INTERNSHIP TRAINING AT GOVT. OF N.C.T. OF DELHI
SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA
DABRI, NEW DELHI

By

COL MANJEET SINGH
PGDHM 2012-2014

International Institute of Health Management Research New Delhi

Internship Training

At

GOVT. OF N.C.T. OF DELHI
SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA
DABRI, NEW DELHI

FINAL ASSESSMENT FOR NABH ACCREDITATION OF HOSPITALS

By

COL MANJEET SINGH

Under the guidance of

DR A K KHOKHAR

Post Graduate Diploma in Hospital and Health Management

2012-14

International Institute of Health Management Research New Delhi

GOVT. OF N.C.T. OF DELHI
SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA
DABRI, NEW DELHI

The certificate is awarded to:

Name: COL MANJEET SINGH

In recognition of having successfully completed his Internship in the department of NABH

Title: **FINAL ASSESSMENT FOR NABH ACCREDITATION OF HOSPITALS**

And has successfully completed his Project on NABH Accreditation in Hospitals

Organization: **GOVT. OF N.C.T. OF DELHI SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA DABRI, NEW DELHI**

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

We wish him all the best for future endeavors.

06/6/14

Authorized Signatory

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F.8(5)/DDMSC/APP/TRG./2014/Vol-II/313 Dated- 06/5/14

TO WHOMSOEVER MAY CONCERN

This is to certify that **COL MANJEET SINGH**, 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 **GOVT. OF N.C.T. OF DELHI SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA DABRI, NEW DELHI**

From 01 FEB 2014 – 01 MAY 2014. The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical. The Internship is in fulfillment of the course requirements.
I wish him all success in all his future endeavors.

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

DR A K KHOKHAR

IIHMR, New Delhi

Certificate Of Approval

The following dissertation titled

FINAL ASSESSMENT TOWARDS NABH ACCREDITATION OF HOSPITALS

AT GOVT. OF N.C.T. OF DELHI

SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA

DABRI, NEW DELHI

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
Prof A K Agarwal	
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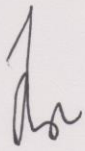
Dr. Suparna Pal	

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **FINAL ASSESSMENT TOWARDS NABH ACCREDITATION OF HOSPITALS** at **GOVT. OF N.C.T. OF DELHI SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA DABRI, NEW DELHI** and submitted by COL MANJEET SINGH Enrollment No. PG/12/046 under the supervision of DR AK KHOKHAR for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 01 FEB 2014 TO 01 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.



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FEEDBACK FORM

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DDMSC

Abstract

1. National Accreditation Board for Hospitals and Health Care Providers (NABH) is a constituent Board of QCI, set up with co-operation of the Ministry of Health & Family Welfare, Government of India and the Indian Health Industry.

2. Shri Dada Dev Matri Avum Shishu Chikitsalaya is 64-bedded mother & child Hospital situated in Dabri, near Dwarka. Its NABH accreditation process started in January 2009 & pre-assessment was done on 9th & 10th February 2011. The NABH assessors pointed deficiencies & hospital is in process of removing these deficiencies. These deficiencies were of the following nature:

(a) Statutory: Licenses related to laws of land such as AERB Certification, building completion certificate etc.

(b) Policies & Manual deficiencies: Formulation of policies in accordance with NABH standards.

(c) Implementation of formulated policies: Above laid policies have to followed & documented in a structured manner.

3. Many of the deficiencies have been rectified except the statutory ones for which the Delhi Govt. is being actively pursued. The matter needs to be taken up at the highest level as otherwise little scope of resolution before final assessment appears. The other deficiencies need to be confirmed and adhered to in letter and spirit before the arrival of assessors. The HCO has already set up committees and nodal heads for overall quality assessment as well as for individual chapters. DDMSC has a functioning NABH Cell with the DMS as its nodal head. It is recommended that this committee should concentrate on obtaining time-based inputs from sub committees. (18) The feedback should be on a monthly basis to be chaired by the DMS. The MS should chair a Quarterly meeting. A max of four quarters be given to show full readiness for final assessment. By end of next financial year the DDMSC may submit its application for final assessment. A closer scrutiny by the committee heads of certain misc. activities can further improve the functional processes of the hospital as per other NABH standards. These aspects have been discussed in great detail in the ensuing chapters.

4. Involvement at the highest levels of management will spur and motivate the staff at all levels to become quality conscious and create the necessary impetus and environment for NABH accreditation. The DDMSC will have to function under various known constraints such as it being a govt. Deptt. Where for every matter one has to seek sanctions of the govt. for funds, making up critical deficiencies in manpower and equipment, building completion certificates, procurement as well as disposal. There are limited penal and disciplinary powers vested in the higher appointments that have all accountability, which are further prone to interference and

understandable external influences. The DDMSC has limited flexibility in the exercise of its powers; financial, legal as well as administrative. (19)

In its endeavors the DDMSC also needs tremendous leaning-in and support of the DHS, Delhi Govt. and GOI. Augmentation of its IT resources will go a long way in making important data available for decision making and analysis which will make the journey of accreditation less arduous and abstract.

Acknowledgements

I deeply acknowledge the invaluable guidance and support of mentors and staff at IIHMR as well as at DDMSC who despite their enormous responsibilities and busy schedules patiently walked me through the reference material, the documents/records, and the physical facilities to collect my data and prepare this dissertation.

I wish to make special mention of my Dean Dr Ashok Agarwal, and mentor Dr A K Khokhar who supported me and helped me to translate the academic learning into on ground application of quality concepts.

Dr Rekha Aggarwal, MS, DDMSC, took time out to share with me her valuable insights on challenges and opportunities in HCO through her vast and rich experience of nearly three decades.

Dr Deepmala Kaul, DMS and mentor at DDMSC summoned the resources at the hospital to ensure I get appropriate access to all the physical facilities, staff, policies and records that were needed for this work. I thank her for her patience and guidance despite her busy schedules.

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Dr Shanakaranarayanan.

Sh. Sunil Sharma.

Table of Contents

List of Tables

List of Symbols and Abbreviations

DDMSC	Dada Dev Matri Avum Shishu Chikitsalaya
IIHMR	International Institute of Health Management & Research
Mgt	Management
NABH	National Accreditation Board for Hospitals & Health care Providers
HCO	Health Care Organization
Org	Organization
Ref	Reference

List of Appendices

APPENDIX	TITLE
A	DAILY INFECTION REPORT
B	EMPLOYEES AWARENESS SURVEY – BMW
C	DAILY ROUND PROFORMA
D	QUALITY INDICATORS FOR A MONTH
E	PHARMACY LICENSE
F	PROCUREMENT FLOWS
G	PATIENT FLOWS

Chapter – 1

Introduction

1.1 Shri Dada Dev Matri Avum Shishu Chikitsalaya is a 64-bedded hospital to provide mother and child care. Located in southwest district at Dabri, New Delhi, it has an area of 10,470 sq. meters with facilities of hostel and staff accommodation. This is the first Hospital of its own kind of GNCT Delhi to provide Mother and Child Health Services in an integrated way.

Vision

1.2 To establish a center of excellence in the field of mother & child health.

Mission

1.3 Provide Mother & Child health care though latest developments and innovation in the field of mother & child health within the available resources.

Bed distribution

1.4 Three wards: B1 and B2 have 24 beds each and B3 has 16 beds.

Scope And Facilities

1.5 Clinical services

- Obstetrics & Gynecology
- Pediatrics
- General Medicine
- Emergency Services (Accident & Other Emergency)
- Nursery Level – Ii
- High Dependency Unit

Para Clinical Services

1.6 Laboratory Services

- *Clinical Biochemistry*
- *Clinical Pathology*
- *Hematology*
- *Cytopathology*
- *Serology*
- X- Ray
- Sonography (Ultrasound) – Outsourced
- ECG
- ICTC (Integrated Center For Testing And Counseling) Services
- Blood Storage
- Pharmacy

1.7 Support Services

- Ambulance Services
- Kitchen Services (Outsourced)
- Laundry Services (Outsourced)
- Security Services (Outsourced)
- Waste Management Services
- T.S.S.U. (Theater Sterile Supply Unit)
- Medical Records Department.
- Medical Gases (Cylinders Only)
- Engineering Services.
- Housekeeping Services And Sanitation (outsourced)

1.8 Administrative Services

- Account Section
- Establishment Section
- IMS (Hospital Information Management System)

Scope Of Services- Department Wise

Department Of Obstetrics And Gynecology

OPD Care

- Routine Antenatal Care (> 34 Weeks)
- Gynecological Consultation
- Contraceptive Advice
- Immunization

Special OPD Care

- Infertility Clinic
- Cancer Screening Clinic And Colposcopy
- High Risk Antenatal Care

Day Care Procedures

- Medical Termination Of Pregnancy (MTP)
- Cu-T Insertion
- Pap Smear
- Endometrial Biopsy
- Cervical Biopsy
- Colposcopy
- Other Minor Gynae Procedures

Major Surgical Procedures

- Mini Laparotomy
- Lap Ligation
- Cesarean Section
- Diagnostic Hysteroscopy
- Laparoscopy
- Hysterectomy
- Other Gynae & Obstetric Procedures

Indoor Facility

- Antenatal Ward
- Gynae Ward
- Pre Operative & Post Operative Wards
- Labor Room With CTG Facility
  - Emergency OT Facility
  - Emergency Services
  -

Department Of Pediatrics

OPD Services

- Routine OPD
- Immunization
- Growth Monitoring – Weight And Height Monitoring On OPD Days Only
- Special Clinic: - Proposed

Indoors Services

- Emergency Services
- Nursery Services
- *Pediatric Surgical Services Are Not Available*

Out Patient Department (OPD)

- Diagnosis And Treatment Of Medical Illness
- Prevention and treatment of medical problem related to prenatal, antenatal & postpartum cases.
- First aid to all emergency patients irrespective of sex.

Indoor Patient Department (IPD)
Department Of Anesthesiology

- The anesthesia and critical care department provides comprehensive 24 hr. services through a team of anesthesiologists.
- Pre-Anesthetic Clinic
- Casualty & Emergency Calls For Resuscitation.
- Operation Theater Services.

- General Anesthesia
- Regional Anesthesia
- Monitored Anesthesia Care.
- Post Operative Patients In Recovery
- Resuscitation Calls From Ward.

Laboratory Services

- Hematology
- Clinical Biochemistry
- Serology
- Special Investigations
- T3, T4, TSH, E2, PROGESTERONE, PROLACTIN, LH, FSH, HCG, TESTOSTERONE.
-

Radiology Services

- Conventional X- Ray
- Ultrasonography (Outsourced)

Registration & Bed Allotment

1.9 SDDMSC registers all those patients that match the scope of the available facilities at this institute. The hospital registers the patient according to the laid down procedures. All patients using the services of SDDMSC are assigned an identification number (C.R NO.). This is allotted to all newly registered patients and is carried forward for all services. General information is provided to the people approaching the hospital for the first time.

1.10 Three registration counters are available: -

- Counter one: for all new patients.
- Counter two: for old patients/ for follow up cases.
- Counter three: for senior citizens / handicapped / mentally retarded / vulnerable patients staff members.

1.11 All new patients are registered at the new case window at the registration counter. All relevant details are recorded and entered in system they are allotted OPD number (which is valid for 12 months) and are directed to the respective OPD room. Registration counters (three in number) in the OPD block, which is functional on all

working days for routine cases. In case of non-disaster episodes the most stable patients are transferred either to wards/ICU/discharged as per the condition may be.

1.12 The decision on labeling patient stable and transferring patients is decided by the emergency in charge in working hours and doctor on duty in consultation with emergency in charge during off hours.(1)

1.13 In case none of the patients is stable and inflow of the patients is still there then vacant beds of the other department will be used.

1.14 In case there is a demand for ICU beds, judge the stability of the patients already in the ICU. The decision on the stability is totally taken by the ICU in charge. Only after being confident about the stability of the patient the patient is shifted to the ICU/ ward.

1.15 Only priority 2 patients of ICU may be considered for stepping down to ward. All are general beds and with 40 beds of Gynae and obstetrics, 20 beds of pediatrics and 04 beds of medicine.

1.16 The trained and competent technicians perform the lab tests. Competence of all the technical staff is checked regularly in the form of knowledge evaluation by giving the tests and technical evaluation in the form of giving random samples for testing. Results are compiled and reviewed by the laboratory in charge for acceptability.

