Internship Training

At

Rungta Hospital, Jaipur

(Feb 3,2014 to May 3, 2014)

"GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FOR NABH PREPAREDENESS"

By

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Under the guidance of

Mr. S.C.Tiwari & Mrs. Pooja Purohit

Post Graduate Diploma in Hospital and Health Management

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International Institute of Health Management Research

New Delhi

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Certificate Of Approval

The following dissertation titled "**GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FOR NABH PREPAREDENESS**" " at **"Rungta Hospital, Jaipur** 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.

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This is to certify that **Ms. Shweta Choudhary,** a graduate student of the **Post- Graduate Diploma i Health and Hospital Management** has worked under our guidance and supervision. She submitting this dissertation titled "**GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FO NABH PREPAREDNESS**" at "**International Institute of Health management Research**, Ne Delhi" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma i Health and Hospital Management.**

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

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TO WHOMSOEVER MAY CONCERN

This is to certify that Ms. Shweta Choudhary 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 Rungta Hospital, Jaipur from 03 Feb 2014 to 03 May 2012.

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 fulfilment of the course requirements.

I wish her all success in all his future endeavours.

9/5/14

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FEEDBACK FORM

Name of the Student: MS. SHWETA CHOUDHARY

Dissertation Organisation: RUNGTA HOSPITAL, JAIPUR

Area of Dissertation: Administration, HR

Attendance: 86%

Objectives achieved: MET

Deliverables: NABH PREPAREDNESS COMMUNICATION, PRESEN
HRD INVOLVEMENT (RECRUITMENT, SALARY COMPUTATIO
SOFTWARE UNDERSTANDING, OPERATIONAL WORK)

Strengths: Hardworking, Sincere, Committed. Confident.

Suggestions for Improvement: - Needs to improve her knowledge on quality improvement in the hospitals.

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertat

6/05/14

Date:
Place:

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06.05.2014

Certificate of Dissertation Completion

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The certificate is awarded to **Ms. Shweta Choudhary, D/o Mr. Ram Pal Singh,** in recognition of having successfully completed her Internship in the department of Administration and Human Resource Department.

And has successfully completed her Project on **"GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FOR NABH PREPAREDNESS"** at **"RUNGTA HOSPITAL, JAIPUR"** from **03 Feb. 2014 to 03 May 2014.**

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 endeavors.

6/05/14

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled .Gap...Analysis....Of..Rungta Hospital.., JAIPUR....For...NABH....Preparedeness..... ..... and submitted by (Name) Ms.....Shweta. ....Choudhary..... Enrollment No. ...PG-12-084..... under the supervision of .....Dr....B..S..Singh..... for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from .03.Feb.,2014 to ...03.May..,2014 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.

Shweta

Signature

[SHWETA CHOUDHARY]

ABSTRACT

Topic: GAP analysis for Rungta Hospital, Jaipur for NABH Preparedness.

Key word: Gap analysis, structure, processes, Outcome and standards, NABH.

Back ground: This study is a Gap analysis which is the first and initial step in the review of the available service management. It is an efficient base to know the deficient areas of the hospital system. The study identifies the significant gaps in terms of Structure, Process and outcome on all the observed non clinical areas of hospital. Then the gaps are reviewed and analysed on the basis tracer checklist prepared by using NABH standards.

Objectives: To prepare RUNGTA HOSPITAL, JAIPUR to be accredited by The National accreditation Board for Hospitals & Healthcare Providers (NABH).

Methodology: Evaluation is done on the parameters of structure, Process and outcome. Information regarding the organization's location, history, manpower, organizational hierarchy, Standard Operating Procedure, Legal Compliances applicability with current working and future plans of implementation will be identified for non clinical services such as housekeeping, Front Office, pharmacy , Linen & Laundry, Medical Records Department, Human resource department. A score of 5, 0, 10 is given against each objective element by using NABH checklist.

Findings: Through analysis it is clear that the hospital is fulfilling the pre-accreditation progressive level criteria. We compare findings by using NABH tracer methodology checklist, with the second evaluation criteria and find that the average rating score for the department Housekeeping and Human resource is having average score less than 7 and the front office, medical record, linen and laundry and pharmacy is having average rating score more than 7. So it is fulfilling the requirement for preparedness for accreditation of NABH. Regular monitoring and audits should be done to keep up the compliance rate that in turn strengthens the existing service delivery system of the hospital.

Recommendations: there are major gaps in the implementation part as the documentation work has been done up to some extent. As of now the hospital is fulfilling the required criteria to some extent.

ACKNOWLEDGEMENT

I take this opportunity to express my profound gratitude and deep regards to my mentor Dr. B.S. Singh at IIHMR New Delhi for his exemplary guidance, monitoring and constant encouragement throughout the course of this project on "**GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FOR NABH PREPAREDENESS**".

From the very core of my heart I would like to thank Mr. S.C.Tiwari and Mrs. Pooja Purohit for his overwhelming support, guidance and cooperation in every aspect either professional or personal from the very first day at Rungta hospital, Jaipur. His dynamic personality and inclusive approach impresses every person who comes in his touch. Without his guidance this project work could never have been done.

My words end to acknowledge the debt of my family. Thanks to Almighty for giving a place in this wonderful world and the opportunity called –LIFE.

SHWETA CHOUDHARY

PG/12/084

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Abbreviations

S. No.	Abbreviated form	Full form
1.	AAC	Access, Assessment and Continuity of care
2.	FMS	Facility Management System
3.	HIC	Hospital Infection Control
4.	HMIS	Hospital Management Information System
5.	HRM	Human Resource Management
6.	IIHMR	International Institute of Health Management Research
7.	IMS	Information Management System
8.	MOM	Management Of Medication
9.	NABH	National Accreditation Board for Hospitals and Healthcare Providers
10.	PRE	Patient Right and Education
11.	ROM	Responsibilities Of Management
12.	HK	Housekeeping
13.	LAMA	Left Against Medical Advice
14.	MLC	Medico legal case
15.	NCI	Nursing Council Of India
16.	MCI	Medical Council Of India
17.	UHID	Unique Hospital Identity
18.	MSDS	Material Safety Data Sheet
19.	SOP	Standard Operating Procedure
20.	AMC	Annual Maintenance Contract
21.	CMC	Comprehensive Maintenance contract
22.	ICD	International classification Of Diseases

INTERNSHIP REPORT

HOSPITAL PROFILE

RUNGTA HOSPITAL, JAIPUR

VISION

To be the most reliable health care provider in society with premium medical skills carried with state of art for enhancing the quality of life of present and upcoming generations.

MISSION

To offer cost effective and quality services that meet international standards.

To deliver quality care with Highest Concern, Greatest Compassion, Latest technology by finest team.

LOGO

RUNGTA HOSPITAL
Serving Mankind

VALUES

1. Services
2. Patient first
3. Integrity
4. Respect
5. Team work

OPD- 20 Chambers

- Collection room
- Procedure Room
- May I Help You counter
- Waiting Area

Bed Strength – 90

Details of Beds

Department/Ward	Number of Bed
ICU	20 (including two beds for isolation ICU)
HDU	03
ER	05
Semi-Suits	02
Super Deluxe	04
Deluxe	01
Deluxe Double Sharing	06
Deluxe Triple Sharing	03
Triple Sharing	06

General Ward (M)	14
General Ward (F)	07

Mother and Child Care Unit

Labour Waiting	**03**
Labour Room	02 (Two Tables)
OW	05
NICU	09

FACILITIES AT HOSPITAL

Waiting area	**Separate Waiting Lobby with space for waiting in OPD Wing a**
Retiring area	32 Bed area with ventilation, air-cooling, sufficient number of toile bathrooms with Clock rook is provisioned.
Privacy in General Wards	Complete Privacy
Bed Quality	New beds procured are fouler beds with side railing made of Fiber
Parking	Sufficient car parking (for 25 cars) with tiles and separate two whe parking is provided with tiles
Cafeteria	24X7 Cafeteria catering for patient, attendant and staff meals and s
Garden	In addition to the normal Grass lawn an elevated Garden with prov of utilization of the same as waiting area with regulated vehicle flo
Hospital Entry	Front Entry with beautiful ambiance
Temple	The Temple is shifted to the North East corner of the land in front main gate with more space and better architecture and as per Vastu
Water Coolers with RO Water	4 Water coolers with RO Water supply are placed on convenient pl for utilization by the beneficiaries.

Cooling System	Centralized Air conditioning in OPD area and Centralized Air Cooling system for General Wards (Male & Female)
Lifts	Two lifts 1. Trolley cum passenger 2. Bed cum passenger
Sample Collection Room	Separate Sample Collection cabin provided near lab
Stores	One Central Store with sufficient storage capacity have been provided.
Provisioning of Stores on Floors	Separate space for storage of material has been provided with each ward/department.
MRD Facilities	Separate MRD Room have been designated and the same is utilized for keeping the records
Medical Store	Medical Store catering for all medicines in an area of 20' X 16' adjacent to the cafeteria have been provisioned.
Staff Change Room	Separate Staff Change Room with Toilets for Male & Female Nursing Staff have been provided on the Mezzanine Floor
Laundry	Separate laundry is provided in backyard of Hospital

Internship Report

Introduction

I did my internship from Rungta Hospital, Jaipur for the period of three months from February 3 to May 3, 2014. Three month of extensive internship provides me with the chance to meet different set of people within and outside the organization. This gives an inside view about the hospital services as a whole. I come to know the practicalities of the healthcare set up that moulds us for the future undertakings.

During my study period besides doing project work I was involved in many ongoing activities in the hospital. Tasks performed and key learning's are as listed:

1. **Analysis of Attendants feedback form –** Patient is the sole consumer of the hospital services and, along with patient, attendant also interacts with the various departments of the hospital especially when patient is in unconscious state or in critical condition. In such cases it is the attendant who judges the services and makes an opinion. Attendants being so crucial must be satisfied and this influenced me to work on this project. In this attendant complaints were tracked by assessing feedback forms filled at the time of discharge. The complaints from

the feedback forms were consolidated and further segregated according to concerned departments to identify the major issues and major departments to work on. After identification of complaints, recommendation for major issues was given.

2. **Working in HR Department -** While working in HR areas of learning are
    - Salary computation. (To compute employee's salary and compliances (PF and ESI). Learn how to calculate Overtime of the employees).
    - Understand the working of the Hospital HR software i.e. Macpay which is a payroll software.
    - Involved in HR recruitment and manpower planning.
    - Monitoring of the attrition rate of the employees and formulation of Exit Interview form.

3. Working on NABH Preparedness – The hospital has provided a framework for quality assurance and quality improvement, while focusing on patient safety and quality of care. These include a strong culture of safety that has been inculcated, a decrease in the incidence of adverse events, and constant monitoring of quality within the system. The aim is to ensure that the hospital follows all the standards and guidelines in accordance to NABH.

