included in decisions, not merely informed.
g. Staff are trained to actively listen to patients and encourage them to ask questions.
h. Patients feel respected when their doubts are heard without judgment.
i. Patients and caregivers are encouraged to speak up if something does not feel right.
j. Their decision is respected in all circumstances.

RPC 2: The organization ensures physical, informational, and emotional privacy of all patients

a. Clinical examinations are conducted in private, with curtains or screens used appropriately.
b. Private spaces are also set up for sensitive conversations.
c. Clinical information including diagnosis or results are not discussed loudly in shared or open areas.
d. Patient health information is stored securely and accessed only by authorized personnel.
e. Privacy impact assessments are conducted for all new digital health tools and IT systems.

RPC 3: Cultural, religious, and personal beliefs are respected in care planning and delivery

a. Care plans incorporate religious or cultural preferences, with affordability especially in diet and end-of-life care.
b. Chaplaincy or spiritual care access is facilitated upon request.
c. Simple words or pictorial instructions are used for patients with limited literacy, or language difficulty.
d. Key points are explained slowly and repeated for elderly or unlettered patients, teachback method can be used to ensure understanding.
e. Individual patients' health beliefs are respected while explaining modern treatment.
f. Staff are trained in cultural competence.
g. The hospital maintains a cultural competence dashboard with real-time compliance tracking.
h. No care or service shall be denied or compromised due to any demographic factor, personal belief, or bias.

RPC 4: Gender and modesty-related preferences are honoured during care delivery

a. Female patients have the option to request same-gender examiners where feasible.
b. Staff also ask if a family member should be present during sensitive examinations.
c. Gowning, draping, and touch are handled sensitively, especially in conservative communities.
d. Proper gowning and draping protocols are reinforced to maintain dignity.
e. When examining a patient of the opposite gender, a caregiver of the same gender as the patient must be present in the examination room for the patient's safety.
f. Include caregivers or family members while conducting physical exam if acceptable.

RPC 5: The organisation has a grievance redressal mechanism for breaches of dignity or privacy

a. Staff are reminded that patients who feel disrespected may not return for follow-up.
b. Feedback regarding rudeness, unclear instructions, or emotional distress is not ignored.
c. Grievances related to disrespect or discrimination are recorded and investigated.
d. Independent patient advocates are available to assist with grievances and rights violations.
e. Complainants are given timely feedback on the resolution.
f. Corrective and preventive actions are taken and documented.
g. Staff annually analyze grievances and identify top priorities for improving the cultural competence areas

RPC 6: The consent process reflects respect, voluntariness, and informed decision-making

a. Informed consent includes risks, benefits, and alternatives, with explanation about procedure and accompanying risks.
b. Consent is obtained in a language the patient understands.

c. Consent is not rushed; adequate time is given to patients and understanding is checked.
d. Audio-visuals & Visuals or translated leaflets are used for low-literacy patients. Videos can be given to patient and their family to understand the proceduce 1-2 hours before performing actual procedure
e. Caregivers' understanding of consent is ensured as well.
f. Orientation of caregivers is done regularly and evidence is preserved.
g. Separate consent exists for photography, teaching, or research.
h. Electronic informed consent (e-Consent) systems with comprehension testing are used with audiovisual explanations.
i. Patients are informed of the validity of consents, if any

RPC 7: End-of-life care respects patient and family values

a. Advance care planning is routinely facilitated and documented for all terminal patients.
b. Cultural and religious preferences are documented in end-of-life cases.
c. Terminal illness conversations are conducted gently, with adequate time allowed.
d. Family meetings are conducted with sensitivity during terminal illness. Adequate information and time is given for sudden and inevitable death cases.
e. Spiritual or traditional preferences during end-of-life care are respected.
f. Families are not rushed after death; adequate time is given for final goodbyes.
g. Bereavement support is offered post-death.

RPC 8: Staff behavior consistently reflects a respectful, patient-centric approach

a. Training modules include ethics, communication, and respect, Health literacy also included in the communication.
b. Staff are trained to respond politely and calmly, even during busy periods.
c. Staff conduct, language, and body language are monitored through feedback and observation.
d. The hospital uses AI-assisted analytics from CCTV and incident reports to flag staff behavior trends.
e. The organization designates an ***Ethics Counsellor*** to oversee staff conduct, mediate concerns, and ensure adherence to ethical standards.
f. All staff undergo regular training on ethics, communication, and respectful behavior, with records of participation maintained.
g. The Chief Ethics Counsellor (CEC) has sufficient visibility into hospital operations, and regular reports are submitted for review to ensure transparency and accountability.
h. Disrespectful behavior is addressed through disciplinary protocols.
i. Respectful behavior is reinforced as an essential component of safe care.

Chapter 4: Patient Centred Clinical Care (PCC)

Patient-centred clinical care places the individual patient—not only the disease, diagnosis, or procedure—at the heart of all care decisions and actions. A patient-friendly hospital recognises that good clinical care must be safe, evidence-based, respectful, and responsive to the patient's needs, values, concerns, and ability to participate in decisions. Patients and families experience care more positively when they are informed, involved, listened to, and supported through consent, privacy, communication, continuity, grievance redressal, and end-of-life decisions. This chapter brings together these dimensions of clinical care to ensure that treatment is not delivered as a one-sided process, but as a partnership that promotes trust, dignity, safety, and better outcomes for patients.

PCC 1: Informed Consent and Patient Autonomy

Every patient has the right to make informed decisions about their own care. The hospital ensures that patients understand their diagnosis, treatment options, and prognosis before consenting to any procedure or treatment.

a. Patients are informed about their diagnosis, available treatment options, and what to expect (prognosis) in a language they understand. Family members and caregivers are included in this conversation.
b. Written informed consent is obtained before every invasive procedure or treatment. Consent forms are available in the patient's preferred regional language. The patient (or their authorised family member in the case of minors) and the doctor performing the procedure must sign the consent form.
c. Visual aids, videos, or translated leaflets are shared with the patient before a procedure to support understanding. A teach-back check confirms the patient has understood.
d. The patient's right to refuse or stop treatment at any time is actively communicated and documented. No patient is forced to continue treatment against their will.
e. Shared decision-making tools are used in clinical pathways so patients feel they are part of the decision-making.
f. A separate consent process exists for teaching, photography, research, or organ donation.
g. For patients who cannot consent (unconscious, minors, mentally incapacitated), a clear protocol identifies who provides consent on their behalf, in line with Indian law.
h. Multilingual consent forms and interpreter services are available and actively used.
i. All refusals of treatment are documented with the reason and outcome.

PCC 2: Right to Privacy and Confidentiality

Every patient deserves physical, informational, and emotional privacy. Hospitals must safeguard patient information and ensure all clinical interactions are conducted with dignity and discretion.

a. Curtains, screens, or private rooms are used whenever a patient is examined, dressed, or having a procedure done. This applies in OPD, wards, ICU, and the Emergency Department.
b. Sensitive conversations: diagnosis of serious illness, mental health, HIV status, sexual health are held in a private space, not in corridors, at nursing stations, or in open wards.
c. Patient health information is never discussed loudly in shared areas. Staff are trained to speak softly and only to those who need to know.
d. Electronic Medical Records (EMR)are accessible only to authorised personnel through role-based access controls; electronic and physical records are stored securely. Each staff member has a unique login ID. Audit logs are maintained.
e. Physical records are kept in locked cabinets or secured rooms. Only the treating team has access.
f. Medical information shared with insurance companies or third parties is limited to sharing only what is necessary in compliance with the Digital Personal Data Protection (DPDP) Act 2023 and IT Act 2000.
g. Privacy impact assessments are conducted when any new digital health tool or IT system is introduced.

PCC 3: Respect for Cultural, Religious and Personal Values

Patients from diverse populations bring varied dietary, spiritual, and cultural needs into the care setting. Healthcare facilities must train staff to recognise and accommodate these needs as a standard part of care.

a. Patient dietary preferences and religious or cultural restrictions are identified at admission and met within 24 hours.
b. Space and time for prayer, religious practices, and spiritual support are facilitated wherever clinically safe.
c. Culturally appropriate family support, such as allowing a female relative during labour, permitting parents to stay overnight with hospitalised children, and providing time for post-death rituals, is accommodated.
d. Staff are trained in cultural sensitivity, including appropriate greetings, gender-based care preferences, and dietary practices for major religious communities.

