Internship Training

At

Octavo Solutions Pvt. Ltd.

GAP ANALYSIS OF DISTRIC HOSPITAL, JHANSI AS PER NABH STANDARDS

By

Dr. Shruti Sharma

Under the guidance of

Ms. M.R. Vanishree

Post Graduate Diploma in Hospital and Health Management

Year 2012 – 14

International Institute of Health Management Research
New Delhi

OCTAVO SOLUTIONS PVT. LTD.
The Health & Hospital Consultants

Registered with NABET NC07 01 | SE Asia Partners for ACHSI

The certificate is awarded to

Dr SHRUTI SHARMA

In recognition of having successfully completed her

Internship in OCTAVO SOLUTIONS PVT. LTD.

And has successfully completed her Project on

"GAP ANALYSIS OF DISTRICT WOMEN'S HOSPITAL, JHANSI AS PER NABH STANDARDS"

Date: 30th April, 2014

Organisation: OCTAVO SOLUTIONS PVT. LTD.

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish her all the best for future endeavours.

Octavo Solutions Pvt. Ltd. New Delhi

Vice President

Octavo Solutions P Ltd.

FEEDBACK FORM

Name of the Student: Dr. Shruti Sharma

Dissertation Organisation: Octavo Solutions P Ltd.

Area of Dissertation: Quality Accreditation & Certification

Attendance: Regular

Objectives achieved: Developed tools for conducting gap analysis in District Women's Hospital, Jhansi, Successfully conducted & compiled the Gap report with Scoring as per NABH

Deliverables: Preparation of Gap Report as per identified gaps interms of structure, process & outcome, manpower and equipment

Strengths: Good interpersonal skill, hard working & group tasking.

Suggestions for Improvement: Should give more effort on writing / Presentation part.

Jhilam Mitra.

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date: 06/05/14
Place: New Delhi

Certificate Of Approval

The following dissertation titled "**GAP ANALYSIS OF DISTRICT WOMEN'S HOSPITAL, JHANSI AS PER NABH STANDARDS**" at **OCTAVO SOLUTIONS PVT. LTD.** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
DR. S. B. ARORA	
Dr A. K. KHOKHAR	7/5/14
Dr Radhika S. Adholeya	

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Shruti Sharma,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"GAP ANALYSIS OF DISTRICT WOMEN'S HOSPITAL, JHANSI AS PER NABH STANDARDS"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

12/05/2014

Ms. M. R. Vanishree
Assistant Professor
IIHMR, Delhi

Ms. Jhilam Mitra
Assistant Consultant
Octavo Solutions Pvt. Ltd.

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled ..GAP ANALYSIS OF DISTRICT WOMEN HOSPITAL, JHANSI, UTTAR PRADESH..... and submitted by (Name) DR. SHRUTI SHARMA ..... Enrollment No. PGH/12/082. under the supervision of ...Ms. MR. VANISHREE.....

for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 1st FEB, 14 ..... to 30th APRIL, 14 .....

embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Shruti Sharma

(DR. SHRUTI SHARMA)

Signature

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. SHRUTI SHARMA** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **OCTAVO SOLUTIONS PVT. LTD.** from 1ST February, 2014 to 30th April,2014

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Ms. M. R. Vanishree

IIHMR, New Delhi

Acknowledgement

I believe, nothing really can be accomplished alone. It's the direction, guidance, involvement, Support and prayers of more than one people around you those results into realization.

My Institute - ***International Institute of Health Management Research (IIHMR), Delhi*** *deserves the foremost appreciation for providing me the opportunities to understand my capabilities. I would like to thank one and all in the IIHMR team for providing me a platform for my professional career as well as for helping me boosting up all my capabilities and making me confident enough to work for health care organisations. I would like to thank* ***Dr.L.P. Singh*** *(Director IIHMR, Delhi) and* ***Dr. A.K Aggarwal*** *(Dean IIHMR, Delhi) for their continuous support.*

I acknowledge the tremendous contribution of my guide ***Ms. Jhilam Mitra*** *in completion of the project right from the word go.*

I would like to render my sincere thanks to ***Octavo Solutions Private Limited****, New Delhi for providing me the opportunity to complete my dissertation.*

I convey my deep and sincere thanks to ***Dr.Bidhan Das****, Director, Octavo Solutions Private Limited New Delhi for giving me the opportunity to work under his guidance.*

I extend my words of thanks to all the staff octavo solutions for always being so cooperative and facilitating me.

Thanking you

Dr. Shruti Sharma

Abbreviations

S.NO.	ABBREVIATED FORM	FULL FORM
1.	AAC	Access, assessment and continuity of care
2.	AC	Air conditioning
3.	ACHSI	Australian Council On Healthcare Standards
4.	ACLS	Advanced cardiac life support
5.	AERB	Atomic Energy Regulatory Board
6.	AHU	Air handling unit
7.	AMC	Annual Maintenance Contract
8.	BARC	Bhaba Atomic Research Centre
9.	BLS	Basic life support
10.	BMW	Bio Medical Waste Management
11.	CCTV	Close Circuit Television
12.	CCU	Critical Care Unit
13.	COP	Care Of Patients
14.	CPR	Cardio Pulmonary Resuscitation
15.	CQI	Continuous Quality Improvement
16.	CSSD	Central Sterile and Supply Department
17.	EOQ	Economic Oder Quantity

18.	FMS	Facility Management System
19.	HDU	High Dependency Unit
20.	HIC	Hospital Infection Control
21.	HMIS	Hospital Management Information System
22.	HRM	Human Resource Management
23.	ICU	Intensive Care Unit
24.	IMS	Information Management System
25.	IPD	In Patient department
26.	LAMA	Leave against Medical Advice
27.	MOM	Management Of Medication
28.	MRD	Medical Records Department
29.	MRI	Magnetic Resonance Imaging
30.	NABH	National Accreditation Board for Hospitals and Healthcare Providers
31.	OPD	Out Patient Department
32.	OSPL	Octavo Solutions Pvt. Ltd.

33.	OT	Operation Theatre
34.	PM	Preventive Maintenance
35.	PPE	Personal Protective Equipment
36.	PRE	Patient Right and Education
37.	QA	Quality Assurance
38.	QCI	Quality Council of India
39.	ROM	Responsibilities Of Management
40.	SOP	Standard Operating Procedure
41.	TQM	Total Quality Management
42.	UTI	Urinary Tract Infection

INDEX

OBJECTIVE OF THE STUDY

I did my internship from Octavo Solutions Pvt Limited New Delhi, for the period of three months from 1st February to 30th April 2013

The objective of the internship at Octavo Solutions Pvt. Ltd. was to gather knowledge about the Dimensions of a Healthcare Consulting Organization and apply the insights so gained to succeed in the same industry.

The Dimensions of a Healthcare Consulting Organization are Planning, System Development and Operation, Quality Healthcare Certification, Public Private Partnership, Capacity Building, Information and Technology, Knowledge Management and Public and Rural Health. Main objective of the internship was to understand the working of my Organization on Quality Management System and Quality Assurance Program.

As a Management Consultant, my roles and responsibilities included understanding the current ongoing Projects being handle by my Organization and understand the functioning of the unit. We are involved in improving the Clinical and Non Clinical Performance Indicators of the Health Facilities. When we talk of improving the performance indicators and achieving the best out of available resources, role of a Healthcare Management Professionals like Management Consultant becomes crucial as they are the person who suggests measures for inputs rectify all the process flow of the healthcare facilities and finally will monitor the healthcare indicators.

ORGANISATION PROFILE

Octavo Solutions Pvt. Ltd. (OSPL) a multidisciplinary Health & Hospital Management Consulting firm, established and managed by health management experts, supported in its initiatives and efforts by experienced and reputed experts in field (like Architecture, Engineering, Public Health, Bio-medical Engineering, Clinical Experts, National and International Quality Gurus, Project Management experts), who have successfully undertaken health, hospital and other infrastructure projects ranging from small nursing homes to large medical college hospitals, including public health. We are associated with a number of reputed consulting organizations and thus can draw upon qualitative and latest expertise as and when required. With our ongoing in-house research and quality improvement efforts, we always strive to be up-to-date and able to provide the client qualitative, cost effective and comprehensive solutions. Our experts have worked with QCI, JCI and Australian Council of Health Standard International (ACHSI) and donor-funded projects like, the World Bank and the distinguished clients served includes the Ministry of Health, Govt. of India; State Governments, Private clients, Corporate House & Charitable Hospitals. Octavo Solutions Pvt. Ltd. is the first Consulting firm registered with Quality Council of India (National Accreditation Board for Education and Training) for providing consulting services in field of Healthcare.

VISION: To focus on continuous development of processes for understanding the needs & expectations of the clients; leading to continual improvement and achievement of real client satisfaction. To redesign (existing) and develop (new) quality healthcare institutions and hospital with competitive process designs/models matching national and international standards.

MISSION: To become the leader in healthcare consultancy in India by providing value for money; effective, efficient solutions and hands on support.

Key Strengths and Salient Features of OSPL

The primary **strength** of our company is to partner the client organization to optimize resources & implement the improvement strategies successfully. An assignment begins with an accurate assessment of people, processes, performance and strategies. Our consultants define competitive strengths, threats and opportunities to define performance gaps and growth potential. To assure successful implementation and competitive advantage, we develop an execution action plan with essential controls for the management system under consideration, (PERT Chart). Unique Bottom-Up consulting **approach** of our consultants ensures success of our consulting assignments. This approach ensures that plans are accepted & practiced at all the levels of management. We have an unmatched 100% success rate for all the projects taken up so far in our journey.

KEY STRENGTHS:

1. A **Private Limited Company**
2. Short listed firm with **NHSRC** (National Health Systems Resource Centre) under aegis of Ministry of Health & Family Welfare (Government of India)
3. **Talented Leadership** from leading institutes like
   - ❖ All India Institute of Medical Sciences (Delhi),
   - ❖ School of Planning and Architecture (Delhi),
   - ❖ Tata Institute of Social Sciences, (Mumbai)
   - ❖ Indian Institute of Health Management and Research (Jaipur)
   - ❖ Symbiosis Institute of Health Sciences (Pune)
   - ❖ Jamia Hamdard University (Delhi)
4. Great Team with all essential skills
5. Dr. Bidhan Das- Member, Technical Committee of NABH for drafting standards
6. Dr T.Venkatesh- Member, Technical Committee of NABL for drafting standards
7. Dr Bidhan Das has Standards for Primary Healthcare (NABH) to his credit which is on its (likely) first test in State of Gujarat
8. Dr. Bidhan Das- First ACHS International Surveyor (Australian Council for Health Standards) in India

9. OSPL is **SE-Asia Partners for ACHSI**
10. OSPL has presence in **14 states (**including Union Territories)
11. We have working offices at **7** different locations across India.
12. OSPL has one overseas **(International)** project to its credit.
13. In short span of just 4 years, OSPL has rendered its **consulting services to over 30,000 beds** within the healthcare sector
14. We have provided consulting services to over 100 Hospitals (bed range 30-1500), 07 Teaching Hospital & Medical Colleges, 01 Rehabilitation Hospital, 02 Dental Hospital & Colleges, 02 AYUSH Hospitals.
15. Combined Years of Experience of our Technical Personnel is 68 Man-Years in ISO/ NABL/ NABH/ QMS and Hospital Planning assignments. Our Key Personnel have rich experience of having conducted over 720 Audits/ Assessments and provided consulting services to 497 client organizations for establishing QMS.
16. We are one solution company for healthcare sector.

PART-2

DISSERTATION

GAP ANALYSIS OF DISTRICT HOSPITAL,

JHANSI, UP

Against NABH standards

EXECUTIVE SUMMARY

The **'Gap Analysis Report'** includes mainly **Structural Gap,** documentation and **review of manpower, equipment, infrastructure, processes including training, services & facilities provided legal compliances** etc against **NABH**. For this the defined format as per the requirement of NABH was used to capture the data. This includes major clinical and non clinical departments of hospital.

The whole **report is submitted as under**:

1. Describes the overall status of all the relevant departments of the **District Women Hospital, Jhansi, UP** with the brief introduction or description of the department

2. **Identifies** the significant **gaps in terms of Structure, Process and Outcome**, observed on all the concerned areas and explanation of the gap statement **with references to the NABH Standards** with objective elements. The **gaps are analyzed based on NABH (3nd edition)** standards.

The gap analysis as per NABH norms was done so as to assess the existing status of the hospital and prepare it for NABH accreditation. The gap analysis was done with the help of Self Assessment Toolkit. For getting the required data the various activities in the hospital were observed, policy manuals and records were referred and patients and hospital staff were interviewed. According to the toolkit the documentation and implementation of each objective element was checked and scores were given accordingly. After this the average scores for the standards and chapters were calculated. Then these were checked against the evaluation criteria. It was found that the analysis results did not match with the set criteria for entry level. There are many gaps needed to be filled and then hospital can apply for accreditation.

Recommendations were given for every department so as to close the major gaps and to make the hospital applicable for NABH.

1. INTRODUCTION

Gap analysis is the initial step in the review of the available service delivery system. It is an efficient base to implement a modern management system. It can be measured against pre set standards. It reveals the areas of improvement in the existing service system. It focuses on the components of the management services and how effective they are.

The scope of improvement will mark the level up to which services are to be upgraded. Scope of improvement will give the percentage of progress needed to achieve the pre set standards.

1.1.NABH

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations. The board while being supported by all stakeholders including industry, consumers, government, has fully functional autonomy in its operation.

Accreditation

A public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.

Benefits of accreditation

Accreditation benefits all Stake Holders. **Patients** are the biggest beneficiaries. Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated. Accreditation to a **Hospital** stimulates continuous improvement. It enables hospital in demonstrating commitment to quality care. It raises community confidence in the services provided by the hospital. It also provides opportunity to healthcare unit to benchmark with the best.

The **Staff** in an accredited hospital are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes. It improves

overall professional development of Clinicians and Paramedical staff and provides leadership for quality improvement within medicine and nursing.

Accreditation provides an objective system of empanelment by insurance and other **Third Parties.** Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

1.2.Problem Statement

Gap analysis is a technique which uncovers any shortfall in some process or characteristics. It is done against the template or model. The technique is often used to discover where to invest efforts for the improvement. It compares the characteristics of the organization's operations against an appropriate model. Gap analysis highlights those areas where the requirements of the model are not fully realized and details the changes necessary. The required changes indicate the gap that exists between the organization's current operations and the desired state and which area is likely to be more responsive to improvement efforts. The hospital management can then judge which are as when improved would be most beneficial to the organization.

1.3. Justification of study

An assessment report is a document, which evolves as per circumstantial requirement of the organization to know scope of activities required to meet standards to achieve project goal i.e. NABH accreditation status.

There is a requirement of measuring the performance of hospital. The performance can be measured once the standards or benchmarks for the same are available. The accreditation of healthcare facilities is concerned with assessing the quality of organizational process and performance using agreed upon standards.

The purpose of accreditation is to establish and encourage best practices, in the organization. It is based on the premises that there are certain actions which should be undertaken to create a good healthcare organization. Accreditation is a process by which an authoritative body gives a formal recognition that an organization is competent to carry out specific tasks.

2. OBJECTIVES

1. To assess the existing service delivery standards of District Hospital, Jhansi
2. To identify the baseline levels of all quality indicators (structure, process and outcome)
3. To identify the gap, if any, as per NABH guidelines.
4. To suggest feasible recommendations for bridging the gaps in departments based on customized requirements for the hospital.
5. To help the hospital management to take appropriate managerial actions to improve the quality of their services
6. To assess the level of compliance as per NABH standards through score analysis

3. REVIEW OF LITERATURE

Davis-Ajami ML, Costa L, Kulik S .GAP ANALYSIS: SYNERGIES AND OPPORTUNITIES FOR EFFECTIVE NURSING LEADERSHIP. Nursing Economics. 2014 Jan-Feb;32 (1):17-25.

Study was conducted to understand the usefulness of Gap analysis. It states that gap analysis provides structure to information gathering and the process of finding sustainable solutions to important deficiencies. Nursing leaders need to recognize, measure, monitor, and execute on feasible actionable solutions to help organizations make adjustments to address gaps between what is desired and the actual real-world conditions contributing to the quality chasm in health care. The study was conducted to improve the effectiveness of nursing leadership through identifying, understanding, addressing and bridging gaps in services. Gaining facility in gap analysis should help the nursing profession's contribution to narrowing the quality chasm.

K. Francis Sudhakar, M. Kameshwar Rao, T.Rahul. "GAPS IN QUALITY OF EXPECTED AND PERCEIVED HEALTH SERVICES IN PUBLIC HOSPITALS" (1Jan 2012)

The study found that as regards tangibles in public hospitals services, there was a wide gap by 3 counts which was statistically significant. With regard to reliability, by 3 counts there is the gap. Such gap or difference in the quality scores was statistically significant. As regards responsiveness it was found that the gap found between them was by 3.0 units. Such gap was statistically significant. With regard to assurance, it was found that the gap was 3.0 units. Such gap was statistically significant. Lastly, with regard to empathy, it was found that the gap was found to be 3.0 units. Such gap was statistically significant.

Di Mclntyre and Laura Anselmi, Health Economics Unit, SCHOOL OF PUBLIC HEALTH AND FAMILY,MEDICINE, University of Cape Town Paper provides an overview of the methods used to promote an equitable distribution of healthcare resources. It highlights that resource allocation is extremely valuable in efficient budgeting. It also highlights the successful implementation of resource distribution can be facilitated by undertaking a detailed gap analysis. Gap analysis will provide basis for developing service development plans. There is also need to strengthen capacity for planning, budgeting and implementing plans to ensure use of limited

healthcare resources. Monitoring and evaluation of these entire can enhance effective redistribution of resources to promote healthcare services.

Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta. Study of Gap Analysis Report for Ishtakal Hospital

The study found 2 types of Gaps.

1) Infrastructure related gaps
2) Process related gaps

Infrastructure related gaps are insufficient space, make shift buildings, improper signage, poor fire safety measure and disaster plan, piped medical gases not available, shortage of equipment and instruments, old and out of order equipments and instruments, lack of biomedical equipment engineering cell. Most of the gaps related to infrastructure related need, external support from the ministry and bilateral donor agencies.

Most of the process related gaps can be worked out at the hospital level with proper training and hand holding. Process gaps related gaps were lack of mission/vision and patient charters, lack of training in hospital operations, lack of control over resources (such as funds, drugs and consumables, equipments, ordnance/general stores). Only few hospitals have quality control department however medical and nursing audits are not done. Equipments did not have AMC/CMC, utilization audit of equipment is not done, proper BMW Management system did not exist, security was not organized in three tier manner (outer ring, middle ring, inner ring).

Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta. Gap Analysis Report for Rehabilitation Center

The study has found that even though it is housed in poly clinic various sub specialties (such as Medicine, Surgery, ENT, Ophthalmology, and Dental) are available here which seems to be duplicity of resources. The centre does not have proper diagnostic, inpatient or utility services (kitchen, laundry). There is no effective signage to guide the patient with in the centre. The radiology department is virtually open from three sides causing radiation hazards to staff and patients. Even though it is the rehabilitation centre it does not have even the basic physiotherapy equipments. The general housekeeping is very bad, all toilets are broken and sinking. Almost all working areas are dirty and unhygienic to work or live. Wards are crowded and lack proper ventilation. Most of the bed linen were dirty. There is shortage of drugs. ICD classification is not

used. CSSD has only one autoclave which is not sufficient for entire hospital. It lacks quality control measures. There is no disaster plan for the hospital

4. RESEARCH METHODOLOGY

4.1. STUDY DESIGN

The study was non – experimental evidence based in nature. The study was based on observation made. It broadly included:

1. Present status of the departments [Through collection of primary data and Secondary Data from the hospital for assessing structure (civil work, manpower, equipment) process (Policies and procedures) and outcome]
2. Comparison of Manpower for the hospitals with the work load and as per MCI Norms
3. Assessment of Equipment gaps using the work load of specialty and advancement of technology
4. Listing of gaps and comparison/ compliance with NABH Standards

4.2. DATA COLLECTION TOOLS

- Interview and discussions with head of the departments.
- Checklists
- Observation
- Using available information
- NABH tool kit

  NABH guidelines were used as yardstick for the above listed tools

4.3. STUDY TIME

Study time was of four weeks which included Review of NABH guidelines, preparing checklist, filling of checklist compiling data, review of secondary data, Gap analysis and final report compilation.

4.4. STUDY METHODOLOGY

The study includes the situational analysis through identification of gaps through gap analysis checklist using different tools (Interviews, Observations, Checklists, Secondary data review, NABH Toolkit) as mentioned and discussed. As per the result scoring was done on a scale of 1 to 10 to know the compliance, partial compliance and non compliance. Available facilities of hospital were compared against the set standards and full compliance was given score 10 which means the parameters present in the checklist fully comply with the services present in the hospital. Similarly if the parameters mentioned in the checklist were completely met by the services present inside the hospital was considered as partial compliance and was given the score of 5. 0 score was given for noncompliance. Scoring was done to measure the scope of improvement.