1.17 Pre-assessment. The pre-assessment of the hospital was carried out on 09-10 Feb. 2011. A no. of conformities and non-conformities were pointed out by the team. The hospital has made considerable endeavors to rectify the non-conformities and has taken great strides in its progress towards becoming an NABH compliant healthcare facility. Being a relatively young hospital and a govt. facility, the hospital has its fair share of challenges to achieve stringent quality standards.

1.18 Aim. The aim of this study is to verify the progress made by the organization in compliance with the NABH pre-assessment report, to determine the extent and reasons of non-compliance and suggest an action plan to achieve accreditation.

1.19 Approach. The aim of this study is to verify the progress made by the organization in compliance with the NABH pre-assessment report by visiting each department, scrutinizing documents and policies, (2) discussing roadblocks and solutions with respective chapter heads and departmental heads, and suggest an action plan to progress towards early amelioration of non-compliance issues and carry out full NABH assessment. The approach included following steps:

- Orientation to the Organization's Services.
- Document Review.
- Policies Review.
- Evidence of compliance with policies.
- Evidence of committees.
- Assessment of Activities.
- Functional Interviews.
- Leadership Interviews.
- Infection Control Review.
- Management of Information/Patient Records.
- Staff Qualifications and Education.

- Visits:
    - Visits to Patient Care Areas Anesthetizing Areas
    - Visits to Ambulatory/Outpatient Clinics
    - Visits to Emergency Services
    - Inpatient Units
    - Visits to Imaging/Radiology Services
    - Pathology and Clinical Laboratory Services
    - Visits to Pharmacy
    - Visits to Departments

- Facility Tour: Address issues related to:

    - Physical facility
    - Security
    - Medical and other equipment
    - Hazardous waste
    - Fire safety
    - Utility systems
    - Patient and visitor safety
    - Infection control

1.20 Steps in accreditation:

- Application for accreditation (submitted by the Healthcare Organization).
- Acknowledgement for accreditation (by NABH secretariat).
- Pre assessment visit (by Assessor).
- Not Done yet:
    - Final assessment of hospitals (by Assessment Team).
    - Scrutiny of the assessment report (by NABH secretariat)
    - Recommendation for accreditation (by Accreditation Committee)
    - Approval for accreditation (by Chairman NABH).
    - Issue of accreditation certificate (by NABH secretariat).

1.21 It is proposed to discuss the various challenges and critical problems in achieving NABH accreditation by a govt. healthcare facility in the NCT of Delhi and arrive at methodologies and solutions that will enable the hospital and its staff to rise to meet the challenges in achieving high standards of health care in line with the best practices country wide as well as internationally. A suggested plan of action will be discussed for a time-based implementation.

CHAPTER – 2

Literature Review

2.1 The following previous literature and studies relevant to the field of study have been surveyed. The U.S., Canada and Australia have the oldest accreditation systems. Germany, France, Ireland and Spain have new accreditation systems. The WHO, World Bank and development banks recognize and endorse the accreditation model.

- JCI standards.
  - 14 Chapters
  - 329 Standards
  - 1196 Measurable Elements
- Delhi Govt. Policies.
- NABH standards.
  - 10 Chapters .
  - 100 Standards
  - 514/503 Objective Elements
  - Chapters:
    - Accesses, Assessment And Continuity Of Care (AAC)
    - Care Of Patients (COP)
    - Management Of Medication (MOM)
    - Patient Rights And Responsibilities (PRE)
    - Hospital Infection Control (HIC)
    - Continuous Quality Improvement (CQI)
    - Responsibilities Of Management (ROM)
    - Facility Management And Safety (FMS)

- Human Resource Management (HRM)
- Information Management System (IMS)

- NABH pre-assessment report of DDMSC.
- DDMSC policies and SOPs.
- ISO standards.

2.2 Mark Graban: Lean Hospitals: Improving Quality, Patient Safety, and Employee Engagement, Second Edition.

- The book explains how to use the Lean management system to improve safety, quality, access, and morale while reducing costs. Lean healthcare expert Mark Graban examines the challenges facing today's health systems, including rising costs, falling reimbursement rates, employee retention, and patient safety. The new edition of this international bestseller begins with an overview of Lean methods. It explains how Lean practices such as value stream mapping and process observation can help reduce wasted motion for caregivers, prevent delays for patients, and improve the long-term health of your organization.

2.3 Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience by Charles Kenny

- The book takes you on the journey of Virginia Mason Medical Center's pursuit of the perfect patient experience through the application of lean principles, tools, and methodology.

2.4 Management Lessons from Mayo Clinic by Kent Seltman.

- The book reveals for the first time how this complex service organization fosters a culture that exceeds customer expectations and earns deep loyalty from both customers and employees. Service business authority Leonard Berry and Mayo Clinic marketing administrator explain how the Clinic implements and maintains its strategy, adheres to its management system, executes its care model, and embraces new knowledge - invaluable lessons for managers and service providers of all industries.

2.5 Management of Healthcare Organizations: An Introduction by Peter C Olden.

- The book explains management as an integrated body of knowledge and shows how to apply it in healthcare organizations. Classic and contemporary management theory, principles, methods, and tools for new managers are presented in a logical sequence of management functions, roles, and activities. The book opens with background on the healthcare industry, then moves on to in-depth coverage of five basic management functions - planning, organizing, staffing, leading, and controlling. It also covers decision-making, managing change, and communication.

2.6 The management must exploit various tools and best business practices available worldwide to motivate the employees of a govt. healthcare organization to adhere to NABH standards of training, practices as well as record keeping. The current information mgt. systems available must be installed to improve decision-making process as well as accuracy of data and data mining.

Objectives

2.7 The objectives of this study are:

(a) To orientate to the Organization's Services by Visits to functional areas:
- Patient Care Areas
- Anesthetizing Areas
- Ambulatory/Outpatient Clinics
- Emergency Services
- Inpatient Units
- Imaging/Radiology Services
- Pathology and Clinical Laboratory Services
- Pharmacy
- Departments

(b) To conduct reviews of Documents & Policies, Infection Control systems and MIS/Patient Records to verify the progress made by the organization in compliance with the NABH pre-assessment report.

(c) To carry out Assessment of Activities and conduct interviews of Functionaries & Leadership to determine Evidence of compliance with policies and determine Evidence of committees.

(d) To determine the extent and reasons of non-compliance and suggest an action plan to enable Final assessment of hospital by Assessment Team.

2.8 Our Study will be able to demonstrate the compliance status department/facility - wise; state the challenges faced, and identify specific actionable measures (3) to enable NABH accreditation.

CHAPTER – 3
Methodology

3.1 Key research questions examined were:

- What are the Organization Tree, Vision, Mission, and Services Provided And Information & Human Resource Management?
- What were the findings of the Pre Assessment Team?
- What were the non-compliances observed?
- What were the present statuses of non-compliances?
- What were the processes and motivations of people to understand readiness of organization to meet NABH accreditation?

3.2 The research design: The research design was descriptive. Naturalistic observation was done along with a survey and review of processes and documents.(4)

The Research Procedures Adopted:

3.3 The study was of a nonclinical nature and no medical interventions were carried out. The study population was picked randomly from the functional staff of DDMSC including NOs, Nurses, Admin staff, security personnel, PWD engineers and maintenance staff and finally the doctors including the JRs, SRs, specialists and senior management. Specimens of reports and records generated by groups were analyzed and collected. The various indicators maintained by deptts were collected and reviewed.
Data was collected pertaining to indicators maintained by hospital and compliance of NABH standards by review of documents, registers and daily reports and returns. The data will be analyzed to assess readiness of org to submit itself for full assessment.
Scanned images and copies of various returns will be attached as appendices.

3.4 Research instruments: The following instruments were used:

- Checklists of NABH standards and objective, measurable elements.
- Direct observation of staff and patients
- Diaries, records and registers maintained.
- Review of records.

- Unstructured Interviews and Verbal reports by staff, patients and mgt.
- Infection Control Review. (5)
- Management of Information/Patient Records. (6)
- Analysis of Staff Qualifications and Education.
- Visits & facilities tours. (7)

3.5 The conditions under which the observations were made were during working as well as non-working hours, during day and night, during training, rehearsals, drills and routine maintenance /op activities.

CHAPTER – 4

Results

4.1 Shri Dada Dev Matri Avum Shishu Chikitsalaya is 64-bedded mother & child Hospital situated in Dabri, near Dwarka. NABH accreditation process started in January 2009 & pre-assessment was done on 9th & 10th February 2011. The NABH assessors pointed deficiencies & hospital is in process of removing these deficiencies. These deficiencies can be broadly divided into following categories:

(a) Statutory –licenses related to laws of land such as AERB Certification, building completion certificate etc. (8)
(b) Policies & Manual deficiencies- Formulation of policies in accordance with NABH standards.
© Implementation of formulated policies: Above laid policies have to followed & documented in a structured manner.

4.2 Status on all these categories is as follows-

TABLE 4-1

STATUS

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 2a	Effective implementation of the organization's procedures for registering patients is found deficient. OP slip is not being stamped with "vulnerable patients" in indicated cases (as mentioned on page 9 of SDDMSC/AAC/02/A/ Version 1/ 1st Oct, 2009). For example, CR No. 902	Effective implementation of the organizational procedures for registering patient being done. 'Vulnerable' stamp has been provided and OPD slips are being stamped in indicated cases.	On-site training & sensitization of registration staff being done. Regular rounds being taken. Round register/ training register

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
5a	The organization has a checklist to capture the assessment being done by a Nurse. On reviewing this record of CR No. 1006 and 550 it is noted that height and weight have not been documented. Further, it is noted that Doctors Initial Assessment form does not have column for BP to be recorded or LMP to be written. The same are however being written as a part of initial assessment.	AAC Height and weight being documented in nursing assessment sheets Requisition for initial forms containing LMP has been made with document committee.	Regular on site training is being given to nursing staff. Round Register & letter -diary no 3409.
AAC 5e	Initial assessment in does not include screening for nutritional needs. For example, CR No. 1006 and 550.	A separate form has been made for screening of nutritional needs.	(9)

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 5f	Evidence to suggest that the initial assessment results in a documented plan of care, which is monitored, is found deficient. For example, for CR No. Who is admitted for surgery there is no mention of surgery in the plan of care (only medication orders are present).	Regular sensitization of doctors is being done, both on the spot as well as during classes. Initial assessment sheets have plan of care including mention of surgery, which is being mentioned as well.	It is being done in case files itself in indicated cases.
AAC 7b	Evidence to suggest that adequately qualified and trained personnel perform the investigations is found deficient. For example, nurses and doctors to run tests, get results and use the same for patient treatment are using Piccolo Analyser present in labour room and casualty.	One of the piccolo machines has been shifted to the lab itself. Other machine is in NICU and the staff is being trained by lab. (10)	Sensitization /training of doctors being done on regular basis. Training register maintained / Round register maintained