PCC 4: Right to Information and Communication

Patients receive accurate, timely information on their diagnosis, prescribed medications, and discharge plan from the treating team during every significant care interaction.

a. At every consultation and during every hospital stay, the treating doctor or nurse explains the diagnosis, treatment plan, medications, and what to expect in simple words that the patient can understand.
b. Patient Rights and Responsibilities are displayed prominently in all patient care areas, in at least two local languages plus English. Posters must include pictorial symbols for patients with low literacy.

c. At the time of admission, patients receive a leaflet or booklet in their preferred language explaining their rights, hospital rules, and what they can expect during their stay.
d. Digital screens or TV displays in waiting areas run short videos about patient rights and hospital services to reach patients who cannot read.
e. A hospital helpline, feedback forms, and grievance desk are available with clear signage. Patients can ask questions or raise concerns at any time.
f. Patients have the right to know the fee structure before any consultation, investigation, or procedure. Estimated and revised costs are communicated in writing.
g. Patients are informed of their right to a second opinion from within or outside the hospital. Any related cost should be discussed with the patient and family.
h. All communication with patients is documented in the medical record.

PCC 5: Right to Safety and Dignity

Every patient, especially those who are vulnerable, has the right to be safe from harm, neglect, abuse, or exploitation during their hospital stay. The hospital maintains a zero-tolerance approach to disrespectful or unsafe conduct.

a. The hospital has a zero-tolerance policy for physical, verbal, or emotional abuse of any patient by any staff member. This policy is documented, displayed, and enforced.
b. All staff sign a Code of Conduct declaration that includes a commitment to patient dignity, non-discrimination, and respectful behaviour.
c. An anonymous reporting mechanism exists so that doctors and nurses can report incidents of disrespect or patient mistreatment by peers without fear of retaliation.
d. Security staff are trained to manage aggressive situations in the Emergency Department calmly and safely, protecting both patients and staff.
e. Vulnerable patients: elderly, confused, unconscious, disabled, and children, are given extra attention and monitored regularly.
f. No staff member may accept gifts, money, or favours from patients or their families. A policy against financial exploitation is documented and enforced.
g. Gender-sensitive care is ensured, and patients receive personal care (such as bathing, dressing, and catheter care) from a nurse of the same gender whenever required.
h. Patients with hearing, speech, vision, or cognitive impairments are given clear written or visual instructions and the additional support they need throughout their stay and at discharge.
i. National Patient Safety Goals (e.g., preventing medication errors, falls, infections, and wrong-site procedures) are implemented and monitored.

PCC 6: Patient and Family Engagement in Care

When patients and families actively participate in care planning, outcomes improve. The hospital builds systems and behaviours that encourage meaningful partnership at every stage of the clinical journey.

a. Discharge planning starts at least one day before discharge. The patient and a primary family member/caregiver are briefed together on the treatment plan, home care instructions, diet, medications, and follow-up schedule.

b. When shifting a patient from the ICU to a ward, the family is clearly briefed on the change, what treatment continues, what the next steps are, and who to contact.
c. Parents of hospitalised children are encouraged and allowed to stay with the child overnight. Their active involvement in care improves the child's recovery and safety.
d. Shared decision-making is encouraged: for surgery vs. medical management, Example for cancer treatment options, for pain relief preferences. The patient's choice is documented and respected.
e. Patient education tools are provided where applicable. These are in simple language and, wherever possible, in the patient's regional language.
f. The teach-back method is used to confirm that patients and caregivers have understood instructions and is documented.
g. A Patient and Family Advisory Council (PFAC) is established at the hospital level to formally include patient voices in quality improvement.

PCC 7: Right to Access Care and Continuity

The hospital ensures fair, respectful, and safe care for every patient, with equal access, timely treatment, and smooth continuity of care for all.

a. No patient is denied care or treated differently because of their financial situation, language, religion, caste, or social background.
b. Emergency life-saving treatment is provided immediately to every patient, without delay, regardless of financial or social circumstances.
c. Patients with HIV, mental health conditions, disabilities, or from any community receive the same standard of care as all other patients, and staff follow universal precautions without bias.
d. Migrant workers, homeless individuals, and people without identity documents receive care without discrimination, following a basic care protocol.
e. Patients with long-term conditions such as diabetes, hypertension, kidney disease, or cancer receive a clear follow-up plan at discharge, including the next visit, required tests, and warning signs to monitor.
f. Patients referred to another facility receive a referral note with complete clinical details to avoid repeat tests and ensure smooth continuation of care.
g. Patients referred to palliative or hospice services are connected to suitable home-based care teams with a written transition plan.
h. A Social Support Desk (or Social Service Officer) helps financially vulnerable patients access government schemes, hospital support funds, and NGO assistance.

PCC 8: Grievance Redressal and Feedback

Patients must be able to raise concerns easily and confidently. Complaints are treated as opportunities to improve.

a. The hospital offers multiple, clearly visible ways for patients to share feedback or complaints, including a feedback box, helpline number, email, WhatsApp, and a physical Grievance Desk.
b. Anonymous feedback is accepted, and patients are not required to share their identity to raise a concern.

c. Nurse managers or patient experience staff conduct daily bedside rounds for inpatients to proactively identify and address concerns.
d. All complaints are acknowledged within 24 hours, and patients or families are informed about the expected resolution timeline.
e. Grievances are resolved within a defined turnaround time, ideally within three working days for non-clinical issues.
f. A designated Grievance Officer is appointed in every hospital, and unresolved cases are escalated to a Grievance Redressal Committee (committee may have a different title)that includes at least one patient representative.
g. Feedback data is reviewed every month, and repeated issues lead to documented corrective actions. At least two service improvements each quarter are linked to patient feedback.
h. Patient feedback is a core part of continuous improvement and is reflected in the hospital's quality policy and quality committee meeting records.

PCC 9: End-of-Life Care and Advance Directives

The hospital ensures that every patient with a terminal illness receives compassionate, dignified, and culturally respectful end-of-life care that supports both the patient and their family.

a. All patients with a terminal illness are offered a palliative care consultation, where the focus includes comfort, pain relief, and quality of life in addition to medical treatment.
b. Patients are informed about their right to make advance care decisions, including preferences for life support, CPR, and pain management.
c. Do-Not-Resuscitate (DNR) orders and Advance Directives, where applicable, are documented, clearly marked in the patient file, and followed by all treating staff in accordance with regulatory guidelines.
d. Cultural and religious preferences for end-of-life care are respectfully documented, including preferred prayers, the presence of spiritual leaders, body-handling practices, and rituals.
e. Family meetings are conducted with sensitivity, giving adequate time for discussion. The medical team explains the prognosis honestly and compassionately to support informed decision-making.
f. Families are given sufficient time after a patient's death for prayers, last rites, and goodbyes before the body is moved.
g. Bereavement support, including counselling, spiritual care, or psychological first aid, is offered to all families after a patient's death.
h. Organ donation wishes, as stated in a living will or advance directive, are supported and coordinated with the appropriate authorities.

Chapter 5: Safe and Healing Environment (SHE)

The environment in which care is delivered has a direct impact on how patients feel, recover, and experience the hospital. A patient-friendly hospital must therefore provide surroundings that are clean, safe, calm, accessible, and supportive of both physical healing and emotional well-being. For patients and families, the condition of the environment—its cleanliness, comfort, quietness, accessibility, signage, safety features, and sensitivity to vulnerable needs—often communicates the hospital's commitment to care even before any clinical interaction begins. This chapter focuses on creating spaces that reduce fear, prevent harm, preserve dignity, and help patients feel secure, welcomed, and cared for throughout their stay.

SHE 1: The hospital is designed and maintained to prevent injuries and promote safety

a. The facility complies with safety codes and infrastructure norms
b. Adequate lighting is available in all patient and visitor areas
c. Handrails, ramps, and elevators are accessible and functional
d. Advanced technology solutions can be adopted as needed for safe design and accessibility
e. Bathrooms are accessible and equipped with grab bars, call bells for patient safety in case of falls or trips in the bathrooms
f. Highfootfall area have displayed posters which says "How Patients Can Prevent Falls In Hospitals"
g. Fire safety systems are in place and regularly maintained, and tested for effectiveness
h. Maintenance concerns are addressed promptly

SHE 2: The environment is kept clean, fresh, and hygienic to protect patients, visitors, and staff

a. Use of checklists - display, check, audit and report gaps periodically
b. Regular cleaning and sanitisation schedules are followed
c. Patient areas, washrooms, and public spaces are disinfected as per protocols
d. Waste is safely collected, segregated, and disposed of
e. Air circulation and ventilation ensure a fresh and healthy atmosphere
f. Used linen and clothing are handled and cleaned hygienically
g. Patients and families are educated on basic hygiene protocols to support hospitals' safety and cleanliness agenda

SHE 3: The environment supports the emotional well-being of patients and caregivers

a. Hospital designs include considerations for the well-being of patients and caregivers
b. Privacy and quiet zones are available for patients and families
c. Waiting areas are comfortable, well-lit, and ventilated
d. Visual elements such as artwork and greenery create a soothing atmosphere
e. Spiritual or faith-based support is available when requested

SHE 4: The environment ensures privacy, dignity, and respect for all individuals

a. Clear, multilingual signage with universal symbols helps patients navigate the hospital independently and confidently.
b. Call bells and toilets are easily accessible from patient beds
c. Gender-sensitive spaces and policies are in place
d. Special accommodations exist for the elderly, children, and Individuals with disabilities

SHE 5: The hospital promotes a calming and restorative environment to aid recovery

a. Natural light and fresh air are accessible inpatient areas
b. Elements like indoor plants, nature-themed artwork, or calming music are used
c. Comfortable spaces are provided for family presence and rest
d. Food and hydration are easily accessible to patients and caregivers, with signanges and directions
e. Digital/visual displays share helpful and timely information

SHE 6: The hospital environment is designed for inclusivity across all age groups and abilities

a. Entrances, pathways, and washrooms are stretcher and wheelchair-friendly
b. Assistive tools like tactile flooring or audio aids are available where needed
c. Paediatric areas are designed to be safe, comforting, and interactive
d. Geriatric areas have features like anti-slip flooring and supportive furniture
e. The hospital provides a comfortable environment, including care provisions, irrespective of the abilities, race or gender.

