**QAI CAHSC 1402**

**Quality and Accreditation Institute**

**Centre for Accreditation of Health & Social Care**



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**ACCREDITATION OF TRANSITION CARE CENTRE**

**Issue No.: 02 Issue Date: March 2024**

**CHANGE HISTORY**

|  |  |  |  |  |  |
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| **Sl. No.** | **Doc No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
| 1 | QAI CAHSC 1402 | 01 | 02 | March 2024  (20 March 2024) | Borders and QAI Logo added in the header |
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**Information & Instructions for Completing an Application Form**

1. Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers accreditation service to Transition Care Centres.
2. Application shall be made in the prescribed form QAI CAHSC 1402 only. Application form can be downloaded from website as a word file. Applicant centre is requested to submit the following:

* Soft copy of completed application form (available on website)
* Soft copy of Self-assessment tool kit along with referenced documents
* Prescribed application fees
* Soft copy of signed QAI CAHSC 003 ‘Terms and Conditions for Maintaining QAI Accreditation/ Certification’

1. Incomplete application submitted may lead to delay in processing of your application.
2. The applicant centre shall provide soft copy of appropriate document(s) in support of the information being provided in this application form.
3. Centre is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure, QAI CAHSC 1401 Information Brochure for Transition Care Centre’ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/ Certification’ before filling up this form.
4. The applicant centre shall intimate QAI CAHSC about any change in the information provided in this application such as scope applied for accreditation, personnel and location etc. within 15 days from the date of changes.

**DEMOGRAPHIC AND GENERAL DETAILS:**

1. **Applying for (please tick the relevant)**
   1. **Accreditation\* □**

**\*** (Centre is advised to implement the standards for at least 2 months

before applying)

* 1. **Re-accreditation □**

**Date of 1st Accreditation ……………**

1. **Name of the Centre:** (the same shall appear on the accreditation certificate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Contact Details of Centre:**
3. **Address**-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Website**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Contact No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Ownership:**

|  |  |
| --- | --- |
| **□**Private – Corporate | **□**Armed Forces |
| **□**PSU | **□**Trust |
| **□**Government | **□**Charitable |
| **□**Others (Specifiy.........................................................................................) | |

1. **Legal Identity of the organisation with the date of registration**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Goods and Services Tax (GST) Number, if applicable** (Please attach a copy of GST Registration Certificate):

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1. **Micro, Small and Medium Enterprises (MSME) Registration Number, if applicable** (Please attach a copy of Registration Certificate):

­­­­­­

1. **Name of the Parent Organisation, if part of a bigger organisation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Contact person(s):** 
   1. **Senior Management in the Centre**

Mr. /Ms. /Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. **Person Coordinating with QAI:**

Mr./Ms./Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel./ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Human Resource:**  
   **a. Details of the staff**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. No. | Name | Designation | Academic and Professional Qualifications\* | Total experience (in years) | Experience in Transition Care Centre |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

\* Please clearly indicate the field of specialisation

**b. Staff Information:**

|  |  |  |
| --- | --- | --- |
| **Category of Staff** | **Numbers** | **Remarks if any** |
| Managerial |  |  |
| Doctors |  |  |
| * Resident (non-PG) / Medical Officer |  |  |
| * Consultants |  |  |
| a) Full Time |  |  |
| b) Part Time |  |  |
| Allied Medical Speciality Staff e.g Physiotherapist |  |  |
| Nurses |  |  |
| Technicians |  |  |
| Housekeeping staff |  |  |
| Others |  |  |

1. **Information about Centres and Services:**

**Size of the Centre (Total number of beds):**

**CLINICAL SERVICES AND RELATED DETAILS**

1. **Patient Data:**
2. **In-Patient Data (Past 2 years)**

|  |  |
| --- | --- |
| **Year** | **Number of Patients Admitted** |
|  |  |
|  |  |

1. **List 5 most frequent clinical diagnosis for patients**
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **List 5 most frequent procedures done for patients**
8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. **Scope of Accreditation –Services**

|  |  |
| --- | --- |
| **TYPE OF CENTRE** | SELECT THE SERVICE(S) |
| Transition Care Centre\* (pl. provide details at sl. no. 16) |  |
| Rehabilitation centres (in-patient or in-patient & out-patient) |  |
| Deaddiction Centre |  |
| Palliative Care Centre |  |
| Geriatric/Senior/Elder Care Centre |  |
| Assisted Living |  |