4.5. STUDY DATA

1. Primary data:- To study the present status and functioning of departments, each section of the department were studied individually by observing the set of activities performed by doctors, technicians, paramedical staff and clerical staff.
2. Secondary data: - Records of various departments.
    I. Present status of the departments.
    II. Comparison/ compliance with NABH Standards.

5. OVERVIEW OF HOSPITAL

- **Name of the Hospital:** District Women Hospital, Jhansi, UP
- **Vision:** Yet to be defined
- **Mission:** Yet to be defined
- **Quality Policy:** Yet to be defined
- **Bed Strength:** 656
- **Address :** District Women Hospital, Jhansi
- **Phone:** +(91)-(522)-2624040
- **Fax:**
- **Contact No. (Director):** +(91)-9935609524
- **Website:**

6.1.EXTERIORS

The hospital is located in the heart of the city, close to Jhansi fort. This hospital has got a new wing added to its old building. The **hospital** is located in two separate buildings connected through a corridor. There is no gate at the main entrance for ensuring safety & security.The hospital has 2 buildings. Floor directory is not displayed anywhere in the entire building.The campus extends over the area of 2826 square meters**.** The builtup area is 1979 square meters**.**

6.2.DIRECTORY OF THE HOSPITAL

<table>
<tr><td colspan="2">GROUP A: CLINICAL SERVICES</td></tr>
<tr><td colspan="2">1. OBSTETRICS & GYNAECOLOGY</td></tr>
<tr><td colspan="2">2. PAEDIATRICS</td></tr>
<tr><td colspan="2">3. ANAESTHSIOLOGY</td></tr>
<tr><td colspan="2">GROUP B: CLINICAL SUPPORT SERVICES</td></tr>
<tr><td>1. RADIOLOGY & IMAGING</td><td>3. LABORATORY</td></tr>
<tr><td rowspan="2">• X-RAY (directed to the nearby DMH)</td><td>• HAEMATOLOGY</td></tr>
<tr><td>• SEROLOGY</td></tr>
<tr><td>• ULTRA SONOGRAPHY</td><td>• PATHOLOGY</td></tr>
<tr><td>1. BLOOD BANK</td><td>• BIOCHEMISTRY</td></tr>
<tr><td colspan="2">GROUP C: SUPPORT SERVICES</td></tr>
<tr><td>1. PHARMACY & MEDICAL STORE</td><td>2. ADMISSION, REGISTRATION & DISCHARGE</td></tr>
<tr><td>3. CENTRAL STORE</td><td>4. GAS MANIFOLD</td></tr>
<tr><td>5. LAUNDRY</td><td>6. HOUSEKEEPING SERVICES</td></tr>
<tr><td>7. MEDICAL RECORDS</td><td>8. SECURITY SERVICES</td></tr>
<tr><td>9. AMBULANCE SERVICE</td><td></td></tr>
<tr><td colspan="2">GROUP D: ADMINISTRATIVE SERVICES</td></tr>
<tr><td>1. GENERAL ADMINISTRATION</td><td>YES</td></tr>
<tr><td>2. FINANCE DEPARTMENT</td><td>YES</td></tr>
</table>

6.3.KEY INDICATORS

INDICATORS	August, 2013	Sept, 2013	Oct,2013	Nov,2013	Dec,2013	Jan,2014	Average
IP Admissions	651	725	613	751	1076	987	800
OPD (new + old)	5314	6361	5262	5417	6086	4994	572
Normal Delivery	430	463	384	393	372	391	405
Surgeries Major (LSCS)	11	15	16	13	14	16	14
Tubectomy	15	33	26	77	439	451	173
Surgeries (Minor)	181	202	180	250	232	237	213
Lab	2434	3200	2759	2340	5065	4076	3312
USG	449	527	212	489	402	417	416
Birth	441	478	400	406	386	407	419
Death (Maternal)	0	0	0	0	0	0	0
Still Births	0	0	01	0	0	0	0.16
BOR (%)	93.61	93.74	90	94	95.74	88.75	92.64

6.4.SIGNAGE SYSTEM

There are number of signage showing the various departments and utilities like drinking water, toilets, different OPDs etc at appropriate places but they are only in English. It is recommended that the signages should be at least in bilingual i.e. English & Hindi for e.g. drinking water, toilets, fire exit, handicapped toilet, scope of service, departmental signage's, floor directories etc.

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)	Remarks (if any)
Citizen Charter	No	No	NA	
Mission	No	No	NA	
Vision	No	No	NA	
Patients Rights & Responsibilities	No	No	NA	
Scope of Services	Yes	No	No	
Tariff List	NA	NA	NA	
Doctors list along with their Specialities and Qualifications	Yes	No	NA	
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	Yes	No	NA	
Biohazard Symbols	No	No	Yes	
Fire Exit Plan	No	No	No	
Floor Directory	Yes	No	No	
Wash Rooms (Differently Able)	No	No	No	

Toilets	Yes	No	Yes	
Ambulance Parking Area	No	No	No	
Drinking Water	Yes	No	Yes	
Health Education Related Signage (HIV & Immunization)	Yes	No	Yes	

6.5. STATUTORY REQUIREMENTS

Licenses	Status *(A / NA)	Available YES/NO
Building Occupancy/Completion Certificate	A	No
Fire License	A	No
License under Bio- medical Management and handling Rules, 1998.	A	No
NOC for Air & Water from State Pollution Control Board	A	No
Excise permit to store Spirit.	NA	---
Permit to operate lifts under the Lifts and escalators Act.	NA	--
Narcotics and Psychotropic substances Act and License.	A	No
Vehicle registration certificates for Ambulances.	A	Yes
Retail drug license (Pharmacy)	NA	--
PNDT Certificate	A	Yes
Site & Type Approval for X-Ray from AERB	NA	--
License for Blood Bank	NA	--

A = Applicable **NA** = Not Applicable

6.6.BED DISTRIBUTION

Floor	Class/Department	Beds
Ground Floor	Post Operative Ward	06
	Female Ward	24
	PPC Ward	16
	TOTAL	**46**

Note: Sanction beds = 47

6.7. MANPOWER PLANNING 2014-15

MARCH

S. No	Designations	Sanctioned	NABH Norms	Actual	Vacant (As per Sanction)	Vacant (NABH)
DOCTORS						
1	Chief Medical Superintendent	01	01	00	01	0
2	Gynaecologist	03	06	03	00	03
3	Paediatrician	01	01	01	00	00
4	Anaesthesiologist	01	02	01	00	01
5	Radiologist	00	01	00	00	01
6	Pathologist	00	01	00	00	01
7	Medical officers (MBBS)	08	05	05	03	00
SUB TOTAL		**14**	**17**	**10**	**04**	**06**
NURSING						

1	Matron/Nursing Superintendent	00	01	00	00	01
2	Nursing In-charge/Sister	00	07	01	00	06
3	Staff Nurse	04	32	08	00	24
4	ANM	02	--	02	00	--
SUB TOTAL		**06**	**40**	**11**	**00**	**31**
PARAMEDICAL						
1	Lab Technician	01	03	01	00	02
2	OT Technician	00	02	00	00	02
3	ECG Technician	00	01	00	00	01
4	LHV	01	--	01	00	--
SUB TOTAL		**02**	**06**	**02**	**00**	**05**
PHARMACIST						
1	Chief Pharmacist	02	04	00	02	02
2	Pharmacist	02		02	00	
SUB TOTAL		**04**	**04**	**02**	**02**	**02**
DRIVER						
01	Driver	01	02	00	01	02
SUB TOTAL		**01**	**02**	**00**	**01**	**02**
DIETARY						
1	Dietician	00	01	00	00	01
2	Cook	01	02	00	01	02
3	Kahar	00	02	00	00	02
SUB TOTAL		**01**	**05**	**00**	**01**	**05**

ADMINISTRATION						
1	Office Supdt	01	01	01	00	00
2	Sr. Clerk	01	02 --	01	00	00
3	Jr. Clerk	02		00	01	
4	(Additional) clerk	00		01	00	
5	Data Entry Operator	01	01	01	00	00
6	Registration clerk	00	02	00	00	02
7	Store keeper	00	01	00	00	01
8	Medical Records Clerk	00	01	00	00	01
SUB TOTAL		**05**	**08**	**03**	**01**	**04**
CLASS 4						
	Ward Aaya	09	08	08	01	00
	Sweeper	01	06	01	00	01
	Sweepress	06		04	02	
	Chowkidar	01	06	02	00	04
	Dhobi	01	02	01	00	01
	Lab Attendant	01	01	01	00	00
	OT attendant	00	01	00	00	01
	Chaprasi	01	01	01	00	00
SUB TOTAL		**19**	**25**	**16**	**03**	**07**
GRAND TOTAL		**52**	**107**	**44**	**12**	**62**

7. GAP ANALYSIS

7.1.OPD, REGISTRATION AND ENQUIRY COUNTER

OPD is the first point of contact between the hospital and the community, and very commonly called “show window” of hospital. A well planned OPD plays a important role in building up the image of the hospital. A properly planned building with pleasant ambience makes the patient and their relative comfortable who are in search of solace and comfort for mitigating their suffering. There is centralized outpatient department which is located in the basement The outpatient department block is located in the Basement of Block-A. OPD block is well visible from the entrance. Drinking water facilities are available in the OPD area. There is a waiting area for the patients in OPD block. The doctors’ name, their specialty, qualifications, time and day of OPD are not displayed outside the OPD.

GAPS IDENTIFIED

STRUCTURAL

1. Non - Availability of enquiry counter
2. Non - Availability of seperate que for differently abled
3. Non - Availability of seperate and functional toilet for differently abled
4. Citizen Charter and Patient Charter not displayed
5. BP apparatus, weighing machine and thermometer are not callibrated
6. Non - Availability of dedicated registration clerk
7. Non - Availability of nurse to direct patients to specific OPDs

PROCESS

8. UHID for patients not generated

OUTCOME

9. Waiting time is not being monitored
10. Patient satisfaction survey is not being conducted

MONTH, 2013 - 2014	**OPD (new + old)**
AUGUST	**5314**
SEPTEMBER	**6361**
OCTOBER	**5262**
NOVEMBER	**5417**
DECEMBER	**6086**
JANUARY	**4994**

Average OPD for the time period August 2013 – January 2014 was 5572

7.2.AMBULANCE SERVICES

The ambulance is defined as a vehicle used for emergency medical care that provides:-

• A driver's compartment

• A patient compartment to accommodate an emergency medical services provider (EMSP) and one patient located on the primary cot so positioned that the primary patient can be given intensive life-support during transit

• Equipment and supplies for emergency care at the scene as well as during transport

• Safety, comfort, and avoidance of aggravation of the patient's injury or illness

• Two-way radio communication

• Audible and Visual Traffic warning devices

There is No Ambulance available in the Hospital. Currently in need of such services 108 ambulances are contacted. The Ambulance available in this Hospital is more a Patient Transfer vehicle (Maruti Omni). Basic life saving facilities is not available in the Ambulance.

7.3.EMERGENCY DEPARTMENT

The emergency departments of most hospitals operate 24 hours a day, although staffing levels may be varied in an attempt to mirror patient volume.

Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

The casualty department is located on ground floor of the Main Building i.e. Block-A. It has 3 beds. There is a triage area for sorting the patients as per the severity. There is a direct Access to the Causality Department from the main entrance of the Hospital. Although there is less space in emergency department still it is serving the need of the patients.

The hospital does not have a separate labour room, so the department is shared in common as both labour room and emergency room

1.Triage are is not marked seperately

2. Emergency departement does not have a seperate entry

3. Emergency signage is not visible from the road and without proper lightning and sign

4. Emergency crash cart, Defeb and Cardiac monitor is not available

5. No system available to review all imaging by a radiologist within 24 hours

6. Unavailability of facilities to perform acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies

7. Electrical equipments are not charged regularly

8. Staff is not trained in BLS

9. Indicators like Time for initial assessment of emergency patients not monitored

6.4. LABORATORY

Laboratory services are an integral and indispensible part of disease diagnosis, treatment, monitoring response to treatment, disease surveillance programs and clinical research.

- It is place of work for testing patient's sample- for results, in favor of diagnosis and treatment.
- According to NABL, the following classification can be used:
  - Small Laboratory: A laboratory receiving up to 100 patients per day
  - Medium Laboratory: A laboratory receiving up to 101-400 patients per day
  - Large Laboratory: A laboratory receiving above 400 patients per day

The main laboratory in this hospital is located at the back side area of the main building. The sample collection area is not near to the laboratory.

1.No provision of personal protective equipemnts for the staff available in the hospital

2. No seperate area is demarcated for sample collection

3. Pathologist is not available

4. Scope of services are not defined

5. Laboratory equipments are not maintained properly

6. Laboratory equipemnts are not callibrated

7. Laboratory staff does not take necessary precautions while handling samples

8. Critical results are not defined , reported and documented

9. Surveillence for lab reports is not being carried out

10. EQAS is not being monitored

11. Laboratory reports are not signed by pathologist

12. Labelling of samples is not being done

13. Turn around time for lab reports is not being monitored

14. Temperature recording of refrigerators is not being done

15. Indicators like Number of reporting errors, % reports having clinical correlation withprovisional diagnosis, % adherence to safety precautions and %of redo's are not monitored

6.6. RADIOLOGY & IMAGING

The main objectives of the radiology department are:

a) To provide comprehension high quality imaging service

b) Establishment and confirmation of clinical diagnosis

c) Providing high quality therapeutic radiology

d) Commitment to training and research

e) Aiding in the effective implementation of therapeutic procedures

The radiology department of the hospital is located in the basement which is easily accessible from OPD and Emergency department. ***Only USG services are provided in the unit as radiology department is functional in the adjacent District Male Hospital.***

GAPS IDENTIFIED

1.Critical results are not Defined, Reported and documented

2. Radiology equipments are not callibrated
3. Reports are not signed by the radiologist
4. Turnaround time of reports are not monitored

5. Indicators like Number of reporting errors, % reports having clinical correlation withprovisional diagnosis, % adherence to safety precautions and %of redo's are not monitored

Note: There is no separate x-ray unit available in the hospital however an ultrasound machine is available which is run by a Qualified and Trained Medical Officer. The following findings were observed during the visit;

1) "Sex determination not done here" warning is displayed outside the ultrasound room.

2) F-Forms are filled for every patient.

3) Centre is registered under the PNDT Act.

4) Monthly report is submitted to local authority.

5) Patient privacy is maintained.

6) Female attendant is present during examination.

6.6. OPERATION THEATRE

Operation theater (OT) is a specialized facility of the hospital where life saving or life improving procedures are carried out on human body, under strict aseptic conditions in a controlled environment by specially trained personnel to promote the healing and cure with maximum

safety and comfort. Operation theater must be designed scientifically to ensure sterility, easy maintenance and effective utilization of resources and manpower.

The main Operation theatre complex of this hospital is located at the 1st floor of Block-A.OT complex was having labour room, Nursery, operating room and recovery room.

GAPS IDENTIFIED

1.HVAC system is notinstalled in the operation suit
2. Unavailability of Crash cart, Defibrillator and ECG machine
3. OT does not have shadowless OT light

4. Pre, Intra and Post operative notes are not prepared
5. Infection control practices are not being followed inside the OT
6. Pre-operative checklist is not being followed

15. Indicators like Number of reporting errors, % reports having clinical correlation withprovisional diagnosis, % adherence to safety precautions and %of redo's are not monitored

6.7. WARDS

An inpatient area is that part of the hospital which includes the nursing station, the beds it serves, storage and public areas needed to carry out nursing care. Since it is a home away from home for a patient, it requires holistic planning and designing to suit the requirements of seekers and providers of patient care

The hospital has wards categorized as Female ward, Male ward, private rooms, semi private room, Daycare & Gynaec ward.

GAPS IDENTIFIED

1. Emergency crash cart is not available in the hospital
2. Colour coding of BMW bins not done
3. Wash basin is not available in each ward

4. Vitals of patient are not checked daily
5. Nurses are not trained in BLS/ACLS
6. Infection control practices are not being followed

6.8. SNCU

There is no SNCU in the hospital. There is a small room in the labour room complex where a phototherapy unit and one baby warmer were evident.

6.9. LABOUR ROOM

GAPS IDENTIFIED

1.No seperate area demarcated for septic and aseptic deliveries

2. Labour roomdonot have a demarcated new born care area with appropriate equipements

3. Unavaialbility of crash cart and ECG monitor

4. Partograms are not used for all the patients

5. APGAR score is not being used

6.10. BLOOD BANK

There is no dedicated blood bank in the hospital. On requirement of blood patients are directed to nearby district male hospital.

6.11. PHARMACY

The pharmacy is located near the main entrance to the Hospital. The department is manned by qualified pharmacists for round the clock.

GAPS IDENTIFIED

1.There is no security system available in the hospital
2. Item storage area are not marked and labelled
3. No demarcated receiving, segregation and storing area
4. No provision for storage of narcotic drugs

5. Items are not labelled and arranged as peralphabetical order
6. Pest/ Rodent control measures are not being taken properly
7. Sound inventory control practices are not being followed
8. Drug & therapeutic committe is not formed
9. Hospital drug formulary not formed
10. Adverse drug reaction not monitored

11.Indicators like Percentage of Local purchases, stockouts, variation from procurement process and goods rejected before GRN not monitored

6.12. BIOMEDICAL WASTE MANAGEMENT DEPARTMENT

The biomedical waste management facility is outsourced. The hospital has a temporary storage room near the Block-B and Kitchen. The biomedical waste management practices in the hospital needs to be strengthened.

GAPS IDENTIFIED

1.Unavailability of hypochlorite solution
2. Unavailability of safe mode of transportation

3. Route of transportation of waste is not seperate from general traffic area
4. No provision of regular health checkup of staff
5. Annual report is not submitted to UP PCB
6 Amount of BMW generated is not monitored

6.13. HOSPITAL INFECTION CONTROL DEPARTMENT

1. No designated and qualified infection control nurse available
2. No designated and qualified infection control officer is available

3. No policies and procedure documented/ implemented to prevent infection
5. Equipment cleaning, disinfection and sterlization practices rae not followed
6. No antibiotic policy in implemented or established
7. Hospital donot adhere to kitchen, sanitation and food handling issues
8. No appropriate engineering controls to prevent infection
9. Hospital donot adhere to mortuary practices
10. Infection prevention and control program is not updated yearly
11. HIC surveillence data is not collected regularly
13. Infectious risks rates and trends are not tracked and analysed
14. No monitoring of effectiveness of house keeping facilities
15. HAI rates are not monitored
16. Infection control committe and team are not formed
18. Non compliance with hand hygiene guidelines
19. No documented procedure to identify an outbreak
20. No implementation of laid down procedures
21. No documented procedure available to guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items
22. Isolation/Barrier nursing facilities are not provided
23. Hospital authority donot visit the disposal site
24. Hospital donot provide resources for infection control programme
25. Organisation donot earmark adequate funds from its annual budget for infection control
26. In- service training sessions are not provided to the staff
27. Pre and Post exposure prophylaxis is not provided to all the concerned staff

28. Indicators like UTI, VAP, SSI rate, central line associated blood stream infection rate is not being monitored

6.14. CSSD/ TSSU

A TSSU is a hospital support service which is entrusted with processing and issue of supplies including sterile instruments and equipment used in various departments of the hospital. It receives, stores, sterilizes and distributes.

The CSSD department of this hospital is located on the terrace of Block-A.

GAPS IDENTIFIED

1.Insufficient space available in CSSD
2. Layout donot follow functional flow
3. Callibration of pressure meter of autoclave is not done
4. Technician is not available in the hospital
5. Transport trolley not available

6. CSSD sterlization register not available
7. Labelling of drums in CSSD not done
8. Chemical, Biological and Bowie-Dick tests are not performed
9. Recall system is not followed
10. Reuse policy for items not available

6.15. MEDICAL RECORD DEPARTMENT

Medical Record Department of a hospital is dedicated for storing all the medical records of patients. A medical record could be defined as a clinical, scientific, administrative and legal document relating to patient care in which are recorded sufficient data written in the sequence of events to justify diagnosis and warrant treatment and end result"

The medical record department of this hospital is located on the 2nd floor of the Block-A.

1.Insufficient space for medical records department
2. Inadequate ventillation present in the department
3. Unavailability of qualified and trained MRD technician
4. Table and chair not provided to the MRD technician
5. Inadequate number of racks available in the MRD department

6. Improper functional flow in the department
7. ICD coding method not used for complete and incomplete files
8. Records are not easily retrievable
9. Deficiency checklist is not followed
10. MRD committe is not available
11. MRD audits are not being conducted
12. Records are not kept under lock and key
13. Destruction policy for records not available
14. Pest control measures are not being taken

15. Indicators like % of missing records, records with ICD codification not done, % medical records not having discharge summary, % medical records not having consent form are not monitored

6.16. *BIOMEDICAL ENGINEERING*

Biomedical Engineering is a fundamental part of managing, maintaining, and/or designing medical devices used or proposed for use in various healthcare settings from the home, the field, the doctor's office, and the hospital.It includes the business processes used in interaction and oversight of the medical equipment involved in the diagnosis, treatment, and monitoring of patients. The related policies and procedures govern activities such as the selection, planning, and acquisition of medical devices, acceptance, maintenance, and eventual retirement and disposal of medical equipment.