SHE 7: The hospital environment is designed to help patients and visitors navigate with ease and minimal confusion

a. Signage is clear, consistent, and positioned at key decision points
b. Navigation aids—such as colour-coded zones, digital displays, or floor directories—are used to improve wayfinding
c. Support through help desks, information counters, or volunteers is available at key locations
d. Maps, directories, or orientation tools (e.g., “You are here” markers) are placed near entrances and major areas of movement or high footfall such as pharmacies, washrooms, diagnostic test labs, lobby.

SHE 8: Patients are cared for in spaces that minimise discomfort from noise, light, or temperature

a. Noise-reducing materials or practices are in place in sensitive areas
b. Lighting is soothing, adjustable, and supports natural rhythms
c. Room temperature and air quality are monitored and optimised
d. Furniture is ergonomic and suited to the patient's needs
e. Decor includes calming colours and nature-based themes

SHE 9: Eco-friendly practices are embedded into the care environment

a. Use of solar energy, natural lighting, or water-saving fixtures
b. Non-toxic materials are used in cleaning and maintenance
c. Waste is minimised and properly managed
d. Indoor air quality is maintained with clean ventilation systems
e. Green spaces or gardens are accessible to patients and families

SHE 10: The hospital is ready for emergencies, with patients feeling safe and informed

a. Emergency exits are clearly marked and unobstructed
b. Special protocols are in place for vulnerable populations (e.g., elderly, ICU, children)
c. Staff are trained to assist patients with disabilities during emergencies
d. Patients are calmly informed and supported during drills or incidents
e. Disaster preparedness or readiness, such as
    - Disaster readiness drills
    - Communication plans with families in case of disasters
    - Contracts including food, water, shelter for the preparation for patients or families
    - Supplies, medications and consumables for emergency preparedness

Chapter 6 Staff Training and Service Behaviour Standards (STB)

The behaviour of hospital staff has a profound influence on how patients experience care, because every interaction can either build trust and reassurance or create fear, confusion, and dissatisfaction. A patient-friendly hospital requires not only competent staff, but staff who consistently demonstrate empathy, courtesy, patience, respect, and accountability in their daily conduct. From greeting a patient and explaining a delay to responding to distress or supporting a vulnerable caregiver, service behaviour directly affects the patient's sense of dignity, safety, and confidence in the institution. This chapter therefore emphasises training, reinforcement, feedback, and leadership oversight so that patient-friendly behaviour becomes a visible and sustained part of hospital culture rather than an individual exception.

STB 1 – Staff Training on Patient-Friendly Behaviour

a. All patient-facing staff shall be trained using a documented behaviour policy.
b. Orientation shall cover empathy, dignity, respect, courtesy, and clear communication.
c. Training shall include role plays, storytelling, and simulations to build respectful interactions.
d. Staff shall learn and demonstrate behaviours on how to greet patients properly, respond to concerns, and support emotional needs.
e. Staff shall be trained to listen actively and encourage patients to ask questions.
f. Patients and caregivers shall be supported to speak up if something feels wrong. The hospital should encourage patients and families to speak up by making them aware that their opinions are valued through posters, displays, and other means.
g. Staff shall use teach-back methods to confirm understanding of treatment and discharge instructions.
h. Refresher training shall be held yearly for high-contact areas such as nursing, reception, diagnostics, and support services.
i. Training effectiveness shall be measured through patient feedback, supervisor reviews, and direct observation.
j. Staff should use Patient Education at every touch point to increase awareness and engage patients in hospitals or at home.

STB 2 – Feedback-Driven Behavioural Improvement

a. Feedback tools such as PREM, PROM, NPS shall monitor and analyse trends about the staff courtesy, responsiveness, and respect.
b. Feedback shall be collected across various care points, reviewed monthly, and shared with relevant department heads and hospital/clinic leaders.
c. Feedback from patients and caregivers shall be documented, especially when it highlights unclear instructions or poor communication.
d. Patients shall be asked if their questions were answered and concerns respected.
e. Positive behaviour shall be recognized in team meetings and appreciation boards.
f. Areas needing improvement shall be addressed through mentoring or focused training.

g. Feedback shall be discussed during staff meetings to improve care.
h. Patients shall be informed that their feedback helps improve staff behaviour and hospital culture.

STB 3 – Service Recovery Through Patient-Friendly Behaviour

a. A service recovery protocol shall guide staff responses during delays or disruptions.
b. Frontline staff shall be trained and authorised to offer sincere apologies, quick solutions, or alternative arrangements.
c. If reports are delayed or missing, staff shall explain what to do next, how long it will take, and what to watch for.
d. If patients do not understand the reason for a delay (e.g., medication, test, discharge), staff shall explain clearly and politely.
e. All recovery actions shall be documented and reviewed for patient satisfaction.
f. Good recovery efforts shall be recognized and shared as examples.
g. Common issues shall be used to improve training and workflows.
h. Patients shall receive follow-up to ensure their concerns were resolved.

STB 4 – Supporting Vulnerable Patients and Their Caregivers

a. Staff shall be trained to speak kindly and patiently with vulnerable patients, for example, children, the elderly, the disabled, and patients who cannot read/hear/speak/see.
b. Staff shall avoid rude, biased, or discriminatory behaviour towards anyone.
c. Regular training shall be conducted using real-life examples and reflective sessions to promote respectful and unbiased conduct.
d. Tools such as picture charts, translators, and simple words shall be used to help patients understand.
e. Caregivers shall be taught what to do in emergencies and how to get help if the patient's condition worsens.
f. Discharge instructions shall include written summaries using simple & advance visual formats. Discharge instructions should be given with adequate time not in rushed manner or alternative of hurried departments.
g. Caregivers shall be trained to help with wound care, giving medicines, and using devices such as catheters or oxygen.
h. Feedback from vulnerable patients and caregivers shall be reviewed to fix behaviour-related issues.
i. Staff shall share ideas to improve care for vulnerable groups during team meetings.

STB 5 – Building a Culture of Respect and Recognition

a. Staff who show kind and respectful behaviour shall be appreciated through awards, newsletters, or team shout-outs.
b. Behaviour scores and service recovery reports shall be used to support staff development.
c. Posters and digital screens shall remind staff about values such as respect, empathy, and dignity.

d. Leaders shall model patient-friendly behaviour during rounds and meetings.
e. Staff shall be trained to explain discharge instructions clearly and respectfully, so patients and caregivers feel confident. Advance and adequate time to be planned.
f. Real stories where staff prevented harm by listening or noticing warning signs shall be celebrated and shared.

STB 6 – Oversight and Continuous Improvement

a. A Patient Safety Committee shall monitor behaviour standards and suggest improvements.
b. Monthly reports shall include feedback highlights, staff recognition, and training results.
c. Lessons from complaints, feedback, and service recovery shall be added to staff orientation and hospital policies.
d. Behaviour problems shall be addressed with coaching—not punishment—unless justified.
e. Caregiver feedback shall be used to improve follow-up care and check how patients are doing after discharge.
f. Feedback protocols should be in place & explained to staff
g. Communication mistakes shall be discussed in department meetings to help staff learn.
h. Feedback about rude behaviour, unclear instructions, or emotional distress shall be treated seriously, as these affect safety.