NABH sensitization programme to the staff is done solely by me.

- Formulation of chapter champions and preparing of departmental sop's and procedure.
- Document all needs and requirements in form of Policies , Procedures / SOPs , Protocols , define indicators and methods of audits / reviews , initiate and coordinate for Corrective/ Preventive actions .
- Preparing tools for the Capturing the data.
- Analyzing and assessing quality assurance on the basis of captured data.
- Comparing the results of the assessment with defined criteria's.
- Taking steps to improve quality on the basis of this assessment of captured data.
- Identify the standard benchmarks, understand and ensure that all have understood their departmental benchmarks.

Dissertation

on

"GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FOR NABH PREPAREDENESS"

"GAP ANALYSIS OF RUNGTA HOSPITAL, JAIPUR FOR NABH PREPAREDENESS"

EXECUTIVE SUMMARY:

The GAP analysis for Rungta Hospital, Jaipur was conducted. 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. A visit to hospital premises and personal interviews of all categories of hospital staff was organized during this period. The purpose was to assess the functional areas of hospital services with a view of preparing the hospital for NABH Accreditation.

Hospital Care system has been broadly divided into two categories specifically for this hospital. This includes base line assessment of the hospital as per normal workflow and basic system and processes followed and other criteria includes quality parameters followed in the department which includes documentation and assessment by the way of indicators. The gap analysis was done with the help of Tracer methodology by using NABH 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 departments were calculated. Then these were checked against the evaluation criteria. It was found that the analysis results matched with the required criteria and there were few gaps. Mainly the gaps were in the department of Human Resource and Housekeeping department. Therefore, great effort and focus is required for fulfilling the gaps found and preparing the hospital for accreditation.

INTRODUCTION

Focus on quality health care has increased greatly because of intention for Health Promotion, Patient Safety, and increasing consumer awareness. Market forces, such as medical tourism, Insurance and corporate sector have accelerated the demand for quality in healthcare services. Hospital accreditation has established comprehensive voluntary standards of health care service. In fact, those hospitals without NABH accreditation will lose out on their credibility and even be excluded from any form of currently universally available subsidy, loans, exemptions from notified taxes and duty payments, empanelment's etc. RUNGTA HOSPITAL, JAIPUR is in the 1st phase i.e. preparatory phase of NABH accreditation program. Therefore Gap Assessment was carried out for preparing RUNGTA HOSPITAL, JAIPUR. Through gap analysis the hospital will be able to attain the standards prescribed by the NABH.

The process of identifying gaps and completion of gaps will strive towards the journey of Accreditation. The advantage to the hospital would be its national recognition as a Quality Care hospital. Patients are the biggest beneficiary. Analyzing gaps and 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 will regularly evaluate.

DEFINITION AND SCOPE OF STUDY:

NABH ACCREDITATION:

National Accreditation Board For Hospitals And Healthcare Professionals (NABH) is a constituent board of QCI (Quality Council of India), set up with co-operation of the Ministry of Health and Family Welfare, Government Of India and the Indian Health Industry. This Board caters to the much desired needs of the consumer and will set standards for progress of the Health Industry.

Patients are the biggest beneficiaries from the NABH Accreditation, as it results in a high quality of care and patient safety. The patients get services by credential medical staff. It also helps the staffs of the hospital as it provides continuous learning and good working environment.

NABH Accreditation to a hospital stimulates continuous improvement. It enables the hospital in demonstrating commitment to quality care and raises the community confidence in the services provided by the hospital. It also provides opportunity to bench mark with the best.

NABH Standards for hospitals and health care providers has 10 chapters with 103 standards and 636 objective elements which are all related to the important functions like patient centred, hospital centred, community centred, and environment centred of the hospitals.

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.

PURPOSE FOR NABH ACCREDITATION:

The main purpose of NABH accreditation is to help planners to promote, implement, monitor and evaluate robust practices in order to ensure that occupies a central place in the development of the health care system.

Current policies and process for health care are inadequate or not responsive to ensure health care services of acceptable quality and prevent negligence. Problem range from inadequate and inappropriate treatment, excessive use of higher technologies, and wasting of scarce resource, to serious problems of medical malpractices and negligence.

Quality assurance should help improves effectiveness, efficiency and in cost containment, and should address accountability and the need to reduce errors and increase safety in the system.

Thus the objective of NABH accreditation is on continuous improvement in the organizational and clinical performance of health services, not just the achievements of a certificate or award or merely assuring compliance with minimum acceptable standards.

REQUIREMENTS FOR NABH ACCREDITATION:

NABH standards for hospitals have been drafted by technical Committee of the NABH and contain complete set of standards for evaluation of hospitals for grant of accreditation. The standards provide framework for quality assurance and quality improvement for hospitals. The standard focus on patient safety and quality of patient care. The standards are equally applicable to hospital and nursing homes in the government as well as in the private sector.

Patients are increasingly and appropriately aware of healthcare issues and desires participation in decisions affecting their health. The ultimate responsibility of a health care system is to the patient. Adherence of high standards, such as those related to

timeliness of treatment, diagnostic accuracy, clinical relevance of the tests performed and interventions, qualifications and training of personnel, and prevention of errors, is an ethical responsibility of all hospital staff.

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.

GAP ANALYSIS:

Gap analysis is a component of the preparatory phase of NABH ACCREDITATION PROGRAMME. It is a tool that helps an organization to compare its actual performance with its potential performance. At its core are two questions “where are we?” and “where do we want to be?”

The goal of gap analysis is to identify the gap between the optimized allocation and integration of the inputs, and the current level of allocation. This helps provide the company with insight into areas which could be improved. The gap analysis process involves determining, documenting and approving the variance between business requirements and current capabilities. Once the general expectation of performance in the industry is understood, it is possible to compare that expectation with the organisation's current level of performance. This comparison becomes the gap analysis. Such analysis can be performed at the strategic or operational level of an organization. Gap analysis is a

formal study of what the organization is doing currently and where it wants to go in the future.

This study will help to identify various gaps in the hospital and enable the staff to take necessary actions towards improvement and implementation as per the NABH standards.

PROBLEM STATEMENT:

Gap analysis is a technique which uncovers any shortfalls 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 organisation'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 organisation current operations and the desired state and which area is likely to be more responsive to improvement efforts.

JUSTIFICATION

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.

AIM OF THE STUDY :

To prepare RUNGTA HOSPITAL, JAIPUR to be accredited by The National accreditation Board for Hospitals & Healthcare Providers (NABH).

Objectives:

1. To assess the existing service delivery standards of the hospital.

2. To identify the baseline level gap of all quality indicators (Structure, process and outcome).
3. To suggest measures/procedures for improvement so as to meet the requirements.

Research Question:

1. To study the manpower deployment against any pre set norms appropriate to the needs as per the requirement of NABH.
2. To indicate the gap in the terms of manpower, equipments etc
3. To facilitate carrying out internal audit as per NABH standards for the facilities.

REVIEW OF LITERATURE:

The National Accreditation Board for Hospitals & Healthcare Providers (NABH) Standards is today the highest benchmark standard for hospital quality in India. Though developed by the Quality Council of India on the lines of International Accreditation Standards like the JCI, ACHS and the Canadian Hospital Accreditation Standards, the NABH is however seen as a more practical set of Standards, topical and very relevant to India's unique healthcare system requirements.

NABH standards: A standard is a statement that defines the structures and processes that must be substantially in place in an organization to achieve outcome and enhance the quality of care.

Patient centred standards

1. Access, Assessment and Continuity of Care (AAC)
2. Care of Patients (COP)
3. Management of Medication (MOM)
4. Patient Rights and Education (PRE)
5. Hospital Infection Control (HIC)

Organization cantered standards

1. Continuous Quality Improvement (CQI)
2. Responsibilities of Management (ROM)
3. Facility Management and Safety (FMS)
4. Human Resource Management (HRM)
5. Information Management System (IMS)

Within just 2 years of its launch, the Indian Accreditation Standards, the NABH was accepted by ISQUA, the International Society for Quality Assurance in Healthcare, as an International Accreditation on par with the world's best.

More important than the infrastructure, it is essential to know if the hospital has a documented process for its healthcare activities. Patient care not only involves the core clinical care, but also other support activities like requisition of tests, medicines, nurse doctor coordination, infection control practices, training, and so on. These need to run seamlessly in the background to provide the best experience to the patient and the relative.

The changing health care environment with revised hospital accreditation guidelines have sharpened the clinical and administrative hospital staff's concern for evaluating the quality of care they provide. Clinicians now see accreditation standards as a framework by which organizational processes will be improved and their patients will receive better care. Physicians and administrators now must face the challenge of establishing comprehensive and vigorous systems of quality assurance and learn to avoid the traps that impede implementation of such systems. Quality assurance is a very simple process that deals with finding problems and fixing them.

A comprehensive definition of quality health care would be, "The optimal achievable result for each patient, the avoidance of physician-induced (iatrogenic) complications, and attention to patient and family needs in a manner that is both cost effective and reasonably documented."

The management and the safety of the hospital facility is an important part of quality improvement and patient safety. The following literatures review attempts to demonstrate and support the study.

1. **Dr. Santosh Kumar, Brig. (Dr.) Swadesh puri, Dr. S.D. Gupta in a study of Gap Analysis Report for rehabilitation Centre** has found that is mainly a destitute centre having 20 beds for disable patients. Even Though it is housed in poly clinic various sub specialities (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 within the centre. The general housekeeping services is very bad, all toilets are broken and sinking. Wards are crowded and lack proper ventilation. Most of the bed linen was dirty. There is shortage of drugs. ICD classification is not in practice. Its lacks quality control measures. There is no Disaster plan for the hospital.
2. **Dr. Santosh kumar, Brig.(Dr.) Swadesh puri, Dr. S.D. Gupta in a study of Gap Analysis report for Ishtakal Hospital have defined two kinds of gaps**
    - Infrastructure related gaps
    - 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

equipments and instruments.

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.

RESEARCH METHODOLOGY

Information regarding the organization's location, history, manpower, organizational hierarchy, Standard Operating Procedure, Legal Compliances applicability with current working and future plans of implementation will be identified for non clinical services such as housekeeping, Front Office, pharmacy , Linen & Laundry, Medical Records Department, Human resource department.

A schedule of visit to the identified area for gap analysis and proceedings to complete the gaps will be prepared and quality coordinator of that respective department will contacted for regular evaluation and implementation.

The observational findings and the information collected compiled and a report will be prepared.

Research Design: - Descriptive study.

Tools Of Data Collection:-

Primary data: -

- Observation.
- Structured interview(Interaction with concerned authorities)
- Gap analysis tools.