Its main purpose is to ensure that equipment and systems used in patient care are operational, safe, and properly configured to meet the mission of the healthcare; that the equipment is used in an effective way consistent with the highest standards of care by educating the healthcare provider, equipment user, and patient; that the equipment is designed to limit the potential for loss, harm, or damage to the patient, provider, visitor, and facilities through various means of analysis prior to and during acquisition, monitoring and foreseeing problems during the lifecycle of the equipment, and collaborating with the parties who manufacturer, design, regulate, or recommend safe medical devices and systems.

MRD department is located on 1st floor

1.Biomedical Engineering Department does not exist
2. Department is not being managed by qualified person
3. Central supply system for biomedical gases does not exist
4. Department is not manned by qualified personnel
5. Preventive maintainance and callibration of equipemnts is not being done
6. Preventive maintainance records as per checklist like anaesthesia , ventillator, IABP etc are not being done
7. Callibration reports are not traceble
8. No documented procedure for equipment replacement and disposal
9. Equipments are not inventorised and proper records are not maintained
10. Reventive and breakdown maintainance plan are not documented
11. Colour coding of pipelines is not done

12. Indicators like % downtime of critical equipments is not being monitored

6.17. ENGINEERING AND MAINTAINANCE

There is no one available in the facility to look after the facility management. There are separate DG sets. The hospital has its own transformer. The water is supplied from bore well. Parking space is available in the hospital premises

1.No statutory requirements have been obtained by the department
2. No uptodate drawings, layout, escape routespresent or displayed
3. No designated individual present for maintainance
4. No staff available for emergency repair
5. Unavailability of safety devices

6. No mechanism available for review of licences
7. Preventive and breakdown maintainance plan are not implemented
8. Checking of alternate sources of energy and water is not done
9. Response time is not being monitored
10. Water quality reports are not being checked
11. Staff is not using any safety devices
12. No facility inspection rounds are being conducted in patient and nonpatient care areas
13. No documentation of facility inspection reports
14. Staff is not being provided with safety education program
15. Safety committe is noyt formed
16. Staff is not trained in disaster and fire management

15. Indicators like number pf variations observed during mock drills is not being observed

6.18. STORE

GAPS IDENTIFIED

1.There is no receiving are, segregation area and storing area

2. Items are not labelled and arranged at designated place
3. Radiography films, spirits etc are not stored at proper place
4. Frequently used items are not arranged and located at most easily accessible area
5. Pest and rodent control measures are not being taken properly
6. Lead time in issuing materials to the department are not being recorded
7. Inventory control practices are not being followed properly

8. Indicators like percentage of stockouts, goods rejected before preperation of GRN, variation from procurement process are not being recorded

There is no dedicated kitchen functioning in the hospital however there is a small room in PPC OPD block where cooking utensils, stove etc are present but since no cook has been posted the kitchen does not function.

Currently breakfast and evening snacks are purchased from outsides and provided to the patients. The food mainly includes bread, milk & eggs.

6.19. HUMAN RESOURCE

GAPS IDENTIFIED

1. There is no dedicated HR department available in the hospital

2. No provision for welfare of staff & family
3. Pre employment healthcheckup &annual health checkup are not being conducted
4. Unavailability of training in-charge in the hospital
5. Training is not being conducted in the hospital

6.20. LINEN & LAUNDARY

GAPS IDENTIFIED

1. Unavailability of seperate covered trolley for transporting dirty linen & washed linen
2. Heavy duty gloves and masks are not available to linen handlers

3. Linen are not changed daily
4. Packing and labelling of soiled & contaminated linen is not done seperately
5. Linen register is not manitained to keep records of clean and dirty linen hand over
6. Linen is not transported in covered trolleys
7. Dirty and clean linen are not stored in seperate areas

6.21. HOUSEKEEPING

GAPS IDENTIFIED

1. Housekeeping staff is not being trained in infection control practices
2. Pest control methods are not being practiced
3. Medical examination of staff is not being done

6.22. SECURITY

GAPS IDENTIFIED

1.There is no connectivity with the emergency room

2. Emergency room do not have a seperate securityguard

3. Main entrance of hospital building and labour room is not manned by security guard

4. Roasters for security guard are not prominently displayed

5. Security guard donot report daily to security in-charge

6. Security in-charge donot wear uniform while on duty

7. Security guards donot restrict unauthorized entry of patients and relatives to the restricted areas of the hospital premises

8. Outgoing items are not checked and entered on the register

9. Security personnels are not trained in disaster nd fire management

10. Inidence of theft and security threats are not being monitored

8. SCORE ANALYSIS

FINDINGS:

After filling up of the NABH self- assessment toolkit the following scores were calculated:

1. The average score of each individual standard
2. The average score of each chapter
3. The average score of all standards

These scores and the findings of each chapter are being provided below:

CHAPTER 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE

S.No.	CHAPTER	SCORE
1.	**AAC 1**	**5**
2.	**AAC 2**	**2.5**
3.	**AAC 3**	**1**
4	**AAC 4**	**4**
5.	**AAC 5**	**6**
6.	**AAC 6**	**3.13**
7.	**AAC 7**	**0**
8.	**AAC 8**	**2**
9.	**AAC 9**	**6.11**
10.	**AAC 10**	**0**
11.	**AAC 11**	**1**
12.	**AAC 12**	**4.29**

13.	**AAC13**	**3.75**
14.	**AAC 14**	**5.71**
	AVERAGE SCORE OF CHAPTER 1	**3.18**

INTERPRETATION

1. **AAC 1.** - The services being provided are clearly defined and are in consonance with the needs of the community but not documented, also some services are not display properly and staff is not properly oriented about services.
2. **AAC 2.** The organization do not have well defined registration and admission process
3. **AAC 3**.The organization does not have appropriate mechanism for transfer or referral of unstable & stable patients. It does not address the staffs that are responsible during transfer.
4. **AAC 4.**Documentation has been done about initial assessment and plan of care, implementation is required. Plan of care do not include the preventive aspects of plan of care. Time frame for initial assessment has also not been documented.
5. **AAC 5**.Patient reassessed at regular intervals and documentation is also maintained but implementation is required.
6. **AAC 6**. The scope of laboratory services is not displayed at the entrance. There are no documented policies and procedures for collection, identification, handling, safe transportation, processing and disposal of specimens but not implemented. The list for outsourced tests is not available.
7. **AAC 7**.Laboratory quality assurance programme has neither been documented nor implemented.
8. **AAC 8**. Laboratory Safety programme has neither been documented nor implemented. The staffs are not trained for the same. Laboratory personnel are not provided with safety equipments/ devices
9. **AAC 9**. The scope of radiology & imaging services are not displayed at the entrance of the Department. There are documented policies and procedures for identification and safe

transportation of patients to imaging services but not implemented. Critical results are not intimated and the turnaround time is not being monitored.

10. **AAC 10**. There is no established quality assurance programme for imaging services.
11. **AAC 11** There is no established radiation safety programme
12. **AAC 12**. Procedure has been documented about information sharing about care of patients, but implementation has not been done till date. There are documented policies and procedures to guide the referral of patients to other departments/specialities but not implemented.
13. **AAC 13** The hospital discharge process has been documented and well planned .Document of policies and procedure exists for coordination of various departments.
14. **AAC 14.**The hospital has defined the content of discharge summary but not documented.

CHAPTER 2: CARE OF PATIENTS

S.No.	CHAPTER	SCORE
1.	**COP 1**	**3.75**
2.	**COP 2**	**2.14**
3.	**COP 3**	**4.38**
4	**COP 4**	**0**
5.	**COP 5**	**2.86**
6.	**COP 6**	**2.86**
7.	**COP 7**	**0**
8.	**COP 8**	**0**
9.	**COP 9**	**1**

10.	**COP 10**	**3.57**
11.	**COP 11**	**2.5**
12.	**COP 12**	**5**
13.	**COP13**	**3.64**
14.	**COP 14**	**3.18**
15.	**COP 15**	**0**
16.	**COP 16**	**0**
17.	**COP 17**	**0**
18.	**COP 18**	**NA**
19.	**COP 19**	**3.33**
20	**COP 20**	**1**
	Average Score	**2.11**

INTERPRETATION

COP-1.Documentation of policy and procedures for uniform care of patients in all setting of the hospital and guided by applicable law, regulation and guideline has been done as per NABH standard is not documented well but implementation has been done as per NABH standard.

COP-2.Emergency services provided by the organisation are not well documented and implemented.

COP-3. Ambulance Services provided by the hospital need to be improved a lot. Ambulances are not well equipped.

COP- 4. There are no policies and procedures to guide the care of patients requiring cardio-pulmonary resuscitation. Staffs are not trained uniformly and periodically updated in CPR.

COP-5.The policy and procedure guiding nursing care has been well documented and implemented.

COP-6. Polices to guide the performance of various procedures is available but not implemented but only qualified personnel order, .plan, perform and assist in performing procedure.

COP -7. There are no documented policies and procedures for rational use of blood and blood components. Staffs are not trained to implement the polices. The transfusion reactions are not analysed for preventive and corrective actions.

COP- 8. The organization has no documented admission and discharge criteria for intensive care unit. For Intensive Care Unit and High Dependency Unit adequate staff and equipments are not there. Staff is not trained to apply these criteria. Infection control practices are not followed uniformly. Quality assurance programme for the ICCU is not implemented.

COP- 9. There are documented policies and procedures to guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged) but not implemented. Staffs are not trained uniformly to care for this vulnerable group.

COP-10. Hospital policy and procedure for obstetric services has not been documented and implementation of policy of maternal nutrition and monitoring performance of pre natal and post natal has not done. Hospital does not provide care for the high risk obstetric cases.

COP-11. The organisation has defined but not displayed the scope of paediatric services. The staffs those care for children are not trained for age specific competency. The children's family members are not uniformly educated about nutrition, immunization and safe parenting.

COP -12. There are documented policies and procedures to guide the care of patients undergoing moderate sedation but not implemented in every case.

COP- 13 There are no documented policies and procedures for guiding the administration of anaesthesia were not implemented properly. An immediate preoperative re-evaluation is not done and documented. Adverse anaesthesia events are not recorded and monitored.

COP- 14 Policies and procedures are not documented for the care of patients undergoing surgical procedures although they are being implemented. A brief of note that should be documented prior to transfer out of patient from recovery area is not documented.

COP-15 Policies and procedures for the care of patients under restraints (physical and/ or chemical) are neither documented nor implemented.

COP-16. The policy and procedure guiding the management of pain are neither documented nor implemented.

COP- 17 The hospital does not provide documented policies and procedures to guide appropriate rehabilitative services nor are being implemented.

COP -18 Research activities are not carried out in the hospital and is not applicable for the hospitall.

COP-19 The organization do not have properly documented policies and procedures for nutritional therapy nor are they implemented properly.

COP- 20. Policies for End of Life Care have not been documented and hospital does not provide any specific facility for such care and the staffs are not trained on the same.

CHAPTER 3: MANAGEMENT OF MEDICATION

S.No.	CHAPTER	SCORE
1.	**MOM 1**	**2.5**
2.	**MOM 2**	**4**
3.	**MOM 3**	**2.86**
4	**MOM 4**	**2.5**
5.	**MOM 5**	**1.67**

6.	**MOM 6**	**4**
7.	**MOM 7**	**2.5**
8.	**MOM 8**	**0**
9.	**MOM 9**	**0**
10.	**MOM 10**	**NA**
11.	**MOM 11**	**NA**
12.	**MOM 12**	**NA**
13.	**MOM 13**	**5**
	Average Score	**2.50**

INTERPRETATION

MOM-1. No documentation has been done regarding pharmacy services and usage of medication neither is being implemented. There is no multidisciplinary committee to guide the formulation and implementation of these policies and procedures.

MOM-2. Hospital formulary has been developed but requires implementation to define process for acquisition of the medication. Drug formulary is not available for the clinicians

MOM-3. There are documented policies and procedures are not available for storage of medications. Sound alike and Look alike medications are not stored separately. Every medicine is not stored according to the manufacturer's recommendations

MOM-4. The organisation do not have documented policies and procedures for prescription of medications and for high risk medications and need to be implemented. The organisation does not determine who can write the prescription

MOM-5. Documentation has not been done for safe dispensing of medications. Implementation needs to be done. Prepared medication is not labelled prior to preparation of a second drug.

MOM-6. Documentation has been done for medication administration, but it is incomplete and implementation is also required.

MOM-7. Monitoring of patients after medication administration is being done now but other polices require to be implemented. Organisation does not define those situations where close monitoring is required.

MOM-8. There are no documented procedure to capture near miss, medication error and adverse drug event and are not implemented well.

MOM-9. Narcotics are not used in hospital

MOM-10: Chemotherapeutic agents are not used in the hospital.

MOM- 11: Radioactive drugs are not used in the hospital.

MOM-12: Implantable prosthesis are not used in the hospital.

MOM- 13: There are documented policies and procedures for use of medical gases but not implemented. Medical supplies and consumables are not kept in clean and safety environment

CHAPTER 4: PATIENT RIGHT AND EDUCATION		
S.No.	CHAPTER	SCORE
1.	**PRE 1**	**2**
2.	**PRE 2**	**3.5**
3.	**PRE 3**	**5**
4	**PRE 4**	**0**
5.	**PRE 5**	**4.38**
6.	**PRE 6**	**3.75**
7.	**PRE 7**	**5**
	Average Score	

INTERPRETATION

PRE -1. Documentation of patient and family rights and responsibilities have neither been documented nor displayed, Staffs are not uniformly aware of their responsibility in protecting patient's rights.

PRE-2. There is no defined and documented policy in which patients rights support individual beliefs, values and involve the patient and family in decision making processes.

PRE-3. There are policies to educate family members about expected results and possible complications but these are no implemented.

PRE -4.Informed consent policy is neither documented nor implemented well. Staff is not uniformly aware about these policies.

PRE-5. The patient and their family members are not uniformly educated about the safe and effective use of medications and their potential side effects.

PRE-6. The patient and their family members are needed to be educated uniformly about the estimated costs of treatment but this policy is not implemented

PRE-7. The documentation of organization redressed procedure has been done but not implemented. All complaints should be analysed according to the documentation but this is not implemented.

CHAPTER 5: HOSPITAL INFECTION CONTROL

S.No.	CHAPTER	SCORE
1.	**HIC 1**	**0**
2.	**HIC 2**	**0**
3.	**HIC 3**	**0**
4	**HIC 4**	**0**
5.	**HIC 5**	**2.5**
6.	**HIC 6**	**0**
7.	**HIC 7**	**0**
8.	**HIC 8**	**4**
9.	**HIC 9**	**0**
	Average Score	**0.72**

INTERPRETATION

HIC-1. The organization do not have a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.

HIC-2. The organization do not have laid down policies and procedures in the Infection Control Manual.

HIC-3. The organization does not perform surveillance activities to capture and monitor infection prevention and control data.

HIC-4. The organization do not take actions to prevent and control Healthcare Associated Infections (HAI) in patients.

HIC-5.Facilities and resources provided to support the infection control programme are inadequate. Barrier nursing facility is not available

HIC-6. Outbreaks of infections are neither documented nor implemented yet

HIC-7. There are no documented policies and procedures for sterilization activities in the organization.

HIC-8. There is no proper segregation and collection of BMW uniformly from all patient care areas of the hospital. The hospital does not monitor that the BMW is transported safely within the time frame. Staffs are not provided with appropriate Personal Protective Equipments (PPE) for handling of BMW.

HIC-9. The infection control programme is not supported by the management including training of staff.

CHAPTER 6: CONTINUOUS QUALITY IMPROVEMENT

S.No.	CHAPTER	SCORE
1.	**CQI 1**	**0**
2.	**CQI 2**	**0**
3.	**CQI 3**	**0**
4	**CQI 4**	**0**
5.	**CQI 5**	**0**
6.	**CQI 6**	**0**
7.	**CQI 7**	**5**
8.	**CQI 8**	**0**
	Average Score	**0.63**

INTERPRETATION

CQI-1. There is no structured quality improvement and continuous monitoring programme in the organization.

CQI-2. There is no structured patient safety programme in the organization

CQI-3. The organization does not identify key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.

CQI-4. The organization does not identify key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.

CQI-5. The quality improvement programme is supported by the management.

CQI-6. There is no established system for clinical audit.

CQI-7. Incidents, complaints and feedback are not collected and analysed properly to ensure continual quality improvement.

CQI-8. Sentinel events are not analysed intensively.

CHAPTER 7: RESPONSIBILITIES OF MANAGEMENT

S.No.	CHAPTER	SCORE
1.	**ROM 1**	**2.78**
2.	**ROM 2**	**1.25**
3.	**ROM 3**	**1.25**
4	**ROM 4**	**5.83**
5.	**ROM 5**	**1.36**
6.	**ROM 6**	**2.5**
	Average Score	**2.5**

INTERPRETATION

ROM-1. Responsibilities of Management not clearly defined. Vision, mission and values of the organisation are not defined. Organogram of the hospital is not available.

ROM-2.The policy and procedure of the organization do not comply with the laid down and applicable legislations. Required laws and regulations are not properly implemented

ROM-3. Services provided by each department are documented but not displayed and staff is not oriented

ROM-4. Organization's Ethical Management needs to be improved.

ROM-5. The organization partially displays professionalism in management of affairs which is needed to be improved.

ROM-6. Documentation of sentinel events has been done. The leaders are not aware of the risk management procedures followed in the hospital. There is no safety and risk management committee in the hospital to oversee the hospital wide safety programme. There is no system for reporting of internal and external process failures.

CHAPTER 8: FACILITY MANAGEMENT & SAFETY

S.No.	CHAPTER	SCORE
1.	**FMS 1**	**2.5**
2.	**FMS 2**	**2.73**
3.	**FMS 3**	**1.67**
4	**FMS 4**	**1.43**
5.	**FMS 5**	**1.67**
6.	**FMS 6**	**0**
7.	**FMS 7**	**0**
8.	**FMS 8**	**0**
	Average Score	**1.25**

INTERPRETATION

FMS-1. The management is conversant with the laws and regulations and knows their applicability to the organization, but are not being implemented properly.

FMS-2. Documentation has been done on the aspects to ensure safety of patients, their families, staff and visitors, but implementation is required

FMS-3. The organization has neither documented program for clinical and support service equipment management, nor implementation is done in proper manner. Response times are not monitored for all the complaints received.

FMS-4. The organization does not have a well documented programme for bio-medical equipment management.

FMS-5. The organization does not have a well documented programme for medical gases, vacuum and compressed air.

FMS-6. The organization have no plans for fire and non-fire emergencies within the facilities.

FMS-7. The organization do not have plans for handling community emergencies, epidemics and other disasters.

FMS-8. The organization does not have a plan for management of hazardous materials.

CHAPTER 9: HUMAN RESOURCE MANAGEMENT

S.No.	CHAPTER	SCORE
1.	**HRM 1**	**2.5**
2.	**HRM 2**	**0**
3.	**HRM 3**	**2.5**
4	**HRM 4**	**0**
5.	**HRM 5**	**5**
6.	**HRM 6**	**2.86**
7.	**HRM 7**	**2.5**
8.	**HRM 8**	**2.5**
9.	**HRM 9**	**5.83**
10.	**HRM 10**	**5.83**
	Average Score	**2.95**

INTERPRETATION

HRM-1 The organization has a documented system of human resource planning but is not being implemented properly and needs updating.

HRM-2. The organization does not have any documented procedure for recruiting staff and orienting them to the organization's environment.

HRM-3. The organization has no documented professional training and development programme for the staff. Training record is not maintained properly.

HRM-4. Staffs are not adequately trained on various safety related aspects.

HRM-5. An appraisal system for evaluating the performance of an employee is documented but not implemented

HRM-6. The organization has no documented disciplinary and grievance handling policies and procedures but are being implemented partially.

HRM-7. No documentation has been done for regular health checkups of staff and addressing of occupational hazards. However pre employment health checkup is being conducted.

HRM-8. Documented personal record for each staff member is maintained but not implemented uniformly.

HRM-9. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals permitted to provide patient care without supervision but is being implemented partially

HRM-10. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of nursing staff. There is a process to identify job responsibilities and make clinical work assignments to all nursing staff members commensurate with their qualifications and any other regulatory requirements.

CHAPTER 10: INFORMATION MANAGEMENT SYSTEM

S.No.	CHAPTER	SCORE
1.	**IMS 1**	**1**
2.	**IMS 2**	**3**
3.	**IMS 3**	**2.14**
4	**IMS 4**	**3.75**
5.	**IMS 5**	**0**
6.	**IMS 6**	**0**
7.	**IMS 7**	**0**
	Average Score	**2.95**

INTERPRETATION

IMS-1. Policies and procedures are not documented to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the Organization However information needs are being identified by the organisation

IMS-2. Documentation is done for processes for effective management of data but implementation has not done. Formats for data collection are standardized.

IMS-3. The organization does not have a complete and accurate medical record for every patient.