STB 7 – Communication as a Safety and Behavioural Competency

a. Staff shall be trained to speak clearly, avoid medical jargon, and listen carefully.
b. In sensitive situations—such as serious illness—staff shall communicate with empathy and honesty.
c. Safety education materials shall be shared in simple formats, including visuals and local languages.
d. Staff shall follow standard handover tools such as SBAR to ensure smooth communication.
e. Ambulance teams shall maintain active communication for safe patient transfers.
f. Counselling shall be offered when needed and documented properly.
g. Staff shall use simple words, diagrams, or translated leaflets to explain medicines, wound care, and diet.
h. Patients and families shall be asked to repeat back what they understood.
i. Staff shall explain why tests are being done and what patients can expect—avoiding vague phrases such as “Doctor will tell later.”
j. Staff shall gently confirm understanding by asking patients: Example
    - “Is there anything you’d like me to clarify?”
    - “Would you like me to go over any part of the instructions again?”
    - Do you have any apprehensions or confusion about any of the instructions?

STB 8 – Safety-Oriented Behaviour Linked to National Goals

a. A safety programme shall guide staff on fire safety, other hazards, and how to respond to incidents.
b. Staff shall keep the environment safe for all patients, especially those who are vulnerable.
c. Daily actions shall follow national and international safety goals—such as checking patient identity and maintaining hygiene.
d. Staff shall be trained on these safety goals and expected to show safe behaviour in all tasks.
e. Safe behaviour shall include checking patient identity, keeping hands clean, and confirming that instructions were understood.
f. Staff shall explain why safety steps—such as checking wristbands or confirming test names—are important for patient safety.
g. Staff shall be educated on IPSGs and encouraged to display safety-oriented behaviours in all actions. Safety behaviour shall be respectful—not rushed, careless, or dismissive.

Chapter 7: Feedback, Grievance and Service Recovery (FGR)

A patient-friendly hospital listens actively to patients and caregivers, responds respectfully to concerns, and uses their experiences as a source of learning and improvement. Feedback and grievances are not merely complaints to be managed; they are important signals that reveal gaps in communication, behaviour, systems, access, and quality of care from the patient's point of view. When hospitals acknowledge concerns promptly, resolve issues fairly, and recover trust through timely action, patients feel heard, valued, and respected even when something has gone wrong. This chapter focuses on building transparent, responsive, and non-punitive systems through which patient voices can strengthen service quality, accountability, and confidence in the hospital.

FGR 1 – Feedback Collection, Analysis and Utilisation

a. The hospital shall have a documented policy and procedure for collecting patient and family feedback on services rendered.
b. Feedback shall be collected at multiple points of care (e.g., admission, discharge, OPD, diagnostics, pharmacy) using structured and patient-friendly tools (written, verbal, electronic, or digital platforms) and kept confidential.
c. Feedback tools shall include provisions to capture Patient-Reported Experience Measures (PREM) and Patient-Reported Outcome Measures (PROM).
d. Inclusive strategies shall be adopted for collecting feedback from vulnerable groups such as pediatric, geriatric, disabled, and unlettered patients or with language difficulties, translators/ interpreters should be facilitated.
e. Feedback shall be analyzed periodically to identify trends, service gaps, and opportunities for improvement.
f. Feedback findings shall be communicated to relevant departments for initiating corrective or preventive actions.
g. Monthly trend analysis and key improvement actions shall be reviewed in Quality Committee meetings.
h. Patients shall be informed that their feedback is valued and used for improvements.
i. This standard does not include punitive measures or public embarrassment of staff.

FGR 2 – Transparent and Responsive Grievance Redressal

a. The hospital shall have a documented grievance redressal policy covering both clinical and non-clinical issues.
b. Patients and families shall be informed of the grievance process at the time of admission and through prominently displayed posters or visual materials.
c. A designated Grievance Officer or Nodal Person shall be appointed to receive, record, investigate, and respond to complaints.
d. Grievances shall be recorded in a structured format and categorized by type, severity, and outcome.

e. Each grievance shall be acknowledged within 24 hours and resolved within a defined turnaround time (preferably within 72 hours).
f. Chronic and recurring problem areas identified through feedback should be communicated to the Research, Quality, and Patient Advisory Council Departments.
g. The resolution shall be communicated to the complainant in writing or verbally in a respectful and empathetic manner.
h. Unresolved grievances shall be escalated to the Grievance Redressal Committee, which shall include at least one patient representative or external member.
i. Grievance data shall be analyzed for trends and used to drive system improvements.

FGR 3 – Proactive and Timely Service Recovery

a. A documented service recovery protocol shall be in place to address lapses in service delivery or adverse patient experiences.
b. Frontline staff shall be trained and empowered to initiate immediate corrective actions (e.g., apology, expedited service, explanation, alternative arrangements) wherever feasible.
c. Service recovery efforts shall be commensurate with the severity of the issue faced by the patient.
d. Recovery actions and outcomes shall be documented and reviewed by the Quality Team for recurrence prevention.
e. Patients shall be re-engaged post-recovery to ensure their concerns have been addressed and satisfaction restored.
f. Lessons learned from service recovery cases shall be integrated into staff training and improvement projects.

FGR 4 – Patient-Centric Culture and Staff Accountability

a. The hospital shall promote a culture of patient responsiveness through regular staff sensitisation on patient rights, dignity, and feedback handling.
b. Training programs shall include communication skills, conflict resolution, cultural sensitivity, and handling of difficult patient interactions.
c. Behaviour-related complaints against staff shall be monitored and addressed through a fair, transparent, and corrective process.
d. Positive and patient-friendly staff behaviours shall be recognised and rewarded through formal acknowledgement systems.
e. Patient satisfaction indicators shall be incorporated into departmental KPIs and linked to staff appraisals.
f. A Feedback and Grievance Oversight Committee shall monitor the implementation of this chapter and report to hospital leadership periodically.

Chapter 8: Discharge, Continuity, and Follow-Up Care (DCF)

The patient's journey does not end when he or she leaves the hospital; in many ways, discharge is the point at which safe recovery and long-term outcomes become most vulnerable. A patient-friendly hospital must therefore ensure that discharge is planned, explained, coordinated, and supported so that patients and caregivers know what to do, what to watch for, and whom to contact after leaving. Poor discharge communication can lead to confusion about medicines, follow-up, warning signs, rehabilitation, costs, or home care, which may result in complications, readmissions, and avoidable distress. This chapter highlights the importance of continuity, patient education, caregiver preparedness, and follow-up support so that care remains connected, understandable, and safe beyond the hospital walls.

DCF 1: The hospital ensures a structured and timely discharge process

a. The hospital has a documented discharge policy guiding clinical and administrative processes
b. The expected date/time of discharge is communicated in advance to the patient/ family members
c. Discharge planning begins early, preferably at least one day before discharge, to avoid a last-minute rush and ensure patient understanding
d. A discharge summary is prepared, reviewed, and handed over to the patient/family at discharge, including an updated consolidated medication list with clear instructions on timing and dosage
e. All charges and dues are communicated in advance, including last day's room rent, to ensure smooth and timely payment
f. Discharge turnaround time (TAT) is monitored and used for improvement process.
g. The Patient Discharge Checklist is cross-checked with patient/caregiver before discharge (refer to annexure) along with relevant patient education material to support and ensure adherenace to treatment protocols at home or transfer to next facility.

DCF 2: The hospital provides comprehensive discharge and OPD follow-up information to ensure continuity of care

a. Discharge summary includes diagnosis, treatment, medications, diet, exercise, physiotherapy, danger signs and symptoms, follow-up instructions, and how/when to obtain urgent care.
b. Patients are informed of follow-up options and how to contact the doctor or healthcare provider for any complications.
c. Patients receive education on medication safety, fall prevention, and infection risks and health monitoring and other relanvant material for their condition.
d. Patients are given clear guidance on return-to-work and safe physical activity.
e. The hospital facilitates referrals or connections to rehab, physiotherapy, or nursing services if needed.

f. OPD follow-up details are documented, explained, and the first post-discharge appointment is scheduled at discharge.
g. A Post-discharge Home Precautions Checklist is completed and explained, covering treatment, medicines, diet, rehab, rest, exercise, lifestyle changes, monitoring, and follow-up. SPOC details are shared.

DCF 3: The hospital educates patients/caregivers during discharge and outpatient visits for home care

a. Patients are educated on medication management, wound care, diet, mobility, warning signs, etc, as applicable.
b. The standardised discharge education checklist format is used.
c. Patient family education materials (printed/audio-visual) are available in local language or pictorial form.
d. The hospital uses teach-back methods to ensure patients and caregivers understand home care instructions.
e. Caregivers are included in discharge instructions to improve recall and support.
f. Written summaries and visual cues of key points discussed during discharge are provided to patients and caregivers.
g. Patient and family education materials (eg, QR codes, handouts, e-brochures) are given for reference at home

DCF 4: Support and guidance are available to patients after discharge or between OPD visits

a. Patients are informed of emergency contact numbers, helplines, follow-up procedures, the person to contact, the doctor's OPD schedule, and available transportation options at discharge and during OPD/IPD visits
b. For chronic/complex cases, a nurse or counsellor follow-up is provided via call or message.
c. Teleconsultation or virtual check-ins are available for patients (if required).
d. Continuity is maintained across multiple OPD visits.
e. Patients referred to other departments are guided and tracked
f. Reminders for follow-ups are sent via SMS/email
g. The hospital uses WhatsApp, SMS, or mobile apps to stay in regular contact with patients and gather feedback.
h. Staff check the patient's health by phone and periodic follow up with calls or visits if problems arise.