Secondary data: - Hospital policy, procedures and records.

Limitation Of Study

1. Only 6 non-clinical services are assessed for Gap analysis.
2. Resistance of staff towards training – Initially when training programs were started the staff showed resistance to attend the trainings.
3. Resistance towards documentation – As per NABH proper documentation of activities is required. But the staff showed resistance to accept it.

Evaluation Criteria:

The assessment of RUNGTA Hospital, Jaipur as per NABH norms has been done by using the self assessment toolkit. The following criteria are used for analysing gaps:-

- Structure
- Process
- Outcome

Tracer Methodology by using NABH checklist.

The following criteria are used for scoring: Compliance to the requirement – 10
Partial compliance – 5
Non Compliance – 0
Not applicable – NA

Analysis

To analyze the findings we compare our findings with the evaluation criteria of NABH so that we can get useful results.

Evaluation Criteria:
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.

GAPS ANALYSIS OF DEPARTMENTS

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 department
3. The average score of all standards

These scores and the findings of each department are being assessed on the basis of Pre-accredited entry and Pre-accredited progressive level evaluation criteria.

Evaluation on the basis of Structure, Process and Outcome :-

1. HUMAN RESOURCE DEPARTMENT

HUMAN RESOURCE DEPARTMENT				
Name of the Hospital: RUNGTA HOSPITAL,JAIPUR				
S. No.	Check Points	Yes/ No	Evidence	Remarks
			STRUCTURE	
1	Is the HR department present	Yes	Signage is present for HR department.	HR department is located in the hospital on the upper basement. department is adjacent to the Di room.
2	Are racks available to store the documents?	Yes	2 Almirahs are present in department.	Racks are available but not suffi
			PROCESS	
3	HR Manpower planning	Yes	Documented Manpower planning evidenced.	On the basis of requirement ger by the department.
4	job description and specification	Yes	Employee's records.	Present in employees file and w employees. Employees are awar their job description and specifi
5	HR recruitment	Yes	It is documented and in practice also.	

6	HR induction and training	Yes	Policy for induction and training is present.	Feedback mechanism is not there in process.
7	HR record keeping	Yes	All documents are there in employees file.	Records are kept both in MIS and MANUAL form.
8	HR welfare-staff and family	Yes	employees records.	Discount policies, ESI Schemes are there for employees.
9	Performance appraisal	Yes	Evidence regarding documents present.	Annual increment for employees is present. Quaterly increment of nursing department is done.
10	Disciplinary procedure	Yes	Policy is present.	Employee's uniform is not present.
11	Staff grievance redressal	Yes	Policy is not present.	Internal compliant committee is present.
12	Mention the types of forms available in this department?	Yes	Interview application form, joining form, personal information form, leave application form, no-dues form.	Forms are available but documentation control does not exist**.**
13	If pre employment health check-up and annual health check up and police verification of the employees is being done	No		It is in process.
14	Is Training In-charge present in the hospital?	Yes	There is no Training in-charge.	Policy is there. Documentation is not present.
15	Is regular training conducted by the hospital?	Yes	There is no Training Manual	KRA is there.

16	Is credentialing and privileging of doctors and nurses being done	Yes	Documentation regarding this is evident.	Employees record
17	Are records of training being maintained?	Yes	Adherence is not present.	Tracking of Training Plan & Training Calendar for employee is not evident. Attendance is taken for every training session.
OUTCOME				
18	Employee attrition rate is monitored?	Yes	**Attrition rate is calculated, but filling of exit interview form is not in practice.**	
19	Is the employee absenteeism rate is monitored?	No	Not Monitored	
20	% of employee provided pre exposure prophylaxis	No	Not Monitored	
21	Is employee satisfaction survey being done and analyzed?	No	Not Monitored	
22	% of employee who are aware of employee rights and responsibilities and welfare schemes	No	Not Monitored	

2. HOUSE KEEPING DEPARTMENT:

HOUSE KEEPING DEPARTMENT				
Name of the Hospital: RUNGTA HOSPITAL,JAIPUR				
S. No.	**Check Points**	**Yes/ No**	**Evidence**	**Remarks**
STRUCTURE				

1	Does the housekeeping being provided with the personal protective equipment(dedicated gown/slippers/masks/gloves/head cover)	yes	Housekeeping staff are being provided PPE	Housekeeping staff working in critical and non critical areas are provided with gloves, gown, mask and hardcover however other G.D.A are only having gloves.
2	Does the housekeeping staff have basic facilities like (toilet/drinking water/change room)	yes	There s no separate facility for G.D.A staff combined facility is there.	No designated change room is provided.
PROCESS				
3	Are the hand washing and floor washing agent being used?	yes	Liquid soap for hand washing. Phenyl, sodium hypochlorite are used for floor cleaning.	
4	Is the house keeping staff being trained in the infection control practices	Yes	Training records	New H.k.Staff is not aware of Infection control practices.
5	Is staff using PPE	Yes	All the H.K. Staff wearing PPE.	All the staff found to be using PPE like gloves but Head cover and Mask is only evident on 1st and 2nd floor G.D.A
6	Is daily cleaning schedule available	yes	Documentated schedule plan for cleaning is there.	
7	Are the staff aware about the preparation of cleaning solutions	yes	Training regarding preparing 1% Sodium Hypochlorite solution is given.	
8	Is the pest control methods being practiced	yes	Whole hospital building is cover on daily basis.	
9	Is the medical examination of staff being done periodically	yes	Medical examination is done once in a year.	Hepatitis B injection is injected to all the G.D.A's

3. PHARMACY DEPARTMENT :

PHARMACY DEPARTMENT				
Name of Hospital- RUNGTA HOSPITAL, JAIPUR				
Sl. No	**Description**	**Yes/ No**	**Evidence**	**Remarks**
		STRUCTURE		
1	The racks are available in sufficient number to store the items	Yes	Big size racks are available in pharmacy.	
2	There is adequate ventilation and lighting in the department	Yes	Cooling is not proper. Lighting system and ventilation is good.	It is not centrally conditioned
3	There is a security system available at the department	Yes	Camera is available	Scanning is not p and physical chec also not carried o
4	Fire detecting & fire fighting systems are available at department	Yes	Mock drill and training are not carried out	2 Fire extinguish present of A,B,C category
5	There is no water seepage/ dampness	Yes	Partially dampness is there.	Partially dampne there in ceiling.
6	All items storage areas are marked and labelled	Yes	Classification of drugs not evidenced.	Labelling requir for some of the d maintained at the dispensing count
7	There is a receiving area; segregation and storing area	Yes	Area is available but short in space	There is no dema area for receiving segregation.

8	Is refrigerator for storing medicines(2-8 degree C) available	Yes	No temperature display on refrigerators	Temperature Charting for refrigerator not practicing.
9	Is qualified and trained staff available	Yes	5 employees are working in medical store and all are certified pharmacist.	
10	Provision for storage of narcotic drugs(double lock and key system)	Yes	Narcotic drug stored in double lock and key system.	Policy and procedures for storage of narcotics is defined, however proper implementation need to be required.
PROCESS				
11	The items are labelled & arranged as per alphabetical order.	Yes	Items are found arranged in alphabetical order. Drugs are stored according to generic name.	Labelling on some items is found damage.
12	Pest/rodent control measures are regularly under taken	Yes	Thrice in a week spray of pest control is done.	Entries in register are not found updated.
13	Is stock register maintained properly	Yes	Register is there in medical store.	Register not received for reviewing.
14	Verification of stock is done every six months.	Yes	Policy is there.	
15	Is sound Inventory control practices followed (ABC, VED, FSN,FIFO)	Yes	VED analysis not followed in the Pharmacy.	SOP's regarding the purchase of items is available(must follow economic order quantity(EOQ)
16	General items required by the hospital are purchased from vendors registered by management	Yes	Items procured by registered vendors only. Medical store is having list of vendors.	In case any item is not available with any of registered vendors then it is purchased by local other vendors(in emergency only)

17	Is there a Drugs and therapeutics committee in the hospital?	No	Drugs and therapeutics committee is not yet formed.	
18	Is hospital drug formulary available	Yes	Drug formulary available however not in used and clinical practice and requires updation.	
19	Is adverse drug reactions are analyzed	Yes	Adverse drug reporting form is not available hence no reporting is done.	
OUTCOME				
20	% of local purchase	No	Not Calculated	
21	% of stock outs	No	Not Calculated	
22	% of variation from the procurement process	No	Not Calculated	
23	% of goods rejected before GRN	No	Not Calculated	

4. LINEN & LAUNDARY DEPARTMENT:

Checklist for Linen and Laundry Management				
Name of Hospital:- RUNGTA HOSPITAL				
S. No.	**Check points**	**Yes/ No**	**Evidence**	**Remark**
STRUCTURE				
1	Number of linens as per no of beds (3 sets)	Yes	250 linens functionally are there in hospital.	Shelf life of lin Days after the discarded.
2	(If laundry services are in house) Is there continuous water supply to this unit?	Yes	Bore well connection facility is there.	
3	(If laundry services are in house) Is adequate drainage system present in this unit?	Yes	Proper sewage system is there.	
4	Is disinfectant available for infected linen? Specify the name	Yes	Sodium hypochlorite 1% is used as disinfectant.	

5	Separate covered trolley for transporting dirty linen & washed linen available?	No	Use of trolley is not in process.	G.D.A picks linen manually and takes to the laundry.
6	Heavy duty rubber gloves, mask available to the linen handlers	Yes	H.K staff is provided with PPE and they use gloves while handling the dirty linen.	
PROCESS				
7	Are linen items being replenished when contaminated?	Yes	Linen is Discarded.	
8	Are linens are changed at least once daily?	Yes	On daily basis linen is changed in all the wards.	
9	Segregation of soiled &contaminated linen is being done	Yes	All the linens are collected from wards and segregated on the basis of soil, dirty and infected linen.	There is no process of segregating the linen at the point of generation of dirty linen.
10	Sluicing of soiled linen is being done? (Specify location where sluicing is being done – ward or laundry)	No	Laundry is in Backyard of the Hospital and a room is not designated for sluicing the linen	
11	Packing of the soiled &contaminated linens in separate bags & labelling/color coding is being done	Yes	Infected linen is carried in yellow poly bags with proper labelling as infected linen, floor name, patient name	
12	The number and type of linen handed over is entered on the dirty linen register	Yes	Entry is being done by H.K. supervisor.	
13	Linens are transported in covered trolley	No	Trolley is not in use.	Packing is made and transported manually.
14	The number and type of linen handed over to the laundry by the ward boy is entered in laundry register.	Yes	Entry is evident and maintained properly.	Entries are found updated.