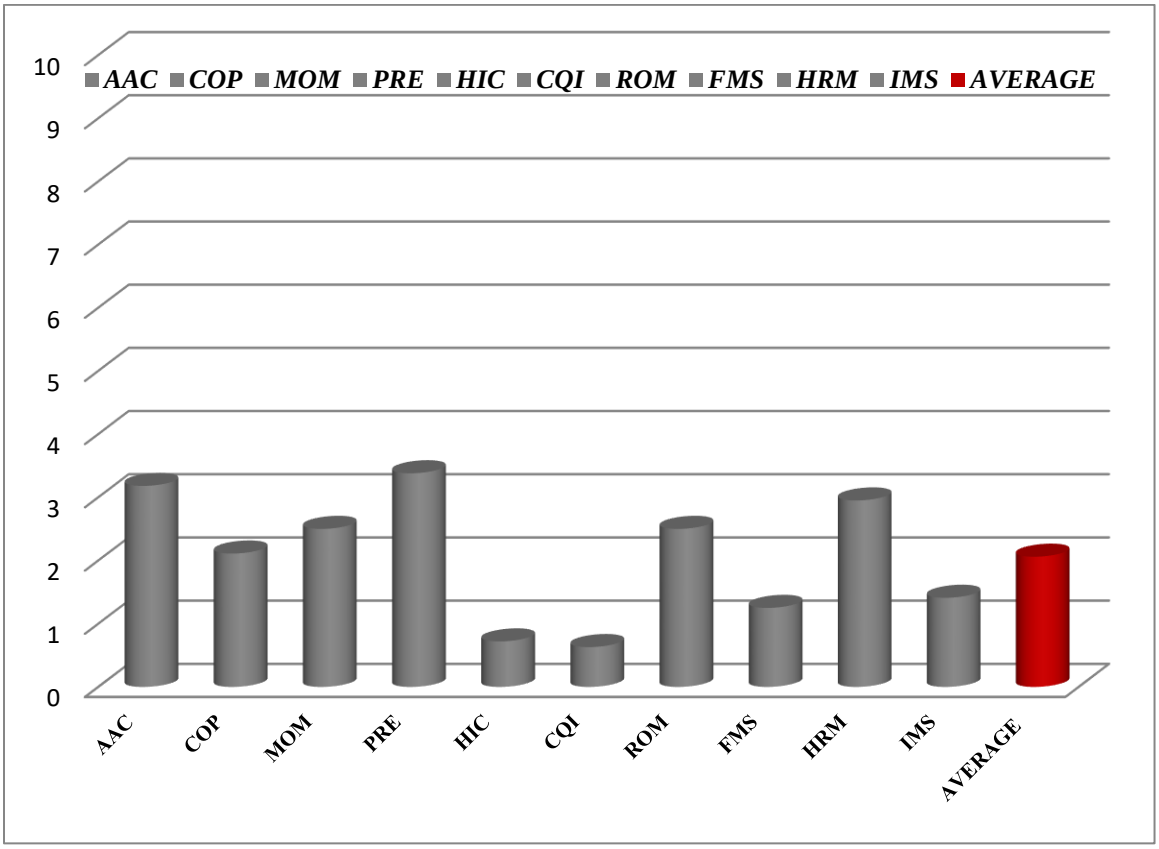
IMS-4. The medical record contains a copy of the discharge summary but is not duly signed by appropriate and qualified personnel and the medical record reflects continuity of care

IMS-5. Policies and procedures are in place for maintaining confidentiality, integrity and security of information, proper implementation is not there.

IMS-6. Documented policies and procedures exist for retention time of records, data and information is not there

IMS-7. The organization does not carried out review of medical records

AVERAGE SCORE CHART OF ALL CHAPTERS



7.2. Analysis

1. Pre-accreditation entry level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

• The average score for individual standard must not be less than 5.

• The average score for individual chapter must be more than 5.

• The overall average score for all standards must exceed 5.

The validity period for pre-accreditation entry level stage is from a minimum 6 months to a maximum of 18 months. It means that a hospital placed under this award cannot apply for assessment before 6 months.

2. Pre-accreditation progressive level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

• The average score for individual standard must not be less than 5.

• The average score for individual chapter must be more than 6.

• The overall average score for all standards must exceed 6.

The validity period for pre-accreditation progressive level stage is from a minimum 3 months to a maximum of 12 months. It means that a hospital placed under this award cannot apply for assessment before 3 months.

3. Accredited:

Conditions for qualifying for accreditation are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than one zero to qualify.

• The average score for individual standards must not be less than 5.

• The average score for individual chapter must not be less than 7.

• The overall average score for all standards must exceed 7.

The validity period for accreditation is 3 years subject to terms and conditions.

ON COMPARING THE HOSPITAL PRESENT STATUS WITH CRITERIA OF NABH PRE ACCREDITATION ENTRY LEVEL WE FIND:

1) There many standards with more than two zero

2) HIC and CQI have average score < 1

3) There is no individual chapter having average score more than 3.38

4) The overall average of all the standards meets the criteria < 2.5

With the above analysis it is clear that the hospital is not even partially fulfilling the pre-accreditation entry level criteria.

8. RECOMENDATION

This report includes assessment of documentation and implementation with respect to Structure (Manpower, equipment, infrastructure and Statutory requirements), Processes (Clinical & Administrative) and Outcome against NABH Standard (3rd edition).

Standardized and pre tested data collection and analysis tools have been used for the onsite assessment and analysis. This includes all departments existing in the hospitals.

The whole report is prepared as under:

1. The scope of services provided by District Women Hospital, Jhansi has been reviewed and represented accordingly.
2. Identifies the significant gaps in terms of Structure, Process and Outcome observed in all the concerned areas.
3. The data on status of the existing Manpower, Equipment and Statutory requirements.
4. Any other data or information as deemed necessary.

The Recommendations are as follows:

EMERGENCY

1. Department should have a separate entrance
2. Emergency signage should be placed with proper lighting and signs so that it will be visible from the main road
3. Emergency crash cart need to be made available
4. Defibrillator should be made available
5. Cardiac Monitor should be made available
6. Radiologist should be made accountable 24x7
7. Acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies.
8. Electrical equipment (e.g. defibrillator) should be charged at all times.
9. Crash cart need to be checked daily for regular testing
10. Staff should be trained in BLS/ACLS
11. Time for initial assessment of emergency patient should be monitored

AMBULANCE - Ambulance need to be purchased

OPD

12. Enquiry counter need to be constructed
13. Separate queue for differently able should be made available
14. Separate and functional toilet availability for differently able should be there
15. Citizen charter and Patient charter are to be displayed in the OPD
16. Calibration of BP apparatus, weighing machine and thermometer should be done at required intervals and documented
17. Dedicated registration clerk need to be appointed
18. Nurse should be made available to direct patients to specific OPDs
19. UHID need to be generated
20. Register should be maintained for monitoring of waiting time in OPD
21. OPD patient satisfaction survey is required to be done at regular intervals and documented

LABORATORY

22. PPE need to be made available to the staff
23. Separate demarcation of sample collection area need to be done
24. Pathologist should be made available
25. Scope of services need to be displayed
26. Laboratory equipments need to be maintained
27. Calibration old lab equipments need to be done
28. Staff should be made aware about the safety precautions
29. Laboratory staff need to take necessary precautions while handling samples
30. Critical results need to be defined, reported and documented
31. Surveillance of lab tests need to be done regularly
32. EQAS need to be monitored
33. Lab reports should be signed by pathologists
34. Samples need to be labelled
35. Turnaround time for lab reports is to be monitored
36. Temperature monitoring of refrigerator need to be done
37. Number of reporting errors per 1000 investigations is to be monitored
38. % of reports having clinical correlation with provisional diagnosis is to be monitored
39. % of adherence to safety precautions is needed to be monitored
40. % of redo's is required to be monitored

RADIOLOGY & IMAGING

41. Policies and procedures to define, report and document critical results of the Radiology is to be prepared and followed
42. Callibration of equipments need to be done
43. Radiology reports need to be signed by Radiologist.
44. Turnaround time of lab reports need to be defined
45. Separate register to be maintained for reporting errors
46. Separate register to be maintained for reports having clinical correlation with provisional diagnosis

WARDS

47. Emergency crash cart need to be procured
48. Foot operated coloue coded bins need to be procured
49. Wash basins need to be constructed in each ward
50. Vitals of patient need to be checked daily and documented
51. Training to be given to the nurses on BLS (CPR) at regular intervals and mock drills to be conducted to check affectivity
52. Infection control practices need to be followed strictly as per the guidelines

LABOUR ROOM

53. A separate area should be demarcated for septic and aseptic deliveries.
54. New Born Care Area need to be demarcated properly with appropriate equipments
55. Crash cart and ECG monitor need to be made available
56. Partograms need to be used for all the patients
57. APGAR SCORE should be used.

OPERATION THEATRE

58. HVAC system need to be installed
59. Crash cart need to be purchased for the OT.
60. Defibrillator need to be purchased for the OT.
61. ECG monitor need to be purchased for the OT.
62. OT need to have shadow less OT light
63. Pre operative checklist need to be followed.
64. % of anesthesia related adverse events need to be monitored
65. % of anesthesia related mortality need to be monitored.

66. % of modification in plan of anesthesia should be monitored.
67. % of Surgical site infection rate need to be monitored
68. Re Exploration rate need to be monitored.
69. Re scheduling of surgeries need to be monitored.

PHARMACY

70. Security system need to be installed
71. Items storage areas need to be marked and labeled
72. Proper receiving, segregation and storing area need to be demarcated
73. Refrigerator for storing medicines(2-8 degree C) need to be made available
74. Proper provision for storing narcotic drugs need to be made available
75. Items need to be labelled and stored alphabetically
76. Pest control measures should be taken on regular basis
77. Inventory control practices should be followed (ABC, VED, FSN,FIFO)
78. Drugs and therapeutics committee should be formed
79. Hospital drug formulary should be available
80. Adverse drug reactions should be analysed
81. Local purchases, stockouts, variation from procurement and goods rejected before GRN should be monitored

BIOMEDICAL WASTE MANAGEMENT

82. ICN need to be designated
83. Infection control officer need to be appointed
84. Policies and procedures need to be formulated for infection control
85. Standard precautions need to befollowed hospital wide
86. Equipment cleaning, disinfection and sterilization should be practiced as per polices
87. Appropriate antibiotic policy need to be established and implemented
88. Hospital should adhere to the laundry and linen management processes.
89. Appropriate engineering controls need to be there in the hospital to prevent infection control.
90. Hospital should adhere to mortuary practices
91. Infection prevention and control programme should be updated
92. HIC surveillance data is should be collected regularly
93. Verification of data should be done on a regular basis by the infection control team
94. Tracking and analyzing of infection risks, rates and trends should be done
95. Surveillance activities should include monitoring the effectiveness of housekeeping services
96. HAI rates should be monitored

97. Appropriate feedback regarding HAI rates should be provided on a regular basis
98. Hospital infection control committee and team need to be formed
99. Identification of outbreak need to be documented
100. Documented procedure to guide the cleaning, packing, disinfection and/or sterilization, storing and issue of items need to be made
101. Isolation/barrier nursing facility should be available there.
102. Visit required to be carried out by the hospital authorities to the disposal site and should be documented.
103. Required resources for the infection control programme need to be available in the hospital.
104. Hospital should earmarks adequate funds from its annual budget for infection control activities.
105. In-Service training sessions need to be conducted for all the staff atleast once in a year.
106. Appropriate pre & post exposure prophylaxis should be provided to all concerned staff members.
107. UTI rate should be monitored.
108. VAP rate should be monitored.
109. SSI rate should be monitored.
110. Central line associated blood stream infection rate should be monitored.

TSSU

111. Sufficient space need to be made available
112. Layout should be according to the functions of the department
113. Pressure meter need to be callibrated
114. Technician need to be appointed
115. Trolleys need to ba made available for transportation
116. Chemical, biological and bowie-dick Tests need to be performed
117. Recall system need to be followed for all items
118. Reuse policy should be available for CSSD

BIOMEDICAL ENGINEERING DEPARTMENT

119. Dedicated Biomedical engineering department need to be constructed
120. Department need to be managed by qualified personnel
121. Central supply system for bio medical gases need to be constructed
122. Department should be manned 24/7
123. Review of Preventive Maintenance record as per checklist like Anesthesia ventilator, IABP etc need to be done
124. Caliberation reports need to be traced and stored

125. Documented procedure need to be made available for equipment replacement and disposal
126. Equipments need to be inventoried and proper logs need to be maintained as required
127. Documented Preventive and breakdown maintenance plans should be available
128. Medical gas pipelines need to be colour coded
129. Downtime of critical equipments need to be monitored

ENGINEERING AND MAINTAINANCE DEPARTMENT

130. Various statutory requirements are to be obtained from the respective organizations
131. Up to date drawing, layout, escape route is to be prepared and displayed
132. Designated individual for maintenance need to be made available
133. Qualified staff need to be made available for emergency repairs 24/7
134. Safety devices need to be made available
135. Mechanism for renew of licences should be available
136. Preventive and breakdown maintainance plan need to be implemented
137. Alternate sources should be available and maintained
138. Response time should be monitored
139. Water quality reports should be maintained
140. Inspection facilities in patient care and non patient care areas need to ba made available
141. Facility inspection report need to be documented
142. Safety education program should be carried out for the staff
143. Safety committee should be made available
144. Staff should be trained for disaster and fire management
145. Mock drills should be conducted and documented
146. Documentation of variations observed during mock drills need to be done

STORE

147. Receiving area, segregation and storing area should be there.
148. Items need to be labeled and arranged at desiganted place
149. Inflammable items need to be stored seperately
150. Frequently used items should be arranged porperly
151. Pest/rodent control measures need to be taken regularly
152. Lead time for issuing materials need to be recorded
153. Sound Inventory control practices need to be followed
154. % of stock outs need to be monitored
155. Register should be maintained for monitoring % of goods rejected before preparation of GRN
156. % of variation from procurement process need to be monitored

HUMAN RESOURCE MANAGEMENT

157. Proper designated area and functional area for HR department need to be made available
158. Training and Induction of employees need to be done
159. HR welfare - staff and family need to be maintained
160. Pre-employment need to be done
161. Training incharge should be available in the hospital
162. Regular training should be conducted
163. Records of training need to be maintained
164. Monitoring of employee absenteeism rate need to be done
165. Pre exposure prophylaxis need to be provided to the employees
166. Employee satisfaction survey need to be done and analyzed
167. Employees should be made aware of their rights and responsibilities and welfare schemes

MEDICAL RECORD DEPARTMENT

168. Sufficient space need to be made available
169. Proper ventilation should be made available in the department
170. Qualified and trained MRD technician need to be appointed
171. Table and chair need to be provided to the MRD technician
172. Adequate number of racks need to be made available for the storage of records
173. MRD should follow functional flow
174. ICD coding of files should be done
175. Records should be easily retrievable
176. Deficiency checklist should be followed
177. MRD committee should be formed
178. MRD audits need to be conducted
179. Records are not kept under lock
180. Retention policy need to be drafted.
181. Destruction policy need to be made available for the records
182. Pest control measures should be taken on regular basis
183. Data of missing records need to be maintained
184. ICD codification of records need to be monitored
185. Medical records not having discharge summary and consent form need to be monitored

LINEN & LAUNDARY

186. Separate covered trolleys for transportation of dirty and washed linen shoukd be made available
187. Heavy duty rubber gloves, mask need to be available to the linen handlers
188. Linen need to be changed daily
189. Packing of the soiled &contaminated linens in separate bags & labeling/color coding should be done
190. The number and type of linen handed over need to be entered on the dirty linen register
191. Linens should be transported in covered trolley
192. The number and type of linen handed over to the laundry by the ward boy need to be entered in laundry register
193. The clean linen need to be handed over to the ward boy against the received sign of Ward boy in the same laundry register
194. Dirty linens & clean linens need to be stored in separate areas

SECURITY

195. Emergency need to be connected through telephone system
196. Separate security guard need to be appointed for Emergency room
197. Main entance of hospital and labour room should be manned by security guards
198. Roasters of security staff need to be prominently displayed
199. Security staff need to wear uniform daily
200. Unauthorized entry of patients and relatives to restricted areas need to be monitored
201. Outgoing items need to be checked and entered on registers
202. Security personnel need to be trained in disaster and fire management
203. Data related to number of thefts and security related incidents need to be monitored

9. CONCLUSION

The analysis shows that are many gaps in the hospital as per NABH norms. Most of the documentation and implementation of policies and procedures is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. There are different stages of accreditation which needs to be fulfilled by the organization. As of now the hospital does not fulfil the criteria for entry level according to which no standard must have more than two zero and the average score of individual standard must not less than 5 and the average score for individual chapter must be more than 5.I conducted gap analysis to analyze the present status of the hospital and concluded that the hospital is not even partially complying to the NABH standards so needs a lot of attention. Thus the hospital is presently not prepared for pre – assessment and requires great effort and focus on the weak points so as to cover the gaps and to be prepared for getting NABH accreditation

10.BIBLIOGRAPHY

- Henriksen K, Isaacson S, Sadler BL, et al. The role of the physical environment in crossing the quality chasm. Jt Comm J Qual Patient Safety 2007; 33 (11 Suppl):68-80.
- K.Francis Sudhakar M.Kameshwar Rao T.Rahul,(2012), A study of gap analysis in hospitals and the relationship between patient satisfaction and quality of services in health care services,IJRIM,volume2,pageno.39.
- Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta 2005, study of Gap Analysis Report for Rehabilitation, book library.
- Eric S. Kastango, MBA, RPh, FASHP, August 24, 2005, A Gap Analysis Review and Action Plan Relative to USP Chapter <797>
- Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta 2009, study of Gap Analysis Report for Rehabilitation, book library.
- **Di Mclntyre and Laura Anselmi**, Health Economics Unit, School of Public Health and Family,Medicine

11. ANNEXURE

		Elements	Documentation (Yes/ No)	Implementation (Yes/ No)	Scores (0/5/ 10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)					
AAC.1: The organization defines and displays the services that it provides.					
	a	The services being provided are clearly defined and are in consonance with the needs of the community.	N	Y	5
	b	The defined services are prominently displayed.	N	Y	5
	c	The staff is oriented to these services.	N	Y	5
		Average Score			5
AAC.2: The organization has a well-defined registration and admission process.					
	a	Documented policies and procedures are used for registering and admitting patients.	N	N	0
	b	The documented procedures address out- patients, in-patients and emergency patients.	N	N	0
	c	A unique identification number is generated at the end of registration.	N	N	0
	d	Patients are accepted only if the organization can provide the required service.	Y	Y	10
	e	The documented policies and procedures also address managing patients during non-availability of beds.	N	N	0
	f	The staff is aware of these processes.	N	Y	5
		Average Score			2.5
AAC.3: There is an appropriate mechanism for transfer (in and out) or referral of patients.					
	a	Documented policies and procedures guide the transfer-in of patients to the organization.	N	N	0
	b	Documented policies and proceduresguide the transfer-out/referralof unstable patients to another facility in an appropriate manner.	N	N	0
	c	Documented policies andproceduresguide the transfer-out/referralof stable patients to another facility in an appropriate manner.	N	N	0
	d	The documented procedures identify staff responsible during transfer/referral	N	N	0
	e	The organization gives a summary of patient's condition and the treatment given	N	Y	5
		Average Score			1
AAC.4: Patients cared for by the organization undergo an established initial assessment.					
	a	The organization defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients	N	Y	5

	b	The organization determines who can perform the initial assessment.	N	Y	5
	c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	N	N	0
	d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy	N	Y	5
	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	N	Y	5
	f	Initial assessment includes screening for nutritional needs	N	Y	5
	g	The initial assessment results in a documented plan of care	N	Y	5
	h	The plan of care also includes preventive aspects of the care where appropriate	N	N	0
	i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	N	Y	5
	j	The plan of care includes goals or desired results of the treatment, care or service	N	Y	5
Average Score					4
AAC.5: Patients cared for by the organization undergo a regular reassessment					
	a	Patients are reassessed at appropriate intervals.	N	Y	5
	b	Out-patients are informed of their next follow up where appropriate.	Y	Y	10
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	N	Y	5
	d	Staff involved in direct clinical care document reassessments.	N	Y	5
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	N	Y	5
Average Score					6
AAC.6: Laboratory services are provided as per the scope of services of the organization.					
	a	Scope of the laboratory services are commensurate to the services provided by the organization.	N	Y	5
	b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	N	Y	5
	c	Adequately qualified and trained personnel perform,supervise and interpret the investigations.	N	Y	5
	d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation,	N	N	0