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 7f	On review of the list of outsourced lab tests it is noted that although PAP smear has been outsourced, the criteria for selecting the lab is not clear. It is being sent to various labs based on the patient's convenience. (11)	PAP smear is being done in SDDMASC lab with all records being maintained .The outsourced labs for other investigations are NABL accredited.	Training of new staff by lab done. Training register being maintained. Regular checks. PAP register being maintained wef Apr. 2011
AAC 8a	Although the organization has a documented lab quality assurance programme implementation of the same is found deficient. For example, External Quality Assurance System for Clinical Haematology and Biochemistry are not being done.	External quality assurance system for biochemistry tied up with CMC Vellore and clinical hematology under process with AIIMS.	CMC Vellore membership username 3819. AIIMS CODE NO 909.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 8d	Periodic calibration and maintenance of all lab equipment is not being done.	Calibration and maintenance of equipment's under warranty period is being done as regular basis. Tender process underway.	Record being maintained in calibration register.
AAC 10b	Evidence to suggest that scope of the imaging services are commensurate to the services provided by the organization is found lacking. For example, the organization does not provide ultrasonography services at present because there is no radiologist to perform the procedure (although it has the equipment). Presently only emergency ultrasonography is being done by the treating doctor.	Outsourcing being done to accredited lab for radiology services, which are not available in hospital under JSSK and EWS scheme.	Forms being counter signed by JSSK In charge. JSSK Circular dated 14 Jan 2012.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 12d	The organization does not have TLD badges for any of the personnel working in Radiology. Further, the lead aprons are not stored properly. They are kept folded.	TLD badges made available to employees and being regularly sent for dosimeter requisition made for hangers for lead aprons and discussed with radiology in charge.	Regular rounds. TLD file being maintained. Letter no. 2400 dated 18 April 12.
AAC 12e	Evidence to suggest that radiation safety devices are periodically tested and documented is found deficient. There are no records of these devices having been tested.	NAHB nodal officer radiology aware about need for periodic testing of radiation safety devices, although they are not in use due to lack of fluoroscopy facility (goggles, thyroid shields, gonadal shields)	Hiring of RSO as consultant under process. Letter dated 20 June 12.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 12g	Imaging signage are not prominently displayed in all appropriate locations. Outside the X-ray room there is only one hand made signage indicating radiation hazard (which too does not adhere to AERB norms).	Bilingual signage displayed outside radiology department.	
AAC 13f	Effective implementation of the policies and procedures to guide the referral of patients to other departments/ specialties is found deficient. For example, although a Physician opinion has been asked for on 25/01/2011 for CR No. 550 there is no documentation of the Physician's notes.	Call books for patient referral made in wards and documentation being done in case sheets.	Regular rounds being taken. Round register being maintained.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 14d	Discharge summary is not given to the patients leaving against medical advice.	LAMA summary being provided to patients.	MRD checks LAMA files while receiving. Register being maintained
AAC 15b	Discharge summary does not contain the significant findings and the patient's condition at the time of discharge.	Discharge summary includes condition of patient on discharge	
AAC 15d	Discharge summary does not contain follow up advice, medication and other instructions in an understandable manner. Phrases like TID are being used.	Regular sensitization is being done for writing proper discharge summary. Discharge summary includes proper follow - up advice, medication and other instructions. Timings being written properly.	Case files being checked during rounds. Round register being maintained

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
AAC 15e	Discharge summary does not incorporate instructions about when to obtain urgent care.	Proper instruction about when to obtain urgent cares being provided to patient in discharge summary.	
COP 1c	Objective evidence to suggest that all care and treatment orders are signed, named, timed and dated by the concerned doctor is found lacking. For example, initial assessment sheet of CR No. 1006, re-assessment notes of CR No. 1006 dated 08/02/2011.	The Staff has been sensitized regarding signing , naming with date & time .	
COP 1d	Evidence to suggest that the care plan is countersigned by the clinician in-charge of the patient within 24 hours is lacking. For example, CR No. 550.	All Deptts. Have started signing care plan.	Regular rounds being taken. Round register being maintained

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 3e	Although equipment in the ambulances is checked on a daily basis it is noted that the same is not being signed by anyone.	Register maintained. Being done now.	Regular checks by HOD's while.
COP 3f	Although medications in the ambulances are checked on a daily basis it is noted that the same is not being signed by anyone.	Register maintained. Being done now.	Regular Training and random checks. In the COP Register -1, record of the daily Random Checks
COP 4a	Evidence to suggest that the organization has a procedure in place for cardio-pulmonary resuscitation is found severely deficient. For example, although a Code Blue has been raised during this assessment even after 20 minutes there was no response.	HOD Anesthesia has already rectified.	Regular Training and random checks. CODE BLUE sheets.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 4c	The events during a cardio-pulmonary resuscitation are not being recorded.	HOD Anesthesia is looking after the same.	
COP 4d	A post-event analysis of all cardiac arrests is not being done.	Code Blue Team has been formed and HOD Anesthesia is the Chairperson. Regular Training is being given. CPR Record sheet has already been put in demand.	The post event analysis is also being done. Morbidity and mortality file.
COP 5c	Evidence to suggest that informed consent is obtained for donation and transfusion of blood and blood products is not found. For example, blood transfusion for CR No. 962.	Informed consent forms for Blood transfusion are available and are being filled.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 7b	Evidence to suggest that care for vulnerable patients is organized and delivered in accordance with its policies and procedures is lacking. For example, the side rails of CR No. 902 are not raised although she is a vulnerable patient. Further, although the organization has toilets for handicapped patients they are not functioning now and are being used for various other purposes.	Mortality and morbidity meets are being done and cases are being discussed. Training is being conducted. Handicapped toilets has been emptied and been made functional.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 8	Although the organization has documented policies and procedures to guide the care of high-risk obstetrical cases, it is noted that in its present system (since there is no ANC card) providing continuity of care to these patients without missing important points is cumbersome.	Amendments have been made in O&G policies and ANC cards made only for high-risk cases.	
COP 11c	Confirmation to suggest that the pre-anesthesia assessment results in formulation of an anesthesia plan which is documented is deficient. For example, CR No. 550.	Now pre anesthesia sheets have Anesthesia plan column and its being done	Staff has been sensitized about the same. Random checks for the same
COP 11d	An immediate preoperative re-evaluation is not documented. For example, CR No. 550.	Now sheets have start column and its being done.	All are sensitized and checked randomly Training schedule and circular.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 11e	A separate Informed consent for administration of anesthesia is not obtained. Presently it is a common form for surgery and anesthesia.	Consents have been made separately by PRE and is being checked that those are attached.	
COP 11f	Documentation of monitoring of respiratory rate, oxygen saturation, airway security and patency and level of anesthesia during anesthesia is found lacking. For example, CR No. 550.	Monitoring is being documented presently.	Case files being checked during rounds.
COP 12c	Although a surgeon has obtained an informed consent it is noted that the same is not dated. For example, CR No. 550 for laparotomy.	It's been dated.	Random checks.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 12d	Implementation of the documented policies and procedures to prevent adverse events like wrong site, wrong patient and wrong surgery is found lacking. On checking the "Pre-operative site verification check list" dated 04/02/2011 for CR No. 550 Check-1 In Anesthetic room is not filled.	The surgical safety checklist is being used so these fallacies have been decreased.	Random checks.
COP 12f	Although a brief operative note is documented prior to transfer out of patient from recovery area for CR No. 550 it is noted that it is neither named nor timed.	Now it's being done.	Checked during rounds. Case sheets.
COP 12i	Evidence to suggest that the validation of air-conditioning of OTs has been done is not found.	Matter pertaining to PWD and is under process	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
COP 13e	Effectiveness of training provided to staff in control and restraint techniques is found deficient. For example, employee number 70748198.	Training is being conducted. Staffs are occasionally questioned about this.	Staff has been sensitized and random checks are being done.
COP 14a	Documented policies and procedures to guide the management of pain are not being implemented.	Pain policies have been amended and only practices that are being followed up are written.	Random checks have been done to decrease error. Pain Management forms being applied in concerned files.
COP 17 b,c,d	Implementation of the organization's documented policies and procedures to guide nutritional therapy is not happening, as at present there is no dietician for the hospital.	Application regarding filling of Dietician's post, sent to DHS.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 1b	The organization's Pharmacy does not have a license.	Pharmacy of SDDMSSC doesn't require license.	Pharmacy of SDDMSSC doesn't require license. Govt. of NCT Delhi Drug control Deptt: Order No. F.13/(18/legal/2012/461 dt.17/4/2012.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 2a MOM 3a	Although the organization has developed a formulary the effectiveness of the same is not evidenced. Some drugs mentioned in the formulary (e.g. T. Ofloxacin 400 mg) are not available, the reason being stock-out. When such instances happen there is no way that the same is communicated to the doctors. In addition there are drugs, which are being prescribed in in the organization but are not present in the formulary (e.g. Urisol). As a result the patient ends up buying medicines from outside. Effective implementation of the documented policies and procedures for storage of medication is not evidenced. For example, near expiry drugs (Inj. Amikacin expiring	Providing available E.M.L. drug list in the O.P.D. and I.P.D. monthly, Maintaining all the E.M.L drug list in the fill in the Pharmacy. Near Expiry drugs are being segregated in the Store properly. Store is lit, clean and air-conditioned. Water Seepage has Been repaired by the P.W.D. Department (Civil).	Training being conducted regularly.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 3d	Evidence to suggest that medications are protected from loss or theft is found deficient. For example, in the present system there is no way to capture the number of medicines actually dispensed.	Pharmacy and store (passages) are under C.C.T.V. surveillance (2) Dispensing register is being maintained in the Pharmacy, regularly checked by Senior Pharmacist and I/C Pharmacy (3) D&T committee is checking and monitoring special drug forms regularly and matching the entries with the dispensing register.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 3e	Although the organization has documented sound alike and look alike drugs, it is noted that this list is improper. For example, T. Atenolol and T. Amlodipine have been identified as look-alike although they are not. Similarly for T. Metrogyl and T. Metformin.	Latest LASA drug list is being made and distributed to all the wards / Labor Room /pharmacy.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 4a	Effective implementation of the organization's documented policies and procedures for prescription of medications. (SDDMSC/MOM/ 04/A/Version 1/ 15th Sept, 2009) is not evidenced. For example, phrases like "CST" are being used. Further, the drug dose is not mentioned. For example, medication orders for CR No. 1006.	Training Session regarding prescription / medication policy is being taken regularly by MOM committee. Target group -Doctors /Staff nurses/Pharmacist (1). Proper name of drugs in the correct dose with the generic name from EML drug list is being used. (2) No abbreviations are being used. (3) Treatment Chart is being maintained in IPD case sheets. (4) Patient is being informed correct dose and route of the medicines by the treating doctor and pharmacist.	Frequent rounds are taken by the members of MOM Committee to ensure all doctors are writing medicines form the E.M.L. list Round register maintained. NABH/MOM/ Reg-3.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 5c	Evidence to suggest that expiry dates are checked prior to dispensing is found deficient. For example, there are cut strips of T. Albendazole which do not have the batch number or expiry date.	Strips of Medicines are being cut only at the time of dispensing, not prior to the dispensing by the Pharmacist and staff nurse on the Duty in the wards.	Information regarding near expiry drug is being sent to the respective HOD's and sister in charges from time to time (3months prior to expiry). Record maintained in the file No.F-8\3.2/16 SDDMASC/M.C/2010 letter No. 134/ Casualty /dt 1/5/2012 letter No. 2/5/ SDDMASC D&T/. Dt 3/6/12
MOM 6d	Evidence to suggest that medication is verified from the order prior to administration is found deficient. For example, for CR No. 1006 T. Brasfen has been administered on 08/02/2011 instead of T. Voveran.	Training Session is being held regularly so that medication errors are not repeated e.g. Correct name of the drug with the correct doses to be prescribed. Staff is verifying the order properly prior to administration of drugs to the patients.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 6e	Evidence to suggest that dosage is verified from the order prior to administration is found deficient. For example, for CR No. 1006 T. Methergine 10 mg has been administered on 08/02/2011 although the dosage for this medication is not mentioned in the orders.	Training session held regarding prescription /medication error.	The members of MOM Committee are taking regular rounds. MOM committee to avoid prescription Medication error is keeping regular checklist. NABH/MOM/Reg-3. All Records maintained in the file and quality indicator Register NABH/MOM/Reg-4 is being maintained

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
MOM 6h	Medication administration for CR No. 1006 for 09/02/2011 has not been documented. Further, it is noted that the documentation does not reflect what has been administered. For example, although T. Brasfen has been given it is documented as T. Brufen. Three medications are mentioned simultaneously (T. FS/CA/BC) in one line to indicate that they have been administered.	All the medicines are being written in the separate lines with correct generic names with correct dose without using abbreviations.	Daily administrative round is being taken by the doctors by roster All Pharmacists sensitized not to dispense essential drugs without SDF's. Administrative round register kept in the casualty which is being checked by the DMS/M.S daily. SDFs register maintained by the I/C Pharmacy. Circular No.106/Cty/dt 13/4/12 Circular No 1632.SDDMASC. dt 13/4/12
			LASA Drug list information sent via letter No. 98/Cty /7/4/2012 - Training Register NABH/MOM/ Reg -2 maintained