1. **\*Details of Services for Transition Care**

|  |  |
| --- | --- |
| **Services** | **Yes/ No** |
| **Physiotherapy:** |  |
| Neurological Physiotherapy |  |
| Geriatric Physiotherapy |  |
| Sports Physiotherapy |  |
| Back and Neck Physiotherapy |  |
| Cardiopulmonary Physiotherapy |  |
| Orthopaedic Physiotherapy |  |
| Any other |  |
| **Rehabilitation** |  |
| Neurological Rehabilitation |  |
| Spine Injury Rehabilitation |  |
| Ortho Rehabilitation |  |
| Respiratory Therapy |  |
| Speech Therapy |  |
| Occupational Therapy |  |
| Any other |  |
| **Medical and Nursing Support** |  |
| Medical Supervision |  |
| Diet and Nutrition |  |
| Bed Sore Management |  |
| Emotional Care |  |
| Social Care |  |
| Nutritional Care |  |
| Palliative Care |  |
| Any other |  |
| **If Others (please specify)** |  |

1. **Scope of Accreditation- Diagnostic Services in the Centre (mention Yes/ No):**

**(ONLY IN-HOUSE SERVICES WILL BE INCLUDED IN THE CERTIFICATE)**

|  |  |  |
| --- | --- | --- |
| **Diagnostic Services** | **In House** | **Out sourced** |
| X-Ray |  |  |
| Ultrasound |  |  |
| Other, please specify |  |  |
| ***Laboratory Services:*** |  |  |
| Clinical Bio-chemistry |  |  |
| Clinical Microbiology and Serology |  |  |
| Clinical Pathology |  |  |
| Haematology |  |  |
| ***Other Diagnostic Service (s):*** |  |  |
| 2D Echo |  |  |
| Audiometry |  |  |
| EEG |  |  |
| EMG/EP |  |  |
| Holter Monitoring |  |  |
| Spirometry |  |  |
| Tread Mill Testing |  |  |
| Urodynamic Studies |  |  |
| *Any Other Diagnostic Service (s):* |  |  |

1. **Details of Non-Clinical and Administrative Departments (mention Yes/ No):**

|  |  |  |
| --- | --- | --- |
| **SUPPORT SERVICE** | **IN HOUSE** | **OUT SOURCED** |
| Bio-medical Engineering |  |  |
| Catering and Kitchen services |  |  |
| CSSD |  |  |
| Housekeeping |  |  |
| Information Technology |  |  |
| Laundry |  |  |
| Maintenance/Centre Management |  |  |
| Management of Bio-medical Waste |  |  |
| Security |  |  |
| Community Service |  |  |
| Supply Chain Management/  Material Management |  |  |
| Other, please specify |  |  |

1. **Statutory/ Regulatory/ Legal Compliance**

Furnish details of following mandatory Statutory/ Regulatory requirements the centre is governed by: (Please submit scanned copies of License/ Certificate

|  |  |  |  |
| --- | --- | --- | --- |
| **Details** | **Licence Number** | **Valid Up to** | **Remarks** |
| Registration Under Clinical Establishment Act (or similar) |  |  |  |
| Registration With Local Authorities |  |  |  |
| Bio-medical Waste Management and Handling Authorisation |  |  |  |
| License for PNDT, if applicable |  |  |  |
| Fire NOC, if applicable |  |  |  |
| **Registration for all Modalities from AERB:** | | | |
| License to operate Radiation emitting equipment (e.g. X-Ray) |  |  |  |

1. **Litigation, if any:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of last Self-assessment:**­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of implementation of QAI standards:** \_\_\_\_\_\_\_\_\_\_\_\_\_

(Centre is advised to implement the standards for at least 2 months before applying)

1. **Application Fees**

 Application fees (Rs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DD/At par cheque number/ bank transfer reference number/ Transaction ID\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Date Application Completed:** \_\_\_\_\_\_\_\_\_ Day \_\_\_\_\_\_\_ Month \_\_\_\_\_\_\_\_Year
2. **Undertaking**

* We are familiar with the terms and conditions of maintaining accreditation/ certification (QAI CAHSC 003), which is signed and enclosed with the application. We also undertake to abide by them.
* We agree to comply fully with the requirements of the Transition Care Centre accreditation standards.
* We agree to comply with accreditation procedures and pay all costs for any assessment carried out irrespective of the result.
* We agree to co-operate with the assessment team appointed by QAI CAHSC for examination of all relevant documents by them and their visits to those parts of the Centre that are part of the scope of accreditation.
* We undertake to satisfy all national, regional and local regulatory requirements for operating the organisation.
* All information provided in this application is true to the best of our knowledge and ability.

Authorised Signatory (Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

Quality and Accreditation Institute

Centre for Accreditation of Health & Social Care

**Website**: www.qai.org.in

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