		processing and disposal of specimens.			
	e	Laboratory results are available within a defined time frame.	N	Y	5
	f	Critical results are intimated immediately to the concerned personnel.	N	N	0
	g	Results are reported in a standardized manner.	N	Y	5
	h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	N	N	0
Average Score					3.13
AAC.7:There is an established laboratory quality assurance programme					
	a	The laboratory quality assurance programme is documented.	N	N	0
	b	The programme addresses verification and/or validation of test methods.	N	N	0
	c	The programme addresses surveillance of test results.	N	N	0
	d	The programme includes periodic calibration and maintenance of all equipment.	N	N	0
	e	The programme includes the documentation of corrective and preventive actions.	N	N	0
Average Score					0
AAC.8: There is an established laboratory safety programme.					
	a	The laboratory safety programme is documented.	N	N	0
	b	This programme is aligned with the organization's safety programme.	N	Y	0
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	N	N	0
	d	Laboratory personnel are appropriately trained in safe practices.	N	Y	5
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	N	Y	5
Average Score					2
AAC.9: Imaging services are provided as per the scope of services of the organization.					
	a	Imaging services comply with legal and other requirements.	Y	Y	10
	b	Scope of the imaging services are commensurate to the services provided by the organization.	N	Y	5
	c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	N	Y	5
	d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	Y	Y	10

	e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	N	N	0
	f	Imaging results are available within a defined time frame.	N	Y	10
	g	Critical results are intimated immediately to the concerned personnel.	N	Y	5
	h	Results are reported in a standardized manner.	Y	Y	10
	i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	N	Y	0
Average Score					6.11
AAC.10: There is an established Quality assurance programme for imaging services.					
	a	The quality assurance programme for imaging services is documented.	N	N	0
	b	The programme addresses verification and/or validation of imaging methods.	N	N	0
	c	The programme addresses surveillance of imaging results.	N	N	0
	d	The programme includes periodic calibration and maintenance of all equipment.	N	N	0
	e	The programme includes the documentation of corrective and preventive actions.	N	N	0
Average Score					0
AAC.11:There is an established radiation safety programme					
	a	The radiation safety programme is documented.	N	N	0
	b	This programme is aligned with the organization's safety programme.	N	N	0
	c	Handling, usage and disposal of radio-active and hazardous materials are as per statutory requirements.	NA	NA	NA
	d	Imaging personnel are provided with appropriate radiation safety devices.	N	N	0
	e	Radiation safety devices are periodically tested and results documented.	N	N	0
	f	Imaging personnel are trained in radiation safety measures.	NA	NA	NA
	g	Imaging signage are prominently displayed in all appropriate locations.	N	Y	5
Average Score					1
AAC.12: Patient care is continuous and multidisciplinary in nature.					
	a	During all phases of care, there is a qualified individual identified as responsible for the patient's care.	N	Y	5

	b	Care of patients is coordinated in all care settings within the organization.	N	Y	5
	c	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	N	Y	5
	d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	N	Y	5
	e	Transfers between departments/units are done in a safe manner.	N	Y	5
	f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	N	Y	5
	g	Documented procedures guide the referral of patients to other departments/ specialities.	N	N	0
Average Score					4.29
AAC.13: The organization has a documented discharge process.					
	a	The patient's discharge process is planned in consultation with the patient and/or family.	Y	Y	10
	b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	N	N	0
	c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	N	N	0
	d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	N	Y	5
Average Score					3.75
AAC.14: Organization defines the content of the discharge summary.					
	a	Discharge summary is provided to the patients at the time of discharge.	N	Y	5
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	N	Y	5
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	N	Y	5
	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	N	Y	5
	e	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.	N	Y	5

	f	Discharge summary incorporates instructions about when and how to obtain urgent care.	N	Y	5
	g	In case of death, the summary of the case also includes the cause of death.	Y	Y	10
Average Score					5.71
AVERAGE SCORE OF AAC					3.18
Chapter 2: CARE OF PATIENTS (COP)					
COP.1: Uniform care to patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.					
	a	Care delivery is uniform for a given health problem when similar care is provided in more than one setting.	N	Y	5
	b	Uniform care is guided by documented policies and procedures	N	N	0
	c	These reflect applicable laws, regulations and guidelines	N	Y	5
	d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	N	Y	5
Average Score					3.75
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.					
	a	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	N	N	0
	b	This also addresses handling of medico-legal cases.	N	Y	5
	c	The patients receive care in consonance with the policies.	N	N	0
	d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	N	N	0
	e	Staffs are familiar with the policies and trained on the procedures for care of emergency patients.	N	N	0
	f	Admission or discharge to home or transfer to another organization is also documented.	N	Y	5
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	N	Y	5
Average Score					2.14
COP.3: The ambulance services are commensurate with the scope of the services provided by the organization.					
	a	There is adequate access and space for the ambulance(s).	Y	Y	10

	b	The ambulance adheres to statutory requirements.	Y	Y	10
	c	Ambulance(s) is appropriately equipped.	N	Y	5
	d	Ambulance(s) is manned by trained personnel.	N	Y	5
	e	Ambulance (s) is checked on a daily basis.	N	Y	5
	f	Equipment is checked on a daily basis using a checklist.	N	N	0
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	N	N	0
	h	The ambulance(s) has a proper communication system.	N	N	0
Average Score					4.38
COP.4: Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.					
	a	Documented policies and procedures guide the uniform use of resuscitation throughout the organization	N	N	0
	b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	N	N	0
	c	The events during a cardio-pulmonary resuscitation are recorded.	N	N	0
	d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	N	N	0
	e	Corrective and preventive measures are taken based on the post-event analysis.	N	N	0
Average Score					0
COP.5: Documented policies and procedures guide nursing care.					
	a	There are documented policies and procedures for all activities of the Nursing Services.	N	N	0
	b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	N	N	0
	c	Assignment of patient care is done as per current good practice guidelines.	N	N	0
	d	Nursing care is aligned and integrated with overall patient care.	N	Y	5
	e	Care provided by nurses is documented in the patient record.	N	Y	5
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	N	Y	5

	g	Nurses are empowered to take nursing related decisions to ensure timely care of patients.	N	Y	5
Average Score					2.86
COP.6: Documented procedures guide the performance of various procedures.					
	a	Documented procedures are used to guide the performance of various clinical procedures.	N	N	0
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	N	Y	5
	c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	N	N	0
	d	Informed consent is taken by the personnel performing the procedure where applicable.	N	Y	5
	e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	N	Y	5
	f	Patients are appropriately monitored during and after the procedure.	N	Y	5
	g	Procedures are documented accurately in the patient record.	N	N	0
Average Score					2.86
COP.7: Documented policies and procedures define rational use of blood and blood products					
	a	Documented policies and procedures are used to guide rational use of blood and blood products.	N	N	0
	b	Documented procedures govern transfusion of blood and blood products.	N	N	0
	c	The transfusion services are governed by the applicable laws and regulations.	N	N	0
	d	Informed consent is obtained for donation and transfusion of blood and blood products.	N	N	0
	e	Informed consent also includes patient and family education about donation.	N	N	0
	f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	N	N	0
	g	Post transfusion form is collected; reactions if any identified and are analysed for preventive and corrective actions.	N	N	0
	h	Staffs are trained to implement the policies.	N	N	0
Average Score					0
COP.8: Documented policies and procedures guide the care of patients in the Intensive care					

and high dependency units.					
	a	Documented policies and procedures are used to guide the care of patients in the Intensive care and high dependency units.	N	N	0
	b	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	N	N	0
	c	Staffs are trained to apply these criteria.	N	N	0
	d	Adequate staff and equipment are available.	N	N	0
	e	Defined procedures for situation of bed shortages are followed.	N	N	0
	f	Infection control practices are documented and followed.	N	N	0
	g	A quality assurance programme is documented and implemented.	N	N	0
Average Score					0
COP.9: Documented policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged).					
	a	Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines.	N	N	0
	b	Care is organized and delivered in accordance with the policies and procedures.	N	N	0
	c	The organization provides for a safe and secure environment for this vulnerable group.	N	Y	5
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	N	N	0
	e	Staffs are trained to care for this vulnerable group.	N	N	0
Average Score					1
COP.10: Documented policies and procedures guide obstetric care.					
	a	There is a documented policy and procedure for obstetric services.	N	N	0
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	N	N	0
	c	Persons caring for high risk obstetric cases are competent.	Y	Y	10

	d	Documented procedures guide provision of ante-natal services.	N	N	0
	e	Obstetric patient's assessment also includes maternal nutrition.	N	Y	5
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	N	Y	5
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	N	Y	5
Average Score					3.57
COP.11: Documented policies and procedures guide paediatric services.					
	a	There is a documented policy and procedure for paediatric services.	N	N	0
	b	The organization defines and displays the scope of its paediatric services.	N	Y	5
	c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	N	N	0
	d	Those who care for children have age specific competency.	N	Y	5
	e	Provisions are made for special care of children.	N	N	0
	f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	N	Y	5
	g	Documented policies and procedures prevent child/neonate abduction and abuse.	N	N	0
	h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	N	Y	5
Average Score					2.5
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.					
	a	Documented procedures guide the administration of moderate sedation.	N	N	0
	b	Informed consent for administration of moderate sedation is obtained.	N	N	0
	c	Competent and trained persons perform sedation.	Y	Y	10
	d	The person administering and monitoring sedation is different from the person performing the procedure.	Y	Y	10
	e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	N	Y	5
	f	Patients are monitored after sedation and the same documented.	N	Y	5

	g	Criteria are used to determine appropriateness of discharge from the recovery area.	N	Y	5
	h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	N	Y	5
Average Score					5
COP.13: Documented policies and procedures guide the administration of anaesthesia.					
	a	There is a documented policy and procedure for the administration of anaesthesia.	N	N	0
	b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	N	Y	5
	c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	N	Y	5
	d	An immediate pre-operative re-evaluation is performed and documented.	N	Y	5
	e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	N	Y	5
	f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	N	Y	5
	g	Patient's post-anaesthesia status is monitored and documented.	N	Y	5
	h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	N	Y	5
	i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	N	Y	5
	j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	N	N	0
	k	Adverse anaesthesia events are recorded and monitored.	N	N	0
Average Score					3.64
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.					
	a	The policies and procedures are documented.	N	N	0
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	N	Y	5
	c	An informed consent is obtained by a surgeon prior to the procedure.	N	Y	5
	d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	N	N	0

	e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	N	Y	5
	f	A brief operative note is documented prior to transfer out of patient from recovery area.	N	Y	5
	g	The operating surgeon documents the post-operative plan of care.	N	Y	5
	h	Patient, personnel and material flow conforms to infection control practices.	N	Y	5
	i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	N	Y	5
	j	A quality assurance programme is followed for the surgical services.	N	N	0
	k	The quality assurance programme includes surveillance of the operation theatre environment.	N	N	0
Average Score					3.18
COP.15: Documented policies and procedures guide the care of patients under restraints (physical and / or chemical).					
	a	Documented policies and procedures guide the care of patients under restraints.	N	N	0
	b	These include both physical and chemical restraint measures.	N	N	0
	c	These include documentation of reasons for restraints.	N	N	0
	d	These patients are more frequently monitored.	N	N	0
	e	Staffs receive training and periodic updating in control and restraint techniques.	N	N	0
Average Score					0
COP.16: Documented policies and procedures guide appropriate pain management.					
	a	Documented policies and procedures guide the management of pain.	N	N	0
	b	All patients are screened for pain.	N	N	0
	c	Patients with pain undergo detailed assessment and periodic re-assessment.	N	N	0
	d	The organization respects and supports management of pain for such patients.	N	N	0
	e	Patient and family are educated on various pain management techniques where appropriate.	N	N	0
Average Score					0
COP.17: Documented policies and procedures guide appropriate rehabilitative services.					
	a	Documented policies and procedures guide the	N	N	0

		provision of rehabilitative services.			
	b	These services are commensurate with the organizational requirements.	N	N	0
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	N	N	0
	d	Care is provided adhering to infection control and safe practices.	N	N	0
	e	Rehabilitative services are provided by a multidisciplinary team.	N	N	0
	f	There is adequate space and equipment to perform these activities.	N	N	0
Average Score					
COP.18: Documented policies and procedures guide all research activities.					
	a	Documented policies and procedures guide all research activities in compliance with national and international guidelines.	NA	NA	NA
	b	The organization has an ethics committee to oversee all research activities.	NA	NA	NA
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	NA	NA	NA
	d	Patient's informed consent is obtained before entering them in research protocols.	NA	NA	NA
	e	Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.	NA	NA	NA
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	NA	NA	NA
Average Score					NA
COP.19: Documented policies and procedures guide nutritional therapy.					
	a	Documented policies and procedures guide nutritional assessment and reassessment.	Y	N	0
	b	Patients receive food according to their clinical needs.	Y	Y	5
	c	There is a written order for the diet.	Y	N	5
	d	Nutritional therapy is planned and provided in a collaborative manner.	Y	N	5
	e	When families provide food, they are educated about the patient's diet limitations.	Y	N	5
	f	Food is prepared, handled, stored and distributed in a safe manner.	Y	N	0
Average Score					3.33
COP.20: Documented policies and procedures guide the end of life care.					

	a	Documented policies and procedures guide the end of life care.	Y	Y	0
	b	These policies and procedures are in consonance with the legal requirements.	Y	N	0
	c	These also address the identification of the unique needs of such patient and family.	Y	N	0
	d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	N	N	5
	e	Staffs are educated and trained in end of life care.	Y	N	0
Average Score					1
AVERAGE SCORE FOR COP					2.11
Chapter 3: Management of Medication (MOM)					
MOM.1: Documented policies and procedures guide the organization of pharmacy services and usage of medication					
	a	There is a documented policy and procedure for pharmacy services and medication usage.	Y	N	0
	b	These comply with the applicable laws and regulations.	Y	N	5
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	N	N	0
	d	There is a procedure to obtain medication when the pharmacy is closed.*	Y	Y	5
Average Score					2.5
MOM.2. There is a hospital formulary.					
	a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	Y	N	5
	b	The list is developed and updated collaboratively by the multidisciplinary committee.	Y	N	5
	c	The formulary is available for clinicians to refer and adhere to.	N	N	0
	d	There is a defined process for acquisition of these medications	Y	N	5
	e	There is a process to obtain medications not listed in the formulary.	Y	Y	5
Average Score					4
MOM.3: Documented policies and procedures guide the storage of medication					
	a	Documented policies and procedures exist for storage of medication	Y	N	0
	b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's	Y	N	5

		recommendation (s).			
	c	Sound inventory control practices guide storage of the medications.	Y	N	5
	d	Sound alike and look alike medications are identified and stored separately.*	Y	N	0
	e	The list of emergency medications is defined and is stored in a uniform manner	Y	N	0
	f	Emergency medications are available all the time.	Y	Y	5
	g	Emergency medications are replenished in a timely manner when used.	Y	N	5
Average Score					2.86
MOM.4: Documented policies and procedures guide the safe and rational prescription of medication					
	a	Documented policies and procedures exist for prescription of medications.	Y	Y	0
	b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	Y	N	0
	c	The organization determines the minimum requirements of a prescription.	Y	N	5
	d	Known drug allergies are ascertained before prescribing.	Y	N	5
	e	The organization determines who can write orders.*	Y	N	5
	f	Orders are written in a uniform location in the medical records.	Y	N	5
	g	Medication orders are clear, legible, dated, timed, named and signed.	Y	N	5
	h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	Y	N	5
	i	Documented policy and procedure on verbal orders is implemented.	Y	N	0
	j	The organization defines a list of high risk medication (s).	Y	N	0
	k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	Y	N	0
	l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	Y	N	0
Average Score					2.5

MOM.5: Documented policies and procedures guide the safe dispensing of medications.					
	a	Documented policies and procedures guide the safe dispensing of medications	Y	Y	0
	b	The procedure addresses medication recall.	Y	N	0
	c	Expiry dates are checked prior to dispensing.	Y	N	5
	d	There is a procedure for near expiry medications.	Y	N	5
	e	Labelling requirements are documented and implemented by the organization.	Y	N	0
	f	High risk medication orders are verified prior to dispensing.	Y	N	0
Average Score					1.67
MOM.6:There are documented policies and procedures for medication management.					
	a	Medications are administered by those who are permitted by law to do so.	Y	Y	5
	b	Prepared medication is labelled prior to preparation of a second drug.	N	N	5
	c	Patient is identified prior to administration.	Y	Y	5
	d	Medication is verified from the order prior to administration.	Y	N	5
	e	Dosage is verified from the order prior to administration.	Y	N	5
	f	Route is verified from the order prior to administration.	Y	N	5
	g	Timing is verified from the order prior to administration.	Y	N	5
	h	Medication administration is documented.	Y	Y	5
	i	Documented policies and procedures govern patient's self- administration of medications.	Y	N	0
	j	Documented policies and procedures govern patient's medications brought from outside the organization.*	N	N	0
Average Score					4
MOM.7: Patients are monitored after medication administration.					
	a	Documented policies and procedures guide the monitoring of patients after medication administration.	N	N	0
	b	The organization defines those situations where close monitoring is required.*	N	N	0
	c	Monitoring is done in a collaborative manner.	N	Y	5
	d	Medications are changed where appropriate based on the monitoring.	N	Y	5
Average Score					2.5

MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.					
	a	Documented procedure exists to capture **near miss, medication error** and adverse drug event.	N	N	0
	b	Near miss, medication error and adverse drug event are defined.	N	N	0
	c	These are reported within a specified time frame.	N	N	0
	d	They are collected and analysed.	N	N	0
	e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	N	N	0
Average Score					0
MOM.9: Documented procedures guide the use of narcotic drugs and psychotropic substances.					
	a	Documented procedures guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations.	N	N	0
	b	These drugs are stored in a secure manner.	N	N	0
	c	A proper record is kept of the usage, administration and disposal of these drugs.	N	N	0
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	N	N	0
Average Score					0
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.					
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.	NA	NA	NA
	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	NA	NA	NA
	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	NA	NA	NA
	d	Chemotherapy drugs are disposed off in accordance with legal requirements.	NA	NA	NA
Average Score					
MOM.11: Documented policies and procedures govern usage of radioactive drugs.					
	a	Documented policies and procedures govern usage of radioactive drugs.	NA	NA	NA
	b	These policies and procedures are in consonance with laws and regulations.	NA	NA	NA
	c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	NA	NA	NA
	d	Staff, patients and visitors are educated on safety precautions.	NA	NA	NA