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
PRE 1b	Although the patients and families are informed of their rights and responsibilities in a format and language that they can understand it is noted that one of its tools for doing the same namely signage has two versions (one with the name and one without the name of the hospital with differing contents). Further there is a discrepancy between English and Hindi version. Awareness of the same among patients is lacking. For example, CR No. 550.	1. Only one version of the sign board i.e. with the name of hospital have been placed on designated places. 2. Discrepancy between Hindi and English version has been corrected and the same has been forwarded to document committee for further action.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
PRE 2h	The documented patient and family rights (page 14-15 of SDDMSC/PRE/01 /A/Version 1/10th Sept, 2009) does not include information on how to voice a complaint. It only states, "To express your concerns, complaints and or grievance to any of our hospital staff."	1. A general policy on methods of voicing the complaint has been formulated. 2. A grievance committee under chairmanship of DMS (Dr. Brijesh) has been formed in addition; complaint boxes have been placed near entrance of all wards. 3. Way to voice a complaints is announced 4 -5 times every day for OPD and IPD patients and they are also being educated by the staff nurse at the time of admission 4. Feedback forms are being distributed to each patient. PRE committee is analyzing at the time of discharge the feedback received from patients every month.	Photocopies of Bilingual consent forms are provided in all departments. 1.No.F8 (3-1) NABH/SDDMSC/2009/2021-Pediatric consent. 2.No.F8 (3-1) NABH/SDDMSC/2009/270/C-Hindi & English version of anesthesia consent. (3)NO.F8(3-1)NABH/SDDMSC/2009/271/C-Hindi version of minor and major surgery &caesarian delivery. 4.No.F8 (3-1) NABH/SDDMSC/2009/272/C Copies of bilingual consents forwarded to document committee

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
PRE 3b	On reviewing the scope of the general consent form it is noted that it has included procedures, which require a specific consent in it. For example, surgery and anesthesia.	Separate consent forms (bilingual) for each types of surgeries and anesthesia have been made and being placed in concerned files	Grievance committee has been formed and has started acting. Letter no. F1 (57)/SDDMSC/Constitution of committees/2011/2468

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
PRE 3d	On review of the HCO's informed consent process the following deficiencies are observed: No separate consent forms for blood transfusion, anesthesia or surgery. No consent form is available for Endometrial Biopsy done on 25/01/2011 for CR No. 550. CR No. 550 has not been explained regarding the procedure. She has only been asked to "sign" by the junior resident.	1. Separate consent forms for BT Surgeries and anesthesia have been made and being placed in the concerned files 2.The consent of endometrial biopsy is being obtained on the OPD card just before the procedure as it is being done in OPD procedure room 3. Patients are being informed in layman language about the complications and need for particular surgery and confirmation regarding read and understood are being obtained from the concerned doctor in writing in the consent forms. Further gyn. specialist also educate the patient about the complication and need for surgery at the time of giving dates in case of elective surgery.	The PRE committee members from time to time as well as the staff nurse are making patients aware of the same at the time of admission. No. F8 (3-1) NABH SDDMSC / 2009 / 272/C. All consent forms distributed to wards & OT. No. F8 (3-1) NABH /SDDMSC /2009/270/C - Hindi & English version of anesthesia consent. No. F8 (3-2) NABH / SDDMSC / 2009 / 271 / C- Hindi version of minor major surgery & caesarean delivery

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HIC 1b	Although the organization has an infection control committee, effective functioning of the same is not evidenced. For example their minutes of the meetings are not documented in a structured manner.	Committee is taking HIC activities seriously, and weekly minutes of meeting is conducted with proper documentation.	
HIC 1c	The composition of the Hospital Infection Control team is inadequate for a hospital of this size and with so many identified high-risk procedures and areas. There are only two members in the team.	The composition of the HIC team is satisfactory comprising of pathologist, one pediatrician, one medical officer and two nursing staff. There is no microbiologist and microbiology department.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HIC 2d	The organization is not adhering to equipment cleaning practices. For example, in the OT post procedure equipment are just washed (in the scrub area) prior to being sterilized.	Deficiency was rectified by TSSU (THEATRE STERLIE SUPPLY UNIT) and proper maintenance and regular follow up is done.	
HIC 3a	There is no evidence to suggest that surveillance activities in its identified high risk areas are happening.	Continuous surveillance activities are still not happening, as there is no microbiology department. We are in the process to collaborate with the department of microbiology, super specialty hospital for air plate culture and sensitivity. Patient samples are out sourced under JSSK (JANANI SHISHU SURAKSHA KARYAKRAM).	Process of acquiring microbiologist is under process in health & family department f - 8 (3-1) NABH / SDDMSC / 2009 / 2275). New committee formed (documented in policy)(f8 (3-1) NABH / SDDMSC / 2009 / 1713)

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HIC 3b	Collection of surveillance data is not an on-going process. It is collected on an ad-hoc basis and no follow up is being done.	-Do-	
HIC 3c	The infection control team does not do verification of data.	Committee on regular basis does verification of data.	Evidence documented in the f5(55/1) DDMSC / HIC / 2008 / 2198

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HIC 3f	Evidence to suggest that surveillance activities include monitoring the effectiveness of housekeeping services is found deficient. For example, a stink is found emanating from the first floor toilet between A and B wing. Further, on the duty roster outside the "Male" toilet there is no signature for evening and night whereas outside the "Female" toilet morning, evening and night has already been signed for 09/02/2011 by 1430 hours.	Housekeeping and nursing orderlies are trained for different surveillance activities and new checklist are issued department wise. Monitoring and proper follow up is done.	Evidence documented in the f5(55/1) DDMSC / HIC / 2008 / 2198.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HIC 5b	Compliance with proper hand-washing is not being monitored.	Conducting training classes for" and washing "Monitoring of doctors, nurses and technicians. Monitoring is done according to WHO Guidelines.	Register (HIC - R-1) for documentation maintained.
HIC 7a	The organization is not authorized by prescribed authority for the management and handling of Bio-medical Waste. It only has an approval to “Establish”. The organization has applied for the same on 04/11/2010.	BMW License is available with BMW NODAL OFFICER.	BMW License is available with BMW NODAL OFFICER. F.5 (7)/SDDMSC/Bio-Medical waste/2008
HIC 9b	The organization has not earmarked separate funds from its annual budget for infection control activities.	For earmarked fund already discussed with NABH Nodal Officer.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
CQI 1b	Effective implementation of its documented quality improvement programme (SDDMSC/CQI/01/A/Version 1/, 24th Feb, 2010) is found deficient. Other than capturing the indicators none of the other aspects are being implemented.	QCC reconstituted. It is regularly reviewing performance of other committees. It is holding its regular meetings. Holding regular morbidity & mortality meetings. All maternal deaths are reviewed at hospital, district and state level.	
CQI 1f	The quality improvement programme is being reviewed only one in six months and not at-least once in four months as laid down in the guidebook..	Review is being done every month.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
CQI 2j	Evidence to suggest that monitoring includes data collection to support further improvements in clinical structures, processes and outcomes is found deficient.	Morbidity and Mortality meetings have been reconstituted to discuss deaths, sentinel events and unusual case problems.	
CQI 3h	Evidence to suggest that monitoring includes data collection to support further improvements in managerial structures, processes and outcomes is found deficient.	Regular meetings.	
CQI 4b	Hospital has not earmarked funds from its annual budget for quality improvement.	NABH nodal officer has requested to earmark separate budget for NABH, which will further put budget for quality improvement.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
CQI 5	There is no established system for audit of patient care services. Clinical audits are not being performed as of now in the organization.	Regular clinical and medical audits are being done.	Regular training session has been organized for patient safety, BMW, Clinical Audit and Fire safety, CPR. Review committee is meeting every two weeks. Audit is done as per guidelines from MOHFW, GOI e.g. clinical audit class on 18/5/12, meetings on 31/5/12&1 june12, mentioned in training register.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
ROM 1a	Although the organization has developed a mission there is a difference in the same. Page 5 of Apex Manual states “To provide state of Art Health Service in mother & child health par excellence with best in world in terms of quality. Individuals within the communities we serve are assured access to quality health care regardless of ability to pay.” Whereas on its website it states “SDDMSC Hospital is a Mother and Child Hospital dedicated to provide quality, value driven health care services with responsibility, care and trust to all we serve at free of cost/ affordable cost. Individual within the committees we serve is assured access to quality health care	Mission and vision statement changed in website as per Mission and Vision statement.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
ROM 1b	The organization does not have documented strategic and operational plans. It only has budget plans and projections.	Strategic and operational plans documented.	Strategic and operational plans documented. Refer PIP plan 2012 - 13 annual plan
ROM 1d	Evidence to suggest that those responsible for governance monitor and measure the performance of the organization against the stated mission is found deficient.	Performance is regularly reviewed.	
ROM 1e	Although the organization has an organogram it is noted that it does not reflect the reporting system in the organization. For example, reporting of JR and SR.	JR and SR sensitized about organogram and about the reporting system.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
ROM 1h	The organization does not have a Building Completion Certificate. Further, it does not possess a permit to have rectified spirit.	Matter taken with PWD and letter written too expedite BCC.	
ROM 5a	The organization does not have an interdisciplinary group assigned to oversee the hospital wide safety programme.	Safety committee reconstituted.	Morbidity & Mortality meetings.
ROM 5d	The organization has not done a comprehensive risk assessment and risk reduction activities. However, the management is aware of a few risks and is able to explain the measures taken to reduce the same.	Risk assessment done and various policies formed for BMW, safe blood, needle stick injuries and enforced .	Patient safety and risk assessment committee formed and earmarked for risk assessment.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 1a	Evidence to suggest that the management is conversant with the laws and regulations and knows their applicability to the organization is found deficient. For example, It is not maintaining "Admission Register" for its MTP cases. Yearly calibration of HT relays is not being done.	Admission register for MTP cases is prepared in OBG department. Requested to PWD (E) for yearly calibration of HT relays.	Regular meetings/ Minutes .

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 1d	Evidence to suggest that there is a mechanism to regularly update licenses/ registrations/ certifications is found deficient. For example, its narcotic authorisation (No. F 7 (12/84)/2010/NAR /DC/7376 dated 05/08/10) has expired in 2010.	Regular updating is being done by the concerned deptts. For fire safety by PWD (E), BMW by HIC. Narcotic license not required.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 2a	Although the HCO has a documented maintenance plan it was observed that the manufacturer's recommendations are not being followed. For example in the case of DG sets A check is not being documented. Further, there is no structured preventive maintenance being carried out.	Documented maintenance plan has been enforced and manufacturer's Recommendations are being followed. Maintenance cell is documenting for operational and maintenance plan.	
FMS 2b	The organization does not have documented fire escape routes.	Fire exit routes are there with signage boards. Requested PWD (E) for proper documentation with map for fire exit. Route.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 2d	The provision of space in the current OT is not in accordance with available literature. For example, there is no zoning evidenced. Further, the hospital has not adhered to some of the minimum requirements that a hospital of its size needs to have (reference IPHS standards). For example, there is no Blood Bank or Blood Storage Unit. However, the organization has started work on this and a correspondence dated 01/02/2011 regarding the same has been reviewed by this team.	1.In MAIN OT 3rd floor zoning is accorded. 2.There is blood storage center since 8 May 12	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 2g	The response times are not being monitored from reporting to inspection and implementation of corrective actions.	For corrective actions response time is to be maintained as per the evidence	Regular rounds.
FMS 3e	Evidence to suggest that equipment is periodically calibrated for their proper functioning is found lacking.	Maintenance Deptt. Of hospital is working for periodical calibration of equipment's.	
FMS 3f	Evidence to suggest that the documented operational and maintenance (preventive and breakdown) plan is being implemented is found deficient.		Matter taken with PWD.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 4c	Evidence to suggest that the organization regularly tests alternate sources of water is found deficient. At present the organization receives its soft water exclusively by tankers. The quality of this water has not been tested at any point of time. A test has been conducted in Oct 2010 of the quality of water from the tank.	Water tankers come through DJB certified water plants. Quality cleaning of water tanks is being done by PWD (CIVIL).	Regular tests of water are done as per policy. F1. (5)/PWD/SDDMSC REQUESTED PWD (CIVIL) for quarterly test of water
FMS 5a	At present none of the organization's fire safety system is working. Most of the fire extinguishers need to be refilled, fire hydrants do not work, smoke detectors are dysfunctional and so too the fire alarm panel.	PWD (E) is correcting all defects in fire fighting system. Training calendar is being prepared fortnightly.	Mechanism regarding regular updating of various Licenses is under process NOC for fire safety by PWD (E) F.1. (5)/SDDMSC/PWD .