DCF 5: The hospital monitors and improves discharge and follow-up care processes

a. Discharge delays, patient feedback, and complaints are reviewed periodically
b. Corrective actions are taken for service gaps identified in post-discharge/OPD care
c. Missed OPD follow-up appointments are tracked & efforts taken to follow up with those patients
d. The hospital reviews and updates treatment plans during follow-up calls or visits based on patient symptoms, concerns, or difficulties.

e. Records of post-discharge calls and follow-up actions are maintained.
f. Patients and providers have access to EHRs or patient portals for continuity of care.
g. Patients are encouraged to keep a health diary to track symptoms, medication effects, and questions for future visits. This can be shared in next consultation.
h. Caregiver input is used to improve follow-up processes and evaluate post-discharge outcomes.

DCF 6: The hospital ensures coordination of care during intra- and inter-departmental transfer of care

a. Transfer protocols exist for intra- and inter-department transfers. The structured handover process is adhered to.
b. The hospital involves the family in decisions during transfers of care, ensuring clarity on the lead physician for patients with multiple conditions.
c. Caregivers are briefed during intra-hospital transfers or transfers to another facility/home to maintain continuity of care.
d. Patient identification and safety checks are conducted during transfers (eg: surgical site marking as applicable, patient identification, medication reconciliation, condition at time of transfer, information of lead physician etc)

DCF 7: The hospital supports home-based care and remote monitoring where needed

a. Home care services are facilitated. The hospital develops personalised home care plans covering medications, disease monitoring, diet, rest, exercise, and rehabilitation.
b. Patients are educated on self-care, nutrition, home safety, and fall prevention.
c. Patients are provided a clear list of required equipment, services, and infrastructure for effective home care.
d. Staff educate on remote monitoring tools as applicable. E.g.: **Smart devices** are used for remote monitoring, tracking vitals and progress, and sending medication or appointment reminders.
e. Treatment adherence is evaluated post-discharge through follow-up calls or home visits.

DCF 8: The hospital engages family members in discharge and follow-up care

a. Caregivers are trained and educated & their readiness is assessed
b. The hospital trains and supports caregivers to recognise adverse symptoms, manage medications, provide wound care, monitor symptoms, identify adverse signs early and handle emergencies.
c. Documentation of caregiver involvement is maintained
d. Guides/checklists are given for complex cases
e. Post-discharge care plan adherence is evaluated post-discharge (eg: post-discharge calls, home visits as applicable)
f. One primary caregiver or family member is identified to ensure continuity of information and care.

Chapter 9. Inclusion, Equity, and Community Engagement (IEE)

A patient-friendly hospital must serve all patients fairly and respectfully, regardless of language, literacy, age, gender, disability, background, income, culture, or social vulnerability. Inclusion and equity are essential because patients do not experience healthcare from the same starting point, and barriers that are invisible to the system may be deeply real for those seeking care. A hospital that actively promotes inclusive communication, equitable policies, accessible facilities, and meaningful engagement with patients, families, and communities is better able to build trust, reduce disparities, and make care more responsive to real needs. This chapter therefore connects patient-friendliness with social responsibility by emphasising fairness, participation, and community partnership as integral parts of quality care.

IEE 1: The organization adopts/implements policies and procedures that promote patient inclusion and equity during their process of care

a. Create and uphold inclusive policies that affirm the dignity and equal access to care for individuals of all backgrounds, regardless of race, ethnicity, gender identity, income level, ability status, or immigration history.
   (Patient rights/ responsibilities are displayed prominently in a bilingual language, and they are made aware of it. Patient and family members are involved in decision-making regarding care and treatment. Patient and family members are informed about the expected and revised cost of treatment in writing. Patients have access to interpretation and translation services in their preferred language.)
b. Address and reduce health disparities by directing resources to underserved populations and tailoring care to meet specific needs.
c. Promote health literacy using culturally and linguistically appropriate tools and communication.
d. Care givers are provided information on their role in patient safety and patient care (Medical emergencies, Preventing Falls, First aid response, hand hygiene etc.).

IEE 2: Staff receive periodic training on effective communication

a. All the staff of the hospital must be trained in patient-friendly communication.
b. Staff should be encourage ensure twio way communication and use teach back method to ensure if they have understood or not
c. Cultivate a diverse workforce through inclusive hiring, retention, and leadership development practices.
d. Staff are trained in healthcare communication techniques, including the importance of empathy, grief support, cultural beliefs, emotional resilience, etc.
   (Ensure workforce training in cultural competency, effective two way communication, trauma-informed care, and implicit bias awareness is ongoing and mandatory. Staff should undergo periodic refresher training on these topics.)
e. Training techniques of MCQ quizzes, simulation roleplay, and situational analysis can be used.

IEE 3: The organisation has provision for Patient Friendly Facilities

a. The organisation ensures a physically accessible, inclusive, and safe environment for all patients, including older adults, individuals with disabilities, children, and their caregivers. (Build accessible physical environments with ramps, inclusive signage, sensory-friendly rooms, and gender-neutral facilities.)
b. The facility is designed to promote patient comfort, privacy, and dignity at every stage of the care experience.
c. Clear and intuitive signage is provided to help patients and visitors move through the facility with ease.
d. d. The organisation offers clean, culturally sensitive, and family-friendly amenities that support the emotional and practical needs of patients and their families during hospital visits.

IEE 4. The organisation ensures governance and accountability in patient equity and Community engagement

a. A designated committee or officer oversees the implementation of PIECE strategies. (example: setting up Patient and Family Advisory Councils – PFACs in partnerships with local non-profits, community leaders, faith groups, and grassroots organisations)
b. Patient-friendly performance indicators/feedback are tracked, reviewed, and acted upon regularly. (E.g. PREMs - Patient-Reported Experience Measures. Host regular listening sessions and public forums to gather lived experiences and co-create solutions.)
c. Progress on PIECE strategies is reported transparently to internal and external stakeholders.
d. Collaborate on health promotion and education initiatives tailored to local health needs.

Chapter 10 - Monitoring, Measurement & Continuous Improvement (MMI)

Patient-friendly care becomes sustainable only when hospitals measure what matters to patients, review their performance regularly, and act on the findings in a structured manner. Standards are meaningful not only when they are written, but when they are monitored through audits, feedback, indicators, incident review, and continuous improvement mechanisms that keep the patient perspective visible in hospital governance. From patient rights awareness and consent processes to PREMs, PROMs, grievances, and safety risks, measurement helps the hospital identify gaps, prioritise action, and demonstrate accountability. This chapter focuses on creating systems that convert patient experience and safety data into learning, corrective action, and long-term improvement in patient-friendly care.

MMI 1: Patients and their families have access to the Hospital's patient rights charter. The hospital has-a system for measuring patients' awareness about rights available to them and includes monitoring of patient rights violations, RCA, and CAPA

a. Bilingual display of patient rights, which is visible in all the patient care areas/settings. There is a method to educate patients and their family members regarding patients' rights for patients at the time of visiting the hospital. A system of measurement of patients and their family members to be made aware of their rights needs to be established by the hospital. It could be done by any tool, obtaining data from patient feedback, general consent for admission, incidents of reported patient right violations and PREMS.
b. Role of Patients, Role of Caregivers to be displayed and explained

MMI 2: Cost implications are made aware to all inpatients

a. Audits are done to ensure that the expected costs are informed to all patients at the time of admission, changes in care settings and analysed for correlation of the cost estimation done with the actual bill of the patient.

MMI 3: Hospital has a mechanism for obtaining and analysing feedback, suggestions, and grievances from patients, community stakeholders for continuous quality improvement. The hospital has a mechanism to promote patient/stakeholder engagement

a. All–patient feedback, suggestions, and/ or grievances are analysed, and necessary corrective actions, preventive or promotive actions are undertaken, and relevant stakeholders are informed about it. At least two meetings are held annually with representatives of patients and family members and/or the community stakeholders to discuss the patient safety and quality measures undertaken by the hospital and the patient feedback received.

MMI 4: Audits are conducted at regular intervals for monitoring that consents are adequately and appropriately taken at all times whenever necessary

a. The Hospital has to define when written informed consent are to be taken. The term 'written' includes digital formats and sharing it with patient and their families 1-2 hours prior to the surgery also.
b. The hospital at defined intervals, conducts an audit to assess if consents are taken whenever needed and the completeness, adequacy, appropriateness of the consents taken and their compliance to statutory requirements.
c. The hospital identifies "grey zones" in consent procedures and aims to address them through innovation and consensus-building.

MMI 5: to Hospital monitors patient-related experience measures(PREMs) for both Outpatient & Inpatients and has validated tools for capturing the defined PREMs. The hospital has defined PREMs for its OP and IP

a. The hospital has validated tools for capturing the defined PRE

MMI 6: There are mechanisms for patient health outcomes (both Outpatient & Inpatient)

a. Hospital has defined the PROMs of each department under the scope of its services that it will measure
b. A hospital can deploy any of the various methodologies, like surveys, app links, Google-based surveys, interviews, forms, can be performed to capture the outcomes of patients of various disciplines that capture health status aspects like functional restoration, symptoms, quality of life with respect to all dimensions of health status post treatment.
c. An analysis of the patient outcomes is made using validated measurement tools for continuous quality improvement, and all relevant stakeholders are informed about the analysis

MMI 7: The hospital has a system for incident reporting and management, and proactive analysis of patient safety risk

a. Incident reports are collected every time, regularly analysed for root cause and corrective actions are taken based on such findings.
b. At a minimum, one patient safety risk identified by proactive analysis tools like Hazard Identification and Risk Analysis (HIRA), Failure Modes and Effects Analysis (FEMA) or Fault \Tree Analysis(FTA) and simulations shall undergo proactive analysis to eliminate unsafe actions and conditions that can cause patient harm.
c. Impact study to be conducted once in 2 years to analyse improvement
d. Patient Advisory Council should be established in hospitals for continuous improvement

Chapter - 11 Designing Safe and Patient-Friendly Hospital Infrastructure (DSI)

Hospital infrastructure is not only a physical asset; it is a practical expression of how safely, respectfully, and inclusively the organisation intends patients to experience care. The design of entrances, corridors, waiting spaces, signage, utilities, sanitation, equipment access, and emergency systems can either support smooth, confident care or create confusion, delay, discomfort, and risk for patients and caregivers. For a patient-friendly hospital, infrastructure must therefore do more than meet technical requirements—it must actively reduce stress, improve accessibility, protect dignity, and make navigation and care delivery safer for all, especially the vulnerable. This chapter emphasises infrastructure planning and governance through a patient lens so that the built environment consistently supports safety, trust, comfort, and equity.

DSI 1 - Safe, Accessible and Inclusive Physical Design

a. Clearly marked and separate Emergency, OPD and IPD entrances.
b. Clearly visible and accessible locations for diagnostics labs (pathology & radiology), report collection, canteens, waiting areas, parking areas, OTs, Prayer room, pharmacy, feedback room, counselling room.
c. Multilingual and pictorial signage at all critical interaction points.
d. Obstruction-free corridors and ramps.
e. Anti-slip flooring, railings or grab bars in washrooms and high-risk areas.
f. Adequate lighting in corridors, staircases, parking, and patient care areas even at night.
g. Easy to climb staircases and lifts in multiple locations
h. Wheelchair/ mobility equipment, accessibility across departments.
i. Dedicated seating for elderly, pregnant women, and differently-abled patients, particularly in waiting areas outside OTs.
j. Interior decor should be calming, soothing with acces to green spaces and natural lights

DSI 2 - Structured Way-Finding and Information Visibility

a. “May I Help You” desk with updated consultant and department information.
b. Clear floor maps displayed at entry points.
c. Token-based queue management systems.
d. Real-time waiting information where feasible.
e. Location-wise patient education displays (waiting areas, pharmacy, labs, wards).
f. Digital and physical directories.

DSI 3 - Environmental Hygiene and Infection Risk Control

a. Defined cleaning schedules with documented checklists.
b. Biomedical waste segregation disposal and monitoring.
c. Hand hygiene promotion at key touchpoints.
d. Ventilation and air quality monitoring in high-risk areas.

e. Clean and accessible drinking water facilities.
f. Sanitization of high-touch surfaces.

DSI 4 - Patient Comfort and Healing-Oriented Spaces

a. Noise control measures in wards and ICU.
b. Adjustable lighting to support rest cycles.
c. Temperature regulation monitoring.
d. Adequate waiting space to avoid overcrowding.
e. Clear visitor guidelines displayed.
f. Visual educational material, handouts and QR codes can be displayed in prominent places promoting safety and prevention .

DSI 5 - Disaster Preparedness and Visible Safety Systems

a. Clearly displayed evacuation maps.
b. Unobstructed emergency exits.
c. Functional fire detection and suppression systems.
d. Periodic mock drills with documented outcomes.
e. Backup systems for power, oxygen, and water.
f. Patient orientation on call bells and emergency response.

DSI 6 - Equipment Reliability and Utility Governance

a. Preventive maintenance schedules.
b. Calibration tracking systems.
c. Reporting protocol for equipment malfunction.
d. Backup support for critical utilities.
e. Risk assessment before new technology introduction.

DSI 7 - Infrastructure for Equity and Diverse Demographics

a. Multilingual communication materials.
b. Visual aids for low-literacy populations.
c. Transparent cost display boards.
d. Financial counselling areas clearly marked.
e. Accessible grievance submission points.
f. Safe caregiver rest zones.

DSI 8 - Facility Governance, Monitoring and Continuous Improvement

a. Monthly facility safety rounds.
b. Environmental hazard reporting mechanism.
c. Integration of patient feedback, PREMs and PAC insights into facility planning.
d. Leadership-level review of infrastructure-related incidents.
e. Defined KPIs for environmental safety.

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Patients For Patient Safety Foundation

PATIENT FRIENDLY HOSPITAL STANDARDS

ASSESSMENT TOOLS & SCORING MATRIX

Patient Friendly Hospital Standards
Assessment Tools & Scoring Matrix

How to Use the Assessment Tool & Scoring Matrix

The **Patient-Friendly Assessment Tool & Scoring Matrix** is a structured tool for **self-assessment, implementation, and continuous improvement** of Patient-Friendly Hospital Practices. It will evolve into a **external assessment tool for certification as Patient Friendly Hospitals**. It is applicable and adaptable across all healthcare settings—small clinics, mid-sized hospitals, and large institutions.

1. Implementation Approach
Adopt a multidisciplinary, role-based approach with:

- A **nodal coordinator** (Quality/Patient Safety team)
- Participation from **clinical, nursing, administrative, and operations teams**
- **Leadership oversight** to ensure alignment and accountability
- CAHO will develop and conduct **Training Program** to facilitate implementation

2. Assessment Method
Evaluate each parameter as:

- **Yes (Fully Implemented)**
- **Partial (Inconsistently Implemented)**
- **No (Not Implemented)**

Support all assessments with objective evidence such as documentation, observation, patient feedback and experiences, qualitative records, and system records.

3. Frequency of Review

- Conduct assessments **monthly or quarterly** based on operational needs
- Review **high-impact areas (safety, communication, discharge)** more frequently
- Include findings in **Quality and Leadership review meetings**

4. Standard Scoring Framework (Common for All Chapters)
Scoring Method:

- Yes = 2 points | Partial = 1 point | No = 0 points

Total Score:

- Maximum = 20 (10 parameters × 2 points)

Score Interpretation:

Score Range	Level	Interpretation
18–20 (90–100%)	Patient-Friendly Infrastructure Ready	Safe, accessible, patient-centric facility
15–17 (75–89%)	Moderate Risk	Gaps exist; improvement required

<15 (<75%)	High Risk	Intervention required

5. KII-Based Measurement

Track defined KIIs (Key Impact Indicators) regularly (monthly/quarterly) to assess effectiveness. It is essential to capture the voice of patients across the patient journey to assess the impact:

KII Trend	Meaning
Improving	Supporting patient-friendly care and patient experience
No Change	Limited impact – no significant improvement
Worsening	High risk to patient-friendly care, efficiency, brand reputation, patient loyalty, and increased patient dissatisfaction and complaints

6. Action & Continuous Improvement

Use assessment findings to identify gaps, implement **Corrective and Preventive Actions (CAPA)** with defined responsibilities and timelines, and monitor progress through regular reviews, focusing on system improvement.