Average Score					NA
MOM.12: Documented policies and procedures guide the use of implantable prosthesis and medical devices					
	a	Usage of implantable prosthesis and medical devices is guided by scientific criteria for each individual item and national / international recognized guidelines / approvals for such specific item(s).	NA	NA	NA
	b	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	NA	NA	NA
	c	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	NA	NA	NA
	d	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record and the master logbook.	NA	NA	NA
Average Score					NA
MOM.13: Documented policies and procedures guide the use of medical supplies and consumables					
	a	There is a defined process for acquisition of medical supplies and consumables.	N	Y	5
	b	Medical supplies and consumables are used in a safe manner where appropriate.	N	Y	5
	c	Medical supplies and consumables are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	N	Y	5
	d	Sound inventory control practices guide storage of medical supplies and consumables.	N	Y	5
Average Score					5
AVERAGE SCORE FOR MOM					2.5
Chapter 4: Patient Rights and Education (PRE)					
PRE.1. The organization protects patient and family rights and informs them about their responsibilities during care.					
	a	Patient and family rights and responsibilities are documented and displayed.	N	N	0
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	N	Y	5
	c	The organization's leaders protect patient and family rights.	N	Y	5
	d	Staff is aware of their responsibility in protecting patient and family rights.	N	N	0

	e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	N	N	0
Average Score					2
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.					
	a	Patients and family rights include respecting any special preferences, spiritual and cultural needs.	N	N	0
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	N	Y	5
	c	Patient and family rights include protection from physical abuse or neglect.	N	N	0
	d	Patient and family rights include treating patient information as confidential.	N	Y	5
	e	Patient and family rights include refusal of treatment.	N	Y	5
	f	Patient and family rights include informed consent before transfusion of blood and blood products, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment.	N	Y	5
	g	Patient and family rights include right to complain and information on how to voice a complaint.	N	Y	5
	h	Patient and family rights include information on the expected cost of the treatment.	N	Y	5
	i	Patient and family rights include access to his / her clinical records.	N	N	0
	j	Patient and family rights include information on plan of care, progress and information on their health care needs.	N	Y	5
Average Score					3.5
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.					
	a	The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.	N	Y	5
	b	The patient and/or family members are explained about the expected results.	N	Y	5
	c	The patient and / or family members are explained about the possible complications.	N	Y	5

	d	The care plan is prepared and modified in consultation with patient and/or family members.	N	N	5
	e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	N	Y	5
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis	N	N	5
	g	The patient and/or family members are explained about any change in the patient's condition.	N	Y	5
Average Score					5
PRE.4: A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.					
	a	Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent.	N	N	0
	b	General consent for treatment is obtained when the patient enters the organization.	N	N	0
	c	Patient and/or his family members are informed of the scope of such general consent.	N	N	0
	d	Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.	N	N	0
	e	The procedure describes who can give consent when patient is incapable of independent decision making.	N	N	0
	f	Informed consent is taken by the person performing the procedure.	N	N	0
	g	Informed consent process adheres to statutory norms.	N	N	0
	h	Staff is aware of the informed consent procedure.	N	N	0
Average Score					0
PRE.5: Patient and families have a right to information and education about their healthcare needs.					
	a	Patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.	N	Y	5
	b	Patient and/or family are educated about food-drug interactions.	N	Y	5
	c	Patient and/or family are educated about diet and nutrition.	N	Y	5
	d	Patient and/or family are educated about immunizations.	Y	Y	10
	e	Patient and/or family are educated about organ donation, when appropriate.	N	N	0

	f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	N	Y	5
	g	Patient and/or family are educated about preventing healthcare associated infections.	N	N	0
	h	Patient and/or family are educated in a language and format that they can understand.	N	Y	5
Average Score					4.38
PRE.6: Patient and families have a right to information on expected costs.					
	a	There is uniform pricing policy in a given setting (out-patient and ward category).	N	Y	5
	b	The tariff list is available to patients.	N	Y	5
	c	The patient and/or family members are explained about the expected costs.	N	N	0
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	N	Y	5
Average Score					3.75
PRE.7: Organization has a complaint redressal procedure.					
	a	The organization has a documented complaint redressal procedure.	N	Y	5
	b	Patient and/or family members are made aware of the procedure for lodging complaints.	N	Y	5
	c	All complaints are analysed.	N	Y	5
	d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	N	Y	5
Average Score					5
AVERAGE SCORE FOR PRE					3.30
Chapter 5: Hospital Infection Control (HIC)					
HIC.1: The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.					
	a	The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections.	N	N	0
	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	N	N	0
	c	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	N	N	0

	d	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	N	N	0
	e	The hospital has designated infection control officer as part of the infection control team.	N	N	0
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	N	N	0
Average Score					0
HIC.2: The organization implements the policies and procedures laid down in the Infection Control Manual.					
	a	The organization identifies the various high-risk areasand procedures and implements policies and/or procedures to prevent infection in these areas	N	N	0
	b	The organization adheres to standard precautions at all times.	N	N	0
	c	The organization adheres to hand hygiene guidelines.	N	N	0
	d	The organization adheres to safe injection and infusion practices.	N	N	0
	e	The organization adheres to transmission based precautions at all times.	N	N	0
	f	The organization adheres to cleaning, disinfection and sterilization practices	N	N	0
	g	An appropriate antibiotic policy is established and implemented.	N	N	0
	h	The organization adheres to laundry and linen management processes.	N	N	0
	i	The organization adheres to kitchen sanitation and food handling issues.	N	N	0
	j	The organization has appropriate engineering controls to prevent infections.	N	N	0
	k	The organization adheres to housekeeping procedures.	N	N	0
Average Score					0
HIC.3: The organization performs surveillance activities to capture and monitor infection prevention and control data.					
	a	Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.	N	N	0
	b	Collection of surveillance data is an on-going process.	N	N	0

	c	Verification of data is done on a regular basis by the infection control team.	N	N	0
	d	Scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	N	N	0
	e	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	N	N	0
	f	Surveillance activities include monitoring the effectiveness of housekeeping services.	N	N	0
	g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	N	N	0
	h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	N	N	0
Average Score					0
HIC.4: The organization takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.					
	a	The organization takes action to prevent urinary tract infections.	N	N	0
	b	The organization takes action to prevent respiratory tract infections.	N	N	0
	c	The organization takes action to prevent intra-vascular device infections.	N	N	0
	d	The organization takes action to prevent surgical site infections.	N	N	0
Average Score					0
HIC.5: The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).					
	a	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.	N	Y	5
	b	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	N	Y	5
	c	Isolation / barrier nursing facilities are available.	N	N	0
	d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	N	N	0
Average Score					2.5
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.					
	a	Organization has a documented procedure for identifying an outbreak.	Y	Y	0

	b	Organization has a documented procedure for handling such outbreaks.	Y	N	0
	c	This procedure is implemented during outbreaks.	Y	N	0
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	Y	N	0
Average Score					0
HIC.7: There are documented policies and procedures for sterilization activities in the organization.					
	a	The organization provides adequate space and appropriate zoning for sterilization activities.	Y	N	0
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	Y	N	0
	c	Reprocessing of instruments and equipment are covered.	Y	N	0
	d	Regular validation tests for sterilization are carried out and documented.	Y	N	0
	e	There is an established recall procedure when breakdown in the sterilization system is identified.	Y	N	0
Average Score					0
HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.					
	a	The organization adheres to statutory provisions with regard to biomedical waste.	Y	N	0
	b	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	Y	N	5
	c	The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	Y	N	0
	d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	Y	N	10
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	Y	N	5
Average Score					4
HIC.9: The infection control programme is supported by the management and includes training of staff.					
	a	The management makes available resources required for the infection control programme.	Y	N	0
	b	The organization earmarks adequate funds from its annual budget in this regard.	Y	N	0

	c	The organization conducts induction training for all staff.	Y	N	0
	d	The organization conducts appropriate "in-service" training sessions for all staff at least once in a year.	Y	N	0
Average Score					0
AVERAGE SCORE FOR HIC					0.72
Chapter 6: Continual Quality Improvement (CQI)					
CQI.1: There is a structured quality improvement and continuous monitoring programme in the organization.					
	a	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.	N	N	0
	b	The quality improvement programme is documented.	N	N	0
	c	There is a designated individual for coordinating and implementing the quality improvement programme.	N	N	0
	d	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	N	N	0
	e	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	N	N	0
	f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	N	N	0
	g	The quality improvement programme is a continuous process and updated at least once in a year.	N	N	0
	h	Audits are conducted at regular intervals as a means of continuous monitoring.	N	N	0
	i	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	N	N	0
Average Score					0
CQI.2: There is a structured patient safety programme in the organization.					
	a	The patient safety programme is developed, implemented and maintained by a multi-disciplinary committee.	N	N	0
	b	The patient safety programme is documented.	N	N	0
	c	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk management.	N	N	0
	d	The scope of the programme is defined to include	N	N	0

		adverse events ranging from “no harm” to “sentinel events”.			
	e	There is a designated individual for coordinating and implementing the patient safety programme.	N	N	0
	f	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	N	N	0
	g	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	N	N	0
	h	The patient safety programme is a continuous process and updated at least once in a year.	N	N	0
	i	The organization adapts and implements national/international patient safety goals/solutions.	N	N	0
	j	The organization uses at least two identifiers to identify patients across the organization.	N	N	0
Average Score					0
CQI.3: The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.					
	a	Monitoring includes appropriate patient assessment.	N	N	0
	b	Monitoring includes safety and quality control programmes of all the diagnostic services.	N	N	0
	c	Monitoring includes medication management.	N	N	0
	d	Monitoring includes use of anaesthesia.	N	N	0
	e	Monitoring includes surgical services.	N	N	0
	f	Monitoring includes use of blood and blood products.	N	N	0
	g	Monitoring includes infection control activities.	N	N	0
	h	Monitoring includes review of mortality and morbidity indicators.	N	N	0
	i	Monitoring includes clinical research.	NA	NA	NA
	j	Monitoring includes data collection to support further improvements.	N	N	0
	k	Monitoring includes data collection to support evaluation of these improvements.	N	N	0
Average Score					0
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.					
	a	Monitoring includes procurement of medication essential to meet patient needs.	N	N	0
	b	Monitoring includes risk management.	N	N	0
	c	Monitoring includes utilisation of space, manpower and equipment.	N	N	0
	d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	N	N	0

	e	Monitoring includes employee satisfaction.	N	N	0
	f	Monitoring includes adverse events and near misses.	N	N	0
	g	Monitoring includes availability and content of medical records.	N	N	0
	h	Monitoring includes data collection to support further improvements.	N	N	0
	i	Monitoring includes data collection to support evaluation of these improvements.	N	N	0
Average Score					0
CQI.5: The quality improvement programme is supported by the management.					
	a	The management makes available adequate resources required for quality improvement programme.	N	Y	0
	b	Organization earmarks adequate funds from its annual budget in this regard.	N	N	0
	c	The management identifies organizational performance improvement targets.	N	N	0
	d	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	N	N	0
Average Score					0
CQI.6: There is an established system for clinical audit.					
	a	Medical and nursing staff participates in this system.	N	N	0
	b	The parameters to be audited are defined by the organization.	N	N	0
	c	Patient and staff anonymity is maintained.	N	N	0
	d	All audits are documented.	N	N	0
	e	Remedial measures are implemented.	N	N	0
Average Score					0
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.					
	a	The organization has an incident reporting system.	N	N	5
	b	The organization has a process to collect feedback and receive complaints.	N	Y	5
	c	The organization has established processes for analysis of incidents, feedbacks and complaints.	N	Y	5
	d	Corrective and preventive actions are taken based on the findings of such analysis.	N	Y	5
	e	Feedback about care and service is communicated to staff.	N	Y	5
Average Score					5
CQI.8: Sentinel events are intensively analysed.					

	a	The organization has defined sentinel events.	N	N	0
	b	The organization has established processes for intense analysis of such events.	N	N	0
	c	Sentinel events are intensively analysed when they occur.	N	N	0
	d	Corrective and Preventive Actions are taken based on the findings of such analysis.	N	N	0
Average Score					0
AVERAGE SCORE FOR CQI					0.63
Chapter 7: Responsibilities of Management (ROM)					
ROM.1: The responsibilities of those responsible for governance are defined.					
	a	Those responsible for governance lay down the organization's vision, mission and values.	N	N	0
	b	Those responsible for governance approve the strategic and operational plans and organization's budget.	N	Y	5
	c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	N	N	0
	d	Those responsible for governance establish the organization's organogram.	N	Y	5
	e	Those responsible for governance appoint the senior leaders in the organization.	N	Y	5
	f	Those responsible for governance support safety initiatives and quality improvement plans.	N	N	0
	g	Those responsible for governance support research activities.	N	N	0
	h	Those responsible for governance address the organization's social responsibility.	N	N	5
	i	Those responsible for governance inform the public of the quality and performance of services.	N	Y	5
Average Score					2.78
ROM.2: The organization complies with the laid down and applicable legislations and regulations.					
	a	The management is conversant with the laws and regulations and knows their applicability to the organization.	N	Y	5
	b	The management ensures implementation of these requirements.	N	N	0
	c	Management regularly updates any amendments in the prevailing laws of the land.	N	N	0

	d	There is a mechanism to regularly update licenses/ registrations/certifications.	N	N	0
Average Score					1.25
ROM.3: The services provided by each department are documented.					
	a	Scope of services of each department is defined	N	Y	5
	b	Administrative policies and procedures for each department are maintained.	N	N	0
	c	Each organizational programme, service, site or department has effective leadership.	N	N	0
	d	Departmental leaders are involved in quality improvement.	N	N	0
Average Score					1.25
ROM.4: The organization is managed by the leaders in an ethical manner.					
	a	The leaders make public the vision, mission and values of the organization.	N	N	0
	b	The leaders establish the organization's ethical management.	N	Y	5
	c	The organization discloses its ownership.	Y	Y	10
	d	The organization honestly portrays the services which it can and cannot provide.	N	Y	5
	e	The organization honestly portrays its affiliations and accreditations.	N	Y	5
	f	The organization accurately bills for its services based upon a standard billing tariff.	N	Y	10
Average Score					5.83
ROM.5: The organization displays professionalism in management of affairs.					
	a	The person heading the organization has requisite and appropriate administrative qualifications.	N	Y	5
	b	The person heading the organization has requisite and appropriate administrative experience.	N	Y	5
	c	The organization prepares the strategic and operational plans including long term and short term goals commensurate to the organization's vision, mission and values in consultation with the various stake holders.	N	N	0
	d	The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	N	N	0
	e	The organization plans and budgets for its activities annually.	N	Y	5
	f	The performance of the senior leaders is reviewed for	N	N	0

		their effectiveness.			
	g	The functioning of committees is reviewed for their effectiveness.	N	N	0
	h	The organization documents employee rights and responsibilities.	N	N	0
	i	The organization documents the service standards.	N	N	0
	j	The organization has a formal documented agreement for all outsourced services.	N	N	0
	k	The organization monitors the quality of the outsourced services.	N	N	0
Average Score					1.36
ROM.6: Management ensures that patient safety aspects and risk management issues are an integral part of patient care and hospital management.					
	a	Management ensures proactive risk management across the organization.	N	N	0
	b	Management provides resources for proactive risk assessment and risk reduction activities.	N	N	0
	c	Management ensures implementation of systems for internal and external reporting of system and process failures.	N	Y	5
	d	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	N	Y	5
Average Score					2.5
AVERAGE SCORE FOR ROM					2.5
Chapter 8:Facility Management and Safety (FMS)					
FMS.1: The organization has a system in place to provide a safe and secure environment.					
	a	Safety committee coordinates development, implementation, and monitoring of the safety plan and policies	N	N	0
	b	Patient safety devices are installed across the organization and inspected periodically.	N	Y	5
	c	The organization is a non-smoking area.	Y	Y	10
	d	Facility inspection rounds to ensure safety are conducted at least twice in a year in patient care areas and at least once in a year in non-patient care areas.	N	N	0
	e	Inspection reports are documented and corrective and preventive measures are undertaken.	N	N	0
	f	There is a safety education programme for staff.	N	Y	5
Average Score					2.5
FMS.2: The organization's environment and facilities operate to ensure safety of patients,					

their families, staff and visitors.					
	a	Facilities are appropriate to the scope of services of the organization.	N	Y	5
	b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	N	N	0
	c	There is internal and external sign posting in the organization in a language understood by patient, families and community.	N	Y	5
	d	The provision of space shall be in accordance with the available literature on good practices (Indian or International Standards) and directives from government agencies.	N	Y	5
	e	Potable water and electricity are available round the clock.	Y	Y	10
	f	Alternate sources for electricity and water are provided as backup for any failure/shortage.	N	Y	5
	g	The organization regularly tests these alternate sources.	N	N	0
	h	There are designated individuals responsible for the maintenance of all the facilities.	N	N	0
	i	There is a documented operational and maintenance (preventive and breakdown) plan.	N	N	0
	j	Maintenance staff is contactable round the clock for emergency repairs.	N	N	0
	k	Response times are monitored from reporting to inspection and implementation of corrective actions.	N	N	0
Average Score					2.73
FMS.3: The organization has a programme for engineering support services.					
	a	The organization plans for equipment in accordance with its services and strategic plan.	N	Y	5
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	N	Y	5
	c	Equipment are inventoried and proper logs are maintained as required.	N	N	0
	d	Qualified and trained personnel operate and maintain equipment and utility systems.	N	Y	5
	e	There is a documented operational and maintenance (preventive and breakdown) plan.	N	N	0
	f	There is a maintenance plan for water management.	N	N	0
	g	There is a maintenance plan for electrical systems.	N	N	0
	h	There is a maintenance plan for heating, ventilation and air-conditioning.	N	N	0

	i	There is a documented procedure for equipment replacement and disposal.	N	N	0
Average Score					1.67
FMS.4: The organization has a programme for bio-medical equipment management.					
	a	The organization plans for equipment in accordance with its services and strategic plan.	N	N	0
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	N	Y	5
	c	Equipment are inventoried and proper logs are maintained as required.	N	N	0
	d	Qualified and trained personnel operate and maintain the medical equipment.	N	Y	5
	e	Equipment are periodically inspected and calibrated for their proper functioning.	N	N	0
	f	There is a documented operational and maintenance (preventive and breakdown) plan.	N	N	0
	g	There is a documented procedure for equipment replacement and disposal.*	N	N	0
Average Score					1.43
FMS.5: The organization has a programme for medical gases, vacuum and compressed air.					
	a	Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases.	N	N	0
	b	Medical gases are handled, stored, distributed and used in a safe manner.	N	N	5
	c	The procedures for medical gases address the safety issues at all levels.	Y	N	0
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	Y	Y	5
	e	The organization regularly tests these alternate sources.	Y	N	0
	f	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	Y	N	0
Average Score					1.67
FMS.6: The organization has plans for fire and non-fire emergencies within the facilities.					
	a	The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.	N	N	0
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	N	N	0
	c	Staffs are trained for their role in case of such	N	N	0

		emergencies			
	d	Mock drills are held at least twice in a year.	N	N	0
	e	There is a maintenance plan for fire related equipment.	N	N	0
Average Score					0
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.					
	a	The organization identifies potential emergencies.	N	N	0
	b	The organization has a documented disaster management plan.	N	N	0
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	N	N	0
	d	Staffs are trained in the hospital's disaster management plan.	N	N	0
	e	The plan is tested at least twice in a year.	N	N	0
Average Score					0
FMS.8: The organization has a plan for management of hazardous materials.					
	a	Hazardous materials are identified within the organization.	N	N	0
	b	The organization implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.	N	N	0
	c	Requisite regulatory requirements are met in respect of radioactive materials.	N	N	0
	d	There is a plan for managing spills of hazardous materials.	N	N	0
	e	Staffs are educated and trained for handling such materials.	N	N	0
Average Score					0
AVERAGE SCORE FOR FMS					1.25
Chapter 9: Human Resource Management (HRM)					
HRM.1. The organization has a documented system of human resource planning.					
	a	Human resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	N	Y	5
	b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	N	Y	5
	c	The required job specification and job description are well defined for each category of staff.	N	N	0
	d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	N	N	0
Average Score					2.5

HRM.2. The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.					
	a	There is a documented procedure for recruitment.	N	N	0
	b	Recruitment is based on pre-defined criteria	N	N	0
	c	Every staff member entering the organization is provided induction training	N	N	0
	d	The induction training includes orientation to the organization's vision, mission and values.	N	N	0
	e	The induction training includes awareness on employee rights and responsibilities.	N	N	0
	f	The induction training includes awareness on patient's rights and responsibilities.	N	N	0
	g	The induction training includes orientation to the service standards of the organization.	N	N	0
	h	Every staff member is made aware of organization wide policies and procedures as well as relevant department / unit / service / programme's policies and procedures.	N	N	0
Average Score					0
HRM.3. There is an on-going programme for professional training and development of the staff.					
	a	A documented training and development policy exists for the staff.	N	N	0
	b	The organization maintains the training record.	N	Y	5
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	N	Y	5
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	N	N	0
Average Score					2.5
HRM.4. Staffs are adequately trained on various safety related aspects.					
	a	Staffs are trained on the risks within the organization's environment.	N	N	0
	b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	N	N	0
	c	Staff members are made aware of procedures to follow in the event of an incident.	N	N	0
	d	Staffs are trained on occupational safety aspects.	N	N	0
Average Score					0
HRM.5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.					
	a	A documented performance appraisal system exists in the organization.*	N	Y	5

	b	The employees are made aware of the system of appraisal at the time of induction.	N	Y	5
	c	Performance is evaluated based on the pre-determined criteria.	N	Y	5
	d	The appraisal system is used as a tool for further development.	N	Y	5
	e	Performance appraisal is carried out at pre-defined intervals and is documented.	N	Y	5
Average Score					5
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures					
	a	Documented policies and procedures exist.	N	N	0
	b	The policies and procedures are known to all categories of staff of the organization.	N	N	0
	c	The disciplinary policy and procedure is based on the principles of natural justice.	N	N	0
	d	The disciplinary procedure is in consonance with the prevailing laws.	N	Y	5
	e	There is a provision for appeals in all disciplinary cases.	N	Y	5
	f	The redress procedure addresses the grievance.	N	Y	5
	g	Actions are taken to redress the grievance.	N	Y	5
Average Score					2.86
HRM.7. The organization addresses the health needs of the employees.					
	a	A pre-employment medical examination is conducted on all the employees.	Y	Y	10
	b	Health problems of the employees are taken care of in accordance with the organization's policy.	N	N	0
	c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	N	N	0
	d	Occupational health hazards are adequately addressed.	N	N	0
Average Score					2.5
HRM.8. There is documented personal information for each staff member.					
	a	Personal files are maintained in respect of all staff.	N	Y	5
	b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	N	Y	5
	c	All records of in-service training and education are contained in the personal files.	N	N	0

	d	Personal files contain results of all evaluations.	N	N	0
Average Score					2.5
HRM.9. There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.					
	a	Medical professionals permitted by law, regulation and the organization to provide patient care without supervision is identified.	Y	Y	10
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	N	Y	5
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	N	Y	5
	d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	N	Y	5
	e	The requisite services to be provided by the medical professionals are known to them as well as the various departments / units of the organization.	N	Y	5
	f	Medical professionals admit and care for patients as per their privileging.	N	Y	5
Average Score					5.83
HRM.10. There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.					
	a	Nursing staff permitted by law, regulation and the organization to provide patient care without supervision are identified.	Y	Y	10
	b	The education, registration, training and experience of nursing staff is documented and updated periodically.	N	Y	5
	c	All such information pertaining to the nursing staff is appropriately verified when possible.	N	Y	5
	d	Nursing Staffs are granted privileges in consonance with their qualification, training, experience and registration.	N	Y	5
	e	The requisite services to be provided by the nursing Staffs are known to them as well as the various departments / units of the organization.	N	Y	5
	f	Nursing professionals care for patients as per their privileging.	N	Y	5
Average Score					5.83