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 5b	The fire exit signage does not follow the recommended color coding (4.2.7 of National Building Code). The fire exits are mentioned in red color. In fact there is another signage system just mentioning "Exit: which is in green color. Moreover, some of the directions are confusing. For example, there are two signage indicating the exit at back lift of 2nd floor A wing, one points down and the other points to the right (facing it).	. The wrong signage are removed, new signage are being placed. Requested to PWD (E) for proper color-coding of fire exit signage.	Matter pertaining to PWD (E). F.1. (5)/SDDMSC/PWD.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 5c	Effectiveness of fire safety training for staff is found deficient. For example, two of its contractual employees (both involved in fire-fighting activities) are unable to distinguish between the classes of fire.	Fire safety training is regularly going on.	Fire safety system is under repairs by PWD. Letter no. 4(1)A.E.(E)/PWD, EMD,M-152/04 DT.24.1.12 FROM PWD Deptt
FMS 5d	Although the organization has conducted a mock fire drill it has not documented any of the events that happened during the same, variations that were observed and the points that need to be improved.	Documentation of mock fire drill is being done.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 7e	Although the organization has conducted a mock disaster drill it has not documented any of the events that happened during the same, variations that were observed and the points that need to be improved.	Disaster drill is to be done in the hospital through I/c Casualty.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
FMS 9d	The organization has not conducted any facility inspection rounds. Further, during the facility inspection rounds conducted during this assessment the following deficiencies are noted: No electrical safety mats in Lift machine room of B wing, Electrical rising main (440 V) between A and B wing (2nd floor). No fire extinguisher near the DG sets. Open wires near the Ground floor OPD in front of immunisation room.	Requested to PWD (E)/civil division for the deficiencies related to their area.	Services for preventive maintenance is being carried out. Check for DG set is being documented in substation room register PWD (E). Requested PWD (E) for proper documentation with map for fire exit.

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HRM 1a	The organization at present has 17 nursing posts, 1 dietician, 1 radiologist and 1 physiotherapist post vacant. As a result care delivery to patients is suffering because it is unable to provide nutritional and rehabilitation services to its patients. Further, only X-ray facility is being provided top the patients. In wards during night time the nurse: patient ratio is as high as 1:24.	Nurses working on diverted capacity from NRHM. New 11 posts of Nurses approved.	
HRM 2a	The organization at present is not conducting induction training for its employees.	Monthly Induction Training is being taken.	
HRM 3a	No documented training calendar for the staff.		

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HRM 3c	There is no evidence to suggest that feedback mechanisms for assessment of training and development programme exist.	Feedback mechanism has been developed.	
HRM 5d	Evidence to suggest that the appraisal system is used as a tool for further development is not found.		
HRM 8c	Regular health checks of staff dealing with direct patient care are not being done at-least once a year. It is being done only at the time of recruitment.	Regular Health checkup is being done	
HRM 11a	The organization has no done privileging for its medical professionals.	Privileging process has been started.	

NABH Ref	Deficiency	Corrective action taken	Preventive Action Taken
HRM 13a	The organization has not done privileging for its nursing staff members.	Privileging process has been started.	
IMS 7a	The medical records are not being reviewed periodically.	The medical records are formed and reviewed periodically.	

Document review observations:

General Comments (12)

4.3 Duplication of documentation can be avoided. The scope of services is mentioned in the Apex Quality Manual & also in SDDMSC/AAC/01/A/Version 1/1st Oct 2009. Instead appropriate linkages could be given.
Status –Closed

4.4 Some of the pages/text is in red color.
Status~~– Noted for Compliance~~/ Closed/ ~~Under Process.~~

4.5 Some manuals have unrelated test. For example, on page 36 of SDDMSC/COP 09 /A/ Version 1/ 21st Jan 2010 has the following statement "*To be added in the manual-Final 03/Aug./10 by Dr Solanki*". Status – Noted for Compliance/ Closed

4.6 A thorough spell check is required. Status – Noted for Compliance/ Closed

4.7 References are not proper. For example, on page 13 of SDDMSC/HIC/02/ Version 1/15th Feb, 2010 there is a statement which states "(se Section 5.2.7)" although such a section does not exist in the document. Status – Noted for Compliance/ Closed.

4.8 Some of the content is blank. For example on page 16 of SDDMSC/BMW/08/A /Version 1/ 18th Dec, 2009 there is a statement which reads "*4. General waste from this facility is taken by the ……..*" Status – Noted for Compliance/ Closed

4.9 Repetition can be avoided. For example, the entire procedure for CPR has been mentioned in the Safety Manual (SDDMSC/FMS / 02/A/Version No 1/ 29th Jan, 2010) although there is a separate document (SDDMSC/COP/04/A/ Version 1/ 25th Nov, 2009) for the same. Status – Noted for Compliance/ Closed
In many manuals there is mention of future expansion/plan. The documentation should cover the present functioning of the organization. Status – Noted for Compliance/ Closed.

4.10 Page numbers do not tally. For example in SDDMSC/COP 09 /A/ Version 1/ 21st Jan, 2010 the page numbers mentioned in the Table of Contents and the page number of the actual content does not match. Status – Noted for Compliance/ Closed.

Specific Comments (13)

4.11 The organization has not defined the time frame within which the initial assessment is completed for outpatients and emergency patients. – AAC 5c Status – Noted for Compliance/ Closed

4.12 The established Quality assurance programme for imaging services (SDDMSC/AAC/11/A/ Version 1/ 12th Nov, 2009) does not address verification and validation of imaging results. – AAC 11b Status – Noted for Compliance

4.13 The established Quality assurance programme for imaging services (SDDMSC/AAC/11/A/ Version 1/ 12th Nov, 2009) does not address surveillance of imaging results. – AAC 11c

Status –Under Process. (14)

4.14 The established Quality assurance programme for imaging services (SDDMSC/AAC/11/A/ Version 1/ 12th Nov, 2009) does not include the documentation of corrective and preventive actions. – AAC 11e

Status – Noted for Compliance/ Closed/

4.15 On review of the organization's documented procedure handling of medico-legal cases (page 17 of SDDMSC/COP/02/A/ Version 1/ 16th Nov, 2009) it is noted that it has not documented as to what constitutes a MLC. There is only a statement stating, "*This shall be decided by CMO*." Further important practices like capturing identification marks or filling MLC register are not mentioned. – COP 2b

Status –Closed

4.16 On review of the organization's documented procedure to guide the triage of patients for initiation of appropriate care (page 16 of SDDMSC/COP/02/A/ Version 1/ 16th Nov, 2009) it is noted that although it has identified 4 categories of patients it has not documented as to who would fall in which category. It has only stated terms like "*alive, requires emergency care; alive, does not require emergency care*" etc. It is not possible to identify from the document as to how the decision regarding requirement of emergency care is decided. – COP 2d

Status – Noted for Compliance/ Closed (15)

4.17 The organization's documented procedure for vulnerable patients (SDDMSC/COP 07/A/ Version 1/ 28th Oct, 2009) does not mention about the procedure for obtaining informed consent from the appropriate legal representative. – COP 7d

Status – Noted for Compliance/ Closed

4.18 Although the organization has documented adverse drug events (page 8-9 of SDDMSC/MOM/08/A/ Version 1/23*th* (rd) Sept, 2009) it is noted that this does not adhere to the definition mentioned in the Guidebook. – MOM 8b
Status – Noted for Compliance/ Closed

4.19 The organization's documented policy for use of medical gases (SDDMSC/MOM/13/A/Version1/30th Sept, 2009) does not address safety. – MOM 13b
Status – Noted for Compliance

4.20 Although the organization has documented patient and family rights and responsibilities it is noted that in its documentation there are two versions of the same: page 3-4 of SDDMSC/COP/01/B/ Version 1/ 10th Nov, 2009 and page 14-15 of SDDMSC/PRE/01/A/Version 1/10th Sept, 2009. – PRE 1a Status – Noted for Compliance/ Closed

4.21 Although the organization has identified the various high-risk areas and procedures it is noted that the same has not been done uniformly. For example, the list of high-risk areas mentioned on page 7 of SDDMSC/HIC/02/A/ Version 1/4th Feb 2010 does not match with the list of areas mentioned on page 15 of SDDMSC/HIC/01/A/ Version 1/1st Feb 2010. There is another list mentioned on page 7 of SDDMSC/HIC/03/A /Version 1/ 1st Feb 2010. Similarly for high-risk procedures. – HIC 2a
Status – Noted for Compliance/ Closed

4.22 Engineering controls to prevent infections are not included in the Infection control manual. – HIC 2h
Status – Noted for Compliance/ Closed

4.23 The organization has not documented its established recall procedure when breakdown in the sterilization system is identified. – HIC 7c
Status –Under Process.

4.24 Although the organization has a documented quality improvement program it is noted that the major elements related to risk management are not covered. – CQI 1d
Status –Closed

4.25 The organization has not documented its established processes for intense analysis of sentinel events. – CQI 6b
Status – Noted for Compliance/ Closed

4.26 There is no documented operational and maintenance (preventive and breakdown) plan. Its document (SDDMSC/FMS/02/B/ Version 1/15thJan, 2010), which is supposed to cover this, does not mention any details regarding how these activities will be carried out. It only states "*Organization has framed and documented its procedures for*

operational & maintenance (preventive and breakdown) plan, which includes all such aspects throughout the whole organization. Monthly inspection to be done by the PWD engineers in co-ordination with SDDMSC Nodal Officer for PWD and to document it in as annexure 1." – FMS 2a
Status –Under Process.

4.27 The organization has not documented employee rights and responsibilities. – HRM 2c Status –Closed

4.28 Policies and procedures to meet the information needs are not documented. Its document regarding the same SDDMSC/MRD/01/A/Version 1/28th Jan 2010 does not address this. – IMS 1b
Status – Noted for Compliance

4.29 The organization has not documented procedures for storing and retrieving data. Its document regarding the same SDDMSC/MRD/01/A/Version 1/28th Jan 2010 does not address this. – IMS 2d
Status – Noted for Compliance
4.30 Organization has not identified those authorized to make entries in medical record. . Its document regarding the same SDDMSC/MRD/01/A/Version 1/28th Jan 2010 mentions about a protocol for entries in medical record. – IMS 3b
Status –Closed
4.31 Documented policies and procedures do not exist for maintaining integrity of information. Its document regarding the same SDDMSC/MRD/01/A/Version 1/28th Jan 2010 does not address this. – IMS 5a
Status – Noted for Compliance/ Closed

4.32 Comments on the application form:

1. 64 beds are operational now.
2. The organization does not have CT and MRI. It does not serve other organizations.
3. The organization does not have a Blood Bank.
4. Total Parenteral Nutrition is not being manufactured.
5. The ambulance service is outsourced.
6. There are no ambulatory units.

7. The maintenance is outsourced to PWD.

TABLE 4.2
Census for 2014:

Average per month	2085.00
Average daily	77.22
Average discharge per month	1010
Average daily discharge	37.40

CHAPTER – 5

Discussion

5.1 The hospital is young; barely eight years since its inception in 2008. The hospital has charted an ambitious growth trajectory and over just a few years added a No. of amenities to its portfolio after making humble beginnings with just OPD facilities.

5.2 Under the stewardship of its past and present senior management the hospital provides quality healthcare to its catchment areas of southwest district. Dr Rekha Aggarwal, the present MS, Dr. Deepmala Kaul, the DMS, and Mrs. Pratima Bhatia, the AO provide inspirational leadership to the team of professionals that spearhead the healthcare delivery and administration in the organization.

5.3 During the tours it was noticed that a very tight ship is being run, and the staff are very concerned about quality and safety issues. The staff is highly motivated, and this translates into a very high bed census rate, and minimal adverse events. (16) Only two maternal deaths have been reported in the period of observation and no codes were raised. The patients are treated very respectfully, and their satisfaction level is of a very high order.