15	The clean linen is handed over to the ward boy against the received sign of Ward boy in the same laundry register.	Yes	Entries are evident.	
16	The ward boy is handing over the clean linen to the nurse In charge in the ward against the issue register.	Yes	Register is present and the appropriate entries are also mentioned.	
17	Dirty linens & clean linens are stored in separate areas	Yes	Separate room is there for storing clean linen.	
18	Are they following hand washing practices?	Yes	Display of hand hygiene practices is there in all the nursing station.	Somehow they know the hand hygiene washing protocols but few nursing and housekeeping staff is not aware of the washing protocols.
20	Are they using disinfectant while washing contaminated linens?	Yes	It is being done by 1% sodium hypochlorite	
21	PPE are used by staff while handling soiled linens?	Yes	Gloves mask and head covers are being used by them.	

5. MEDICAL RECORD DEPARTMENT:-

CHECKLIST FOR MEDICAL RECORDS DEPARTMENT				
Name of Hospital:- Rungta Hospital				
S. No.	**Check Points**	**Yes/ No**	**Evidence**	**Remarks**
STRUCTURE				
1	Is the sufficient space for medical record department available	No	Space is not enough and proper maintained.	
2	Is proper ventilation present in the department	Yes	Provision of exhaust fan is there but atmosphere is not comfortable.	

3	Is the fire fighting system available in the unit	No	Fire fighting equipments are not available in department.	
4	Is qualified and trained MRD technician available in the department	Yes	MRD In charge is qualified in MRD Diploma.	
5	Is table and chair provided to the MRD technician	Yes	2 chairs are there in MRD department and a table with computer is available in department.	
6	Is adequate number of racks available for the storage of records		The racks in the department is not sufficient to manage the patient records	
PROCESS				
7	Is the functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing	Yes	MRD In charge receives patient files after 48 hours of patient discharge. Then files are check for deficiency and if files are found to be incomplete then files are sent back to the nursing station for deficiency correction thereafter coding is done.	
8	Is ICD coding method used for complete and incomplete files	Yes	Legal reporting to NRHM is having ICD coding for the death case mentioned. ICD coding on patient file is not in practice.	
9	Are the MLC cases/dead cases stored separately under lock and key	Yes	MLC files are completed and are differentiated from other patient files and kept in almirah.	
10	Is the retrieval of the records easy	Yes	All the files are arranged in chronological order of number.	
11	Is deficiency checklist is followed	Yes	Deficiencies are identified but documentation needs to be improved.	

12	Is MRD Committee available?	Yes	Committee Meetings are recorded and appropriate follow up is carried out.	
13	MRD audits is being conducted	Yes	Records are reviewed as per the defined committee meetings. Any frequent / scheduled audit is not in practice.	
14	If the hospital has retention policy for documents	Yes	Department is having requisition slip which is to be filled by the department.	
15	Is the destruction policy for records available	Yes	Policy is available.	
16	Is pest control done on a regular basis	Yes	Pest control is done on daily basis.	
OUTCOME				
17	Is number of births/deaths monitored		Not Monitored	
18	Is number of diseases notified to the local authority		Not Monitored	
19	% of missing records		Not Monitored	
20	% of records with ICD codification done		Not Monitored	
21	Percentage of medical records not having discharge summary		Not Monitored	
22	Percentage of medical records not having consent form		Not Monitored	

6. FRONT OFFICE DEPARTMENT:-

Checklist for front office Department				
Name of hospital:- RUNGTA HOSPITAL, JAIPUR				
Sl. No	**Description**	**Yes/No**	**Evidence**	**Remarks**
STRUCTURE				
1	The racks are available in sufficient number to store the items	Yes	Racks are available in sufficient number to store files, report and documents.	
2	There is adequate ventilation and lighting in the vicinity of Front Office department	Yes	Atmosphere is soothing and comfortable (central A.C is present)	
3	Signages are available in Bilingual language.	Yes	Signage's are displayed in bilingual	
4	Fire detecting & fire fighting systems are available at department	Yes	2 Fire extinguishers are present.	
5	Patient Rights and Responsibilities are displayed.	Yes	Displayed in bilingual in corridor.	
6	Mission statement is displayed.	Yes	Vision, Mission and Values are displayed in Front office.	Displayed in English la only.
PROCESS				
7	Prior fixing of appointment	Yes	Policy is present for fixing appointments of patient and done successfully.	
8	Are Training schedule prepared for staff.	Yes	Training regarding patient rights and responsibilities are available but not in continuous practice.	
OUTCOME				

9	Monitoring of waiting time for consultation is captured	No	Not monitored.	
10	Monitoring of patient satisfaction survey is done	Yes	Patient Satisfaction feedback form is tracked and accordingly corrective and preventive action is taken.	

FINDINGS

Tracer methodology by Using NABH Checklist:-

Table 1:- Checklist of Human Resource Department:

Standard	**Objective Element**	**score**
HRM 1a-d	Human resource planning	10
	Job specification/Job description for each category of staff	10
	Criminal /negligence antecedents verification of the potential employee	10
HRM 2a-h	Documented procedure for recruitment of staff	5
	Pre-defined criteria of recruitment	10
	Induction training	5
	o Orientation to vision, mission and goals	5
	o Policies and procedures	5

	o Rights and responsibilities-patient and employee	5
	o Service standards(code of conduct)	5
	o Performance appraisal (HRM 5b)	10
HRM 3a-d	Training policy, Training identification, Training calendar	5
	Training records	5
	Training effectiveness(for e.g.:-on new equipments)	5
	· Training feedback for assessment of training programme and tool to improve the training programme	0
	Training requirements as per the standard	5
	o CPR (COP 4b)	
	o Blood and blood products (COP 7a,h)	
	o Vulnerable patients (COP 9e)	
	o Restraint techniques (COP 15e)	
	o End of life care (COP 20e)	
	o Infection control (HIC 9c,d)	
	o Quality improvement (CQI 1e)	
	o Safety (CQI 2f)	
	o Fire and non-fire emergencies (FMC 5c)	
	o Disaster management (FMS 7d)	
	o Hazardous materials (FMC 8e)	
	o Occupational safety (HRM 4d)	
HRM 4a,b,c,d	Training on risks	5
	Staff demonstrate and take actions to report, eliminate / minimize risks	5
	Awareness of procedures to follow in the event of an incident	5
	Training on occupational safety aspects	5

HRM 5a-e	Documented performance appraisal system	10
	Employees are aware of Appraisal system at the time of induction.	5
	Frequency of appraisal at pre-determined criteria	10
	Used as tool for further development	10
HRM 6a-g	Documented disciplinary procedure based on principles of natural justice and in consonance with laws	10
	Documented grievance handling mechanism (committee)	10
	Provision of appeal	5
	Redressal procedure to addresses the grievance	5
	Actions for grievance redressal	5
HRM 7a-d	Pre-employment medical examination	0
	Medical benefits for employees	10
	Regular health check (at least once a year) of staff involved in patient care. Health check of employees exposed to radiation as per statutory requirements	0
	Occupational health hazards(PPE)	5
HRM 8a-d	Personal file for every employee containing information on	10
	o Educational qualification, Disciplinary background, Health status.	10
	o In service training and education	10
	o Performance appraisal	10
HRM 9a-f	Credentialing of doctors	10
	Updating of credentials	5
	Verification where appropriate	10
	Privileging of doctors	10
	Communication of same	10
HRM 10a-f	Credentialing of nurses	10
	Updating of credentials	5

	Verification where appropriate	10
	Privileging of nurses	5
	Communication of same	5
ROM 2b	Policy on prevention of sexual harassment (committee)	5

Table 2:- The scores and the findings of Human resource department are being provided below:

DEPARTMENT:- HUMAN RESOURCE	
STANDARDS	AVERAGE SCORES
HRM 1	10
HRM 2	6.25
HRM 3	4
HRM 4	5
HRM 5	8.75
HRM 6	7
HRM 7	3.75
HRM 8	10
HRM 9	8.75
HRM 10	7.5
ROM 2	5
DEPARTMENT AVERAGE	**6.9**

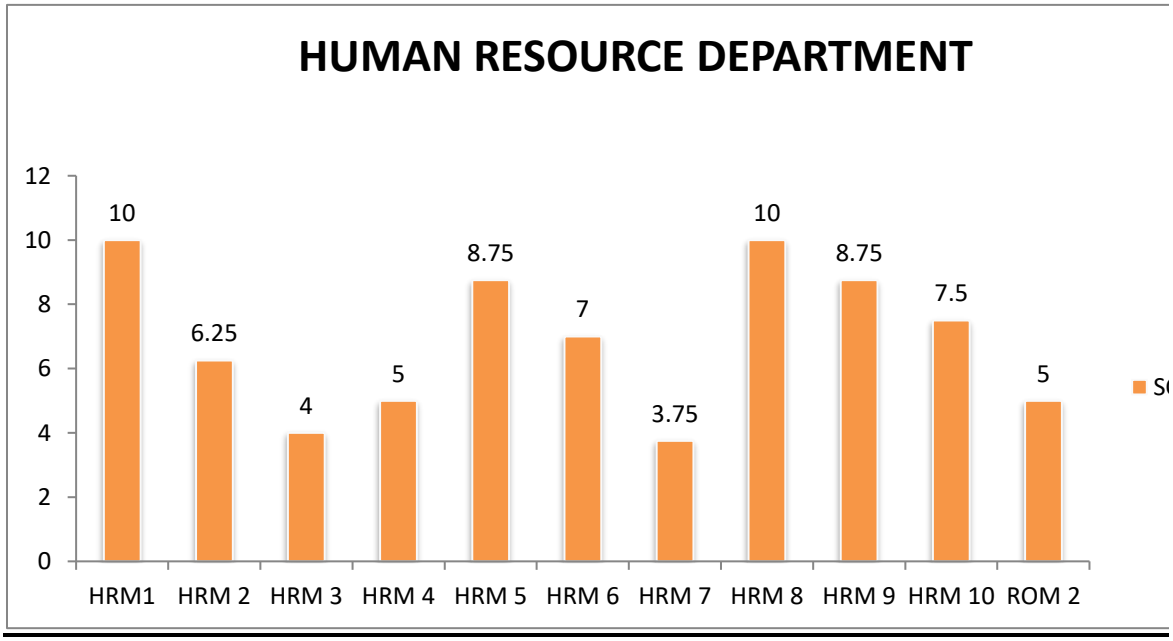

Figure1:- Score for HR department.

Table 3 :- Checklist of Housekeeping department:

Standard	Objective Element	Score
HIC 2f	The organisation adheres to cleaning, disinfection and sterilization practices.	10
HIC.2h	The organization adheres to laundry and linen management processes.	5
HIC 2k	Adherence to housekeeping procedures	10
HIC 3f	Effectiveness of housekeeping services	5
FMS 8a-e	Identified hazardous materials	10
	Hazardous materials identified have documented procedure for sorting, labelling, storing, handling, transportation and disposal etc.	5
	Availability of MSDS for all hazardous materials	5
	Spill management plan of hazardous materials	5
	Staff awareness	5

Table 4 :- The scores and the findings of Housekeeping department are being provided below

DEPARTMENT:- HOUSE KEEPING	
STANDARDS	AVERAGE SCORE
HIC 2	8.33
HIC 3	5
FMS 8	6
DEPARTMENT AVERAGE	**6.44**

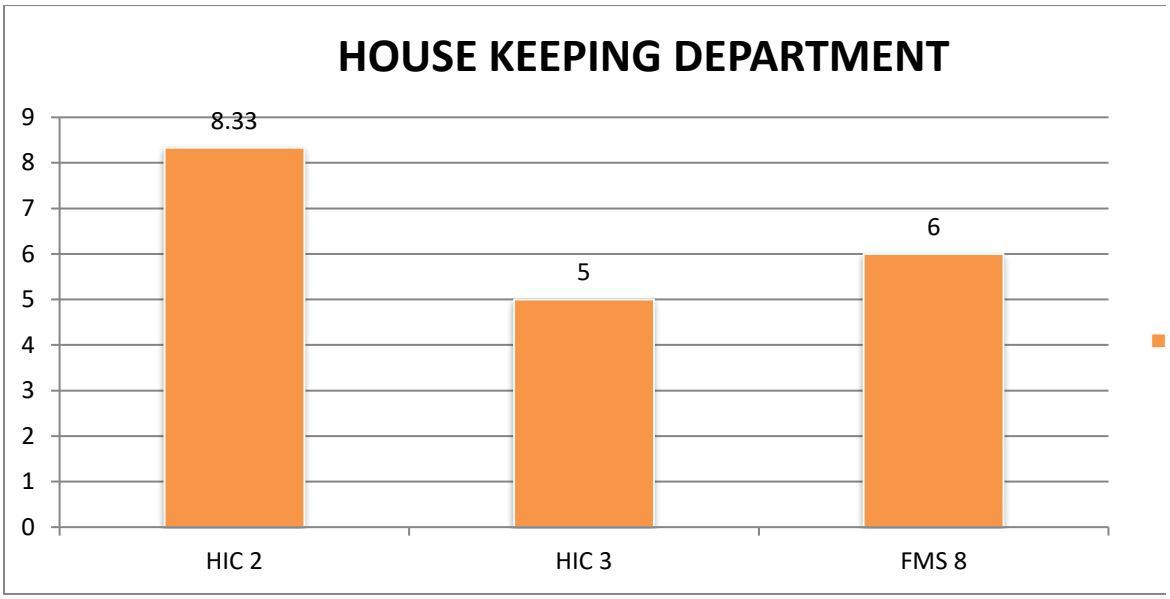

Figure 2:- score for housekeeping department.

Table 5:- Checklist for pharmacy department:

Standard	Objective Element	score
MOM 1a,b,c,d	· Documented policies and procedures on medication procurement, storage, formulary, prescription, dispensing, administration, monitoring etc.	5
	· Separate license for the pharmacy.	10
	· Multidisciplinary committee	0
	· Duty roster to ensure that there is a qualified pharmacist at all times (his/her name being mentioned in the license)	10
	· Procedure to obtain medications when the pharmacy is closed	10
MOM 2a,b,c,d,e	· Hospital formulary	5
	· List is developed and collaborate updated by multidisciplinary committee.	0
	· Defined process of procurement of medicine and to obtain non- listed medicines	5

	· Availability of Formulary for clinicians to refer and adhere to	5
MOM 3a-g	· Documented policies and procedures for storage	10
	· Storage of medicines in clean, well lit and ventilated environment and/or as per manufacture's requirement	5
	· Inventory control practices like FIFO	10
	· Identification and storage of sound alike and look alike drugs	5
MOM 4a-l	· Identified high risk medicines	5
MOM 5a-f	· Procedures for safe dispensing of medicines	10
	· Medication recall procedure	10
	· Expiry date check before dispensing	10
	· Procedure for near expiry medications	10
	· Proper labelling on medicines	5
	· Verification of High risk medication orders before dispensing	5
MOM 8a-c	· Documented procedure on near miss, medication error and adverse drug event	5
	· Near miss, medication error and adverse drug event are defined	5
	· Reporting of near miss, medication error and adverse drug event within a specified time frame.	5
MOM 9a,b,d	· Procedure for narcotic drugs, Storage, Proper record, Handling	10
PRE 5a	· Patient and family educated on:- o safe and effective use of medication o potential side effects of the medication o food drug interactions	10

Table 6 :- The scores and the findings of Pharmacy department are being provided below

DEPARTMENT:- PHARMACY	
STANDARDS	AVERAGE SCORE
MOM 1	7
MOM 2	3.75
MOM 3	7.5
MOM 4	5
MOM 5	8.33
MOM 8	5
MOM 9	10
PRE 5	10
DEPARTMENT AVERAGE	7.07

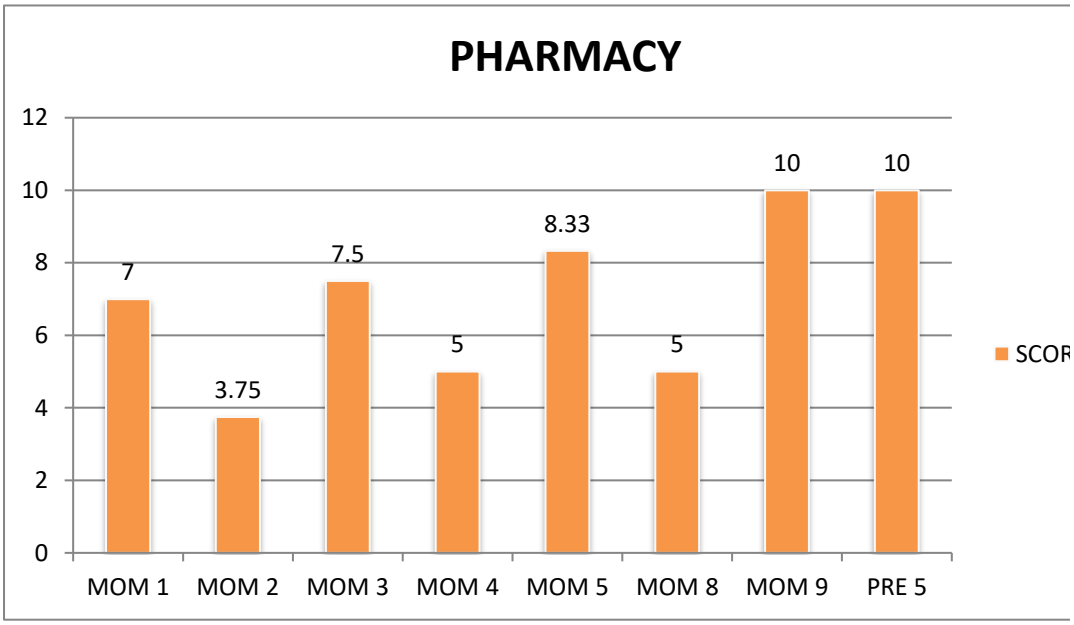

Figure 3: Score for Pharmacy department.

Table 7:- Checklist of Linen & Laundry department:

STANDARDS	**OBJECTIVE ELEMENT**	**score**
HIC 2h	· Laundry and linen management processes	10
	· Process flow	10
	· Segregation of linen	5
	· Disinfection	5

	· Bags and labels	10
	· Quality control system	5
	· Quality control of outsourced activity (if outsourced)	NA
FMS 2a,i	· Layout / space	10
	· Maintenance plan of machinery	10
FMS 3g,f	· Electrical safety practices	10
	· Staff awareness on safety practices	5
FMS 8a-e	· Identified hazardous materials	10
	· Hazardous materials identified have documented procedure for sorting, labelling, storing, handling, transportation and disposal etc.	10
	· Spill management plan of hazardous materials	10
	· Staff awareness	5

Table 8:- The scores and the findings of line and laundry department are being provided below:

DEPARTMENT:- LINEN & LAUNDARY	
STANDARDS	AVERAGE SCORE
HIC 2	8
FMS 2	10
FMS 3	7.5
FMS 8	8.75
DEPARTMENT AVERAGE	**8.56**

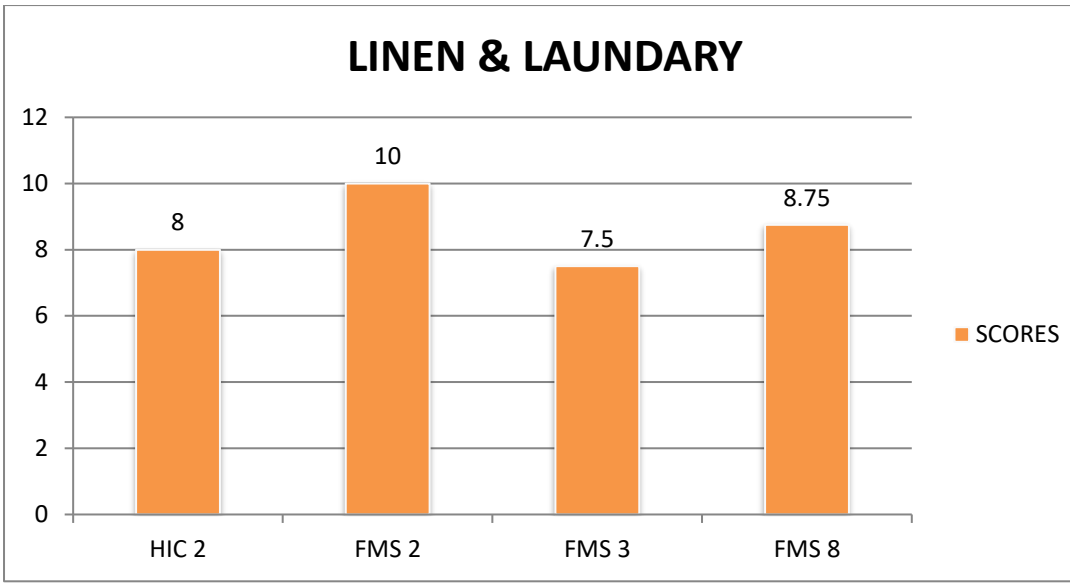

Figure 4 : - score for Linen and laundry department.

Table 9:- Checklist of Medical record department.

Standard	Objective Element	score
IMS 3a-g	· Medical record unique number	10
	· Policy on authorized person to make entry	10
	· Every entry is named, signed, dated and timed	5
	· Author is clear	5
	· Contents of medical record are identified and documented	5
	· Records are up to date and chronologically arranged	5
	· 24-hour availability of the patient's record to healthcare providers to ensure continuity of care	10
IMS 4a-h	· Medical record has reason for admission / diagnosis/ plan of care.	5
	Operative and other Procedure sheet	10
	· Medical record contains the results of tests carried out and the care provided	5
	· Transferring patients medical records have date of transfer/reasons/name of receiving hospital	10
	· Signed Discharge note/copy of death certificate with cause, date and time of death	10
	· Copy of clinical autopsy report (where applicable)	10

	· Access to current and past medical record	10
IMS 5a-g	· Security, integrity and confidentiality of data and information	10
	· Safeguarding data/ record against loss, destruction and tampering	0
	· Technology used for improving/maintaining confidentiality, security and integrity	10
	· Usage of privileged health information	10
	· Documented policies and procedures on how to handle MR information requirement	10
IMS 6a-d	· Retention policy of patient's clinical records, data and information	10
	The policies and procedures are in consonance with the local and national laws and regulations.	5
	· Maintenance of confidentiality and security at all stages	10
	· Method for destruction of medical records, data and information	10
IMS 7a-g	· Medical record audit	5
	o Active and discharged patients records	5
	o Deficiencies identified and documentation of same	5
	o Corrective and preventive actions undertaken	5
AAC 13b,c	· Medico legal case documentation	10
	· LAMA case file has discharge summary and risks explained	10

Table 10:- The scores and the findings of medical record department are being provided below:

DEPARTMENT:- MEDICAL RECORD	
STANDARDS	AVERAGE SCORES
IMS 3	7.14
IMS 4	8.57
IMS 5	8
IMS 6	8.75
IMS 7	5
AAC 13	10
DEPARTMENT AVERAGE	**7.91**

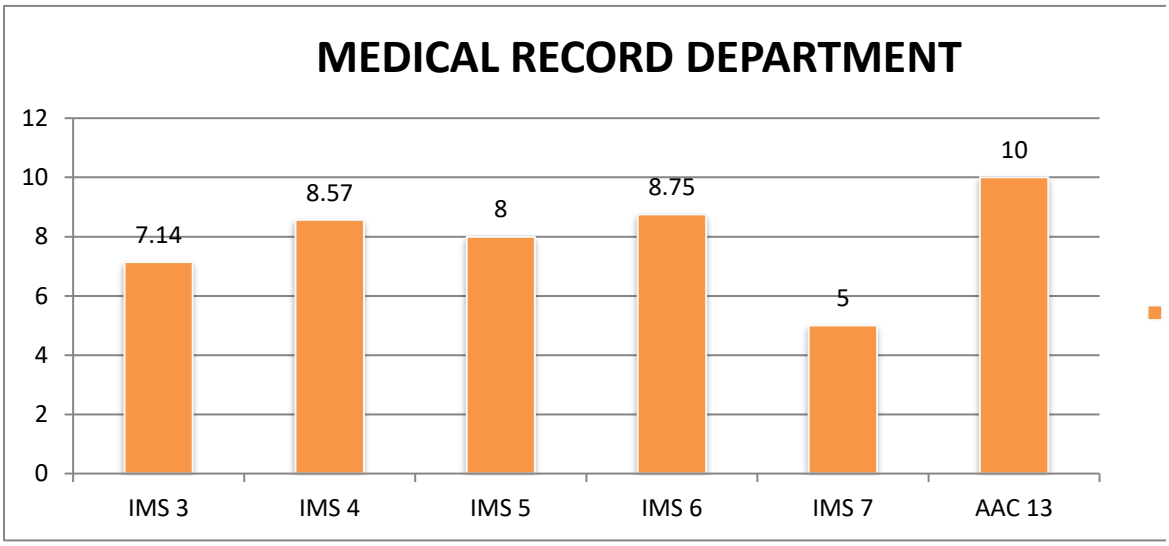

Figure 5 :- score for Medical Record department

Table 11:- Checklist for Front office department:-

Front office: Registration, Admission and Billing counters		
Standard	**Objective Element**	**Scor**
AAC 1a-c	The services being provided are clearly defined and are in consonance with the needs of the community.	10
	The defined services are prominently displayed.	5
	· Orientation of staff with respect to available services	5
AAC 2a-f	· Policy and Procedure for registration and admission (OP, IP and Emergency) patients	10
	· Generation of UHID number at the end of registration	10
	· Management of patients when beds are not available	10
	· Acceptance of patients for the services provided by HCO	10
	· Awareness of staff	5
PRE 1a,d	· Display of patient rights and responsibilities	5

	· Awareness of staff about their responsibility in protecting patient and family rights	5
PRE 6a,b,c	· Uniform pricing policy in a given setting	10
	·Availability of tariff list	10
	·Explanation about the expected cost	5
ROM 4a	· Display of mission, vision and values	5
AAC 13.a,d	The patient's discharge process is planned in consultation with the patient and/or family.	10
	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	10

Table 12:- The scores and findings of the Front Office department are listed below:-

DEPARTMENT:- FRONT OFFICE DEPARTMENT	
STANDARDS	AVERAGE SCORES
AAC 1	6.66
AAC 2	9
PRE 1	5
PRE 6	8.33
ROM 4	5
AAC 13	10
DEPARTMENT AVERAGE	**7.33**

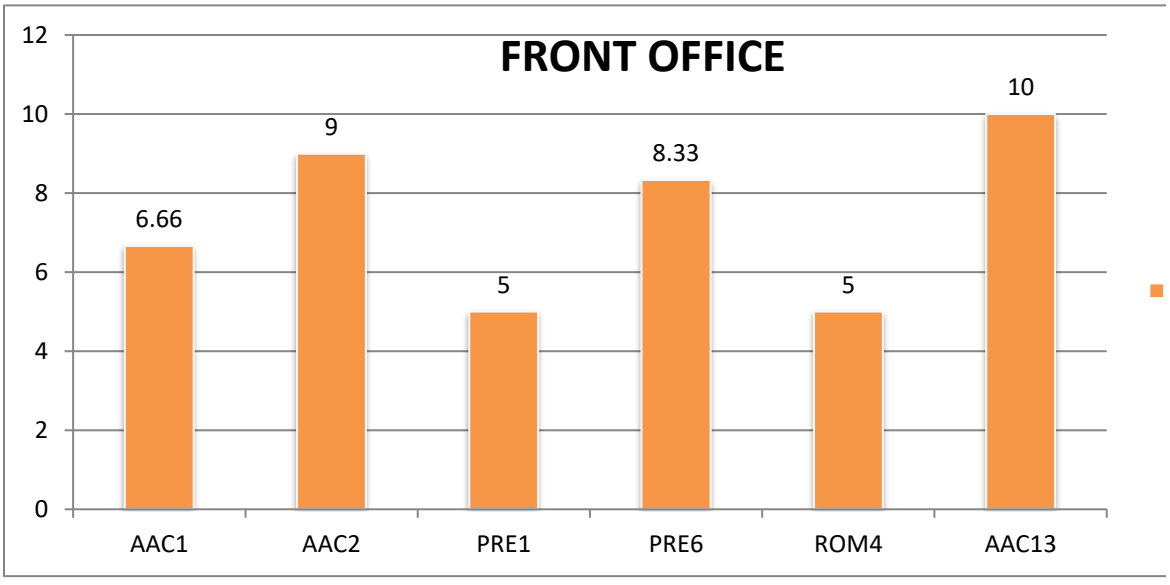

Figure 6:- Front office department

Data Analysis:

With the above analysis (done by using excel) it is clear that the hospital is fulfilling the pre-accreditation progressive level criteria and hence closes to getting assessment level. We compare findings by using NABH tracer methodology checklist, with the second evaluation criteria and find that the average rating score for the department Housekeeping and Human resource is having average score less than 7 and the front office, medical record, linen and laundry and pharmacy is having average rating score more than 7. So it is fulfilling the requirement for preparedness for accreditation of NABH. Regular monitoring and audits should be done to keep up the compliance rate that in turn strengthens the existing service delivery system of the hospital.

RECOMENDATION:

Human resource department:-

1. Periodic Training record for the employees (One record copy for the hospital Administrative section and another copy in the individual personnel file). These records should include feedback reports.
2. Reports of performance appraisal (one copy for hospital and another for the personnel files) should be documented.
3. Pre employment health checkups should be conducted.
4. Records for Annual health check up of all staff with extra investigations for checking "disease carriers" (e.g.: VI antigen test for Salmonella Typhi).
5. Immunization record for staff against Hepatitis and typhoid, for all staff including trainees.
6. Records for In-house training and any Continuing Medical education programs.
7. Record for result of outcome of in- house training in terms of enhanced performance by staff thus trained.
8. A HR manual along with a training and development manual to be created.
9. Proper documentation of manpower planning has to be there.
10. Employee satisfaction rate and other indicator need to be calculated.

House keeping

1. Some of the Housekeeping staff was seen working without any safety equipments. They are to be provided with heavier elbow level gloves, Aprons and Boots. They also need greater Motivation to use them regularly as some of them do not have the desired motivation to use them and give precedence to convenience over safety.
2. Rigorous training programme should be conducted for H.K staff for infection control practices.
3. Use of Trolley should bring in practices to avoid infections acquired in hospital.
4. A room readiness checklist should be prepared by H.K supervisor so that delivery of services could be made better

Medical Record Department:

1. Periodic medical records audit needs to be done for smooth functioning of MRD
2. As per best practices few sections of MRD needs attention to standardize the services:

- Nurses (instead of doctors) take the patient consent for any operation/procedure and this is not acceptable according to standard practices.
- Signature of the doctors is not available on the few consent form.
- Consent forms need to be modified to follow standard formats and should be bilingual.

- Lab Reports can be color coded as per investigation test, so that, time is not wasted in going through piles of lab reports of the patient to locate specific test results as in chronic cases with repeated visits, etc.
- Patient/Family Education Plan to be incorporated in IPD files.
- A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on discharge and the recommendations and arrangements for future care.

Linen and laundry:

1. Segregation practices in the wards are not appropriate. Staffs needs to be trained for the cleaning and linen handling processes.
2. Only single machine used for cleaning of all the hospital laundry despite availability of two machines. More machines need to be installed as this is a very vital component of the infection control chain of processes.
3. A separate room should be designated for sluicing the infected linen.

Front Office department:

Bilingual language display of scope of all services is required along with the major facilities which the hospital does not provide.

Placement of directional boards, fire extinguisher, fixtures and electrics fittings and also placed enough number of wheelchairs and trolleys for patient convenience.

Pharmacy:

1. There is no method for documentation of the adverse drug reaction, or reporting and remedial actions. It is strongly suggested that a separate "Adverse Drug Reaction" Cell must be established. This cell would be able to seek and help in advising doctors in dealing with new forms of drug-reactions.
2. Inventory control practices and store management practices and pilferage control are to be strengthened.
3. The formulary needs to be created.

4. A drugs and therapeutics committee to be constituted. A multidisciplinary committee to guide the formulation & implementation of organization of pharmacy services needs to be formed

Conclusion

The analysis shows that there are some gaps in the hospital as per NABH norms. There are major gaps in the implementation part as the documentation work has been done up to some extent. So, major focus on implementation of norms is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. As of now the hospital fulfils the required criteria partially. No standard must have more than one zero to qualify but the analysis shows 6 standards having more than one zeros. Also departments have average score less than the required score of 7. Mainly quality improvement as no department is tracing quality indicator, pharmacy and human resource department and Housekeeping department are the areas which require greatest attention.

The need of the hour is to re-modulate the system and processes as per the laid down guidelines, with the involvement of all staff members which includes the grass root employees too. In totality institution has high potential for accreditation. Thus the hospital is presently prepared for pre – assessment as far as concerned from these departments and requires great effort and focus on the weak points so as to cover the gaps and to be prepared for getting NABH accreditation.

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ANNEXURE

NABH TRACER METHODOLOGY CHECKLIST

Standard	Objective Element	DOCUMENTATION (Yes/No)	IMPLEMENTATION (Yes/No)	EVIDENCE (Documents/Manual/Training)	score
HRM 1a-d	Human resource planning	Yes	Yes	On the basis of requirement generated by the department.	10
	Job specification/Job description for each category of staff	Yes	Yes	Present in employees file and with employees. Employees are aware of their job description and specification.	10
	Criminal /negligence antecedents verification of the potential employee	Yes	Yes	Document of verification of employees done from last organisation. Present in employees files.	10
HRM 2a-h	Documented procedure for recruitment of staff	Yes	Yes	Policy is there regarding procedure recruitment.	5
	Pre-defined criteria of recruitment	Yes	Yes	Policy is present.	10
	Induction training	Yes	Yes	Feedback mechanism is not there in process. Policy for induction and training is present.	5
	o Orientation to vision, mission and goals	Yes	Yes	Training records are present.	5
	o Policies and procedures	Yes, few policies are defined.	Yes	Documentation control is not there.	5
	o Rights and responsibilities-patient and employee	Yes	Yes	Policies and documents are not evident	5

	o Service standards(code of conduct)	Yes	Yes	Policies and documents not evident.	5
	o Performance appraisal (HRM 5b)	Yes	Yes	Policies and document are evident. Annual increment for employees is present.	10
HRM 3a-d	Training policy,Training identification, Training calendar	Yes	Yes	Training records are present however training calendar is not maintained.	5
	Training records	Yes	Yes	Policy is there but Documentation is not present for all the training carried out.	5
	Training effectiveness(for e.g.:-on new equipments)	Yes	Yes	Training records are not present as per intervals.	5
	· Training feedback for assessment of training programme and tool to improve the training programme	NO	NO	Feedback mechanism is not there in process.	0
	Training requirements as per the standard	Yes	Yes	Training records are available but not updated.	5
	o CPR (COP 4b)				
	o Blood and blood products (COP 7a,h)				
	o Vulnerable patients (COP 9e)				
	o Restraint techniques (COP 15e)				
	o End of life care (COP 20e)				
	o Infection control (HIC 9c,d)				
	o Quality improvement (CQI 1e)				

	o Safety (CQI 2f)				
	o Fire and non-fire emergencies (FMC 5c)				
	o Disaster management (FMS 7d)				
	o Hazardous materials (FMC 8e)				
	o Occupational safety (HRM 4d)				
HRM 4a,b,c, d	Training on risks	Yes	Yes	policy and procedures is not defined. Some training records are missing.	5
	Staff demonstrate and take actions to report, eliminate / minimize risks	NO	Yes	mock drills is not done, policy and documents is not evident.	5
	Awareness of procedures to follow in the event of an incident	Yes	Yes	Reporting committee and person is not designated. In case of incident employees report to their concerned H.O.D.	5
	Training on occupational safety aspects	Yes	Yes	Training records are there. Policy is not present.	5
HRM 5a-e	Documented performance appraisal system	Yes	Yes	Annual increment for employees is present.	10
	Employees are aware of Appraisal system at the time of induction.	Yes	Yes	Policy and documents for is evident.	5
	Frequency of appraisal at pre-determined criteria	Yes	Yes	Policy is evident. Appraisal is done on the basis of A, B, C grade.	10
	Used as tool for further development	Yes	Yes	Yes	10
HRM 6a-g	Documented disciplinary procedure based on principles of	Yes	Yes	Policies and procedure is evident.	10

	natural justice and in consonance with laws				
	Documented grievance handling mechanism (committee)	Yes	Yes	Policies and procedures is evident. Internal compliant Committee is also there.	10
	Provision of appeal	Yes	NO	Policies and procedure is defined for appeal but not in practice.	5
	Redressal procedure to addresses the grievance	Yes	Yes	Policies and procedure is evident.	5
	Actions for grievance redressal	Yes	Yes	Policy is evident but requires proper implementation.	5
HRM 7a-d	Pre-employment medical examination	NO	NO	NO	0
	Medical benefits for employees	Yes	Yes	policy is present.	10
	Regular health check (at least once a year) of staff involved in patient care. Health check of employees exposed to radiation as per statutory requirements	NO	NO	NO	0
	Occupational health hazards(PPE)	Yes	Yes	All the employees are not having PPE [G.D.A working in O.T (orthopaedic cases) are not having T.L.D badges, vaccination given.]	5
HRM 8a-d	Personal file for every employee containing information on	Yes	Yes	Employee's records.	10
	o Educational qualification, Disciplinary	Yes	Yes	Employee's records.	10

	background, He alth status.				
	o In service training and education	Yes	Yes	Summary of all training attended by the employee is filled in their files.	10
	o Performance appraisal	Yes	Yes	Documentation regarding this is present. Appraisal sheet is attached in all the employees who got performance appraisal	10
HRM 9a-f	Credentialing of doctors	Yes	Yes	MCI, guidelines.	10
	Updating of credentials	Yes	Yes	Documentation regarding this is not evident in all the files.	5
	Verification where appropriate	Yes	Yes	Verification is done for all the doctor staff like JR and SR. Documents are also present in employees file.	10
	Privileging of doctors	Yes	Yes	policy is there regarding privileging	10
	Communication of same	Yes	Yes	Done by department and this is displayed in O.P.D also.	10
HRM 10a-f	Credentialing of nurses	Yes	Yes	NCI guidelines.	10
	Updating of credentials	Yes	Yes	Documentation regarding this is not evident in few employees file.	5
	Verification where appropriate	Yes	Yes	Documents are present in all the files.	10
	Privileging of nurses	Yes	Yes	Policy is there regarding privileging. But some employees file requires updating.	5
	Communication of same	Yes	Yes	Policy is evident.	5
ROM 2b	Policy on prevention of sexual harassment (committee)	Yes	Yes	Policy and committee has been constituted however the committee meetings are not in process.	5

HOUSEKEEPING					
Standard	**Objective Element**	**DOCUMENTATION (Yes/No)**	**IMPLEMENTATION (Yes/No)**	**EVIDENCE (Documents/Manual/ Training)**	**Score**
HIC 2f	The organisation adheres to cleaning, disinfection and sterilization practices.	Yes	Yes	Policy and its adherence is regarding this is evident.	10
HIC.2h	The organization adheres to laundry and linen management processes.	Yes	Yes	Sluicing SOP's are defined, Linen received for sluicing are not bifurcated as infected linen or soiled linen, Appropriate Space and Equipment are available; External Q.A of linen has never been done.	5
HIC 2k	Adherence to housekeeping procedures	Yes	Yes	policy is evident and adherence to procedure is also present	10
HIC 3f	Effectiveness of housekeeping services	Yes	Yes	Policy is evident. However Continuous Monitoring is being done by H.K. Supervisor but training records are not updated.	5
FMS 8a-e	Identified hazardous materials	Yes	Yes	Policy regarding this is evident.	10
	Hazardous materials identified have documented procedure for sorting, labelling, storing, handling, transportation and disposal etc.		Yes	Objective evidence of documentation for sorting, cleaning, packing, disinfection and sterilization is found. The process for storage and issue of items is not found.	5

	Availability of MSDS for all hazardous materials	yes	Yes	MSDS is present. Partial Compliance for the knowledge and understanding of Hazardous Material by H.K Staff	5
	Spill management plan of hazardous materials	yes	yes	Staff Training & Records : Managing and Handling Spillage of Hazardous Material (Spillage) ; Bio-Medical Waste. HAZMAT Kit is not present.	5
	Staff awareness	yes	Yes	New H.K.Staff is not aware of BMW Handling, Spillage Management	5

Pharmacy department					
Standard	**Objective Element**	**DOCUMENTATION (Yes/No)**	**IMPLEMENTATION (Yes/No)**	**EVIDENCE (Documents/Manual/ Training)**	**Score**
MOM 1a,b,c, d	· Documented policies and procedures on medication procurement, storage, formulary, prescription, dispensing, administration, monitoring etc.	Yes	Yes	SOP is there. Documentation is there for procurement, storage and dispensing but implementation is need to be done.	5
	· Separate license for the pharmacy.	Yes	Yes	Licence is evident.	10
	· Multidisciplinary committee	No	No	Drugs and therapeutics committee is not yet formed.	0

	· Duty roster to ensure that there is a qualified pharmacist at all times (his/her name being mentioned in the license)	Yes	Yes	Medical incharge name is there in license.	10
	· Procedure to obtain medications when the pharmacy is closed	Yes	Yes	Pharmacy services are available for 24*7.	10
MOM 2a,b,c, d,e	· Hospital formulary	Yes	No	Policy is there but requires implementation.	5
	· List is developed and collaborately updated by multidisciplinary committee.	No	No	Drugs and therapeutics committee is not yet formed.	0
	· Defined process of procurement of medicine and to obtain non- listed medicines	Yes		Policy is there. Items procured by registered vendors only. Medical store is having list of vendors.	5
	· Availability of Formulary for clinicians to refer and adhere to	Yes	no	Policy is there for prescribing drugs which are present in drug formulary. However sometimes doctors prescribe medicines which are not there in pharmacy. Prescription rejected is not monitor	5
MOM 3a-g	· Documented policies and procedures for storage	Yes	Yes	Policy is evident. And in practice.	10
	· Storage of medicines in clean, well lit and ventilated environment and/or as per manufacture's requirement	Yes	Yes	Policy is there. Temperature Charting for refrigerator not practicing.	5

	· Inventory control practices like FIFO	Yes	Yes	Policy evident and in practice.	10
	· Identification and storage of sound alike and look alike drugs	Yes	Yes	SOP's is there. There is no demarcated area for receiving and segregation.	5
MOM 4a-l	· Identified high risk medicines	Yes	Yes	No SOP is formed out for verbal orders. Prescription audit is not carried out. List is present in medical store listing all the emergency drugs and high risk medications.	5
MOM 5a-f	· Procedures for safe dispensing of medicines	Yes	Yes	Policy is evident. And in practice also.	10
	· Medication recall procedure	Yes	Yes	Computer operated system is adopted for recalling procedures.	10
	· Expiry date check before dispensing	Yes	Yes	Policy is evident. Strict rules and regulations is formed for checking expiry date of drugs.	10
	· Procedure for near expiry medications	Yes	Yes	SOP's is formed for near expiry medications.2months prior to expiry date drugs are sorted and placed separtely from other drugs.	10
	· Proper labelling on medicines	Yes	Yes	All drugs are labelled. Labelling requirement for some of the drugs not maintained at the dispensing counter	5
	· Verification of High risk medication orders before dispensing	Yes	Yes	Policy is evident but implementation needs to done.	5

MOM 8a-c	· Documented procedure on near miss, medication error and adverse drug event	Yes	no	Document is evident for monitoring patients after administrating drugs but not implemented properly.	5
	· Near miss, medication error and adverse drug event are defined	Yes	no	Policy is present, but not adheres too. 2 new medical staff is not aware about policy.	5
	· Reporting of near miss, medication error and adverse drug event within a specified time frame.	Yes	Yes	Policy is present. But formats for reporting near miss and medication error is not evident.	5
MOM 9a,b,d	· Procedure for narcotic drugs, Storage, Proper record, Handling	Yes	Yes	SOP's is defined for storage of narcotic drugs. Narcotic drugs are stored in double lock and key system.	10
PRE 5a	· Patient and family educated on:- o safe and effective use of medication o potential side effects of the medication o food drug interactions	Yes	Yes	Policy is present. All patients are counselled about the administration procedures and side effects of drugs.	10

Linen & Laundry					
STANDARDS	**OBJECTIVE ELEMENT**	**DOCUMENTATION (Yes/No)**	**IMPLEMENTATION (Yes/No)**	**EVIDENCE (Documents/Manual/ Training)**	**score**
HIC 2h	· Laundry and linen management processes	Yes	Yes	Linen stock register, issue and receiving register are present and in proper practice.	10
	· Process flow	Yes	Yes	Implemented and adherence to process flow is also seen.	10

	· Segregation of linen	Yes	Yes	Linen is being scrutinised on the basis of soil, dirty and infected linen. Proper implementation need to be done.	5
	· Disinfection	Yes	Yes	Disinfect with 1% sodium Hypochlorite. Policy is not available.	5
	· Bags and labels	Yes	Yes	Infected linen is carried in yellow poly bags with proper labelling as infected linen, floor name, patient name.	10
	· Quality control system	Yes	Yes	Quality control of linen is maintained and after shelf life of linen which is 90 days the linen is discarded. But on reviewing some linen are found ruptured.	5
	· Quality control of outsourced activity (if outsourced)	NA	NA	NA	NA
FMS 2a,i	· Layout / space	Yes	Yes	Sufficient layout is there and proper space is there for the movement of soiled, infected and dirty linen.	10
	· Maintenance plan of machinery	Yes	Yes	AMC, CMC and Breakdown record is maintained. Policy is available.	10
FMS 3g,f	· Electrical safety practices	Yes	Yes	All the safety measures are been undertaken to prevent electrical shocks and short circuit	10
	· Staff awareness on safety practices	Yes	Yes	Policy is there but training record is not evident regarding safety measure in laundry.	5
FMS 8a-e	· Identified hazardous materials	Yes	Yes	Hazardous material (phenol category) are being identified by the organisation.	10

	· Hazardous materials identified have documented procedure for sorting, labelling, storing, handling, transportation and disposal etc.	Yes	Yes	MSDS is available.	10
	· Spill management plan of hazardous materials	Yes	Yes	Policy is evident.	10
	· Staff awareness	Yes	Yes	Staff is not aware of proper spill management technique. Implementation need to be done.	5

Medical Record department					
Standard	**Objective Element**	**DOCUMENTATION (Yes/No)**	**IMPLEMENTATION (Yes/No)**	**EVIDENCE (Documents/Manual/ Training)**	**Score**
IMS 3a-g	· Medical record unique number	Yes	Yes	Compliance: UHID is generated for all the O.P.D and I.P.D. Patient in our organisation.	10
	· Policy on authorized person to make entry	Yes	Yes	Compliance: Organisation is having a documented policy for making different entries in the patient files.	10
	· Every entry is named, signed, dated and timed	Yes	Yes	Partial Compliance: In few files entries are not evident.	5
	· Author is clear	Yes	Yes	Partial Compliance: Provision for writing full name is mentioned in departmental manual but it is not implemented, evidence of full name is not found however	5

				signatures of the concerned are present.	
	· Contents of medical record are identified and documented	Yes	Yes	Partial Compliance: Objective evidence is found in the patient records. The same is not updated in the Departmental Manual.	5
	· Records are up to date and chronologically arranged			Partial Compliance: Objective evidence of chronological order checklist is found in the patient records. The chronological order, completeness of the contents is varying as seen in random samples of files.	5
	· 24-hour availability of the patient's record to healthcare providers to ensure continuity of care			Compliance: In the absence of MRD In charge, the administrator / AMS on duty are authorized for the access to MRD.	10
IMS 4a-h	· Medical record has reason for admission / diagnosis/ plan of care.			Partial Compliance: It is documented in departmental manual. In random sampling the objective evidence of admission, diagnosis are found, however plan of care is either not properly filled or not filled at all.	5
	Operative and other Procedure sheet			Compliance	10

	· Medical record contains the results of tests carried out and the care provided			Partial compliance: Legal reporting to NRHM is having ICD coding for the death case mentioned. ICD coding on patient file is not in practice.	5
	· Transferring patients medical records have date of transfer/reasons/name of receiving hospital			Compliance	10
	· Signed Discharge note/copy of death certificate with cause, date and time of death			Compliance	10
	· Copy of clinical autopsy report (where applicable)			Compliance	10
	· Access to current and past medical record			Compliance	10
IMS 5a-g	· Security, integrity and confidentiality of data and information			Compliance: Objective Evidence of Case file demand slip found in the department.	10
	· Safeguarding data/ record against loss, destruction and tampering			Non-Compliance: The space in the department is not sufficient to manage the patient records, there are no lights in the department, there are chances of fire hazard in the department.	0

	· Technology used for improving/maintaining confidentiality, security and integrity			Compliance	10
	· Usage of privileged health information			Compliance	10
	· Documented policies and procedures on how to handle MR information requirement			Compliance	10
IMS 6a-d	· Retention policy of patient's clinical records, data and information			Compliance	10
	The policies and procedures are in consonance with the local and national laws and regulations.			Partial Compliance: The policies and procedures are documented, however the tracing of previous records cannot be done, due to the unavailability of records	5
	· Maintenance of confidentiality and security at all stages			Compliance	10
	· Method for destruction of medical records, data and information			Compliance	10
IMS 7a-g	· Medical record audit			Partial-Compliance: Records are reviewed as per the defined committee meetings. Any frequent / scheduled audit is not in practice.	5
	o Active and discharged patients records			Partial Compliance: The active files are not considered in any of the committee	5

				Meetings.	
	o Deficiencies identified and documentation of same			Partial Compliance: Deficiencies are identified but documentation needs to be improved.	5
	o Corrective and preventive actions undertaken			Partial Compliance: Committee Meetings are recorded and appropriate follow up is carried out. However the policy is not defined in the departmental manual.	5
AAC 13b,c	· Medico legal case documentation			Compliance: MLC files are completed and are differentiated from other patient files.	10
	· LAMA case file has discharge summary and risks explained			Compliance: LAMA files are completed and all documents are present and completely filled.	10

Front office: Registration, Admission and Billing counters					
Standard	**Objective Element**	**DOCUMENTATION (Yes/No)**	**IMPLEMENTATION (Yes/No)**	**EVIDENCE (Documents/Manual/Training)**	**Score**
AAC 1a-c	The services being provided are clearly defined and are in consonance with the needs of the community.	Yes	Yes	Policy is available.	10

	The defined services are prominently displayed.	Yes	Yes	As per AAC.1.b the displayed scope of services are required to be at least bilingual (in the form of Citizen Charter or display Boards. Display in the form of brochures only is not acceptable.	5
	· Orientation of staff with respect to available services	Yes	Yes	There is a requirement of availability of Documented Training Programme and its attendance in Departmental Training Register. Absence of Training Programme and its attendance is leading to the Partial-compliance of AAC.1.c	5
AAC 2a-f	· Policy and Procedure for registration and admission (OP, IP and Emergency) patients	Yes	Yes	Staff is aware of Policies and Procedures	10
	· Generation of UHID number at the end of registration			Staff is aware of Policies and Procedures	10
	· Management of patients when beds are not available			Staff is aware of Policies and Procedures	10
	· Acceptance of patients for the services provided by HCO			Staff is aware of Policies and Procedures	10
	· Awareness of staff	Yes	Yes	Training records are missing however staff is aware about the policies and procedures for admission and discharge process.	5

PRE 1a,d	· Display of patient rights and responsibilities	Yes	Yes	The displayed scope of patient rights and responsibilities are required to be at least bilingual.	5
	· Awareness of staff about their responsibility in protecting patient and family rights	Yes	Yes	Staff is aware of Patient and Family Rights, however there is no document available at Front Office to hand over to the patient and for permanent display pertaining to Patient and Family Rights ; Responsibilities leading to the partial-compliance of PRE.1.a,b	5
PRE 6a,b,c	· Uniform pricing policy in a given setting	Yes	Yes	Staff is aware of Policies and Procedures and it is in practice.	10
	·Availability of tariff list	Yes	Yes	Tariff list is available at the front office.	10
	·Explanation about the expected cost	Yes	Yes	Estimate to the patient are not given in writing in all the scenarios. However there is a track of written estimate form in In-patient file at billing. NABH guides (PRE.6.c) that estimate shall be prepared on basis of treatment plan and which could be prepared by OPD/Registration/Admission staff in consultation with treating consultant.	5

ROM 4a	· Display of mission, vision and values	Yes	Yes	Display in English language only.	5
AAC 13.a,d	The patient's discharge process is planned in consultation with the patient and/or family.	Yes	Yes	Staff is aware of Policies and Procedures	10
	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	Yes	Yes	Staff is aware of Policies and Procedures	10