AVERAGE SCORE FOR HRM					2.95
Chapter 10: Information Management System (IMS)					
IMS.1. Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.					
	a	The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization.	N	Y	5
	b	Documented policies and procedures to meet the information needs exist.	N	N	0
	c	These policies and procedures are in compliance with the prevailing laws and regulations.	N	N	0
	d	All information management and technology acquisitions are in accordance with the documented policies and procedures.	N	N	0
	e	The organization contributes to external databases in accordance with the law and regulations.	N	N	0
Average Score					1
IMS.2. The organization has processes in place for effective management of data.					
	a	Formats for data collection are standardized.	N	Y	5
	b	Necessary resources are available for analysing data.	N	Y	5
	c	Documented procedures are laid down for timely and accurate dissemination of data.	N	N	0
	d	Documented procedures exist for storing and retrieving data.	N	N	0
	e	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	N	Y	5
Average Score					3
IMS.3. The organization has a complete and accurate medical record for every patient.					
	a	Every medical record has a unique identifier.	N	N	0
	b	Organization policy identifies those authorized to make entries in medical record.	N	Y	5
	c	Entry in the medical record is named, signed, dated and timed.	N	Y	5
	d	The author of the entry can be identified.	N	Y	5
	e	The contents of medical record are identified and documented.	N	N	0
	f	The record provides a complete, up-to-date and chronological account of patient care.	N	N	0
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	N	N	0
Average Score					2.14
IMS.4. The medical record reflects continuity of care.					

	a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	N	Y	5
	b	The medical record contains the results of tests carried out and the care provided.	N	Y	5
	c	Operative and other procedures performed are incorporated in the medical record.	N	Y	5
	d	When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.	N	Y	5
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	N	Y	5
	f	In case of death, the medical record contains a copy of the cause of death certificate.	N	N	0
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	N	Y	5
	h	Care providers have access to current and past medical record.	N	N	0
Average Score					3.75
IMS.5. Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.					
	a	Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information.	N	N	0
	b	Documented policies and procedures are in consonance with the applicable laws.	N	N	0
	c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	N	N	0
	d	The organization has an effective process of monitoring compliance of the laid down policy and procedure.	N	N	0
	e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	N	N	0
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	N	N	0
	g	A documented procedure exists on how to respond to patients / physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.*	N	N	0
Average Score					0
IMS.6. Documented policies and procedures exist for retention time of records, data and information.					

	a	Documented policies and procedures are in place on retaining the patient's clinical records, data and information.	N	N	0
	b	The policies and procedures are in consonance with the local and national laws and regulations.	N	N	0
	c	The retention process provides expected confidentiality and security.	N	N	0
	d	The destruction of medical records, data and information is in accordance with the laid down policy.	N	N	0
Average Score					0
IMS.7. The organization regularly carries out review of medical records.					
	a	The medical records are reviewed periodically.	N	N	0
	b	The review uses a representative sample based on statistical principles.	N	N	0
	c	The review is conducted by identified care providers.	N	N	0
	d	The review focuses on the timeliness, legibility and completeness of the medical records.	N	N	0
	e	The review process includes records of both active and discharged patients.	N	N	0
	f	The review points out and documents any deficiencies in records.	N	N	0
	g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	N	N	0
Average Score					0
AVERAGE SCORE FOR IMS					1.41
TOTAL SCORE OF ALL CHAPTERS					2.06

DATA COLLECTION SHEET FOR
GAP ANALYSIS AS PER NABH STANDARDS

HOSPITAL INTRODUCTION

SCOPE OF SERVICES			
Sl. No.	**Name of Services/ Department**	**Availability (Yes/No/NA)**	**Remarks**
GROUP A – CLINICAL SERVICES			
01	General Medicine		
02	Obstetrics and Gynaecology		
03	Paediatrics and Neonatology		
04	Orthopaedics		
05	Ophthalmology		
06	Anaesthesiology		
07	General Surgery		
08	Dentistry		
09	ENT		
10	Dermatology		
GROUP B: CLINICAL SUPPORT SERVICES			
11	Laboratory		
12	Radiology & Imaging		
13	Blood Bank		
14	Dialysis		
15	Physiotherapy		
GROUP C: SUPPORT SERVICES			
16	Pharmacy		
17	General Store		
18	Kitchen & Dietary		
19	Laundry		
20	CSSD/TSSU		
21	Medical Records		
22	Ambulance & Transport		
23	Security Services		
24	Housekeeping Services		
25	Biomedical engineering		
26	Maintenance		
27	Mortuary services		
GROUP D: ADMINISTRATIVE SERVICES			
28	General Administration		

29	Account & Finance		

KEY INDICATORS

INDICATORS	August, 2013	Sept, 2013	Oct,2013	Nov,2013	Dec,2013	Jan,2014
IP Admissions						
OPD						
SURGERIES (Minor)						
SURGERIES (Major)						
X-RAYS						
USG						
LAB						
BIRTH						
DEATH						

SIGNAGE SYSTEM

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)	Remarks (if any)
Citizen Charter				
Mission				
Vision				
Patients Rights & Responsibilities				
Scope of Services				
Tariff List				
Doctors list along with their Specialities and Qualifications				
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)				
Biohazard Symbols				
Fire Exit Plan				
Floor Directory				
Wash Rooms (Differently Able)				
Toilets				
Ambulance Parking Area				
Drinking Water				
Health Education Related Signage (HIV & Immunization)				

STATUTORY REQUIREMENTS

Licenses	Status *(A / NA)	Available YES/NO
Building Occupancy/Completion Certificate		
Fire License		
License under Bio- medical Management and handling Rules, 1998.		
NOC for Air & Water from State Pollution Control Board		
Excise permit to store Spirit.		
Permit to operate lifts under the Lifts and escalators Act.		
Narcotics and Psychotropic substances Act and License.		
Vehicle registration certificates for Ambulances.		
Retail drug license (Pharmacy)		
PNDT Certificate		
Site & Type Approval for X-Ray from AERB		
License for Blood Bank		
Noise & Air pollution certificate for Diesel Generators		

A = Applicable **NA** = Not Applicable

Name of the person interacted to gather data/information: ……

Signature of the person:

BED DISTRIBUTION

Floor	Class/Department	Beds
Ground Floor		
First Floor		
Second Floor		
Third Floor		
TOTAL		

Name of the person interacted to gather data/information: ……

Signature of the person:

STRUCTURAL DETAILS

Category			
A. Land	..... acres		
B. Building	..... sq. ft		
C. HVAC	Availability of HVAC system		Yes/No
		Number	**Capacity**
D. Electricity	Transformer		.....KVA
	DG set		.....KVA
	UPS		.....KVA
	Total Load Sanctioned		.....KVA
E. Water	Water Tanks (Sump)		.....litres
	Water Tanks (Overhead)		.....litres
	Sources of water		

Name of the person interacted to gather data/information: ……

Signature of the person:

DEPARTMENTAL GAPS

10.1 EMERGENCY

Checklist for Emergency					
Name of the Hospital:					
S. No.		**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1.	Whether the triage area is marked separately				
2.	Does the Emergency department have a separate entrance?				
3.	Is the Emergency signage visible from the road with proper lighting and signs?				
4.	Is the doctor available round the clock for emergency care of patients?				
5.	Is there a nurse available round the clock for emergency care of patients?				
6.	Does the number of trolleys and wheelchairs commensurate to the needs?				
7.	Does the emergency room retain a list of all staff that contains Name, Contact details, Designation?				
8.	Is Doctor's name and contact number kept posted at all times in the emergency room?				
9.	Is there an appropriate waiting area for the relatives of the patient?				
10.	An appropriately qualified staff member is scheduled to manage triage activities.				
11.	Is Emergency Crash Cart available?				
12.	Defibrillator				
13.	Cardiac Monitor				
14.	Emergency drugs				
15.	Resuscitation bags (i.e. AMBU) of various				

	sizes				
16.	Oral Airways of various sizes				
17.	Laryngoscope with various blades				
18.	Laryngoscope replacement batteries and bulbs.				
19.	Endotracheal tubes of various sizes.				
PROCESS					
20.	Is there a system to review all imaging by a radiologist within 24 hours				
21.	Ability to perform acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies.				
22.	Security staffs are immediately available when required in the emergency room.				
23.	Electrical equipment (e.g. defibrillator) is charged at all times.				
24.	Is Crash cart checked daily regarding regular testing?				
25.	The documentation from a medico-legal and treatment view point is detailed, professional and accurate.				
26.	Are the separate registers maintained for medico legal cases, discharge, admissions to ward?				
27.	Is BMW segregated and handled properly.				
28.	Is Triaging of the patients done?				
29.	Does the initial assessment of the patient take place?				
30.	Are the patients attended by attendants when they come or when they are transferred to wards?				
31.	Is staff trained in BLS/ACLS				
OUTCOME					
32.	Time for initial assessment of emergency patient				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.2 AMBULANCE

Checklist for Ambulance					
Name of the Hospital:					
Sl.no	**Check points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Adequate communication system exists in ambulance				
2	Required equipments (stetho, sphygno, suction app, defib, monitor, oxygen cylinder) are available in the ambulance.				
3	Required medicines are available in the ambulance.				
4	Is Vehicle license available?				
5	Is driver license present?				
6	Maintenance of the medical gas (oxygen) to 90% of the total capacity.				
7	Calibration of Equipments present				
PROCESS					
8	Is staff trained in BLS				

9	Is Medication and equipment checklist maintained				
10	Is infection control practices followed				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.3 OPD

Checklist for OPD					
Name of the Hospital:					
Sl. No.	**Check Points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Availability of enquiry counter				
2	Availability of registration counter				
3	Availability of separate queue for Differently able.				
4	Availability of designated waiting area with adequate sitting arrangement				
5	Availability of drinking water facility				
6	Availability of separate and functional toilet for differently able.				
7	Availability of fan & lights in waiting area				
8	Is the Scope of services displayed?				
9	Is citizen charter and Patient charter displayed				

10	Is list of doctors along with OPD Timings displayed				
11	Are the different OPD rooms numbered				
12	Is there provision of patient privacy in the consultation room				
13	Is BP apparatus with stethoscope present				
14	Is weighing machine present				
15	Is thermometer present				
16	Is calibration of BP apparatus, weighing machine and thermometer				
MANPOWER					
17	Availability of dedicated registration clerk				
18	Availability of nurse to direct patients to specific OPDs				
PROCESS					
19	Is UHID generated for all patients				
20	Is separate registration done for old and new OPD patients				
21	Is the tariff rates defined and made aware to the patients/ attendant				
22	Is patient privacy maintained during consultation time				
23	Is the staff aware of all the information like Doctors OPD timings, charges etc				
OUTCOME					
24	Monitoring of waiting time				

25	OPD patient satisfaction survey				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.4 LABORATORY

Checklist for Laboratory					
Name of the Hospital:					
Sl. NO	**Check points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is laboratory present in hospital? (In house/ outsourced)				
2	Specify the functional units of laboratories present in the hospital				
3	Is there continuous water supply to this unit?				
4	Is adequate drainage system present in this unit?				
5	Is there provision for hand washing facility in this unit?				
6	Is there provision of personal protective devices for staff?(if yes mention the name)				

7	Is the staff licensed and competent in knowledge and skill?				
8	Is there separate area available for sample collection?				
9	Is pathologist available?				
10	Are BMW bins are present in the department?				
11	Is there power back up facility available				
PROCESS					
12	Is the scope of services defined				
13	Is maintenance of laboratory equipments done?				
14	Are laboratory equipments calibrated?				
15	Is laboratory staff aware about the safety precautions while handling samples?				
16	Is laboratory staff taking necessary precautions while handling samples?				
17	Is BMW segregation done as per BMW guidelines?				
18	Is critical results defined, reported, and documented.				
19	Is surveillance for lab test being carried out				
20	Is EQAS being monitored				

21	Laboratory reports are signed by Pathologist.				
22	Is labeling of sample done?				
23	Is time frame defined for dispatching lab reports?				
24	Is turnaround time for lab reports monitored?				
25	Is MOU available for outsourced tests				
26	Is temperature monitoring of refrigerator is done?				
OUTCOME					
27	Number of reporting errors per 1000 investigations				
28	% of reports having clinical correlation with provisional diagnosis				
29	% of adherence to safety precautions				
30	% of redo's				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.5 RADIOLOGY & IMAGING

Checklist for Radiology & Imaging					
Name of the Hospital:					
S. No.	**Check points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is this unit has AERB (SITE/TYPE approval)				
2	Are basic facilities for staff present? (toilet/drinking water/change room)				
3	Is the staff licensed and competent in knowledge and skill?				
4	Is there a change room available for patients?				
5	TLD badges available (Are they sufficient in number)				
6	Lead glass available (Are they sufficient in number)				

7	Lead apron available (Are they sufficient in number)				
8	Gonad shield available (Are they sufficient in number)				
9	Thyroid shield available (Are they sufficient in number)				
10	Is radiologist available?				
11	Is critical results defined, reported, and documented.				
12	Radiation hazard symbol is present				
13	PNDT license is available				
PROCESS					
14	Is maintenance of radiology equipments done?				
15	Are radiology equipments calibrated?				
16	Is radiology staff aware about the safety precautions?				
17	Is radiology staff taking safety measures?				
18	Quality Assurance program is followed or not				
19	Radiology test requisition form is signed by doctor.				
20	Radiology reports are signed by Radiologist.				

21	Is time frame defined for dispatching reports?				
22	Is turnaround time for reports monitored?				
OUTCOME					
23	Number of reporting errors per 1000 investigations				
24	% of reports having clinical correlation with provisional diagnosis				
25	% of adherence to safety precautions				
26	% of redo's				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.6 WARDS

Checklist for Ward Management					
Name of the Hospital:					
SL.NO	**Check points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is Medical Gas Facility available in the ward?				
2	Are basic facilities for staffs present (toilet/ drinking water)?				
3	Is needle cutter present in each ward?				
4	Emergency crash cart is present in the ward?				
5	Color coded BMW bins are present in each ward?				
6	Is there a nursing station in the ward?				
7	Is there adequate number of nurses in each shift?				

8	Racks are present to store linen?				
9	Wash basin is present in each ward.				
10	PPE is provided in each ward?				
PROCESS					
11	Is staff aware of the admission process?				
12	Does the cleaning of the department take place?				
13	Are the vitals of the patient checked every day?				
14	Administration of medication is done by qualified nurse?				
15	Indent of medicines and other items is placed by nurses regularly?				
16	PPE is used by the nurses?				
17	Are the BMW segregated at the point of generation?				
18	Does the nurse on duty record the details of the patient in the BHT on a daily basis?				
19	Are the nurses trained in BLS(CPR)				
20	Is infection control practices being followed				
21	Is bio medical waste management practice followed				
22	Is the staff aware about transfer				

	IN/OUT system				
23	Is cost estimate for treatment provided to the patient/attendant				
24	Is discharge process defined and documented?				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.7 LABOUR ROOM

Checklist for Labour Department					
NAME OF THE HOSPITAL:					
Si. No	**Description**	**Yes**	**No**	**Evidence**	**Remarks**
INFRASTRUCTURE					
1	Are there separate areas demarcated for septic and aseptic deliveries?				
2	Does the Labour room have a toilet facility?				
3	Are number of Labour tables present appropriate for the daily load?				
4	Is continuous water available for the unit?				
5	Does the Labour Room have a hand washing facility?				
6	Is scrubbing area present for the Labour Room staff?				

7	Is the fire fighting system available in the unit?				
8	Is the changing room available for the doctors and nurses?				
9	Is there a continuous power back up for Labour Room?				
10	Is the Labour Room having a demarcated New Born Care Area with the appropriate equipments?				
11	Does the Labour Room have any sterilization equipment?				
12	Are there Disposable Delivery Kits in required quantities?				
13	Does the Labour Room have a Crash Cart?				
14	Is there an ECG monitor?				
15	Does the Labour Room have adequate Oxygen supply as per demand?				
16	Is the staff provided with the Personnel Protective Devices/ Equipments?				
17	Does the Labour Room have round the clock coverage by Trained Nurses/ Mid wives for conducting supervised deliveries?				
18	Are there screens for privacy?				

19	Are there Cusco's vaginal speculum (each of small, medium and large size); Sim's vaginal speculum – single & double ended - (each of small, medium and large size); Anterior Vaginal wall retractor; Sterile Gloves; Sterilized cotton swabs and swab sticks in a jar with lid; Kidney tray for keeping used instruments; Bowl for antiseptic solution; Antiseptic solution: Chlorhexidine 1% or Cetrimide 2% (if povidone iodine solution is available, it is preferable to use that); Chittle forceps; Proper light source / torch				
PROCESS					
20	Are Bio Medical Waste Management followed?				
21	Are Work Instructions prominently displayed?				
22	Does the Labour Room Register have a record of referred cases?				
23	Is the part preparation of the patient done before the operation?				
24	Are the number of Labour Room instruments counted before and after use?				
25	Are Partograms used for all patients?				

26	Is Labour Room disinfection done after every procedure?				
27	Is APGAR SCORE being used?				
28	Are Standard Operating Procedures being followed for Induction of Labour and progress of labour?				
OUTCOME					
29	Is Maternal mortality rate monitored?				
30	Is still birth rate monitored?				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.8 ICU

Intensive Care, Neonatal/ Pediatric ICU and High Dependency Units					
Name of the Hospital:					
Sr. No			**Yes / No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is the required equipments available (Crash cart, Defib, oxygen cylinder, multi para monitors, central line connection, ventilator, pulse oximetre, oxygen concentrator				
2	Qualified and trained nurses available.				
3	Is air condition available				
4	Is fowler's bed available				
PROCESS					
5	Are the admission and discharge criteria for ICU and high dependency units defined?				
6	Is the staff trained to apply these criteria?				
7	Are the infection control practices documented and followed?				
8	Is the quality assurance programme documented and implemented?				
9	Procedures for situation of bed shortages are defined and followed?				
10	Do the policies and procedures guide the care of patients under restraints?				
11	Are the reasons for restraints				

	documented?				
12	Is the patient under restrain frequently monitored?				
13	Is the staff aware about the end of life care policy?				
14	Are the policy for initial assessment and re-assessment of patient documented and present?				
15	Does the Initial assessment include screening for nutritional needs?				
16	Is the time frame for doing and documenting initial assessment defined?				
17	Is the frequency of reassessment defined and followed by the staff?				
18	Does the documented policies and procedures on uniform use of resuscitation present?				
19	Is the staff trained on resuscitation?				
20	Are the documented policies and procedures for rational use of blood and blood products available?				
21	Is the informed consent obtained before donation and transfusion of blood and blood products?				
22	Are the patient and family educated about donation?				
23	Are the post transfusion reaction monitored and analyzed for preventive and corrective actions?				
24	Is the scope of pediatric services defined				

	and displayed?				
25	Does who care for children have age specific competency?				
26	Is there a written order for the diet?				
27	Is the nutritional therapy planned and provided in a collaborative manner?				
28	Are emergency medications available all the time and replenished in a timely manner when used?				
29	Are the medication orders written in a uniform location and are clear, legible, dated, timed, named and signed?				
30	Is a written order for high risk medication done?				
31	Do the policies and procedures guide the monitoring of patients after medication administration?				
32	Is the medication administration documented?				
33	Is the policy for patient's medications brought from outside the organization available?				
34	Knowledge to pick adverse drug events and reporting of the same?				
35	Does the policy and procedure guide the use of narcotic drugs and psychotropic substances?				
36	Are the narcotic drugs stored in a safe manner?				