5.4 It is indeed praiseworthy that an organization should strive for NABH accreditation, just within three years of its raising. It shows its commitment to the noble task at hand, and how seriously it prides itself on the care it delivers, in quality as well as quality. Despite a heavy workload, and nearly 40% manpower deficiency, which it is trying hard with DHS to ameliorate, rarely are voices raised or tempers frayed. There have been no instances of severe, notable disciplinary or penal actions, and harmonious and cordial relations are maintained among staff. (17) The OPD figures for Jan 2014 were 14507 and for Feb were 15717, which shows the high No. of daily footfalls in the clinics. A sample indication of detailed activities performed during the periods which will demonstrate its mammoth workload were:

TABLE 5.1

ACTIVITIES PERFORMED

Area	Feb 2014	Mar 2014
OPD	14507	15717
IPD	1485	2756
OT	266	220
MTP	31	29
CU T	231	121
ANC	4319	4279
X RAY	0	56
LAB TEST	34951	30684
ECG	172	183
VACCINATION	3440	3031
CASUALTY	2133	2029
STERILISATION	58	53
LSCS	123	86
DELIVERIES	620	523

5.5 Shri Dada Dev Matri Avum Shishu Chikitsalaya is 64-bedded mother & child Hospital situated in Dabri, near Dwarka. NABH accreditation process started in January 2009 & pre-assessment was done on 9th & 10th February 2011. The NABH assessors pointed deficiencies & hospital is in process of removing these deficiencies. These deficiencies can be broadly divided into following categories:

(a) Statutory –licenses related to laws of land such as AERB Certification, building completion certificate etc.

(b) Policies & Manual deficiencies- Formulation of policies in accordance with NABH standards.

© Implementation of formulated policies: Above laid policies have to followed & documented in a structured manner.

5.6 Status on all these categories is as follows-

Category A: Statutory.

5.7 They have obtained all licenses except to be provided by PWD. Hence it is suggested it may taken up at secretariat level:

- Building completion certificate via PWD to MCD.
- Pollution under control certificate via PWD to Delhi pollution control board.

Category B: Policies & Manual deficiencies.

5.8 They have mostly corrected this category of deficiencies.

Category C: Implementation of formulated policies.

5.9 For implementation of policies as suggested by assessors manpower is deficient as per their report:

"S No55- The composition of the Hospital Infection Control team is inadequate for a hospital of this size and with so many identified high risk procedures and areas. There are only two members in the team."

5.10 Hence proposal for additional manpower has already been sent to HR department for pursuing with Delhi govt. which includes posts of:

1) Microbiologist. (NA).
2) Infection control & BMW nurse.
3) Technicians etc.

S. No. 9 "Evidence to suggest that scope of the imaging services are commensurate to the services provided by the organization is found lacking. For example, the organization does not provide ultrasonography services at present because there is no radiologist to

perform the procedure (although it has the equipment). Presently only emergency ultrasonography is being done by the treating doctor"

5.11 For services such as Diagnostics including radiology are being obtained from Private lab by having MOU at DGEHS/ Open tender rates till in-house services are made available.

5.12 The state of quality consciousness and adherence to standards in various critical facilities is discussed as follows.

Area: Medical Record Department (MRD)

Conformances:

- Sanitation was good.
- Fire well signage's and safety equipment were adequate general polices were adequately known (among nursing orderly's & house-keeping staff).
- Hygiene/ medical records were neatly kept.
- Departmental policies existed:
    - Record retrieval.
    - Confidentiality of record.
    - Reporting of notifiable infection.

Proposed Corrective Actions:

- Intensive implementation of the departmental policies.
- Pest control and other physical and environmental parameters to be ensured.
- More Storage cabinets be procured.

Area: O.P.D.

Conformances:

- General sanitation is very good.
- Nursing orderlies and housekeeping staff are very well oriented w.r.t hospital infection control policies and B.M.W
- All signage's (including mission, vision, emergency code) hand washing procedure well displayed in the O.P.D premises.
- Fire exit signage's are well displayed, fire safety equipment are well installed.
- Crash cart is complete as per standard checklist present.

- Monitoring of the temperature of refrigerator. Where the all vaccination are stored done 3 times a day.
- Records time maintained properly.
- Mission, vision, emergency codes are well known to doctors, staff, no's.

Proposed Corrective Actions:

- Mission, vision emergency codes, and other scope of services must be well known to security guards & NO'S.
- Patient waiting area spaces be enhanced. Seating arrangements be made outside the building in front space.
- The entrance and exit of hospital must be cleared of all vendors, rickshaws and waiting vehicles etc. If necessary barriers be installed at road itself. This will facilitate access of ambulances.
- Corridor congestion be removed by constructing annexes'.
- Dress changing room be made available for staff, NO's.
- Female security guards to be posted in Gynae department and also male/female security guards must be deputed for patient queues in OPD area & waiting areas.
- Complaint boxes be placed in OPD 'A block and B block.
- Induction training be increased for security guards and nursing orderly at department level.

Area: Operation Theater (OT)

Conformances:

- General sanitation is good.
- Fire exit signage's are well displayed. Fire safety equipment (fire extinguishers & other sprinkler with alarm system) are well installed & in adequate number.
- Nursing orderlies and housekeeping staff are very well oriented w.r.t hospital infection control policies.

Proposed Corrective Actions:

- More Mission, vision statements, PRE, emergency codes with contact number and other hand-washing posters need to be displayed on boards.
- Stretcher (with side rails on both the side) and wheel- chair with safety belt needs to be provided and should be rust free and in good working condition. Designated area should be marked for keeping it. These can also be locked with chains.

- Zoning concept be followed to discourage free movement of visitors.
- Instrument washing areas be provided
- Narcotics be stored in double lock system.
- Monitoring of the temperature of the refrigerator where drugs/vaccines are stored be done and logged at stipulated intervals.
- Crash cart must have all items as per the standard checklist.
- Need booklets/leaflets on Lab – qualification of staff as per NABL 112 and ISO 15189 not there.

SUGGESTED REMEDIAL ACTIONS & RECOMMENDATIONS

5.13 List of formulary & high-risk medication needs to be made available.
5.14 All records register needs to be labeled properly in proper condition.
5.15 Tracking of indicators be done.

Area: Pharmacy

5.16 Adequate space & storage cabinets be provided. Look–alike & sound-alike drugs be stored separately. Adequate pest control measures to be taken.

Area: TSSU

5.17 For transport of the sterile and unsterile material more trolleys are required. Proper area for TSSU is suggested

Area: Ward

5.18 No disposable towels.
5.19 Bed allocation for different specialties to be defined.

Misc

5.20 Certain misc. activities can further improve the functional processes of the hospital as per other NABH standards are discussed below: -

AAC

- All registers and forms used in hospital must be numbered and linked to master NABH file.
- In due course Deptt may consider patient tracking systems by barcoded wrist bands.
- ISO 15189 be followed for lab QA and calibration.
- Deficiencies of radiologist and microbiologist have been taken up and must be pursued vigorously.

COP

5.21 Training is well oriented towards NABH aspects. A Master Training register be opened to briefly record on a single page the following:

- Subject/NABH reference.
- Speaker& Attendees
- Brief notes.

5.22 Hospital may consider acquiring its own ambulances with trained staff.

5.23 ANC cards be diligently maintained.

5.24 Circumstances for restraints be diligently and unambiguously stated in SOPs.

MOM

5.25 Very stringent standards have been implemented and excellent records are maintained.

5.26 SOPs on vendor selection, rating, stock outs, and inventory control techniques using the power of automation be exploited.

5.27 LASA lists, formulary and policy on self-administration of medicines be widely promulgated.

PRE

5.28 Citizens charters, signage's, records and grievance redressal mechanism is adequate.

5.29 Specific consent for procedures must be diligently assured.

HIC

5.30 Another well documented area of the hospital. A highly motivated team is complying with nearly all standards.

5.31 The Anti biotic policy must be revised every three months.

5.32 The HIC manual must be updated regularly.

5.33 The hospital infection control program must be well circulated.

5.34 Infection rates must be risk adjusted.

5.35 A newsletter on HAI be published.

5.36 Funds for HAI be earmarked.

IMS

- Compliance be made to mission mode project of delhi govt.
- IMS be modeled along lines of AIMS Trauma Center.
- GA Digital has scripted the OPD regn system which is automated.
- Funds have been received for MRD digitization. These must be expended fruitfully.

5.37 MCTS (Mother Child Tracking System) is being adequately implemented. It is linked with JSSY grants and funding system. Can do with more staff though. It provides an 18 digit unique coding system, which connects, to GOI through Internet. Through UID all patient details can be viewed.

5.38 Store inventory management system needs to be developed.

5.39 Presently the IMS team is working on CMS (CENTRAL MGT SYSTEM) which can remotely access website on java platform.

5.40 All 64 indicators must be monitored online.

5.41 The hardware Mgt and AMC is done by PWD. The AMC of UPS and systems is under progress.

5.42 A computer cell with adequate staff may be created.

5.43 There is no separate IT Head for funding. May consider if deemed appropriate by higher mgt. the constraint is that for every decision Delhi govt. must be consulted, including disposal.

5.44 MRD

- Med records must be reviewed annually.
- The MRD has done well to color code the files on basis of deptts. It may change the file covers and get them reprinted to include details of CR No., ICD No., Pt details, Diagnosis, Discharge state and have a checklist on the inner cover.
- Stamp , date , designation must be filled in by doctors.
- Nursing education form must be filled in completely.
- Different persons should be responsible for prescription, administration and monitoring of medication.
- Path/lab reports must be signed.
- Death/LAMA cases must be dealt with great care.
- Cataloguing must be done.
- Public dealing of MRD is exquisite. Patients are treated with great care and respect. Which is most heartening.
- The indexing of records may be as per ICD.
- A patient master index be prepared in alphabetical order.
- The progress notes must be filed in chronological order.
- TPR chart must have all details- not just T.
- Diploma and certificate holder persons be deployed in MRD (MRT).
- It may be reorganized as Census desk, Vital Stats desk, Discharge desk, coding & indexing desk.
- The staff and space is adequate as per standards:
    - <99 beds - 50 sq. meters
    - MRT - 1
    - Clerk - 1

- Attendant - 1

- MIS / HIS must be automated earliest, following in the footsteps of Guru Gobind Hospital.
- There must be a statistical bulletin and data management policy on safeguards.

5.45 CQI

- The quality manual must be reviewed once in six months.
- Key indicators must be monitored.
- Quality audit be done regularly.
- Funds must be allotted.

5.46 ROM

- Building completion certificate is required.
- Rectified spirit permission has been acquired.
- Reporting system in organogram has been defined.
- Safety org must be spelt out.

5.47 HRM

- The vacancies of nurses (17) must be vigorously pursued as it adversely impacts nurse-patient ratio (1:20).

5.48 FMS

- A master maintenance manual be prepared.
- Equipment calibration by third parties be done.
- Water testing be done by Director Treatment and QC at Wazirabad water works.
- Facility inspection rounds must be done twice a year.
- All drawings of site plans, floor plans and exits be kept with facility managers.
- Logbooks and history sheets be opened.
- Schedules of equipment inspection be laid down.
- Emergency illumination plans be made.
- FNEC committee be formed. (Fire non-fire emergency committee).
- NOC of FF systems has been issued by PWD vide letter no DDH/AE(E) 1521/PWD EMD M-152/12-13/572 DT 30/10/2012.
- Delhi Fire Service has found all shortcomings rectified vide letter no F-6/DFS/MS/2012/3234 DT 4 SEP 12.

5.49 Disaster Manual

- All tele no's be mentioned for codes.
- Show code review forms and sign by code leaders.

- Display individual responsibilities lists.
- Inspection and mock drills be done per quarter and records maintained.
- Display duty rosters of safety persons.
- Conduct mutual fire aid with local fire stations.
- PMG doesn't exist- please remove from list.
- Equipment supposed to be carried by fire control persons must be reviewed.
- No of fire teams should be clear (3 or 4)?
- ERT composition be spelt out.
- There is no night shift engineer- amend manual.
- There are no safety officers, CEOs, Engineering Directors, bomb threat action commands, assembly areas, OIC housekeeping, medical gas pipeline plants, fire wardens, emergency commands, IRTs, HsOD engineering, I/Cs PWD, staff cafes, fire control rooms, fire pump houses, maintenance engineers, front office desks or emergency base stations- these be deleted from manual.
- OIC security is doing a lot of work: carrying keys, fighting fire, clearing car parks, informing local police, organizing cordons, carrying out evacuation, preventing pilferage, taking attendance of customers/visitors and doing roll call! His duties be reviewed.
- Similarly OIC reception (who he is, is not known) is a busy man: he takes roll calls (like OIC Security), organizes search & evacuation (again ike him). his job be reviewed.
- OIC Kitchen is to provide manpower for fire fighting! May review.
- Doctors are to provide wheelchairs- may review!
- Hospital staff cannot evacuate bombs. They must not be touched. Please review.
- Disaster vests, jackets and armbands be procured.
- Who is incident command?
- There should be color coded bands for triage.
- Place for triaging be earmarked.
- Earthquake training be done once in six months.
- Week long hazard training be done every year.
- Indoor patients do not have a dress code.
- There is no DJB water supply and RO plant. Please delete.
- Water testing be done every six months.
- Annual evaluation of safety be done.
- The following points may be added:
    - Communication plan.
    - Buddy system.

- Checklists.
- Recovery plan.
- Alert states- normal function/recall from leave/total evacuation.
- Debriefing.
- Insurance.
- Triage flows->holding->definitive care areas.
- Drills.
- Types of disasters
- Types of injuries
- Staff/supplies required.
- Additional bids.
- Damage assessment- ac, elevators, structure, water supply and sewage.
- Emergency disaster kits- battery, torch, etc.
- Hiring during disaster.
- PIO.
- The manual can have following headings:
- Objective.
- Scope.
- Intro.
- Responsibilities.
- Definitions.
- Responsibility of announcement system, shutting off electricity, switching on generators etc. be spelt out.

Chapter – 6

Conclusion

6.1 National Accreditation Board for Hospitals and Health Care Providers (NABH) is a constituent Board of QCI, set up with co-operation of the Ministry of Health & Family Welfare, Government of India and the Indian Health Industry.

6.2 The ten chapters of NABH standards cover all aspects of functioning of an HCO as under:-

- ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC).
- CARE OF PATIENTS (COP).
- MANAGEMENT OF MEDICATION (MOM).
- PATIENT RIGHTS AND RESPONSIBILITIES (PRE).
- HOSPITAL INFECTION CONTROL (HIC).
- CONTINUOUS QUALITY IMPROVEMENT (CQI).
- RESPONSIBILITIES OF MANAGEMENT (ROM).
- FACILITY MANAGEMENT AND SAFETY (FMS).
- HUMAN RESOURCE MANAGEMENT (HRM).
- INFORMATION MANAGEMENT SYSTEM (IMS).

6.3 The steps in accreditation process are as follows:

- Already Complete:

- Application for accreditation (submitted by the Healthcare Organization).

- Acknowledgement for accreditation (by NABH secretariat).

- Pre assessment visit (by Assessor).

6.4 In Process:

- Final assessment of hospitals (by Assessment Team).
- Scrutiny of the assessment report (by NABH secretariat).
- Recommendation for accreditation (by Accreditation Committee).
- Approval for accreditation (by Chairman NABH).
- Issue of accreditation certificate (by NABH secretariat).

6.5 The benefits of accreditation are enormous and affect positively the patients, the HCO as well as the community, as follows:

- Highest quality of care.
- Credentialed and privileged medical staff.
- Trained and evaluated staff.
- Access to a quality focused organization.
- Rights are respected and protected.
- Understandable education and communication.
- Satisfaction is evaluated.
- Involvement in care decisions and care process.
- Focus on patient safety.
- Improves professional staff development.
- Provides education on consensus standards.
- Provides leadership for quality improvement within medicine and nursing.
- Increases satisfaction with working conditions, leadership and accountability.
- Stimulates continuous improvement.
- Demonstrates commitment to quality care.
- Raises community confidence.
- Comparison with self and other similar organizations
- Quality revolution.
- Disaster preparedness.
- Access to comparative databases.

6.6 Shri Dada Dev Matri Avum Shishu Chikitsalaya is 64-bedded mother & child Hospital situated in Dabri, near Dwarka. NABH accreditation process started in January 2009 & pre-assessment was done on 9th & 10th February 2011. The NABH assessors pointed deficiencies & hospital is in process of removing these deficiencies. These deficiencies can be broadly divided into following categories:

(a) Statutory –licenses related to laws of land such as AERB Certification, building completion certificate etc.
(b) Policies & Manual deficiencies- Formulation of policies in accordance with NABH standards.
© Implementation of formulated policies: Above laid policies have to followed & documented in a structured manner.

6.7 In order to achieve NABH standards and succeed in final assessment the following measures are recommended.
6.8 The HCO has already set up committees and nodal heads for overall quality assessment as well as for individual chapters. DDMSC has a functioning NABH Cell

with the DMS as its nodal head. It is recommended that this committee should concentrate on obtaining time-based inputs from sub committees. (18) The feedback should be on a monthly basis to be chaired by the DMS. The MS may chair the Quarterly meeting as per her convenience or delegate to DMS.

6.9 Each committee must come forward and give a presentation on the progress made in their sphere of responsibilities as under:

- Progress/confirmation on deficiencies.
- Progress on all measurable NABH elements.
- Show measurable indicators of their responsibility.
- Documentation and records.
- Functional Processes.
- Physical Facilities.

6.10 A max of four quarters be given to show full readiness for final assessment. By end of next financial year the DDMSC may submit its application for final assessment. A closer scrutiny by the committee heads of certain misc. activities can further improve the functional processes of the hospital as per other NABH standards .

6.11 Corrective actions suggested in previous chapter may be applied.

6.12 Involvement at the highest levels of management will spur and motivate the staff at all levels to become quality conscious and create the necessary impetus and environment for NABH accreditation. The DDMSC will have to function under various known constraints such as it being a govt. Deptt. Where for every matter one has to seek sanctions of the govt. for funds, making up critical deficiencies in manpower and equipment, building completion certificates, procurement as well as disposal. There are limited penal and disciplinary powers vested in the accountable appointments, which are further prone to interference and understandable external influences. The DDMSC has limited flexibility in the exercise of its powers; financial, legal as well as administrative. (19)

6.13 In its endeavors the DDMSC also needs tremendous leaning in and support of the DHS, Delhi Govt. and GOI. Augmentation of its IT resources will go a long way in making important data available which will make the journey of accreditation less arduous and abstract.

Chapter – 7

Supplementary

7.1 Research instruments: The following instruments were used:

7.2 Checklists of NABH standards and objective, measurable elements.

- Direct observation of staff and patients
- Diaries, records and registers maintained.
- Review of records.
- Unstructured Interviews and Verbal reports by staff, patients and mgt.
- Infection Control Review.
- Management of Information/Patient Records.
- Analysis of Staff Qualifications and Education.
- Visits & facilities tours.

7.3 The conditions under which the observations were made were during working as well as non-working hours, during day and night, during training, rehearsals, drills and routine maintenance /op activities.

7.4 Appendices – Contd.

APPX – A

GOVT. OF N.C.T. OF DELHI
SHRI DADA DEV MATRI AVUM SHISHU CHIKITSALAYA
DABRI, NEW DELHI.

Date:-

Daily Infection Report

Name : _____
Age/Sex: _____
C.R no : _____
Bed No: _____
Ward : _____
Date of admission: _____
Date of IV cannula Insertion : _____
Date of U. Catheter Insertion : _____
Date of change
IV Cannula _____
U. Catheter _____

Daily Inspection
IV Site _____
Palpatation findings _____

Short clinical history (On set of symptoms) _____

Clinical diagnosis ----------

Investigation report ----------

Signature of consultant/S.R
(With name)

APPX – B

EMPLOYEES AWARENESS SURVEY ON HOSPITAL WASTE HANDLING (BMW 08A)

*You are requested to go through the following questionnaire and try to answer the question with open mind and in clean handwriting as per the instructions given. The information marked as * is optional and if you so desire, you may not respond to it.*

***NAME:**
AGE:
***ADDRESS:**
TELEPHONE NO.:
Department/Area where working at SDDMSC:
DATE:
(Please tick only one answer for each of the following questions)

S. No.	Question	YES	NO
1.	Did you know that there are established guidelines on Bio Medical Waste Handling at SDDMSC?		
2.	Did you get formal orientation on this aspect at SDDMSC from your departmental head or some other designated person?		
3.	Did You have any dissatisfaction with the hospital regarding your requirements on study material on Bio Medical Waste Handling at SDDMSC?		
4.	Did You have any dissatisfaction with the hospital regarding provision of training as per your requirements on Bio Medical Waste Handling at SDDMSC?		
5.	Will you recap the needle after use in a patient?		
6.	How frequently do you wash your hands when on duty at SDDMSC? *(Please tick one only)* • Once, when I come to the duty • Once, before I go home from my duty • Both of the above • Whenever I examine a patient or conduct a procedure on a patient • Every time I go to a patient.		
7.	Are you vaccinated against Hepatitis-B?		
8.	All plastic materials like used syringes, I/V sets, Gloves, Bottles etc are disposed in the following: *(Please tick one only)* • Red Bag • Yellow bag		

	• Black bag • Blue bag • Puncture proof container		
9.	Materials like used bandages, swabs, plasters, tapes, dressings etc are disposed in the following: (Please tick one only) • Red Bag • Yellow bag • Black bag • Blue bag • Puncture proof container		
10.	Segregation of hospital waste at the source of its generation is the most important step in Managing the bio-medical waste in a hospital. *(Tick one)*	True	False
11.	At bed side of a patient all the waste can be placed in a single bin/ container and this is then segregated as per the color coded categories at the central collection point in the ward/ area. *(Tick One)*	True	False
12.	Materials like Waste hospital sharps- used blades, needles etc. are disposed in the following: *(Please tick one only)* • Red Bag • Yellow bag • Black bag • None of the above		
13.	One needs to do the following while handling the biomedical waste for packing, storing and transporting. *(Please tick one only)* • Wear Surgical gloves, that are available • No, the gloves are not required; one can simply wash hands after such activity. • Wear Red, workers gloves		
14.	Please give your suggestions here:		

APPX – C

DAILY ROUND PERFORMA

DATE :- _____ TIME:- _____

S.NO	ADMINISTRATION ROUND REGISTER	SCORING	Taken By
1	Overall Cleanliness		
2	Attendance		
3	Availability Of Consumables		
4	Bed Vacancy Position		
5	Condition Of Bathroom & Toilets		
6	Kitchen		
7	Laundry		
8	OPD Area		
9	Condition Of O.T. & No. Of Surgeons		
10	Condition Of Furniture's (Bed / Linen)		
11	Ward Area		
12	Condition Of Electrical Fittings		
13	Reception / Emergency /L.Room/ Nursery		
14	Ambulance		
15	B.M.W Disposal		
16	Referral System		
17	IPD & OPD Attendance		
18	Diagnostic Facilities (X - Ray / Lab / USG)		
19	Evening & Night Shift Working		
20	Blood Bank		
21	C.C.T.V. Surveillance		

SCORING :- 5= Excellent ,4=Good , 3=Satisfactory , 2=Fair, 1=Poor

Remarks :-

SIGNATURE DATE

Maximum 0 = Compulsory training of all the staff, strict rules application, Regular rounds
Maximum 1=
Maximum 2= needs regular
Maximum 3=Give appreciation for future maintenance.

ROUND CHECKLIST
DEPARARTMENT:-

S.No	**Particulars**						
1.	Overall Cleanliness						
2.	Availability Of Consumables /medicines						
3.	Condition Of Bathroom & Toilets						
4.	B.M.W Segregation						
5.	Condition Of Bed / Linen						
6.	Cleanliness Of Patients						
7.	Patients Documents						
8.	Crash Carts						
9.							
10.							
	Total Score						
SCORING :- 3= Excellent ,2=Good, 1=Fair ,0=Poor							

APPX – D

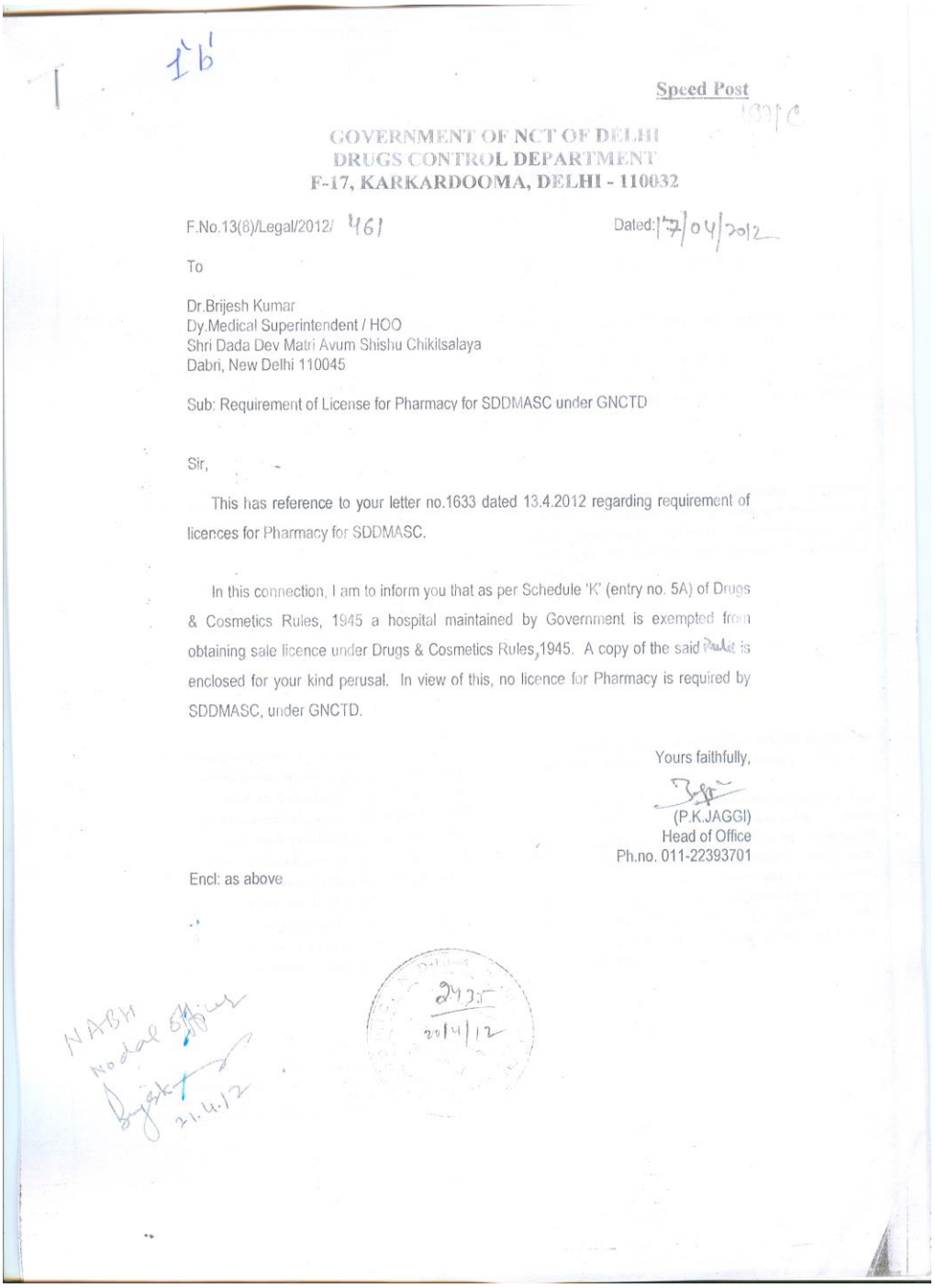
Quality Indicators For A Month

S No	Indicator	Value
	Time to initial assessment by doctor	32 mts
	Time to initial assessment by S/N	19 mts
	Patient satisfaction score IPD	14.8/20
	Time to discharge	6 hr 36 mts
	Registration to doctor OPD	54 mts
	Doctor to Pharmacy OPD	23 mts
	Patient satisfaction score OPD	10.2/20
	Medication errors	3
	Falls	1
	Blood & body fluid exposure	4
	Needle Stick Injuries	0
	Surgical site infections	3.6%
	Thrombophlebitis	5.86/1000 iv days
	Urinary tract infections	23.8 / 1000 catheter days
	Re Intubations	0
	% of Re dos lab investigations	1
	Reporting errors	0
	Blood Smeared forms %	1
	% component usage blood	45%
	Major Transfusion reactions	0
	BOR	96%
	ALS	3
	Main OT utilization	19.2%
	Gynae OT utilization	15.8%
	Variation in mock drills code blue	88%
	% case sheets wherein care plan documented and countersigned	95

	% case sheets screening for nutritional needs done	0
	% case sheets nursing plan is documented	99.5
	% case sheets where medication charts with error prone abbreviations	0.5
	% case sheets not having discharge summary	1.1%
	% of case sheets not having coding as per ICT	0.5
	% of case sheets with improper consent	0.5
	Deaths	1
	% of missing records	0
	Store & Purchase	
	Number of items in hospital formulary	97
	Number of items NA	0
	Number of items purchased by local purchase	41
	Number in which variations in purchase	

APPX – E

Pharmacy license



Speed Post

GOVERNMENT OF NCT OF DELHI
DRUGS CONTROL DEPARTMENT
F-17, KARKARDOOMA, DELHI - 110032

F.No.13(8)/Legal/2012/ 461 Dated: 17/04/2012

To

Dr.Brijesh Kumar
Dy.Medical Superintendent / HOO
Shri Dada Dev Matri Avum Shishu Chikitsalaya
Dabri, New Delhi 110045

Sub: Requirement of License for Pharmacy for SDDMASC under GNCTD

Sir,

This has reference to your letter no.1633 dated 13.4.2012 regarding requirement of licences for Pharmacy for SDDMASC.

In this connection, I am to inform you that as per Schedule 'K' (entry no. 5A) of Drugs & Cosmetics Rules, 1945 a hospital maintained by Government is exempted from obtaining sale licence under Drugs & Cosmetics Rules,1945. A copy of the said Rules is enclosed for your kind perusal. In view of this, no licence for Pharmacy is required by SDDMASC, under GNCTD.

Yours faithfully,

(P.K.JAGGI)
Head of Office
Ph.no. 011-22393701

Encl: as above

NABH Nodal Officer 21.4.12

APPX – F
PROCUREMENT FLOW

Demand generated and proposal prepared in procurement section

Procurement section

Open tender Item

(within 30 days)

Purchase Committee

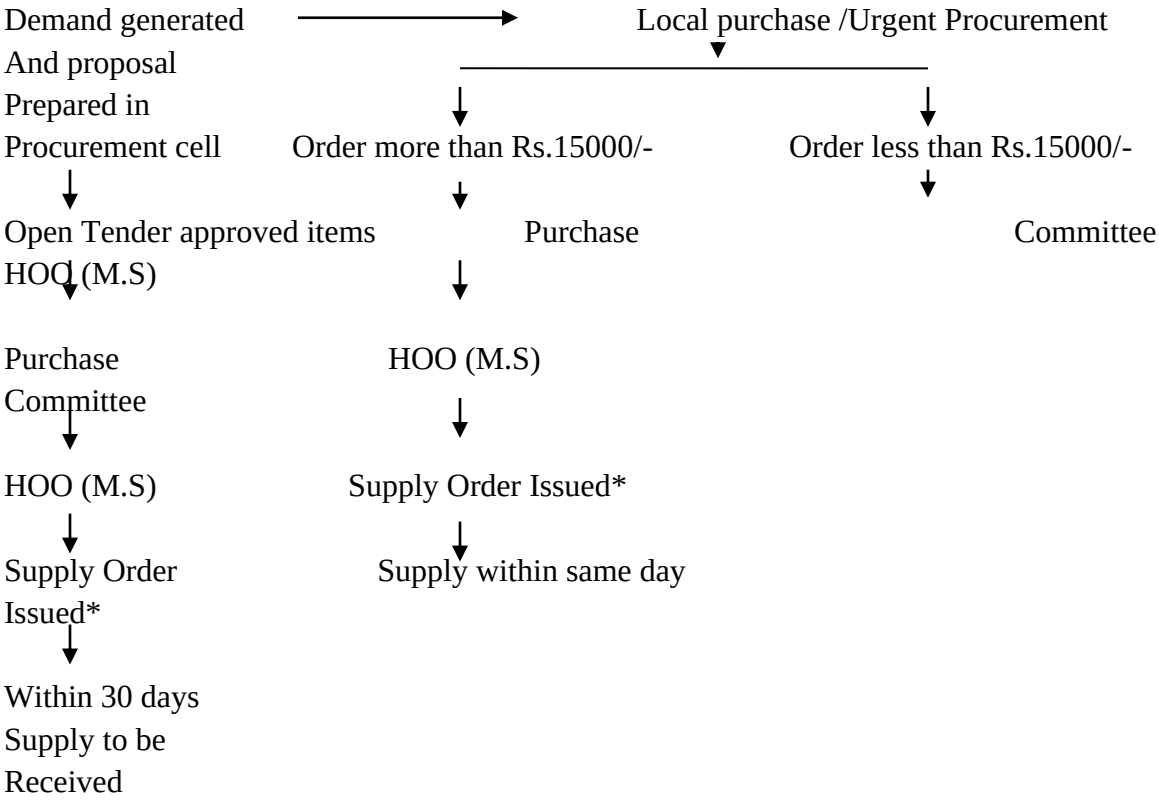
M.S

Supply order Issued

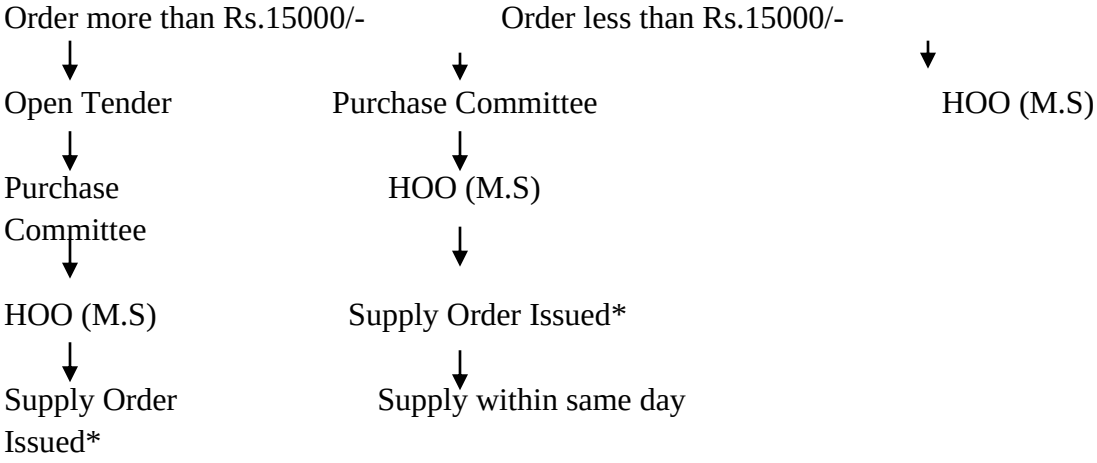
Within 30 days supply to be receive

Demand generated requirement / Consumption Pattern given
Procurement section
Local Purchase Items
(Within 24 hrs.)
M.S
Supply order
Within 24hrs

PROCUREMENT FLOW CHART



*Approx. time to issue supply order within 3 days



APPX – G

APPX – G

FLOW OF PATIENT

AS IS PROCESS MAPPING OF NEW PATIENT (ANC)

D1

Arrival of patient

Registration of Patient (1 hour) **BOTTLE NECKS**

Body Weight (15min.)

B.P / Urine Exam (30mins)

Doctor visit (30mins)

MCTC Registration (10mins)

D1 / D2

Investigation /USG/ HIV Counseling (30mins) **BOTTLE NECKS**

D2 / D3

Report Collection (10mins)

D3

Doctor visit (30mins)

D2 / D3

To collect Medicine (20mins)

Total Time: - 3 hours 55 min.

FLOW OF NEW PATIENT (Med.)

Arrival of patient

⇩

Registration of Patient (1 hour)

⇩

Doctor visit (30mins)

⇩

D1 / D2

⇩

Investigation /USG (30mins)

⇩

Report Collection (10mins)

⇩

D3

⇩

Doctor visit (30mins)

⇩

D2 / D3

⇩

To collect Medicine (20mins)

FLOW OF NEW PATIENT (Paeds.)

D1

⇩

Arrival of patient

⇩

Registration of Patient (1 hour)

⇩

Body Weight (15min.)

⇩

Doctor visit (30mins)

⇩

D1 / D2

Investigation (30mins)

⇩

D2 / D3

⇩

Report Collection (10mins)

⇩

D3

⇩

Doctor visit (30mins)

⇩

D2 / D3

⇩

To collect Medicine (20mins)

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