Chapter 1: Access to Care and Patient Navigation (ACN)

*(**Who can Review** - Operations, Nursing, Front Office, Quality & Leadership Team)*

Patient-Friendly Access & Navigation Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/ Action
1.	Entry points clearly marked and physically accessible (ramps, lifts, railings)		Photographic / facility audit		
2.	Corridors and patient pathways obstruction-free		Walkthrough audit		
3.	Wheelchairs/stretchers available at all entry points		Equipment log		
4.	Priority access provided to elderly, disabled, and vulnerable patients		Observation audit		
5.	Pictorial and bilingual signage across hospital		Signage audit		
6.	Help desks / navigation support available and functional		Duty roster / observation		
7.	Registration and appointment system functional with monitored waiting times		System report / dashboard		
8.	Waiting time information clearly displayed to patients		Display verification		
9.	Doctor schedules, services, and charges transparently displayed		Physical verification		
10.	Interpreter support / simplified communication tools available for patients		Interpreter log / IEC audit		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Average time from entry to registration (TAT)
2. Navigation-related complaints
3. Average OPD waiting time / consultation delay
4. Complaints related to accessibility (elderly/disabled patients)
5. Interpreter service utilisation / communication-related feedback

CEO Review Dashboard *(Quarterly Review Should Include):*

- Average OPD waiting time
- Registration TAT
- Navigation-related complaints
- Accessibility incident trends
- Priority patient handling compliance
- Interpreter service utilization
- Multi-department coordination delays

Chapter 2: Communication and Patient Education (CPE)

*(**Who can Review -** Clinical Heads, Nursing, HR, Quality & Leadership Team)*

Patient-Friendly Communication & Education Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/ Action
1.	Structured handover communication (SBAR/SOAP/checklist) in use		Handover audit		
2.	Staff communicate in simple, patient-understandable language (no jargon)		Observation audit		
3.	Teach-back method used and documented		Case file audit		
4.	Staff introduce name, role, and purpose to patients		Patient feedback / observation		
5.	Families informed timely about delays, risks, and prognosis		Case documentation		
6.	Disease-specific and need-based patient education provided		Case file audit		
7.	Patient education documented and effectiveness assessed		Documentation review		
8.	Education materials available in simple, pictorial, and regional language formats		IEC material audit		
9.	Interpreter / communication support available for special needs patients		Interpreter log / facility audit		
10.	Patient feedback (PREMs) and communication indicators monitored regularly		Dashboard / feedback reports		

KIIs (Key Impact Indicators for Patient Friendliness):

1. PREMs score (communication clarity & understanding)
2. % patients with documented patient education
3. Teach-back compliance rate
4. Readmissions linked to communication / discharge misunderstanding
5. Complaints related to poor explanation or communication gaps

CEO Review Dashboard *(Quarterly Review Should Include):*

- PREMs score (Communication domain)
- % documented patient education
- Teach-back compliance rate
- Readmissions linked to discharge misunderstanding
- Complaints related to poor explanation
- % staff trained in empathetic communication

Chapter 3: Respect, Privacy and Cultural Sensitivity (RPC)

*(**Who can Review** - Clinical Heads, Nursing, HR, Ethics Committee, Quality & Leadership Team)*

Patient-Friendly Respect, Privacy & Cultural Sensitivity Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Patient Rights Charter visibly displayed and communicated		Photographic audit		
2.	Informed consent obtained before procedures and explained (risks, benefits, alternatives)		Consent audit		
3.	Patients informed of right to withdraw consent		Documentation review		
4.	Shared decision-making practiced and documented		Case file audit		
5.	Privacy maintained during examinations and sensitive discussions		Observation audit		
6.	Patient information securely stored and access restricted		IT / record audit		
7.	Cultural and religious preferences documented in care plans		Case file review		
8.	Gender sensitivity maintained (chaperone, dignity, modesty practices)		Policy / observation audit		
9.	Grievance mechanism for dignity/privacy issues functional and responsive		Grievance log / CAPA		
10.	Staff trained and monitored for respectful behaviour and ethics		Training records / feedback analysis		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Number of dignity / disrespect-related complaints
2. % complete and valid informed consent documentation
3. Privacy breach incidents / confidentiality violations
4. Patient-reported autonomy and respect score
5. Average grievance resolution time (dignity/privacy issues)

CEO Review Dashboard *(Quarterly Review Should Include):*

- Dignity-related complaints
- Consent completeness rate
- Cultural competence compliance score
- Privacy breach incidents
- End-of-life satisfaction feedback
- Staff behaviour trend analysis

Chapter 4: Patient Centred Clinical Care (PCC)

*(**Who can Review -** Medical Superintendent, Clinical Heads, Nursing, Ethics Committee & Quality Team)*

Patient-Centred Clinical Care Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/ Action
1.	100% documented informed consent before invasive procedures		Consent file audit		
2.	Risks, benefits, alternatives, and patient right to refuse documented		Case file audit		
3.	Privacy maintained during examination and sensitive discussions		Observation audit		
4.	Patient information securely managed (EMR access control & confidentiality)		IT / record audit		
5.	Cultural, religious, and dietary preferences documented and respected		Case file / diet log		
6.	Diagnosis, treatment plan, and medications explained in simple language		Case notes / patient feedback		
7.	Zero-tolerance policy for abuse and dignity violations implemented		Policy / incident log		
8.	Patient and caregiver involved in care planning and discharge decisions		Case file audit		
9.	No denial of care based on socioeconomic or demographic factors		Incident log / audit		
10.	Grievance redressal and feedback system functional with defined TAT		Grievance tracker / CAPA		

KIIs (Key Impact Indicators for Patient Friendliness):

1. % procedures with valid and complete informed consent
2. Privacy breach / confidentiality violation incidents
3. Patient-reported understanding of diagnosis and treatment
4. Grievance resolution within defined TAT (%)
5. Readmissions / care gaps linked to poor engagement or communication

CEO Review Dashboard *(Quarterly Review Should Include):*

- Consent compliance rate
- Privacy breach incidents
- Cultural sensitivity complaints
- Discharge education compliance
- Chronic patient follow-up compliance
- Grievance resolution TAT
- End-of-life documentation compliance

Chapter 5: Safe and Healing Environment (SHE)

*(**Who can Review -** Facility Management, Nursing, Infection Control, Safety Officer, HR & Leadership Team)*

Safe & Healing Environment Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Facility compliant with safety norms (ramps, lighting, infrastructure safety)		Compliance certificate / audit		
2.	Fire safety systems functional and regularly tested		Fire audit / drill report		
3.	Corridors, washrooms, and high-risk areas safe (anti-slip, grab bars, accessibility)		Physical inspection		
4.	Cleaning, disinfection, and hygiene protocols consistently followed		Housekeeping / infection audit		
5.	Biomedical waste segregation and disposal compliant		Waste audit		
6.	Ventilation, air quality, and linen hygiene maintained		HVAC / audit logs		
7.	Environment supports patient comfort (quiet areas, seating, lighting, ventilation)		Facility audit		
8.	Privacy, dignity, and accessibility ensured (signage, call bells, inclusive design)		Observation / audit		
9.	Wayfinding system functional (signage, maps, help desks)		Walkthrough audit		

10.	Emergency preparedness systems functional (exits, drills, staff readiness)		Safety audit / drill report		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Patient fall incidents / infrastructure-related injuries
2. Hospital Acquired Infection (HAI) rates
3. Cleanliness and hygiene-related complaints
4. Patient comfort / environment satisfaction score
5. Emergency drill compliance and response effectiveness

CEO Review Dashboard *(Quarterly Review Should Include):*

- Fall rate per 1000 patient days
- HAI rates
- Infrastructure incident reports
- Cleanliness audit score
- Noise & comfort complaints
- Emergency drill compliance
- Accessibility audit score

Chapter 6 Staff Training and Service Behaviour Standards (STB)

*(**Who can Review -** HR, Nursing, Clinical Heads, Patient Safety Committee & Leadership Team)*

Staff Training & Patient-Friendly Behaviour Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Documented patient-friendly behaviour policy implemented		Policy file		
2.	100% patient-facing staff trained in empathy, respect, and communication		HR training records		
3.	Teach-back method used and reinforced through training		Training / case audit		
4.	Staff encourage patients and caregivers to “Speak Up”		IEC display / observation		
5.	Feedback systems (PREMs/PROMs/NPS) used to monitor behaviour		Feedback reports		
6.	Monthly review of behaviour feedback and action taken		Meeting minutes / CAPA		
7.	Service recovery protocol implemented (apology, explanation, follow-up)		SOP / recovery logs		
8.	Staff trained to support vulnerable patients (elderly, disabled, children)		Training records		
9.	Structured communication practices followed (SBAR, no jargon, clarity)		Audit / observation		
10.	Safety-oriented behaviour practiced (ID checks, hand hygiene, IPSG compliance)		Audit / infection control report		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Patient feedback score on staff behaviour (PREMs)
2. % staff trained in patient-friendly behaviour
3. Complaints related to rude behaviour / poor communication
4. Service recovery success rate / patient satisfaction post-resolution
5. Hand hygiene compliance / safety behaviour adherence

CEO Review Dashboard *(Quarterly Review Should Include):*

- Staff training coverage %
- Behaviour satisfaction score (PREMs)
- Service recovery success rate
- Vulnerable patient satisfaction score
- Handover error incidents
- Hand hygiene compliance rate
- Rude behaviour complaints trend

Chapter 7: Feedback, Grievance and Service Recovery (FGR)

*(**Who can Review -** Quality Team, Grievance Officer, Patient Safety Committee & Hospital Leadership)*

Feedback, Grievance & Service Recovery Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial /No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Documented system for feedback collection across all care points		Policy / tool audit		
2.	Feedback tools include PREMs and PROMs		Survey tool review		
3.	Feedback collected inclusively (vulnerable patients, translators support)		Accessibility audit		
4.	Monthly feedback analysis conducted with documented actions		Quality report / CAPA		
5.	Patients informed that feedback leads to improvement		IEC display / communicatio n		
6.	Documented grievance redressal policy implemented		Policy review		
7.	Grievances acknowledged within 24 hours and resolved within defined TAT		Grievance tracker		
8.	Structured grievance recording, categorisation, and escalation system		Register / committee records		
9.	Service recovery protocol implemented (apology, explanation, resolution, follow-up)		SOP / recovery logs		
10.	Patient-centric culture reinforced (staff training, recognition, accountability mechanisms)		Training / HR / KPI dashboard		

KIIs (Key Impact Indicators for Patient Friendliness):

1. PREMs satisfaction score (overall patient experience)
2. % grievances resolved within defined TAT (≤72 hours)
3. Repeat complaint rate
4. Service recovery success / patient satisfaction post-resolution
5. Feedback response rate

CEO Review Dashboard *(Monthly Review Should Include):*

- Feedback response rate
- PREMs & PROM trends
- Total grievances received vs resolved
- % grievances resolved within 72 hours
- Repeat complaint percentage
- Service recovery success rate
- Behaviour-related complaint trend
- Top 3 recurring systemic issues

Chapter 8: Discharge, Continuity, and Follow-Up Care (DCF)

*(**Who can Review -** Clinical Heads, Nursing, Discharge Desk, Quality Team & Leadership)*

Discharge, Continuity & Follow-Up Care Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Documented discharge policy implemented		Policy file		
2.	Expected discharge date/time communicated in advance		Case file audit		
3.	Discharge planning initiated early (≥1 day prior)		Case sampling		
4.	Discharge summary complete with diagnosis, treatment & medication instructions		File audit		
5.	Follow-up appointment scheduled before discharge		Appointment log		
6.	Discharge education provided using checklist & teach-back method		Case file audit		
7.	Caregiver involved and trained for post-discharge care		Documentation review		
8.	Emergency contact details and follow-up support provided		Discharge summary audit		
9.	Post-discharge follow-up system functional (calls, reminders, teleconsultation)		Call log / system report		
10.	Safe transfer and continuity ensured (handover, ID checks, coordination)		Audit / transfer records		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Readmission rate (7-day / 30-day) due to discharge gaps
2. % patients with scheduled and completed follow-up
3. Discharge turnaround time (TAT)
4. Medication misunderstanding / post-discharge complication complaints
5. % patients contacted post-discharge (follow-up compliance)

CEO Review Dashboard *(Monthly Review Should Include):*

- Average discharge TAT
- % discharge summaries complete at handover
- Readmission rate within 7/30 days
- Missed follow-up rate
- Post-discharge contact compliance
- Transfer-related incident rate
- Chronic patient adherence rate

Chapter 9. Inclusion, Equity, and Community Engagement (IEE)

*(**Who can Review -** Hospital Leadership, HR, Quality Team, Patient Advisory Council & Community Outreach Team)*

Inclusion, Equity & Community Engagement Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial/ No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Inclusive non-discrimination policy implemented and visible		Policy file / display audit		
2.	Patient rights & responsibilities displayed and communicated (bilingual)		Photograp hic audit		
3.	Interpretation and translation services available for patients		Service log		
4.	Patients informed about treatment costs (expected and revised) transparently		Billing documenta tion		
5.	Health literacy materials provided in culturally appropriate formats		IEC audit		
6.	Staff trained in cultural competence, empathy, and bias awareness		Training records		
7.	Inclusive and accessible infrastructure (ramps, signage, facilities) available		Accessibil ity audit		
8.	Data on patient demographics and disparities collected and analysed		MIS / analytical report		
9.	Targeted interventions for vulnerable/underserved populations implemented		Action plan		
10.	Governance system for equity & community engagement functional (committee/PFAC)		Committe e records / reports		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Discrimination / inequity-related complaints
2. Translation / interpreter service utilisation rate
3. Health literacy / patient understanding satisfaction score
4. Outcome gap between different patient groups (disparity trend)
5. Community engagement frequency / PFAC activity level

CEO Review Dashboard *(Quarterly Review Should Include):*

- Diversity & inclusion metrics
- Translation utilisation rate
- Equity-related complaints
- PFAC meeting frequency
- Community outreach initiatives conducted
- Disparity reduction trend
- Vulnerable patient satisfaction score

Chapter 10 - Monitoring, Measurement & Continuous Improvement (MMI)

*(**Who can Review -** Quality Committee, Medical Superintendent, HR, Finance, Patient Safety Committee & Leadership Team)*

Monitoring, Measurement & Continuous Improvement Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial /No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Patient Rights Charter displayed and awareness measured		Photographic audit / survey tool		
2.	System for tracking and analysing patient rights violations (RCA & CAPA)		Incident log / CAPA tracker		
3.	Cost communication system implemented (estimated vs actual tracking)		Billing audit / dashboard		
4.	Structured system for feedback, suggestions, and grievance analysis		Feedback audit / reports		
5.	Stakeholder engagement (patient/community meetings) conducted regularly		Meeting minutes		
6.	Consent process defined, audited, and compliant (including completeness)		Consent audit		
7.	PREMs defined, collected, and analysed systematically		Data dashboard / reports		
8.	PROMs defined and used to monitor patient outcomes		Outcome reports		
9.	Incident reporting system functional with RCA and CAPA tracking		Incident records		
10.	Proactive risk assessment (HIRA/FMEA/FTA) and impact evaluation conducted		Risk reports / impact studies		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Patient rights awareness score
2. PREMs satisfaction score (overall patient experience)
3. PROMs outcome improvement trend (clinical + quality of life)
4. Incident reporting rate and RCA closure rate
5. % CAPA implemented and effective (improvement success rate)

CEO Review Dashboard *(Quarterly Review Should Include):*

- Patient rights awareness score
- Cost variance index
- PREMs & PROM trends
- Consent audit compliance rate
- Incident reporting frequency
- RCA closure rate
- Proactive risk analyses completed
- CAPA effectiveness score
- Stakeholder engagement frequency

Chapter - 11 Designing Safe and Patient-Friendly Hospital Infrastructure (DSI)

*(**Who can Review -** Facility, Quality & Leadership Team)*

Safe Patient-Friendly Hospital Infrastructure Assessment Tool & Scoring Matrix

S.No.	Audit Parameter	Compliance (Yes/Partial /No)	Evidence Required	Score (2/1/0)	Remarks/Action
1.	Emergency, OPD, and IPD entry points clearly marked and accessible		Photographic audit		
2.	Multilingual and pictorial signage available across facility		Signage audit		
3.	Corridors and pathways obstruction-free and safe		Walkthrough audit		
4.	Anti-slip flooring, grab bars, and safety features in high-risk areas		Physical inspection		
5.	Adequate lighting in all patient care and movement areas		Inspection log		
6.	Structured wayfinding system (help desk, maps, queue systems) functional		Facility audit		
7.	Cleaning, hygiene, and infection control systems implemented		Cleaning logs / audit		
8.	Emergency preparedness systems functional (exits, drills, backup systems)		Safety audit / drill report		
9.	Equipment maintenance, calibration, and downtime tracking systems functional		Maintenance records		
10.	Inclusive infrastructure (wheelchairs, seating, cost transparency, grievance access) available		Accessibility audit		

KIIs (Key Impact Indicators for Patient Friendliness):

1. Patient fall incidents linked to infrastructure
2. Navigation-related complaints / missed movement efficiency
3. Hospital Acquired Infection (HAI) rates (environment-linked)
4. Emergency drill performance / response time
5. Equipment downtime / infrastructure-related service delays

CEO Review Dashboard *(Quarterly Summary Should Include):*

- Fall incidents linked to infrastructure
- Navigation-related complaints
- Infection trends linked to environment
- Emergency drill performance
- Equipment downtime
- Top 5 infrastructure risks pending
- Budget utilization for facility safety upgrades

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Safety is the baseline
Patient-friendly care makes the difference