37	Is a proper record kept for the usage, administration and disposal of narcotic drugs?				
38	Is the antibiotic policy adhered and followed by the staff?				
39	Is the infection control data collected?				
40	Availability of various HAI rates of that area and action taken report?				
41	Is the layout of beds, its spacing, visual privacy appropriate?				
42	Are all the equipments periodically inspected and calibrated?				
43	Service labels on Equipment and calibration records present?				
44	Is the Information exchanged and documented during transfers between units/departments?				
45	Documented procedures guide the referral of patients to other departments/ specialties?				
46	Qualified individual identified as responsible for the patient's care?				
47	Is a policy in place for LAMA patients and patients being discharged on request?				
48	Is the policy for care of vulnerable patients available?				
49	Does the organization provide a safe and secure environment for the vulnerable patients?				
50	Is the informed consent obtained by a				

	surgeon prior to the procedure?				
51	Are the instructions for proper hand washing displayed and followed by the staff?				
52	Are the adequate PPE like gloves, masks available and used by the staff?				
53	Isolation /Barrier nursing facility available?				
54	Is the Segregation of bio-medical waste done as per the guidelines?				
55	Is the policy for obtaining consent present?				
56	Does the procedure describe who can give consent when patient is incapable of independent decision making?				
OUTCOME					
1	Re intubation rate				
2	ICU utilization				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.9 OT

Checklist for Operation Theatre					
Name of the Hospital:					
S. No.		**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is HVAC System present inside OT				
2	Is proper Zoning concept followed(Clean zone, protective zone, sterile zone, and disposal zone)				
3	Is the number of OT tables present in the hospital appropriate for the daily load				
4	If any OT has got more than one OT table				
5	Does the OT have a hand washing facility				
6	Is the fire fighting system available in the unit				
7	Is continuous water available for the unit?				
8	Is the changing room available for the doctors and nurses				
9	Is there a continuous power back up for OT				
10	Does the OT have a crash cart				
11	Does the OT have defibrillator				
12	Does the OT have an ECG monitor				

13	Does the OT have oxygen supply				
14	Does the OT have shadow less OT light				
15	Is the staff provided with the personnel protective devices				
16	Is scrubbing area present for the OT staff				
PROCESS					
17	Is the consent for the surgery and anesthesia taken from the patient				
18	Is the OT list prepared				
19	Is the OT booking being done				
20	Is the preparation of patient done before the operation				
21	Does the nurse enter the patient details in the OT register				
22	Are the number of OT instruments counted before and after operation				
23	Is OT disinfection done after every procedure				
24	Is the pre anesthesia check up done by the anesthetists				
25	Is pre, intra, post operative notes are documented				
26	Is infection control practices being followed in OT				
27	Is pre operative checklist being followed				

28	Is bio medical waste management practices being followed				
OUTCOME					
29	Is % of anesthesia related adverse events being monitored				
30	% of anesthesia related mortality				
31	% of modification in plan of anesthesia				
32	% of unplanned ventilation following anesthesia				
33	Is % of Surgical site infection rate monitored				
34	Re Exploration rate				
35	Re scheduling of surgeries				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 10 BLOOD BANK

Checklist for Blood Bank					
Name of the Hospital:					
Si. No	**Description**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is the required layout available: (Reception, examination room, bleeding room, refreshment room, blood separation and storage area and doctors room?)				
2	Is power back up available				
3	A full time qualified Blood Bank In-charge manages the blood collection/distribution department.				
4	A couch/cot is provided during venipuncture & the correct equipment for blood agitation/ volume measurement is present				
5	Refrigerators, insulated carrier boxes with ice pack, warmers, Bio mixers, Tube scale, Component separator if applicable, Thawing bath, Centrifuge and freezers are in adequate quantity				
6	Blood bank signage and schedule of charges are displayed				
7	Blood Bank Technician is present				
8	Nurse is present				
9	All sections have bilingual signage				
10	Separate counseling section is present				
PROCESS					

11	Is bilingual consent for blood donation available				
12	If patients are educated and given counseling.				
13	Donors are appropriately screened prior to blood donation.				
14	Evidence is present that blood is cross matched, labeled, recipient identified, compatibility level noted, units dispensed.				
15	Refrigerators, warmers and freezers must have temperature monitoring devices which are monitored daily				
16	A list of all department staff exist and is prominently displayed				
17	Is Policies and procedures for blood bank available				
18	Appropriate disposal of blood and blood products are done as per BMW management rules				
19	A blood collection/issue register exists.				
20	Is blood transfusion committee in existence				
21	Donated blood is labeled appropriately with adhesive labels.				
22	Register of all recipient adverse reactions to blood and blood products are maintained				
23	Data collected regarding recipient adverse reactions is collated, analyzed and reported to the blood transfusion committee.				
24	Work instructions are visibly displayed and prominent				
OUTCOME					
25	% of transfusion reactions				

26	% of blood and blood products wastage				
27	% of component usage				
28	Turnaround time for issue of blood and blood products.				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 11 PHARMACY

Checklist for Pharmacy					
Name of the Hospital:					
Si. No	**Description**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	The racks are available in sufficient number to store the items				
2	There is adequate ventilation and lighting in the department				
3	There is a security system available at the department				
4	Fire detecting & fire fighting systems are available at department				
5	There is no water seepage/ dampness				
6	All items storage areas are marked and labeled				
7	There is a receiving area; segregation and storing area				
8	Is refrigerator for storing medicines(2-8 degree C) available				
9	Is qualified and trained staff available				
10	Provision for storage of narcotic drugs(double lock and key system)				
PROCESS					

11	The items are labeled & arranged as per alphabetical order.				
12	Pest/rodent control measures are regularly under taken				
13	Is stock register maintained properly				
14	Verification of stock is done every six months.				
15	Is sound Inventory control practices followed (ABC, VED, FSN,FIFO)				
16	General items required by the hospital are purchased from vendors registered by management				
17	Is there a Drugs and therapeutics committee in the hospital?				
18	Is hospital drug formulary available				
19	Is adverse drug reactions are analyzed				
OUTCOME					
20	% of local purchase				
21	% of stock outs				
22	% of variation from the procurement process				
23	% of goods rejected before GRN				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 12 BIOMEDICAL WASTE MANAGEMENT

Checklist for Biomedical Waste Management					
Name of the Hospital:					
Sl.No	**Check Points**	**Yes**	**No**	**Evidence**	**Remarks**
	STRUCTURE				
1	Availability of colour coded Foot operated Bins at point of BMW generation				
2	Availability of coloured plastic bags				
3	Display of work instructions at the point of segregation				
4	Is needle destroyer present				
5	Availability of PPE(Personal Protective Equipments) with biomedical waste handlers				
6	Availability of sodium hypochlorite solution and puncture proof boxes				
7	Availability of safe mode of transportation				
8	Is Temporary storage area available				
	PROCESS				
9	Is segregation of BMW at point of generation				
10	Is the route for transportation of waste separate from the general traffic area				
11	Is there provision of regular health checkup for staff of this unit?				
12	Usage of PPE by staff is being practiced				
13	Is Annual report submitted to UP PCB				
14	Is monitoring done for the amount of BMW generated				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 13 HOSPITAL INFECTION CONTROL

Audit Checklist for HIC					
Name of the Hospital:					
S.No		**Yes**	**No**	**Evidence**	**Remarks**
INFRASTRUCTURE					
1	A designated and qualified infection control nurse(s) is present?				
2	Adequate and appropriate facilities for hand hygiene in all patient care areas Provided?				
3	Are adequate and appropriate personal protective equipment, soaps, and disinfectants available?				
4	A designated infection control officer is present?				
PROCESS					
5	Does the hospital implements policies and/or procedures to prevent infection in these areas?				
6	Does the organization adhere to standard precautions at all times?				
7	Equipment cleaning, disinfection and sterilization practices as polices?				
8	An appropriate antibiotic policy is established and implemented?				

9	Hospital adheres to laundry and linen management processes?				
10	Hospital adheres to kitchen sanitation and food handling issues?				
11	Does the hospital have appropriate engineering controls to prevent infections?				
12	Does the hospital adhere to mortuary practices?				
13	Is the infection prevention and control programme updated at least once in a year?				
14	Is the HIC surveillance data collected regularly?				
15	Is the Verification of data done on a regular basis by the infection control team?				
16	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities?				
17	Tracking and analyzing of infection risks, rates and trends				
18	Do the surveillance activities include monitoring the effectiveness of housekeeping services?				
19	HAI rates monitored?				
20	Appropriate feedback regarding HAI rates provided on a regular basis to appropriate personnel?				

21	A hospital infection control committee and team are formed?				
22	Are the personal protective equipment used correctly by the staff?				
23	Compliance with hand hygiene guidelines monitored?				
24	Documented procedure for identifying an outbreak present?				
25	Implementation of laid down procedure done?				
26	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items?				
27	Isolation / barrier nursing facilities are available?				
28	Appropriate personal protective equipment used by the BMW handlers?				
29	Visit by the hospital authorities to the disposal site done and documented?				
30	Does the hospital makes available resources required for the infection control programme				
31	Does the organization earmarks adequate funds from its annual budget for infection control activities?				

32	Appropriate “in-service” training sessions for all staff at least once in a year conducted?				
33	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members?				
OUTCOME					
34	UTI rate				
35	VAP rate				
36	SSI rate				
37	Central line associated blood stream infection rate				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 14 CSSD / TSSU

Checklist for CSSD / TSSU					
Name of the Hospital:					
SL.NO	**CHECK POINTS**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is sufficient space available(0.75sq mts/bed)				
2	Does the layout follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing?				
3	Autoclaves are present?				
4	Calibration of pressure meter of autoclave is done?				
5	Racks are present in the department?				
6	Technician is present in CSSD?				
7	Sterilizer drums are present?				
8	Is decontamination solution present?				
9	Transport trolley present for items?				
PROCESS					
10	CSSD sterilization register present? (receipt/Issue)				
11	Labeling of drums in CSSD				

	takes place?				
12	Is chemical, biological and bowie-dick test performed				
13	If recall system of items followed				
14	If reuse policy for items available				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 15 BIOMEDICAL ENGINEERING

Audit Checklist for Biomedical Equipment Management: Equipment, Medical Gases, Vacuum System etc.					
Name of the Hospital:					
SR. No		**Yes**	**No**	**Evidence**	**Remarks**
INFRASTRUCTURE					
1	Does bio medical engineering department exist				
2	Does the department is managed by a qualified person				
3	Is Central supply system for bio medical gases exist				
4	Is Safety devices available				
5	Is the department manned by 24 hours				
PROCESS					
6	Preventive maintenance and calibration				
7	Review of Preventive Maintenance record as per checklist like Anesthesia ventilator, IABP etc.				
8	Traceability of calibration report				
9	Is there a documented procedure for equipment replacement and disposal?				
10	Equipments are inventoried and proper logs are maintained as required.				
11	Training of staff when new equipment is installed (HRM 3b)				
12	Documented Preventive and breakdown				

	maintenance plans				
13	Color coding of pipelines				
OUTCOME					
14	% of downtime of critical equipments				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 16 ENGINEERING AND MAINTENANCE

Checklist for Facility Management: Engineering and Maintenance					
Name of the Hospital:					
SR. No	**Check points**	**Yes**	**No**	**Evidence**	**Remarks**
	STRUCTURE				
1	Various statutory requirements				
	o Fire				
	o Diesel storage				
	o Liquid oxygen and storage of medical cylinders.				
	o Boiler				
	o Lift				
	o Water (ETP/STP)				
	o Air (DG sets)				
2	Up to date drawing, layout, escape route present and displayed?				
3	Various required signage's displayed?				
4	Designated individual for maintenance present?				
5	Presence of staff round the clock for emergency repairs				
6	Alternative source of water and electricity				
7	Availability of (personnel) safety devices				
8	Availability of safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC)				

PROCESS					
9	Mechanism for renewing licenses				
10	Preventive and break down maintenance plan implemented?				
11	Alternate sources and their checking done?				
12	Response time monitored?				
13	Water quality reports				
14	Are staff using safety devices				
15	Facility inspection rounds twice a year in patient care areas and once in non-patient care areas				
16	Documentation of facility inspection report				
17	Safety education program for all staff				
18	Safety committee present				
19	Is staff trained for disaster management and fire management				
20	Are the mock drills conducted at periodic intervals and documented				
OUTCOME					
21	Number of variations observed during mock drills				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 17 STORE

CHECKLIST FOR STORE					
Name of the Hospital:					
Si. No	**Description**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	The racks are available in sufficient number to store the items				
2	There is adequate ventilation and lighting in the department				
3	Is there a qualified/ trained personnel available				
4	Fire detecting & fire fighting systems are available at department				
5	There is no water seepage/ damp in the store				
6	There is a receiving area; segregation and storing area				
PROCESS					
7	The items are labeled & arranged at designated place.				
8	Items such as radiographic films, spirits etc (which are inflammable) are stored in a separate location.				
9	Inventory recording system is present either computerized or				

	on register				
10	Frequently used items are arranged and located in most easily accessible area.				
11	Pest/rodent control measures are regularly under taken				
12	Lead time in issuing material to the department are recorded				
13	Stock Turnover details are calculated on a monthly basis.				
14	If sound inventory control practices followed (ABC/VED/FSN/FIFO)				
15	Is condemnation policy followed?				
16	Is there a purchase and condemnation committee in the hospital?				
17	A comparative list of rates of potential suppliers maintained				
OUTCOME					
18	% of stock outs				
19	% of goods rejected before preparation of GRN				
20	% of variation from procurement process				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 18 KITCHEN/DIETARY

Checklist for Kitchen/Dietary Services					
Name of the Hospital:					
Sl. No.	**Check Points**	**Yes**	**No**	**Remarks**	**Evidence**
STRUCTURE					
1	Does the layout follow the functional flow: Receiving, storage, preparation, distribution and cleaning?				
2	Is there continuous water supply (Hot/ Cold) to this unit?				
3	Is adequate drainage system present in this unit?				
4	Is there DG power supply to this unit?				
5	Dedicated refrigeration areas exist to ensure food preservation				
6	Is dedicated food storage area exist				
7	Are measures for fire detection/fire fighting installed in this unit?				
8	The person responsible for this department is a qualified dietician or has supervision from a consultant dietician.				
PROCESS					
9	Health check up of all staff is done at least once a year.				
10	Record maintained for food materials				
11	If nutritional Assessment done for all the patients				

12	Diet Sheet is prepared by Dietician as per the treating Doctors instruction on the patient's case sheet.				
13	Each patient's Case sheet are checked by doctor and dietician and changes made in their diet depending on their condition				
14	Food distribution to patients occurs in covered trolleys				
15	Is infection control practices followed				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.19 HUMAN RESOURCE

CHECKLIST FOR HUMAN RESOURCE					
Name of the Hospital:					
S. No.	**Check Points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is the HR department present				
2	Are racks available to store the documents?				
PROCESS					
3	HR Manpower planning				
4	job description and specification				
5	HR recruitment				
6	HR induction and training				
7	HR record keeping				
8	HR welfare-staff & family				
9	Performance appraisal				
10	Disciplinary procedure				
11	Staff grievance redressal				
12	Mention the types of forms available in this department?				
13	If pre employment health checkup and annual health check up is being done				
14	Is Training In-charge present in the hospital?				

15	Is regular training conducted by the hospital?				
16	Is credentialing and privileging of doctors and nurses being done				
17	Are records of training being maintained?				
	OUTCOME				
18	Employee attrition rate is monitored?				
19	Is the employee absenteeism rate monitored				
20	% of employee provided pre exposure prophylaxis				
21	Is employee satisfaction survey being done and analyzed?				
22	% of employee who are aware of employee rights and responsibilities and welfare schemes				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.20 MEDICAL RECORDS DEPARTMENT

CHECKLIST FOR MEDICAL RECORDS DEPARTMENT					
Name of the Hospital:					
S. No.	**Check Points**	**Yes**	**No**	**Evidence**	**Remarks**
	STRUCTURE				
1	Is the sufficient space for medical record department available				
2	Is proper ventilation present in the department				
3	Is the fire fighting system available in the unit				
4	Is qualified and trained MRD technician available in the department				
5	Is table and chair provided to the MRD technician				
6	Is adequate number of racks available for the storage of records				
	PROCESS				
7	Is the functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing				
8	Is ICD coding method used for complete and incomplete files				
9	Are the MLC cases/dead cases stored separately under lock and key				
10	Is the retrieval of the records easy				
11	Is deficiency checklist is followed				

12	Is MRD Committee available ?				
13	MRD audits is being conducted				
14	Are the records kept under lock				
15	If the hospital has retention policy for documents				
16	Are the forms and formats standardized				
17	Is the destruction policy for records available				
18	Is pest control done on a regular basis				
OUTCOME					
19	Is number of births/deaths monitored				
20	Is number of diseases notified to the local authority				
21	% of missing records				
22	% of records with ICD codification done				
23	Percentage of medical records not having discharge summary				
24	Percentage of medical records not having consent form				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.21 LINEN/LAUNDRY

Checklist for Linen and Laundry Management					
Name of Hospital:					
S. No.	**Check points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Number of linens as per no of beds (3 sets)				
2	(If laundry services are in house) Is there continuous water supply to this unit?				
3	(If laundry services are in house) Is adequate drainage system present in this unit?				
4	Is disinfectant available for infected linen? Specify the name				
5	Separate covered trolley for transporting dirty linen & washed linen available?				
6	Heavy duty rubber gloves, mask available to the linen handlers				
PROCESS					
7	Are linen items being replenished when contaminated?				
8	Are linens are changed at least once daily?				
9	Segregation of soiled &contaminated linen is being done				
10	Sluicing of soiled linen is being done? (Specify location where sluicing is being done – ward or laundry)				
11	Packing of the soiled &contaminated linens in separate bags & labeling/color coding is				

	being done				
12	The number and type of linen handed over is entered on the dirty linen register				
13	Linens are transported in covered trolley				
14	The number and type of linen handed over to the laundry by the ward boy is entered in laundry register.				
15	The clean linen is handed over to the ward boy against the received sign of Ward boy in the same laundry register.				
16	The ward boy is handing over the clean linen to the nurse In charge in the ward against the issue register.				
17	Disinfection of decontaminated linen (Especially high risk areas) done				
18	Dirty linens & clean linens are stored in separate areas				
19	Are they following hand washing practices?				
20	Are they using disinfectant while washing contaminated linens?				
21	PPE are used by staff while handling soiled linens?				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 22 HOUSEKEEPING

Checklist for Housekeeping Department					
Name of the Hospital:					
S. No.	**Check Points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Does the housekeeping being provided with the personal protective equipment(dedicated gownslippers/masks/gloves/head cover)				
2	Does the housekeeping staff have basic facilities like (toilet/drinking water/change room)				
PROCESS					
3	Are the hand washing and floor washing agent being used?				
4	Is the house keeping staff being trained in the infection control practices				
5	Is staff using PPE				
6	Is daily cleaning schedule available				
7	Are the staff aware about the preparation of cleaning solutions				
8	Is the pest control methods being practiced				
9	Is the medical examination of staff being done periodically				

Name of the person interacted to gather data/information: ……

Signature of the person:

10. 23 SECURITY

Checklist for Security					
Name of the Hospital:					
Si. No	**Description**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is there a separate security room for security guards to work from?				
2	Is there a system of telephone connectivity from Emergency room?				
3	Is the room manned by at least one Security guard round the clock?				
4	Does the Emergency Room have a separate Security Guard?				
5	Are the main entrances to the hospital buildings and Labour Room manned by Security Guards?				
PROCESS					
6	Does the duty hour of the security guard cover peak working hours?				
7	Is there a roster for the security guards prominently displayed?				
8	Do the security guards report daily to the security in charge?				
9	Do the security guards wear				

	uniforms while on duty?				
10	Do the security guards restrict unauthorized entry of patients and relatives to the restricted areas of the hospital?				
11	Are the outgoing items checked and entered on a register?				
12	Are the security persons trained in disaster and fire management				
OUTCOME					
13	No. of thefts and security related incidents				

Name of the person interacted to gather data/information: ……

Signature of the person:

10.24 MORTUARY

Checklist for Mortuary					
Name of the Hospital:					
Sl. No.	**Check Points**	**Yes**	**No**	**Evidence**	**Remarks**
STRUCTURE					
1	Is this unit present in the hospital?				
2	Is freezer available for dead bodies				
3	Is calibration and maintenance is done regularly				
4	Cold storage and back-up power available?				
5	Are measures for fire detection/fire fighting installed in this unit?				
PROCESS					
6	Is temperature being regularly monitored				
7	Is there any process of infection control followed				

Name of the person interacted to gather data/information: ……

Signature of the person:

MANPOWER

Sl. No	Designations	Sanctioned	NABH Norms	Actual	Vacant/ Surplus (Sanction - Actual)	Vacant (NABH)
DOCTORS						
1	Chief Medical Superintendent/ Equivalent					
2	Medical Specialist (General Medicine)					
3	General Surgery Specialists					
4	Obstetrics & Gynaecology specialist					
5	Dermatologist /Venereologist)					
6	Paediatrician					
7	Anaesthesiologist					
8	ENT Surgeon					
9	Ophthalmologist					
10	Orthopedician					
11	Radiologist					
12	Pathologist & Blood Bank In-charge					
13	Medical Officer					
14	Dental Surgeon					
15	AYUSH					

SUB TOTAL						
NURSING STAFF						
1	Matron/Nursing Superintendent					
2	Nursing In-charge					
3	Staff Nurse					
4	Nursing Orderly					
SUB TOTAL						
PARAMEDICAL STAFF						
1	Dental Mechanic					
2	OT Technician					
3	OT assistant					
4	Lab Supervisor					
5	Laboratory Technician (Lab +BB)					
6	Laboratory Attendant (Hospital Worker)					
7	Radiographer					
8	Dark Room Assistant					
9	ECG Technician					
10	Optometrist					
11	Physiotherapist					
12	CSSD Technician					
13	Ophthalmic Assistant					

14	Maternity assistant (Dai)					
SUB TOTAL						
PHARMACIST						
1	Pharmacist					
SUB TOTAL						
KITCHEN						
1	Dietician					
2	Cook					
3	Cook Assistant					
4	Cook Bearer					
SUB TOTAL						
ADMINISTRATIVE						
1	Bio Medical Engineer					
2	Engineer					
3	Office Superintendent					
4	Accountant/Asst. accountant					
5	Office Clerk					
6	Registration Clerk					
7	Store keeper					
8	Medical Records Clerk					
9	Mortuary Attendant					

10	Electrician					
11	Plumber					
12	Sr. Assistants					
SUB TOTAL						
CLASS 4						
1	Mali					
2	Choukidar					
3	Dhobi					
4	Tailor					
5	Housekeeping Supervisor					
6	Class IV					
7	Driver					
8	Security					
SUB TOTAL						
TOTAL						

Name of the person interacted to gather data/information: ……

Signature of the person: