Gap Analysis of District Hospital as Per NABH Standards

A dissertation submitted in partial fulfillment of the requirements

For the award of

Post-Graduate Diploma in Health and Hospital Management

by

Gurdeep Birla

(PG/12/112)

International Institute of Health Management Research

New Delhi -110075

May, 2014

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Internship Training

At

Octavo Solutions Pvt. Ltd, New Delhi

Gap Analysis of District Hospital as Per NABH Standards

By

Gurdeep Birla

Under the guidance of

Prof (Dr) A K Khokhar

Post Graduate Diploma in Hospital and Health Management

2012-14

International Institute of Health Management Research

New Delhi-110075

OCTAVO
SOLUTIONS PVT. LTD.
The Health & Hospital Consultants

The certificate is awarded to

Mr. GURDEEP BIRLA

In recognition of having successfully completed his

Internship in OCTAVO SOLUTIONS PVT. LTD.

And has successfully completed his Project on

"GAP ANALYSIS OF DISTRICT WOMEN'S HOSPITAL, RAMPUR As PER NABH STANDARDS"

Date: 30th April, 2014

Organisation: OCTAVO SOLUTIONS PVT. LTD.

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 endeavours.

Vice President
Octavo Solutions P. Ltd.

TO WHOMSOEVER MAY CONCERN

This is to certify that Gurdeep Birla student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at Octavo solutions Pvt. Ltd. from 10th Feb to 30th April.

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.

12/5/14

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
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Dr. A.K khokhar

Professor

IIHMR, NEW DELHI

Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Gurdeep Birla**, a participant of the **Post Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled, **"A Study on Gap Analysis of District Women Hospital, Rampur (U.P) as per NABH Standards"** in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

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

Dr. A.K khokhar

Professor

IIHMR, NEW DELHI

Dr Kriti Yadav

Assistant consultant

Octavo solutions Pvt.Ltd.

Certificate of Approval

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

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Ravindra Aggarwal	5/5/14
Dr A.K. KHOKHAR	5.5.14
Kusla Udaya	

FEEDBACK FORM

Name of the Student: Gurdeep Birla

Dissertation Organisation: Octavo Solutions Private limited.
New Delhi.

Area of Dissertation: "Quality cell"
Gap Analysis of a district hospital, Rampur. (U.P.)

Attendance:
95%.

Objectives achieved:
* Data collection (site visited)
* Data compilation & Analysis

Deliverables:
* Report preparation
Report on Gap Analysis of district hospital Rampur.

Strengths:
* Sincerity towards work
* Good learning skill.

Suggestions for Improvement:
* Should develop a confidence level to show all capabilities he has.
Can do much better.

Organisation Mentor (Dissertation) Dr. Kriti Yadav.

Date: 2/05/2014

Place: New Delhi

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled A Gap Analysis of District Women's hospital Rampur as per NABH Standards and submitted by (Name) Gurdeep Birla Enrollment No. PG-12-112 under the supervision of Dr. A.K. Khakar for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 10th Feb to 30th April 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.

Gurdeep Birla

Signature

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I am also deeply thankful to **Dr.A.K khokhar**, my mentor at IIHMR for their valuable comments and recommendations which were greatly added to my research.

This report is submitted as a part of practical orientation programme in the curriculum of IIHMR Dissertation for the period from Fed, 10th 2014 to April, 30th 2014.

ACRONYMS/ABBREVIATIONS

S.NO.	ABBREVIATED FORM	FULL FORM
1	AAC	Access, assessment and continuity of care
2	AC	Air conditioning
3	ACHSI	Australian Council On Healthcare Standards
4	ACLS	Advanced cardiac life support
5	AERB	Atomic Energy Regulatory Board
6	AHU	Air handling unit
7	AMC	Annual Maintenance Contract
8	BARC	Bhaba Atomic Research Centre
9	BLS	Basic life support
10	BMW	Bio Medical Waste Management
11	CCTV	Close Circuit Television
12	CCU	Critical Care Unit
13	COP	Care Of Patients
14	CPR	Cardio Pulmonary Resuscitation
15	CQI	Continuous Quality Improvement
16	CSSD	Central Sterile and Supply Department
17	EOQ	Economic Order Quantity
18	FMS	Facility Management System
19	HDU	High Dependency Unit
20	HIC	Hospital Infection Control
21	HMIS	Hospital Management Information System
22	HRM	Human Resource Management
23	ICU	Intensive Care Unit
24	IMS	Information Management System
25	IPD	In Patient department
26	LAMA	Leave against Medical Advice

27	MOM	Management Of Medication
28	MRD	Medical Records Department
29	MRI	Magnetic Resonance Imaging
30	NABH	National Accreditation Board for Hospitals and Healthcare Providers
31	OPD	Out Patient Department
32	OSPL	Octavo Solutions Pvt. Ltd.
33	OT	Operation Theatre
34	PM	Preventive Maintenance
35	PPE	Personal Protective Equipment
36	PRE	Patient Right and Education
37	QA	Quality Assurance
38	QCI	Quality Council of India
39	ROM	Responsibilities Of Management
40	SOP	Standard Operating Procedure
41	TQM	Total Quality Management
42	UTI	Urinary Tract Infection

INTERNSHIP

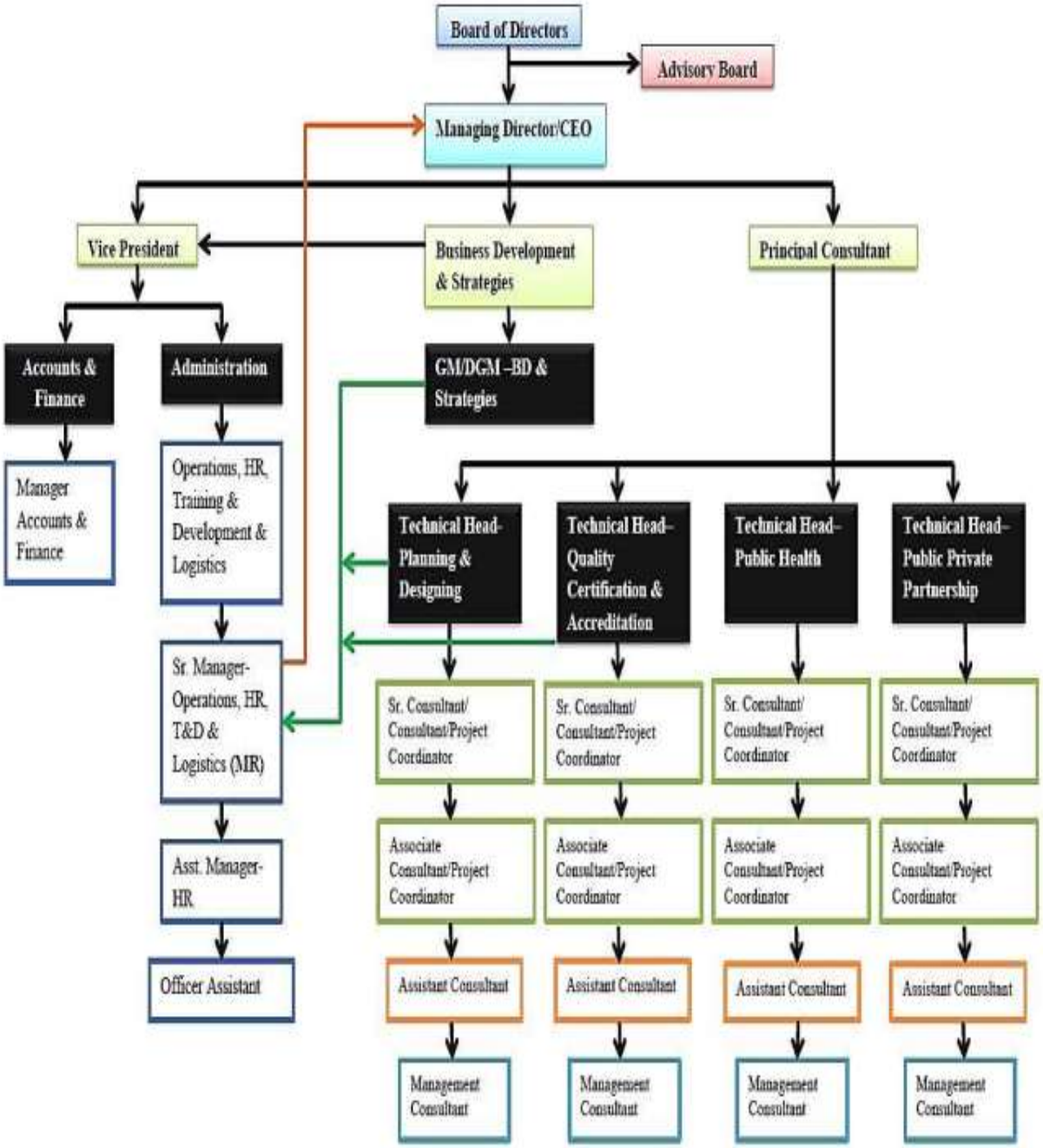
ORGANIZATION PROFILE.

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

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

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

Organization Chart



Key Strengths and Salient Features of OSPL

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

KEY STRENGTHS:

1. **A Private Limited Company**

2. Short listed firm with **NHSRC** (National Health Systems Resource Centre) under aegis of Ministry of Health & Family Welfare (Government of India)

3. **Talented Leadership** from leading institutes like
    - ❖ All India Institute of Medical Sciences (Delhi),
    - ❖ School of Planning and Architecture (Delhi),
    - ❖ Tata Institute of Social Sciences, (Mumbai)
    - ❖ Indian Institute of Health Management and Research (Jaipur)
    - ❖ Symbiosis Institute of Health Sciences (Pune)
    - ❖ Jamia Hamdard University (Delhi)

4. Great Team with all essential skills

5. Dr. Bidhan Das- Member, Technical Committee of NABH for drafting standards

6. Dr T.Venkatesh- Member, Technical Committee of NABL for drafting standards

7. Dr Bidhan Das has Standards for Primary Healthcare (NABH) to his credit which is on its (likely) first test in State of Gujarat

8. Dr. Bidhan Das- First ACHS International Surveyor (Australian Council for Health Standards) in India

9. OSPL is **SE-Asia Partners for ACHSI**

10. OSPL has presence in **14 states (**including Union Territories)

11. Working offices at **7** different locations across India.

12. OSPL has one overseas **(International)** project to its credit.

13. In short span of just 4 years, OSPL has rendered its **consulting services to over 30,000 beds** within the healthcare sector

14. Provided consulting services to over 100 Hospitals (bed range 30-1500), 07 Teaching Hospital & Medic
    al Colleges, 01 Rehabilitation Hospital, 02 Dental Hospital & Colleges, 02 AYUSH Hospitals.

15. Combined Years of Experience of our Technical Personnel is 68 Man-Years in ISO/ NABL/ NABH/ QMS and Hospital Planning assignments. Key Personnel have rich experience of having conducted over 720 Audits/ Assessments and provided consulting services to 497 client organizations for establishing QMS.

16. One of the solution company for healthcare sector.

TASK PERFORMED

1. Drafted time bound action plan for the district hospitals under guidance.
2. Assisted in the drafting of cost estimation sheets for the gaps.
3. Assisted in proposal writings, feasibility studies being managed by the organisation

.

KEY LEARNINGS

1. This internship period has enhanced my skills and has provided the direction to my career. Ensuring meticulous timely reporting of the work progress and motivation of the staff to perform work efficiently and effectively.
2. I have learned about working of hospital and the functioning of departments in the hospital.
3. Learned about the structural, process and outcome parameters of the hospital
4. Significance and importance of maintaining quality parameters in the hospital.
5. Learnt how important is the proper documentation of the work done and progress made in implementation of the schemes. This helps us finding the gap areas and make targeted interventions.
6. I learnt how important the training programs for the field staff are. Regular training programs keeps the grass root level workers updated on the current program developments and this in turn would lead to a responsive society.

DISSERTATION

EXECUTIVE SUMMARY

The GAP analysis for District Women Hospital Rampur, Uttar Pradesh was conducted by OCTAVO Solutions Pvt .Ltd. during the period 20th March 2014 to 20th April 2014.

A visit to hospital premises and personal interviews of all categories of hospital staff was organized during this period. The purpose was to assess the functional areas of hospital services with a view of preparing the hospital for NABH Accreditation. The following points indicate the need for further intervention and enhancement, in order to meet the standards set by the NABH.

Hospital Care system has been broadly divided into two categories specifically for this hospital. This includes base line assessment of the hospital as per normal workflow and basic system and processes followed and other criteria includes quality parameters Followed in the department which includes documentation and assessment by the way of indicators.

This assignment would guide the State in understanding the existing deficiencies/gaps in healthcare delivery services thereby enabling the policy makers to formulate a strategy to fulfil such deficiencies/gaps and strive towards further improvement.

The Octavo Solutions Private Limited, New Delhi has put all efforts to ensure that all components with respect to NABH Standard (3rd edition) are covered and relevant deficiencies are accordingly addressed.

To conclude, the actions to be taken for compliance with the Accreditation standards of NABH (3rd edition) at **District Women Hospital, Rampur** are likely to impact the delivery of healthcare services positively, ensuring quality services, efficient outcomes with economy, risk management with patients, staff and visitors safety and above all equity in healthcare services for all the citizens.

INTRODUCTION

GAP ANALYSIS

DEFINITION OF GAP ANALYSIS :

It is a formal means to identify and correct gaps between desired levels and actual levels of performance. Used by organizations to analyze certain processes of any division of their company.

Gaps can be found in any process of an organization's operations. Gap Analysis is one of the best procedures to help lead an organization to not only improve their processes, but recognize which processes are in need of improvement.

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

NABH

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organisations. The board is structured to cater to much desired needs of the consumers and to set benchmarks for progress of health industry. The board while being supported by all stakeholders including industry, consumers, government, have full functional autonomy in its operation.

The standards provide framework for quality assurance and quality improvement for hospitals. The standards focus on patient safety and quality of care. The standards call for continuous monitoring of sentinel events and comprehensive corrective action plan leading to building of quality culture at all levels and across all the functions.

The 10 chapters reflect two major aspects of healthcare delivery i.e. patient centred functions (chapter 1-5) and healthcare organisation centred functions (chapter 6-10).

Outline of NABH Standards:

Patient Centred Standards

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

Organisation Centred Standards

- 6. Continuous Quality Improvement (CQI).
- 7. Responsibilities of Management (ROM).
- 8. Facility Management and Safety (FMS).
- 9. Human Resource Management (HRM).
- 10. Information Management System (IMS)

HOSPITAL ACCREDITATION:

Hospital Accreditation is a public recognition by a National Healthcare Accreditation Body, of the achievement of accreditation standards by a Healthcare Organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.

In India, Heath System currently operates within an environment of rapid social, economical and technical changes. Such changes raise the concern for the quality of health care. Hospital is an integral part of health care system. Accreditation would be the single most important approach for improving the quality of hospitals. Accreditation is an incentive to improve capacity of national hospitals to provide quality of care. National accreditation system for hospitals ensure that hospitals, whether public or private, national or expatriate, play there expected roles in national health system. Confidence in accreditation is obtained by a

transparent system of control over the accredited hospital and an assurance given by the accreditation body that the accredited hospital constantly fulfils the accreditation criteria.

ASSESSMENT CRITERIA

A hospital willing to be accredited by NABH must ensure the implementation of NABH standards in its organization.

The assessment team will check the implementation of NABH Standards in organization. The Hospital shall be able to demonstrate to NABH assessment team that all NABH standards, as applicable, are followed.

OBJECTIVES:

- To identify and analyze the gaps existing in the current practices against the pre set NABH standards for effective management of hospitals
- To provide recommendations on the basis of identified gaps.

PROBLEM STATEMENT

- Uttar Pradesh is the most populous state constituting 16.49% (Census 2011) of the total Indian population and among the less developed states of the country. The **TFR** stands to 3.4 (2.7 for India), **IMR** -57(44 for India), **MMR**-359 (212 for India) (according to AHS 2012 -13) due to which case load characterised by OPDs attendance, bed occupancy and institutional deliveries have increased tremendously in the state. So there is need of up gradation of public health facilities in order to cope with increasing demand of health care services and to provide best quality and cost-effective health care with main focus on patient safety according to NABH standards.

LIMITATIONS OF STUDY

The following are the limitations of the study:

- The study is limited to Rampur District women hospital and therefore, the results of the study are applicable only to this hospital.
- The data obtained is based on the existing set-up, which prevails in the hospital at the time of the system study.
- The study is based on the perception of the employees' only working in hospital and may be biased.
- The NABH was an entirely a new fascinating thing to study and therefore it's possible to have some limitation in study.

REVIEW OF LITERATURE

K. Francis Sudhakar, M. Kameshwar Rao, T.Rahul (1Jan 2012) in a study on

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

Di Mclntyre and Laura Anselmi, Health Economics Unit, School of Public Health and Family,

Medicine, University of Cape Town Paper provides an overview of the methods used to promote an equitable distribution of healthcare resources. It highlights that resource allocations is extremely valuable in efficient budgeting. It also highlights the successful implementation of resource distribution can be facilitated by undertaking a detailed gap analysis. Gap analysis will provide basis for developing service development plans. There is also need to strengthen capacity for planning, budgeting and implementing plans to ensure use of limited healthcare resources. Monitoring and evaluation of these entire can enhance effective redistribution of resources to promote healthcare services.

RESEARCH METHODOLOGY

RESEARCH DESIGN:

Research design is a plan outlining how information is to be gathered for an assessment that includes identifying the data gathering methods and how the information will be organized and analyzed.

The research design used in this study is descriptive and observational study

DESCRIPTIVE RESEARCH:

It is a fact finding investigation describing, recording, analyzing and interpreting conditions that exist. It helps in analysing the condition that exists. It gives proper basis for understanding and solving the current problems. In this research information may be collected through interviews, questionnaires, or systematic direct observation. The purpose of the research is to

Receive evidence concerning existing standards

Identify norms with which to compare present conditions in order to plan for the next step

PERIOD OF STUDY

Conducted study for a period of months from March, 20th to 20th April, 2014.

DATA COLLECTION TOOLS

- Checklist
- Existing records of the departments
- Interviews of the Head of the Departments
- Direct observation of the departments
- Self assessment toolkit

Primary data: - To study the present status and functioning of departments, each section of the department will be studied individually by observing the set of activities performed by doctors, technicians, paramedical staff and clerical staff.

Secondary data: - Records of various departments.

HOSPITAL INTRODUCTION

Scope of services provided by District Women Hospital Rampur (U.P).

Sl. No.	Name of Services/ Department	Availability (Yes/No/NA)	Remarks
GROUP A – CLINICAL SERVICES			
01	General Medicine	Yes	
02	Obstetrics and Gynaecology	Yes	
03	Paediatrics	Yes	
04	Orthopaedics	No	
05	Ophthalmology	No	
06	Anaesthesiology	Yes	
07	General Surgery	No	
08	Dentistry	No	
09	ENT	No	
10	TB & Chest	No	
GROUP B: CLINICAL SUPPORT SERVICES			
11	Laboratory	Yes	
12	USG	Yes	No Radiologist
13	Blood Bank	No	
14	Physiotherapy	No	
GROUP C: SUPPORT SERVICES			

16	**Medical Store**	**Yes**	
17	**Kitchen & Dietary**	**Yes**	**Non Functional**
18	**Laundry**	**No**	
19	**CSSD/TSSU**	**Yes**	**TSSU present**
20	**Medical Records**	**Yes**	**Not as per Standards**
21	**Ambulance & Transport**	**Yes**	**Transport Vehicle**
22	**Security Services**	**No**	
23	**Housekeeping Services**	**Yes**	**In house**
24	**Biomedical engineering**	**No**	
25	**Maintenance**	**No**	
26	**Mortuary services**	**No**	
GROUP D: ADMINISTRATIVE SERVICES			
28	**General Administration**	**Yes**	
29	**Account**	**Yes**	

KEY INDICATORS

INDICATORS	Aug,2013	Sept, 2013	Oct,2013	Nov,2013	Dec,2013	Jan,2014
IP Admissions	**921**	**1988**	**1205**	**921**	**2027**	**674**
OPD	**4257**	**5497**	**4451**	**4374**	**5661**	**2454**
SURGERIES (Minor)	**74**	**62**	**53**	**55**	**52**	**34**
SURGERIES	**57**	**90**	**58**	**55**	**73**	**38**

(Major)						
Delivery (Normal)	**296**	**343**	**282**	**280**	**378**	**174**
Delivery (C section)	**57**	**90**	**58**	**55**	**73**	**38**
USG	**0**	**0**	**0**	**0**	**0**	**0**
LAB	**2345**	**2920**	**2202**	**2197**	**3605**	**1396**
BIRTH	**331**	**404**	**332**	**320**	**292**	**82**
DEATH (neonatal)	**1**	**1**	**0**	**0**	**0**	**0**

SIGNAGE SYSTEM

- **Though few Hospital Signage system was observed inside the hospital , most of them were painted on walls and are not bilingual**

Signage's	**Displayed (Yes / No / NA)**	**Bilingual (Yes / No / NA)**	**Pictorial (Yes / No / NA)**	**Remarks (if any)**
Citizen Charter	**No**		**NA**	
Mission	**No**		**NA**	
Vision	**No**		**NA**	
Patients Charter	**No**		**NA**	
Scope of Services	**No**		**NA**	
Tariff List	**N.A**		**NA**	
Doctors list along with their Specialities and Qualifications	**No**		**NA**	

OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	**No**		**NA**	
iohazard Symbols	**No**		**NA**	
Fire Exit Plan	**No**		**NA**	
Floor Directory	**No**		**NA**	
Wash Rooms (Differently Able)	**No**		**No**	
Toilets	**No**		**No**	
Ambulance Parking Area	**No**		**No**	
Drinking Water	**No**		**N.A**	
Health Education Related Signage (HIV & Immunization)	**Yes**	**No**	**Yes**	

STATUTORY REQUIREMENTS

Licenses	**Status *(A / NA)**	**Available YES/NO**
Building Occupancy/Completion Certificate	**A**	**No**
Fire License	**A**	**No**
License under Bio- medical Management and handling Rules, 1998.	**A**	**No**
NOC for Air & Water from State Pollution Control Board	**A**	**No**
Excise permit to store Spirit.	**NA**	
Permit to operate lifts under the Lifts and escalators Act.	**A**	**No**
Narcotics and Psychotropic substances Act and License.	**A**	**No**

Vehicle registration certificates for Ambulances.	**A**	**Yes**
Retail drug license (Pharmacy)	**NA**	
PNDT Certificate	**A**	**Yes**
Site & Type Approval for X-Ray from AERB	**NA**	
License for Blood Bank	**NA**	
Noise & Air pollution certificate for Diesel Generators	**NA**	

A = Applicable NA = Not Applicabl

BED DISTRIBUTION

Floor	Class/Department	Beds
Ground	**Immediate Post-Operative Ward**	**07**
	ANC	**06**
	Eclampsia and Septic Ward	**07**
First Floor	**Laparoscopic Post-Operative and General Ward**	**23**
Second Floor	**POP Ward (post partum ward)**	**09**
	Private Ward	**08**
TOTAL		**60**

STRUCTURAL DETAILS

Category			

A. Land	• **Total land area- 20,661.44 sqm**		
B. Building	• **Hospital building (combined female +male) – 16157.31sqm** • **Total Residential area- 1504.13 sqm** • **Total Garden Area and free space- 3000 sqm**		
C. HVAC	**Availability of HVAC system**		**No**
		Number	**Capacity**
D. Electricity	**Transformer/Power station**	**1**	**200KVA**
	DG set	**2**	**50 &20 KVA**
	Inverter	**4**	**3(500w), 1(1kwh)**
	Total Load Sanctioned		**111 KVA**
E. Water	**Water Tanks (Overhead)**	**4**	**1(30000 litres) & 2(5000 litres)**

MANPOWER

Sl. No	Designations	Sanctioned	Actual	Vacant/ Surplus (Sanction- Actual	NABH	Vacant (NABH)
DOCTORS						

1.	**Chief Medical Superintendent/ Equivalent**	**1**	**1**	**0**	**-**	
2.	**Consultant/ObsGynae**	**01**	**01**	**00**	**01**	**0**
3.	**Anaesthetist**	**1**	**1**	**0**	**1**	**0**
4.	**Pathologist**	**1**	**0**	**1**	**1**	**1**
5.	**Radiologist**	**1**	**0**	**1**	**1**	**1**
6.	**EMO**	**05**	**02**	**3**	**08**	**06**
7.	**Sister &Staff Nurse**	**11**	**07**	**04**	**40**	**33**
8.	**Chief Pharmacist**	**01**	**01**	**00**	**01**	**01**
9.	**Pharmacist**	**2**	**01**	**01**	**02**	**01**
10.	**Lab Technician**	**1**	**01**	**00**	**3**	**02**
11.	**Senior Clerk**	**02**	**00**	**02**	**1**	**01**
12.	**Junior Clerk**	**02**	**00**	**02**	**1**	**01**
13.	**Storekeeper**	**01**	**01**	**00**	**1**	**00**
14.	**Driver**	**01**	**01**	**00**	**1**	**00**
15.	**Ward boy**	**03**	**03**	**00**	**3**	**00**
16.	**Ward Aya**	**06**	**05**	**1**	**04**	**1 surplus**
17.	**Hospital Servant/Attendant**	**03**	**01**	**02**	**-**	**-**
18.	**Choukidar**	**01**	**01**	**00**	**3**	**02**

19.	**Mali**	**01**	**00**	**01**	**-**	**-**
20.	**Dhobi**	**01**	**01**	**00**	**1**	**0**
21.	**Cook**	**2**	**2**	**0**	**2**	**0**
22.	**Sweeper**	**05**	**03**	**02**	**03**	**00**
	SUBTOTAL	**53**	**33**	**20**	**78**	**49**

Equipment Details.				
Area	**Equipments**	**Quantity (nos)**	**Functional (Yes / No)**	**Remarks**
Radiology	**Ultrasound**	**01**	**No**	**Not functional due to staff not available**
Laboratory	**Binocular Microscopy**	**02**	**Yes**	
	Chemical Balance	**00**	**-**	
	Electric Calorimeter	**02**	**Yes**	
	Auto Analyser	**00**	**-**	
	Semi-Auto Analyser	**01**	**Yes**	
	Micro Pippetes of Different Volume	**03**	**Yes**	
	Hot Air Oven	**01**	**Yes**	**Kept in TSSU**
	Lab Incubator	**01**	**No**	

	Distilled Water Plant	**00**	**-**	
	Centrifuge machine	**02**	**Yes**	**1 functional**
	Electric Centrifugal Top	**03**	**Yes**	
	Counting Chamber	**01**	**Yes**	
	Glucometer	**01**	**Yes**	
	Haemoglobino meter	**01**	**Yes**	
	TC DC Count Apparatus	**01**	**Yes**	
	ESR Stand Tubes	**02**	**Yes**	
	Test Tubes Stand	**08**	**Yes**	
	Test Tubes Rack	**05**	**Yes**	
	Spirit Lamp	**04**	**Yes**	
	Alarm Clock	**01**	**Yes**	
	ELISA Reader Cum Washer	**00**	**-**	
	Blood gas Analyser	**00**	**-**	
	Electrolyte Analyser	**00**	**-**	
	Haematology Analyser 22 Parameter	**00**	**-**	
	Laboratory Autoclave	**00**	**-**	
Operation Theatre	**Autoclaves**	**07**	**Yes**	**5 functional**
	Operation Table Hydraulic	**07**	**Yes**	
	Operation Table Non	**00**	**-**	

	Hydraulic Field type			
	Instrument sterilizer	**01**	**Yes**	
	Shadow less Lamp Ceiling Type	**02**	**Yes**	**1 functional**
	Suction Apparatus	**08**	**Yes**	**5 functional**
	Apparatus trolley	**02**	**Yes**	
	C arm	**NA**		
	Pulse oxymeter	**01**	**Yes**	
	Ventilator	**00**	**-**	
	Refrigerator	**01**	**Yes**	
	Iron stool	**02**	**Yes**	
	Screen stand	**01**	**Yes**	
	Cystoscope	**00**	**-**	
	I.V. Stand	**04**	**Yes**	
	Wheel chair	**01**	**Yes**	
	Diagnostic Laparoscope	**00**	**-**	
	Gastro scope	**00**	**-**	
	Hysteroscope	**00**	**-**	
	Auto mist	**00**	**-**	
	Video Calposcopy	**00**	**-**	
	Cautery	**01**	**No**	
	Defibrillator	**00**	**-**	
	Boyel's Apparatus	**01**	**Yes**	

	Multipara Monitor	**00**	**-**	
	Diathermy	**00**	**-**	
	Crash cart	**00**	**-**	
OPD	**Stethoscope**	**02**	**Yes**	
	Sphygmomanometer	**03**	**Yes**	**1 functional**
	X-ray View box	**00**	**-**	
	Refrigerator	**02**	**Yes**	**1 functional**
	Thermometer	**01**	**Yes**	
	Screen stand	**06**	**Yes**	**3 functional**
	Wheel chair	**01**	**No**	
	Iron stool	**03**	**Yes**	**2 functional**
	Water bath	**04**	**Yes**	**2 functional**
	Weighing Machine (Adult)	**01**	**Yes**	
	Weighing Machine (Paed)	**02**	**Yes**	**1 functional**
	Screen	**01**	**Yes**	
SNCU	**Baby incubator**	**01**	**No**	
	Phototherapy unit	**03**	**No**	
	Emergency Resuscitation Kit	**01**	**Yes**	
	Multi Para Monitors	**00**	**-**	
	Nebulizer Kit Baby	**00**	**-**	

	Weighing Machine Adult	**00**	**-**	
	Weighing Machine Baby	**04**	**Yes**	**1 functional**
	Syringe Infusion Pump	**00**	**-**	
	Defibrillator	**00**	**-**	
	Ventilator	**00**	**-**	
	Infant Warmer /Resuscitation Unit	**01**	**Yes**	
	Transport Monitor –Critical Care	**00**	**-**	
	Portable X ray Unit –Multi	**00**	**-**	
	Pulse Oxymeter With Paediatric Sensor	**00**	**-**	
Wards(Gen)	**Stethoscope**	**00**	**-**	
	Sphygmomanometer	**02**	**Yes**	**1 functional**
	X-ray View box	**00**	**-**	
	Thermometer	**00**	**-**	
	Stretcher trolley	**05**	**Yes**	**3 functional**
	Stretcher	**05**	**Yes**	**4 functional**
	Sputum stand	**20**	**Yes**	
	I.V. Stand	**18**	**Yes**	
	Weighing Machine	**00**	**-**	
	Crash Cart	**00**	**-**	

	Medicine/Dressing Trolley	**01**	**No**	

Labour Room	**Equipment for MH**			
	C-section kit	**00**	**-**	
	Assisted delivery kit	**00**	**-**	
	Anaesthesia Kit	**00**	**-**	
	Suction Machine	**00**	**-**	
	Oxygen Cylinder	**01**	**Yes**	
	Delivery Table	**04**	**Yes**	**2 functional**
	Foot operated Suction Machine	**01**	**No**	
	Shadowless lamp	**02**	**Yes**	**1 functional**
	Autoclave	**02**	**-**	
	Multi Para monitor	**00**	**-**	
	Foetal Monitor	**00**	**-**	
	Dressing drum big	**02**	**Yes**	
	Boiler	**01**	**Yes**	
	Neonatal Mask	**01**	**Yes**	
	Neonatal Laryngoscope with endotracheal tube	**00**	**-**	
	Foetal stethoscope	**00**	**-**	
	Oxygen hood for neonatal	**00**	**-**	
	Equipment for EP		**-**	

	DNC kit	**00**	**-**	
	Laparoscope	**00**	**-**	
	Minilap Kit	**00**	**-**	
	NSV kit	**00**	**-**	
	IUCD insertion kit	**00**	**-**	
	PPIUCD (Kelly's) forceps	**00**	**-**	

DEPARTMENTAL GAPS

1 OPD:

OPD is the first point of contact between the hospital and the community, and very commonly called “show window” of hospital. A well planned OPD plays an important role in building up the image of the hospital. A properly planned building with pleasant ambience makes the patient and their relative comfortable who are in search of solace and comfort for mitigating their suffering.

IDENTIFIED GAPS

STRUCTURAL	• The consultation room is not well equipped. • There is no availability of enquiry counter. • Separate queue for differently able is not available. • Separate and functional toilet for differently able is not available. • The Scope of services citizen charter and Patient charter are not displayed. • List of doctors along with OPD Timings are not displayed. • Calibration of BP apparatus, weighing machine is not done.
PROCESS	• UHID is not generated for patients. • Separate registration is not done for old and new OPD patients. • Patient privacy is not maintained during consultation time more than 1 patent at a time present in consultation room. • The staff is unaware of all the information like Doctors OPD timings, charges etc

OUTCOME	Following indicators were not captured properly • Patient satisfaction • Waiting time of OPD patients

MONTH	TOTAL	AVERAGE OPD/MONTH
Aug, 2013	4257	4449
Sep, 2013	5497	
Oct, 2013	4451	
Nov, 2013	4374	
Dec ,2013	5661	
Jan, 2014	2454	
Total	**26694**	

2. AMBULANCE:

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

• A driver's compartment

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

IDENTIFIED GAPS

STRUCTURAL	• There is no adequate communication system exists in ambulance. • Required equipments (stetho, sphygmo, suction app, defib, monitor,are not available in the ambulance. • Required medicines are not available in the ambulance. • The medical gas (oxygen) to 90% of the total capacity is not maintained. • Calibration of Equipments is not done.
PROCESS	• Staff is not trained in BLS. • Medication and equipment checklist is not maintained. • Infection control practices are not followed.
OUTCOME	Following is not monitored: • Response time of ambulance

3. LABORATORY:

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

- It is place of work for testing patient's sample- for results, in favour of diagnosis and treatment.

STRUCTURAL	• Scope of the services is not displayed at the entrance. • Pathologist is not available. • There is no separate area available for sample collection. • BMW bins are not present in the department. • Maintenance and calibration of equipments was not done.
PROCESS	• Laboratory staff is unaware about the safety precautions and not taking necessary precautions while handling samples. • Staffs are not trained in lab safety measures and proper segregation & disposal of BMW • Critical results are not defined, reported, and documented. • Surveillance of test results is not carried out regularly. • EQAS is not being carried out. • Labeling of sample is not done. • Time frame is not defined for dispatching lab reports. • Temperature monitoring of refrigerator is not done.
OUTCOME	Following need to be monitored; • Turnaround time for investigations • No. of reporting errors/1000 investigations, • Percentage of Redo's • Percentage of reports correlating with clinical diagnosis • Percentage of employees adhering to safety precautions working in diagnostics

4. WARDS:

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

The hospital has wards categorized as **Immediate Post-Operative Ward, Eclampsia and Septic Ward, Laparoscopic Post-Operative and General Ward, POP Ward, Private Ward.**

IDENTIFIED GAPS

STRUCTURAL	○ Medical Gas Facility is not available in the ward. ○ Basic facilities for staffs is not present (toilet/ drinking water) ○ Emergency crash cart is not present in the ward. ○ Color coded BMW bins are not present in each ward. ○ There is inadequate numbers of nurses in each shift only 2 nurse in each shift. ○ Racks are not present to store linen.
PROCESS	○ The vitals of the patient are not checked every day. ○ Indent of medicines and other items is not placed by nurses regularly. ○ PPE is not used by the nurses. ○ The BMW is not segregated at the point of generation. ○ The nurse on duty does not record the details of the patient in the BHT on a daily basis. ○ The nurses are not trained in BLS (CPR). ○ Infection control practices are not being followed. ○ Bio medical waste management practices are not followed. ○ The staff is unaware about transfer IN/OUT system. ○ Is discharge process is not defined and documented.
OUTCOME	Following are not monitored: • medication errors • ADR, accidental removal of tubes & catheters, strip & falls, sentinel events etc.

5 .LABOUR ROOM

The hospital is running round the clock labour room and about 275-300 deliveries are conducted per month.

IDENTIFIED GAPS

STRUCTURAL	• No separate areas demarcated for septic and aseptic deliveries • No scrubbing area, only wash basin present for labor room staff. • The Labour Room does not have a demarcated New Born Care Area with the appropriate equipments. • The Labour Room does not have any sterilization equipment. • There are no Disposable Delivery Kits in required quantities. • The Labour Room does not have a Crash Cart. • There is no ECG monitor.
PROCESS	• The staffs are not provided with the Personnel Protective Devices/ Equipments. • The Labor Room Register does not have a record of referred cases. • The part preparation of the patient is not done before the operation. • The numbers of Labor Room instruments are not counted before and after use. • Partograms is not used for all patients.
	• Labor Room disinfection is not done after every procedure. • Standard Operating Procedures are not being followed for Induction of Labor and progress of labor.
OUTCOME	• Following are not monitored: • Maternal mortality rate. • Still birth rate.

STRUCTURAL	• OT complex does not adhere to proper zoning concept as per the standard guidelines. • HVAC System is not present inside OT. • The number of OT tables present in the hospital are not appropriate for the daily load • OT has got more than one OT table. • The firefighting system is not installed the unit. • The changing room is not available for the doctors and nurses. • OT does not have a crash cart. • OT does not have defibrillator. • OT does not have an ECG monitor.

6. OPERATION THEATRE:

Operation theater (OT) is a specialized facility of the hospital where life saving or life improving procedures are carried out on human body, under strict aseptic conditions in a controlled environment by specially trained personnel to promote the healing and cure with maximum safety and comfort. Operation Theater must be designed scientifically to ensure sterility, easy maintenance and effective utilization of resources and manpower.

IDENTIFIED GAPS

PROCESS	• The OT list is not prepared. • The OT booking is not being done. • Pre, intra, post-operative notes are not documented. • Infection control practices are not being followed in OT. • Pre-operative checklist is not being followed. • Bio medical waste management practices are not being followed.
OUTCOME	• % of anesthesia related adverse events are not being monitored. • % of LSCS done is not monitored. • % of anesthesia related mortality is not being monitored. • % of modification in plan of anesthesia is not being monitored. • % of unplanned ventilation following anesthesia is not being monitored. • % of surgical site infection rate is not monitored. • Re Exploration rate is not monitored. • Re scheduling of surgeries is not monitored.

7. TSSU

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

IDENTIFIED GAPS

STRUCTURAL	• Sufficient space for sterilization activities is not available (Proper zoning, unidirectional flow & separation of clean & dirty areas). • Calibration of pressure meter of autoclave is not done. • Racks are not present in the department. • Technician is not present in TSSU.
PROCESS	• TSSU sterilization register is not present. • Labeling of drums in TSSU does not take place. • Chemical, biological and bowie-dick test is not performed. • No recall procedure available for sterile & unsterile items. • No reuse policy available in the department. • Infection control practices needs to be strengthened.
OUTCOM E	• No record available for monitoring of pressure during the load run. • No proper issue & receipt register available.

8. MEDICAL STORE/PHARMACY

IDENTIFIED GAPS

STRUCTURAL	• The racks are not available in sufficient number to store the items. • Fire detecting & firefighting systems are not available at department. • There is no dedicated receiving area; segregation and storing area.

PROCESS	• Verification of stock is not done every six months. • The items are not labeled & arranged at designated place. • Items such as radiographic films, spirits etc (which are inflammable) are not stored in a separate location. • Inventory recording system is not present. • Frequently used items are not arranged and located in most easily accessible area. • Pest/rodent control measures are not under taken regularly. • Lead time in issuing material to the department is not recorded. • Stock Turnover details are not calculated on a monthly basis. • Sound inventory control practices are not followed (ABC/VED/FSN/FIFO). • Condemnation policy is not followed. • Purchase and condemnation committee is not present in the hospital. • Comparative list of rates of potential suppliers is not maintained.
OUTCOME	Following need to be monitored • Percentage of stock out including emergency drugs, • Incidence of variation from the procurement process • Percentage of goods rejected before preparation of GRN.

9. MEDICAL RECORD DEPARTMENT

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

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IDENTIFIED GAPS

STRUCTURAL	• Fire fighting system is not installed inside the MRD. • Qualified and trained MRD technician is not available in the department. • Table and chair is not provided to the MRD technician. • Adequate number of racks is not available for the storage of records.
PROCESS	• The functional flow at MRD: Receiving, assembling, deficiency check, coding, indexing, filing, issuing is not followed. • ICD coding method is not used for complete and incomplete files. • The MLC cases/dead cases are not stored separately under lock and key. • The retrieval of the records is not easy. • Deficiency checklist is not followed. • MRD Committee is not formed • MRD audits are not being conducted. • The records are not kept under lock. • The hospital does not have retention policy for documents. • The forms and formats are not standardized. • The destruction policy for records is not available. • Pest control is not done on a regular basis.
OUTCOME	Following are not monitored • Percentage of medical records not having discharge summary • Percentage of medical records having incomplete and/or improper consent. • Percentage of missing records. • Number of births/deaths. • Number of diseases notified to the local authority. • Percentage of records with ICD codification done.

10.HOSPITAL INFECTION CONTROL

The Hospital infection control practices are found very poor in the hospital. Many gaps are identified in this hospital. The hospital does not has an infection control committee to oversee the infection control practices

IDENTIFIED GAPS

STRUCTURAL	• A designated and qualified infection control nurse is not present • Inadequate and inappropriate facilities for hand hygiene in all patient care areas. • Inadequate and Inappropriate personal protective equipment, soaps, and disinfectants. • A designated infection control officer is not present. • Isolation facilities are not available in the hospital. • Hand wash signage is not displayed uniformly in all washing areas.
PROCESS	• No documented infection control manual available. • Soap bars are found in all hand washing areas. • The HIC surveillance data is not collected. • HAI rates are not monitored • Hospital infection control committee and team are not formed. • Isolation / barrier nursing facilities are not available. • Appropriate personal protective equipment is not used by the BMW handlers. • Appropriate "in-service" training sessions for all staff is not conducted about infection control practices.
OUTCOME	Following need to be monitored • Infection rates like UTI, VAP, CRBSI, and SSI.

11.BIO-MEDICAL WASTE MANAGEMENT

The biomedical waste management facility is outsourced. Various gaps are found in biomedical waste management practices .The biomedical waste management practices in the hospital needs to be strengthened.

IDENTIFIED GAPS

STRUCTURAL	• Appropriate colour bins with colour plastic bags were not evident uniformly. • Housekeeping staffs handling BMW are not provided with PPE like heavy duty rubber gloves, shoes, mask, plastic apron & caps. • There is no proper segregation in terms of colour coding. • No labelling of biohazard symbol in the BMW buckets.

PROCESS	• No documented SOP for BMW management. • Staffs are not trained uniformly to handle BMW properly (no proper segregation at the source of generation & no proper transport to the temporary storage area). • No evidence of on site visit by the team of the hospital to the treatment facility periodically. • Bio-medical waste management audit needs to be carried out.
OUTCOME	• No monitoring of biomedical waste generated per bed per day in the hospital.

12.HOUSEKEEPING DEPARTMENT

The Hospital does not have a specified Housekeeping Department. Only 3 sweepers are appointed for complete hospital.

IDENTIFIED GAPS

STRUCTURAL	• Housekeeping staffs are not provided with PPE like heavy duty rubber gloves, shoes, mask & caps. • Hazardous materials are not identified. • Master cleaning schedule is not available. • Spillage kit is not available in the department.

PROCESS	• No documented SOP for housekeeping service. • Material Safety Data Sheet is not available. • Staffs are not trained on handling of hazardous materials & spill management. • Efficacy test for disinfectant is not done periodically.
OUTCOME	• Effectiveness of housekeeping services is not being monitored

Score Analysis:-

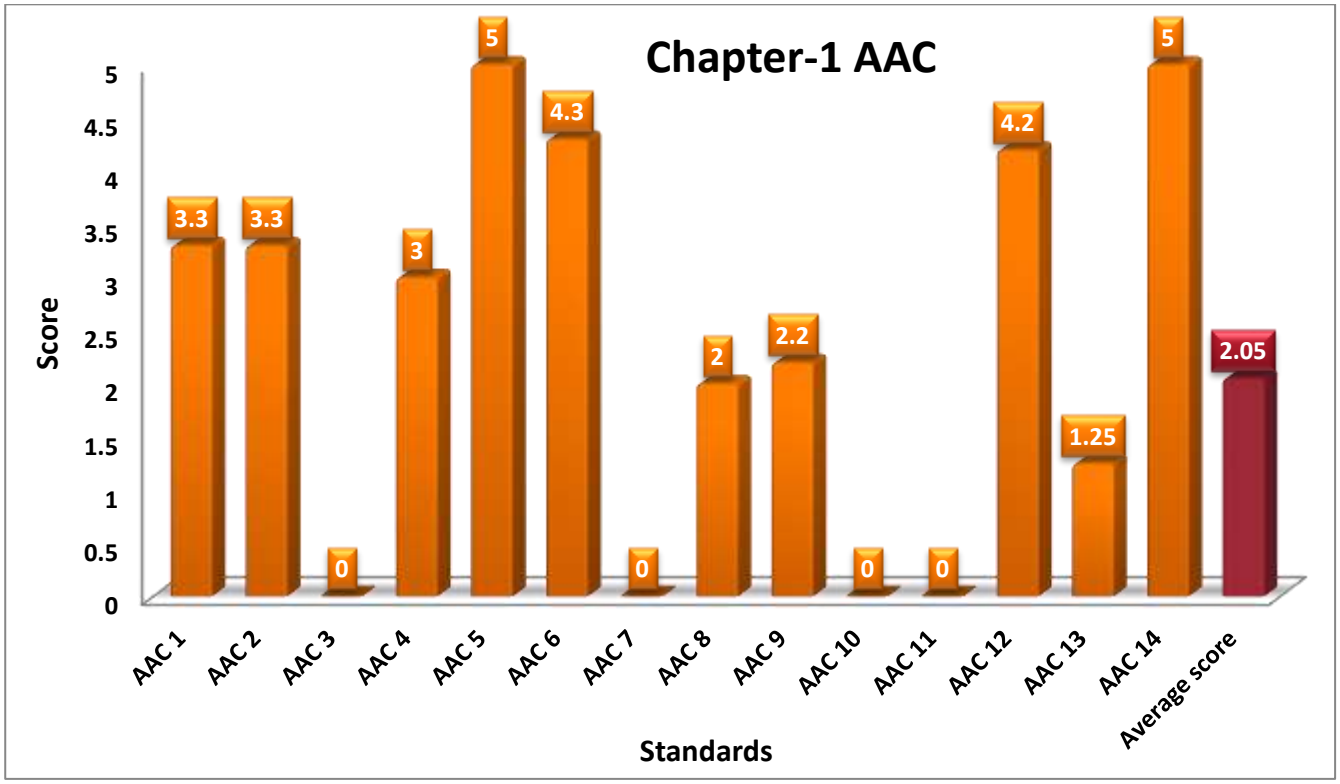
Findings:

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

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

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

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)	
AAC 1	3.3
AAC 2	3.3
AAC 3	0.0
AAC 4	3.0
AAC 5	5.0
AAC 6	4.3
AAC 7	0.0
AAC 8	2.0
AAC 9	2.2
AAC 10	0.0
AAC 11	0.0
AAC 12	4.2
AAC 13	1.25
AAC 14	5.0
Chapter average	2.05



INTERPRETATION

AAC 1. - The services being provided are clearly defined and are in consonance with the needs of the community but the defined services are not prominently displayed.

AAC 2. The organization does not have well defined documentation and policies and procedures for registration of patients. It does not have policies & procedures for managing patients during non availability of beds.

AAC 3-The organization does not have appropriate mechanism for transfer or referral of unstable & stable patients. It does not address the staffs that are responsible during transfer.

AAC 4. Documentation has not been done about initial assessment and plan of care, implementation is required.

AAC 5.Patient are not reassessed at regular intervals and documentation is also not maintained.

AAC 6. The scope of laboratory services is not displayed at the entrance. There are no documented policies and procedures for collection, identification, handling, safe transportation, processing and disposal of specimens but not implemented. The list for outsourced tests is not available.

AAC 7.Laboratory quality assurance programme has not been documented .Validation has not been done till date. Surveillance of test results is not being implemented. It also does not address periodic calibration and maintenance of all equipments.

AAC 8. Laboratory Safety programme has not been documented. There are no written procedures which guide the handling and disposal of infectious and hazardous materials. The staffs are not trained for the same.

AAC 9. The scope of radiology & imaging services are not displayed at the entrance of the Department. There are no documented policies and procedures for identification and safe transportation of patients to imaging services.
The infrastructure (physical) is adequate but there is no manpower to provide services.

AAC 10. There is no Quality assurance programme for imaging services established.

AAC 11 There is no radiation safety programme established.

AAC 12. There are no documented procedures which guide the referral of patients to other departments/ specialities.

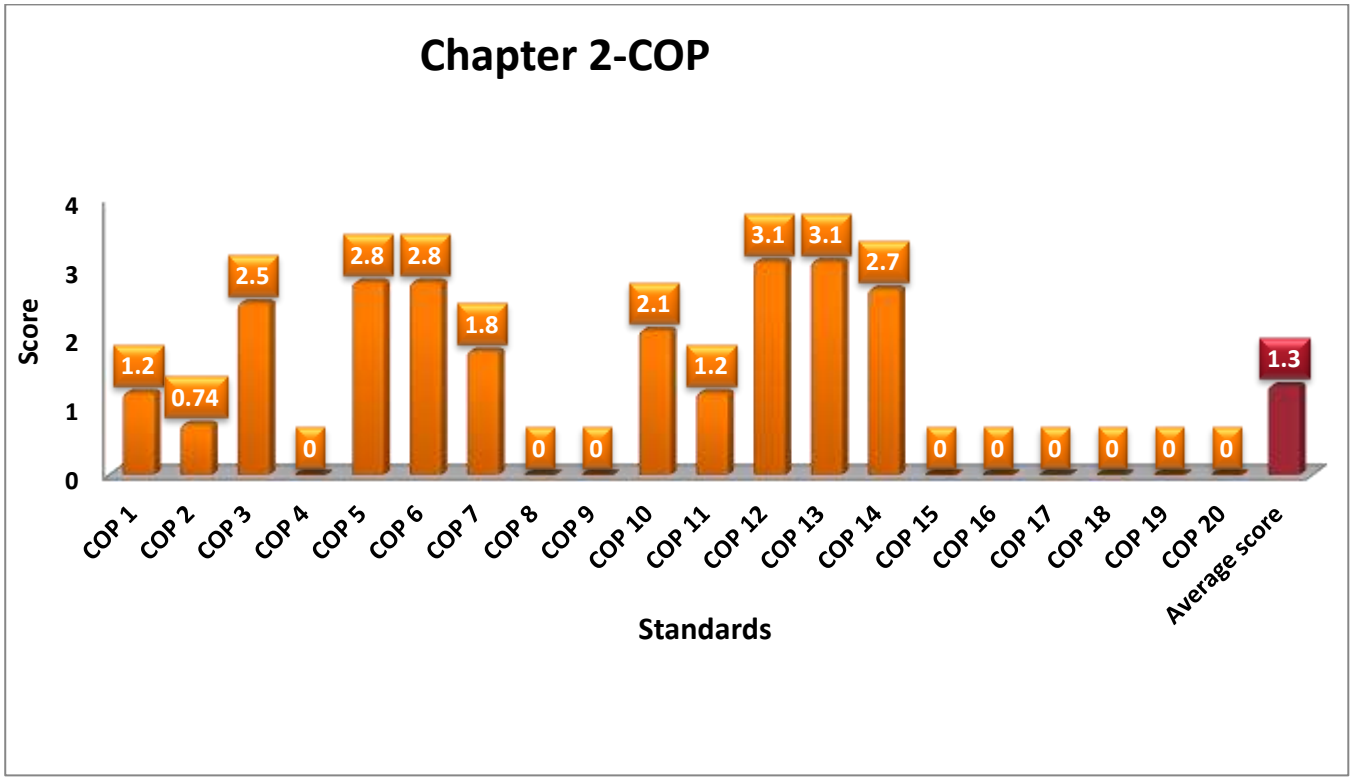
AAC 13 There is no documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal

and absconded cases). There are no documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request

A discharge summary is not given to all the patients leaving the organization.

AAC 14. Discharge summary is not provided to the patients at the time of discharge**.** The hospital does not has defined and documented the content of discharge summary.

Chapter 2: CARE OF PATIENTS (COP)	
COP 1	1.2
COP 2	0.7
COP 3	2.5
COP 4	0
COP 5	2.8
COP 6	2.8
COP 7	1.8
COP 8	0
COP 9	0
COP 10	2.1
COP 11	1.2
COP 12	3.1
COP 13	3.1
COP 14	2.7
COP 15	0
COP 16	0
COP 17	NA
COP 18	NA
COP 19	0
COP 20	0
Chapter average	1.36



INTERPRETATION

COP-1.There is no documentation of policy and procedures for uniform care of patients in all setting of the hospital which is guided by applicable law, regulation and guidelines. The organization does not adapt evidence based medicine and clinical practice guidelines to guide uniform patient care

COP-2. Emergency services are not guided by documented policies, procedures, and not applicable as per laws and regulations. There are no documented policies and procedures which guide the triage of patients for initiation of appropriate care. . Admission or discharge to home or transfer to another organization is also not documented.

COP-3. Ambulance Services provided by the hospital need to be improved a lot. Ambulances are not well equipped. There is no adequate access and space for the ambulance. It is not checked on a daily basis.. Equipments are not checked on a daily

basis using a checklist. Emergency medications are not checked daily and prior to dispatch using a checklist. The ambulance does not have a proper communication system.

COP- 4. Policies and procedures to guide the care of patients requiring cardio-pulmonary resuscitation are not available. Staffs are not trained in CPR. The events during a CPR are not recorded and hence post event analysis is not carried out.

COP-5. There are no documented policies and procedures for all activities of the Nursing Services.

COP-6. Polices to guide the performance of various clinical procedures is not available. No documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure. Standard precautions and asepsis is not adhered during the conduct of the procedure.

COP -7 - There are no documented policies and procedures for rational use of blood and blood components. Staffs are not trained to implement policies. The organization does not defines the process for availability and transfusion of blood/blood components for use in emergency. The transfusion reactions are not analysed for preventive and corrective actions.

COP- 8. The organization does not have a documented admission and discharge criteria for intensive care unit. For Intensive Care Unit and High Dependency Unit adequate staff and equipments are not there. Staffs are not trained to apply these criteria. Infection control practices are not followed uniformly. Quality assurance programme is not documented & implemented.

COP- 9. There are no documented policies and procedures to guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged) . Staffs are not trained to care for this vulnerable group.

COP-10. Hospital policy and procedure for obstetric services has not been documented. Hospital does not provide care for the high risk obstetric cases. There

are no documented procedures which guide provision of ante-natal services. Obstetric patient's assessment does not include maternal nutrition.

COP-11. There is no documented policy and procedure for paediatric services. The organization does not define and displays the scope of its paediatric services. The policy for care of neonatal patients is not in consonance with the national/ international guidelines. Patient assessment does not include detailed nutritional, growth, psychosocial and immunization assessment. No documented policies and procedures which prevent child/neonate abduction and abuse. The children's family members are not made educated about nutrition, immunization and safe parenting and this is not documented in the medical record.

COP -12. There are no documented policies and procedures to guide the care of patients undergoing moderate sedation. Informed consent for administration of moderate sedation is not obtained. Intra-procedure monitoring is not done. Criteria are not used to determine appropriateness of discharge from the recovery area

COP- 13 There are no documented policies and procedures for guiding the administration of anaesthesia. The anaesthesiologist does not applies defined criteria to transfer the patient from the recovery area. The type of anaesthesia and anaesthetic medications used are not documented in the patient record. Procedures are not complying with infection control guidelines to prevent cross infection between patients. Adverse anaesthesia events are not recorded and monitored.

COP- 14 Policies and procedures are not documented for the care of patients undergoing surgical procedures. There are no documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery. The operating surgeon does not document the post-operative plan of care. Patient, personnel and material flow are not conforms to infection control practices. A quality assurance programme is not followed for the surgical services.

COP-15 Policies and procedures for the care of patients under restraints (physical and/ or chemical) are not documented. Staffs are not trained to control and restraint techniques.

COP-16. The policy and procedure guiding the management of pain has not been documented All patients are not screened for pain. Patients with pain are not undergoing detailed assessment and periodic re-assessment. The organization does not respect and supports management of pain for such patients. Patient and family members are not educated uniformly on various pain management techniques.

COP- 17 - N/A

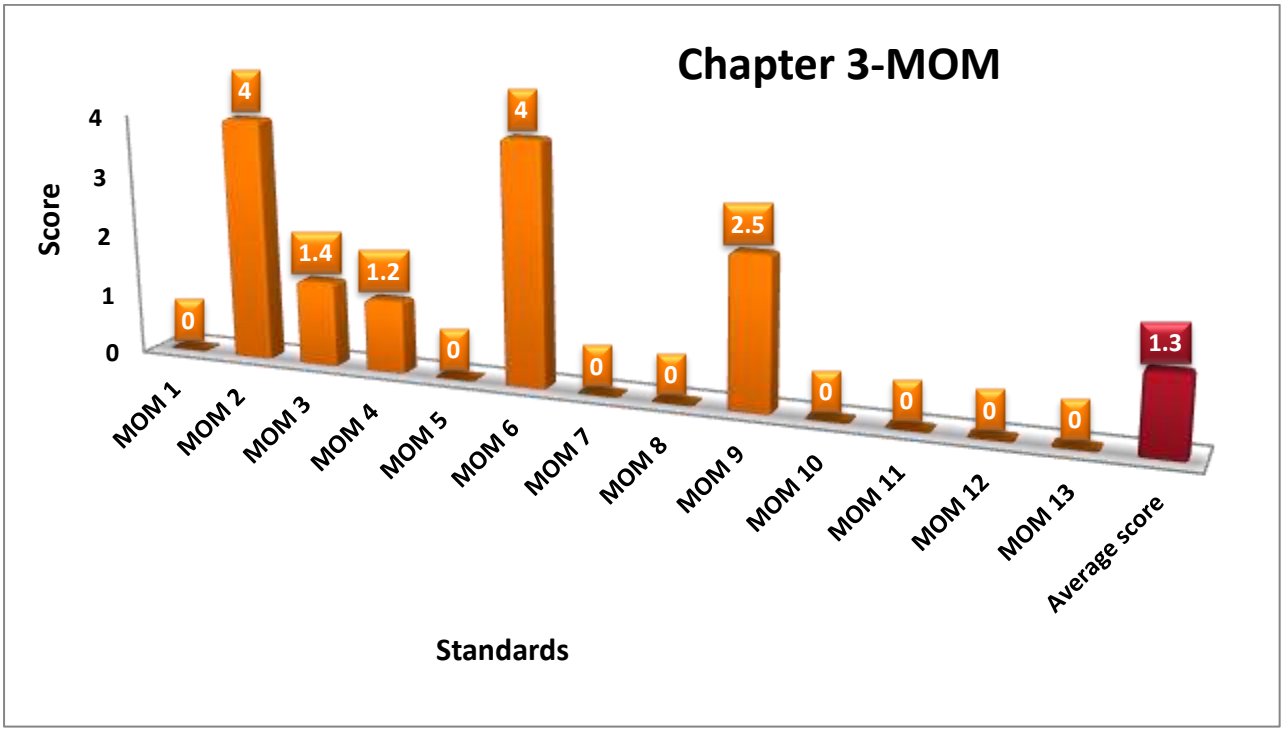
COP -18 -N/A

COP-19 The organization does not have documented policies and procedures for nutritional assessment and reassessment. Patients are not screened for nutritional needs uniformly. Patients do not receive food according to their clinical needs. When families provide food, they are not made educated about the patient's diet limitations.

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

Chapter 3: MANAGEMENT OF MEDICATION (MOM)	
MOM 1	0.0
MOM 2	4.0
MOM 3	1.4
MOM 4	1.2

MOM 5	0.0
MOM 6	4.0
MOM 7	0.0
MOM 8	0.0
MOM 9	2.5
MOM 10	N/A
MOM 11	N/A
MOM 12	N/A
MOM 13	0.0
Chapter average	1.3



INTERPRETATION

MOM-1. There is no documented policy and procedure for pharmacy services and medication usage. There is no multidisciplinary committee to guide the formulation and implementation of these policies and procedures. There is no procedure to obtain medication when the pharmacy is closed.

MOM-2. The formulary is not available for clinicians to refer and adhere to.

MOM-3. There are no documented policies and procedures for storage of medications. Sound inventory control practices are not followed for storage of the medications. Sound alike and Look alike medications are not stored separately. The list of emergency medications is not defined and is not stored in a uniform manner. Emergency medications are not replenished in a timely manner when used.

MOM-4. There are no documented policies and procedures exist for prescription of medications. The organization does not determine the minimum requirements of a prescription. Known drug allergies are not ascertained before prescribing. Medication orders are not clear, legible, dated, timed, named and signed. Medication orders do not contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration. Documented policy and procedure on verbal orders are not present. The organization does not define a list of high risk medication. Audit of medication orders/prescription is not been carried out to check for safe and rational prescription of medications. Corrective and/or preventive action is not taken based on the analysis where appropriate.

MOM-5. Documentation has not been done for safe dispensing of medications. The procedure does not address medication recall. Expiry dates are not checked prior to dispensing. There is no procedure for near expiry medications. Labelling requirements are not documented and implemented by the organization. High risk medication orders are not verified prior to dispensing.

MOM-6. Timing is not verified from the order prior to administration. Documented policies and procedures are not present to govern patient's self- administration of

medications. Documented policies and procedures are not present to govern patient's medications brought from outside the organization.

MOM-7. Documentation policies and procedure to guide the monitoring of patients after medication administration is not present. Organisation does not define those situations where close monitoring is required.

MOM-8. Documented procedure does not exist to capture near miss, medication error and adverse drug event. Adverse drugs events are not reported within a specified time frame. They are also not collected and analysed by multidisciplinary committee

MOM-9. Documented procedures are not present which guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations. These drugs are not stored in a secure manner.

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

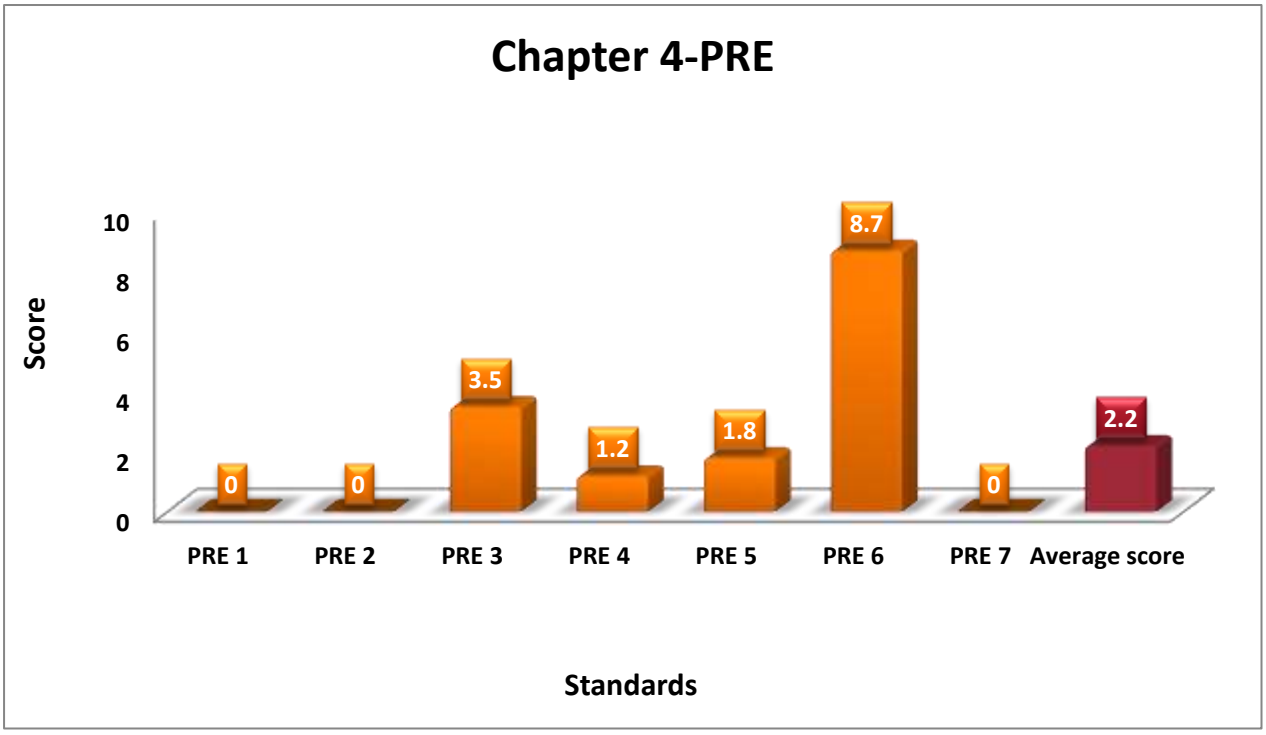
MOM- 11: Radioactive drugs are not used in the hospital.

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

MOM- 13: There are no documented policies and procedures for use of medical gases. Medical supplies and consumables are not stored in a clean; safe and secure environment; and manufacturer's recommendation are not followed.

Chapter 4: PATIENT RIGHT AND EDUCATION (PRE)	
PRE 1	0.0
PRE 2	0.0
PRE 3	3.5

PRE 4	1.2
PRE 5	1.8
PRE 6	8.7
PRE 7	0.0
Chapter average	2.2



INTERPRETATION

PRI -1. Documentation of patient and family rights and responsibilities has not been done and displayed, Staffs are not uniformly aware of their responsibility in protecting patient's rights. Violation of patient and family rights is not been recorded, reviewed and corrective / preventive measures are not taken.

PRI-2 There is no policy in which patient's rights and responsibility has been described and many other policies which need to be documented and need to be implemented.

PRI-3. The care plan is not prepared and modified in consultation with patient and/or family members .possible patient and/or family concerns and requests does not incorporated's in care plan

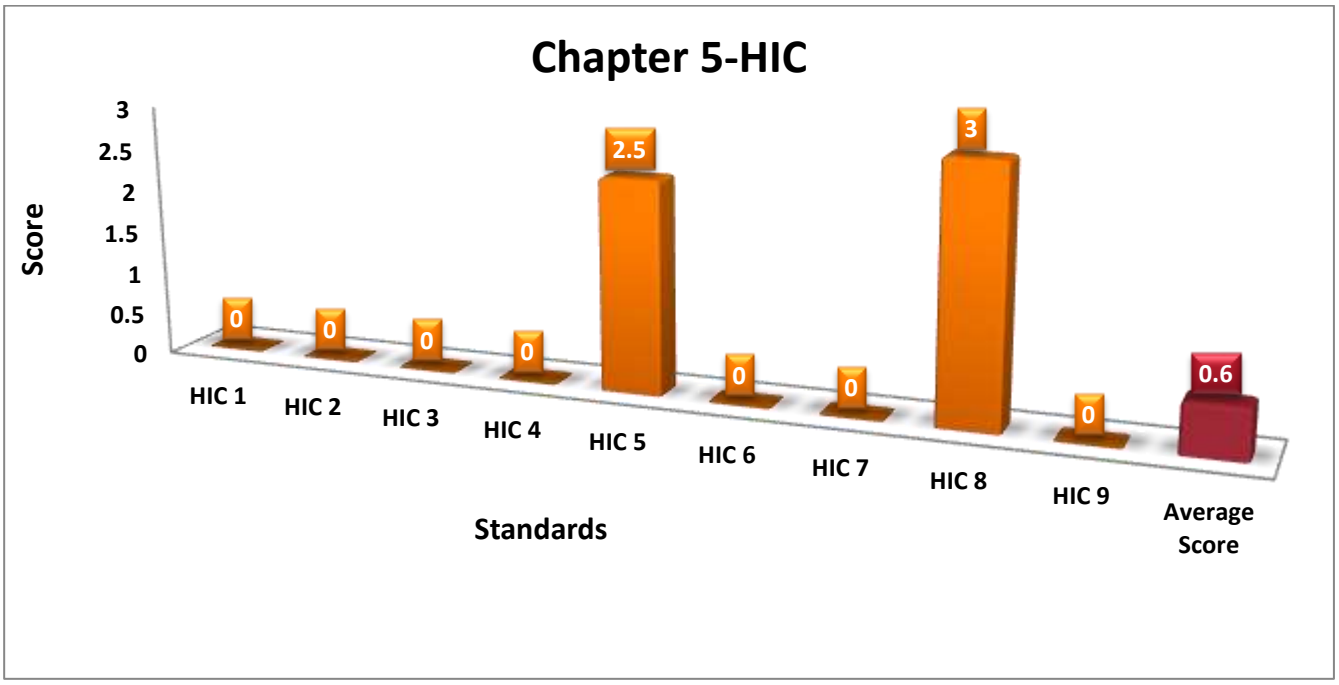
PRI -4.Informed consent policy is not documented and implemented. General consent for treatment is not obtained when the patient enters the organization. The procedure does not describe who can give consent when patient is incapable of independent decision making. Informed consent is not taken by the person performing the procedure. Informed consent process does not adhere to statutory norms.

PRI-5. The patient and their family members are not uniformly educated about the safe and effective use of medications and their potential side effects. Patient and/or family are not educated about food-drug interactions, diet and nutrition. Patient and/or family are not educated about organ donation, when appropriate. Patient and/or family are not educated about preventing healthcare associated infections.

PRI-6. The tariff list is not displayed.

PRI-7. The documentation of organization redressed procedure has not been done. All complaints should be analysed according to the documentation.

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)	
HIC 1	0.0
HIC 2	0.0
HIC 3	0.0
HIC 4	0.0
HIC 5	2.5
HIC 6	0.0
HIC 7	0.0
HIC 8	3.0
HIC 9	0.0
Chapter average	0.6



INTERPRETATION

HIC-1. The hospital does not has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care. Hospital does not have infection control committee, infection control team and nurse.

HIC-2.Infection Control manual has not been documented. The Hospital does not identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas The organization does not adheres to hand hygiene guidelines. The organization does not adhere to cleaning, disinfection and sterilization practices. The organization does not adhere to transmission based precautions at all times.

HIC-3.Survillance is not performed to capture and monitor infection prevention and control data. Proper documentation and implementation is required.

HIC-4.The organization does not take actions to prevent or reduce the different risk of Hospital Associated Infections (HAI) in patients and employees the organization should take action to prevent surgical site infections. These policies are needed to be documented.

HIC-5.Barrier nursing facility is not available. Appropriate pre and post exposure prophylaxis is not provided to all concerned staff members.

HIC-6. Outbreaks of infections are not documented. No appropriate action to control outbreaks of infections is taken. There is no documented procedure for handling such outbreaks.

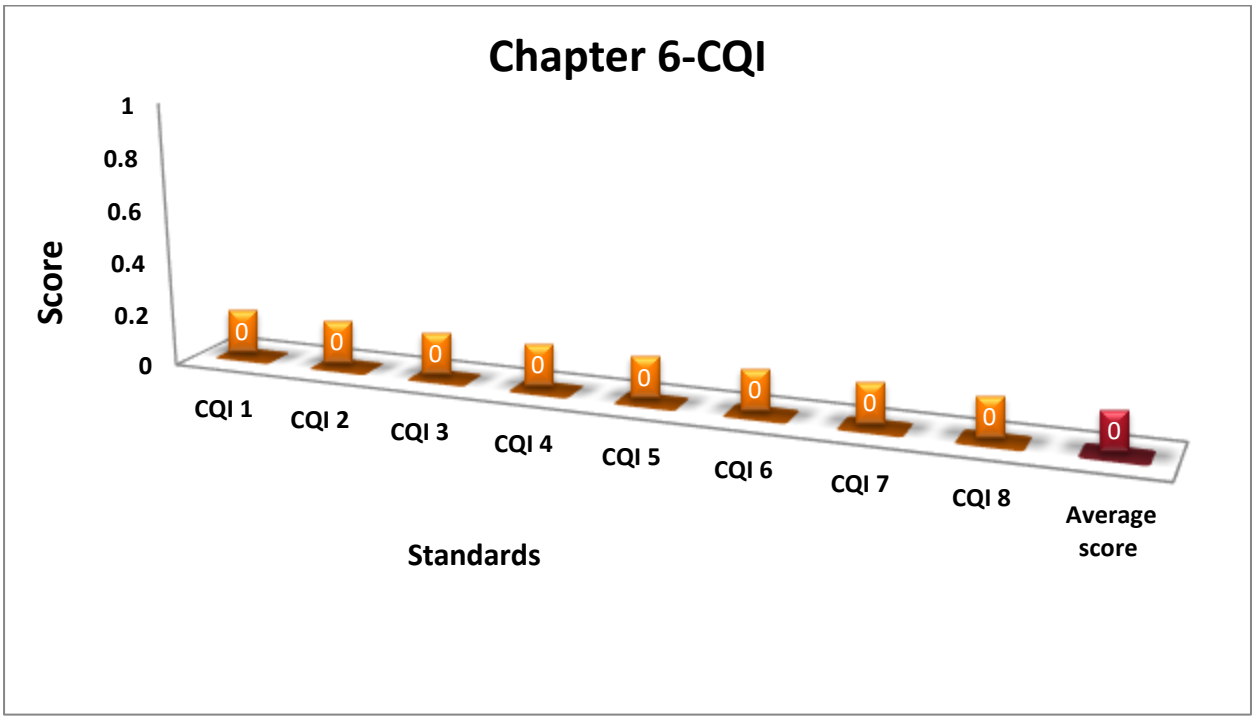
HIC-7. Documentation has been done for procedures for sterilisation activities in the organisation. There is no adequate space and appropriate zoning for sterilization activities. Regular validation tests for sterilization (Bowie dick tape test and leak

rate test) are not carried out No established recall procedure for sterile and non sterile items.

HIC-8. The organization does not adhere to statutory provisions with regard to biomedical waste. Proper segregation and collection of biomedical waste from all patient care areas of the hospital is not implemented and monitored.

HIC-9. The management does not makes required resources available for the infection control programme. The organization does not earmarks adequate funds from its annual budget in this regard. The organization does not conduct induction training for all staff. The organization does not conducts appropriate "in-service" training sessions for all staff at least once in a year.

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)	
CQI 1	0.0
CQI 2	0.0
CQI 3	0.0
CQI 4	0.0
CQI 5	0.0
CQI 6	0.0
CQI 7	0.0
CQI 8	0.0
Chapter average	0.0



INTERPRETATION

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

CQI-2. Structured patient safety programme is not documented. There is no multidisciplinary committee to implement the programme.

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

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

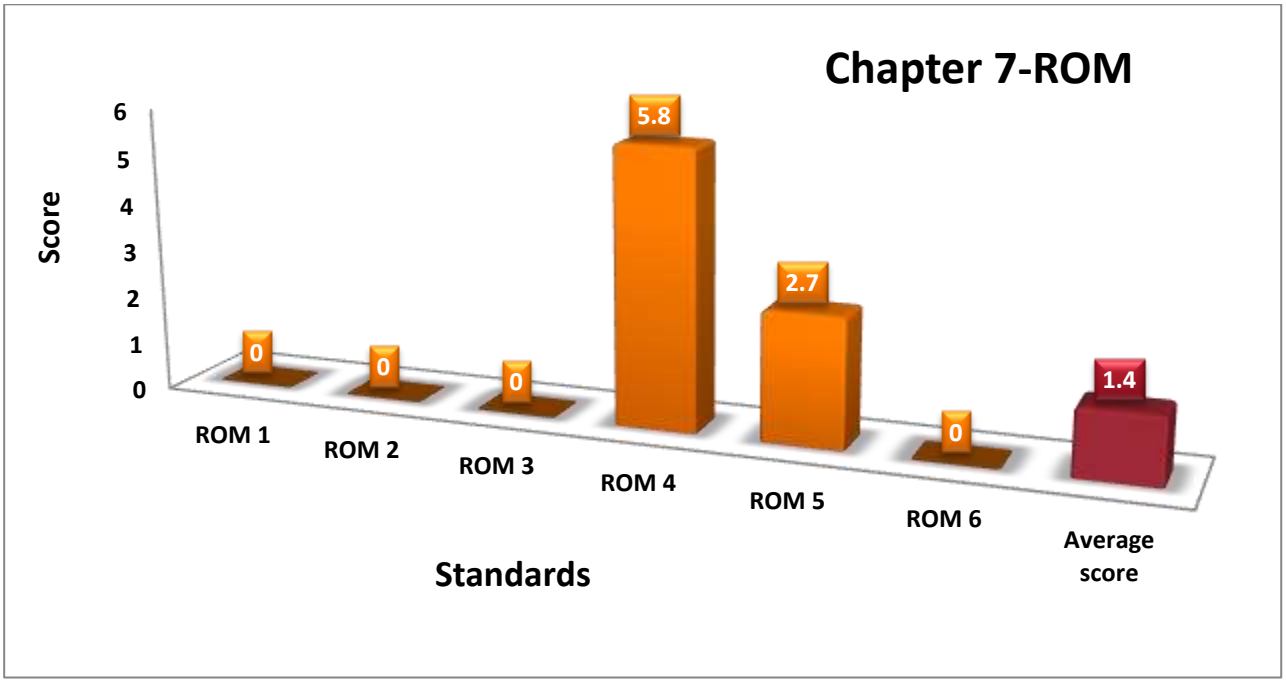
CQI-5. The quality improvement programme is not supported by the management.

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

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

CQI-8. The organization has no established process for analysis of sentinel events.

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)	
ROM 1	0.0
ROM 2	0.0
ROM 3	0.0
ROM 4	5.8
ROM 5	2.7
ROM 6	0.0
Chapter average	1.4



INTERPRETATION

ROM-1. Responsibilities of Management are not defined.

ROM-2.The policy and procedure of the organization does not complies with the laid down and applicable legislations.

ROM-3. Services provided by each department are not documented and displayed. Departmental leaders are not involved in quality improvement. Scope of services of each department is not defined.

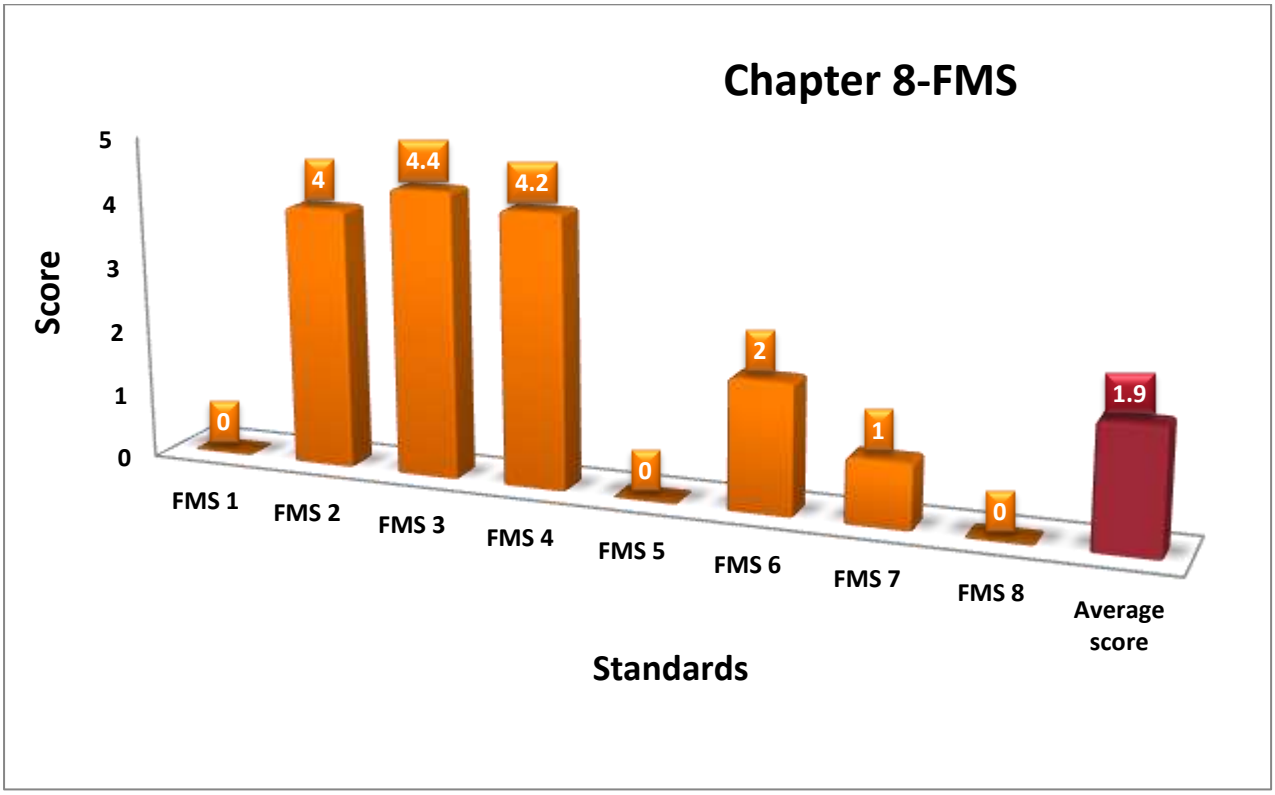
ROM-4. Organization's Ethical Management needs to be improved.

ROM-5. The performance of the senior leaders is not reviewed for their effectiveness. The organization does not documents employee rights and responsibilities. The organization does not document the service standards. The organization does not have a formal documented agreement for all outsourced services. The organization does not monitor the quality of the outsourced services.

ROM-6. Documentation of sentinel events has not been done the leaders are not aware of the risk management procedures followed in the hospital. There is no safety

and risk management committee in the hospital to oversee the hospital wide safety. There is no system for reporting of internal and external process failures.

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)	
FMS 1	0.0
FMS 2	4.0
FMS 3	4.4
FMS 4	4.2
FMS 5	0.0
FMS 6	2.0
FMS 7	1.0
FMS 8	0.0
Chapter average	1.9



INTERPRETATION

FMS-1. Safety committee is not formed safety plan and policies are not formed. Patient safety devices are not installed across the organization. Smoking is not restricted in hospital. Facility inspection rounds to ensure safety are not conducted. There is no safety education programme for staff.

FMS-2. No Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes. There is no internal and external sign posting in the organization in a language understood by patient, families and community.

FMS-3. The organization does not has documented a program for clinical and support service equipment management. Response times are not monitored for all the complaints received. There is no maintenance plan for heating, ventilation and air-conditioning

FMS-4. Equipment are not periodically inspected and calibrated for their proper functioning. There is no documented operational and maintenance (preventive and breakdown) plan.

FMS-5. The organization does not has documented programme for medical gases, vacuum and compressed air. Medical gases are not handled stored and distributed in safe manner.

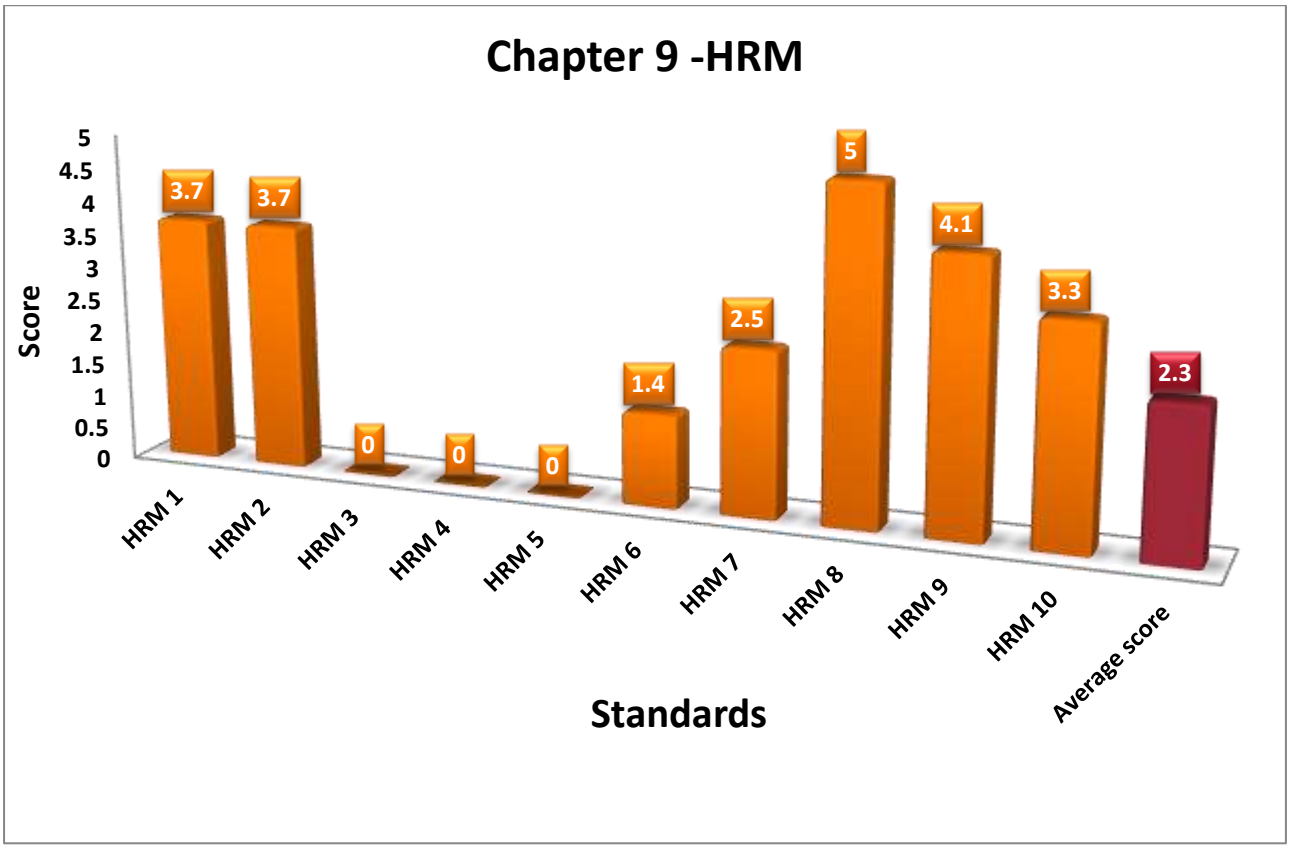
FMS-6. The organization does not have a documented safe exit plan in case of fire and non-fire emergencies. Staffs are not trained for their role in case of such emergencies .Mock drills are not held at least twice in a year.

FMS-7. The organization does not have a documented disaster management plan. Staffs are not trained in the hospital's disaster management plan.

FMS-8. Plan for management of hazardous materials has not been documented. There is no plan for managing spills of hazardous materials. Staff are not educated and trained for handling such materials.

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)	
HRM 1	3.7
HRM 2	3.7
HRM 3	0.0
HRM 4	0.0
HRM 5	0.0
HRM 6	1.4
HRM 7	2.5

HRM 8	5.0
HRM 9	4.1
HRM 10	3.3
Chapter average	2.3



INTERPRETATION

HRM-1 The organization does not have a documented system of human resource planning and it is implementation and needs updating. The required job specification and job description are not well defined for each category of staff.

HRM-2. The induction training does not include orientation to the organization's vision, mission and values. The induction training does not include awareness on employee rights and responsibilities. The induction training does not include awareness on patient's rights and responsibilities. The induction training does not include orientation to the service standards of the organization.

HRM-3. A documented training and development policy does not exist for the staff. Training does not occur when job responsibilities change/ new equipment is introduced.

HRM-4. Staff members are not adequately trained on specific job duties or responsibilities related to safety .Staffs are not trained on risks within the hospital environment and to take actions to report, eliminate/minimize risks. Reporting processes for common problems, failures and user error does not exist. Staffs are not trained on occupational safety aspects.

HRM-5. An appraisal system for evaluating the performance of an employee does not exist in the organization.

HRM-6. The organization does not has documented disciplinary and grievance handling policies and procedures.

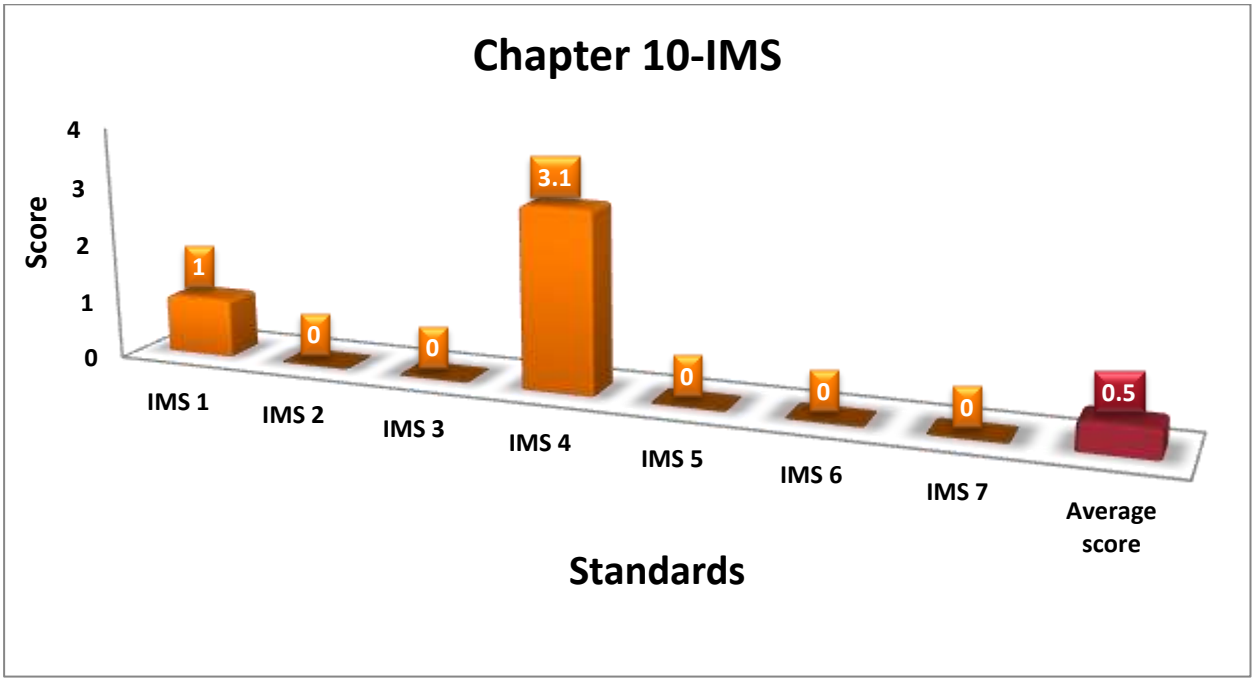
HRM-7. A pre-employment medical examination is not conducted on all the employees. Regular health checks of staff dealing with direct patient care are not done at-least once a year.

HRM-8. All records of in-service training and education are not contained in the personal files. Personal files do not contain results of all evaluations.

HRM-9. Medical professionals are not granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration. The requisite services to be provided by the medical professionals are not known to them as well as the various departments / units of the organization.

HRM-10. The education, registration, training and experience of nursing staff is not documented and updated periodically. Nursing staff are not granted privileges in consonance with their qualification, training, experience and registration.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)	
IMS 1	1.0
IMS 2	0.0
IMS 3	0.0
IMS 4	3.1
IMS 5	0.0
IMS 6	0.0
IMS 7	0.0
Chapter average	0.5



INTERPRETATION

IMS-1. Documented policies and procedures to meet the information needs do not exist. The organization does not contribute to external databases in accordance with the law and regulations.

IMS-2. Formats for data collection are not standardized. Necessary resources are not available for analysing data. Documented procedures are not laid down for timely and accurate dissemination of data. Documented procedures do not exist for storing and retrieving data. Appropriate clinical and managerial staff does not participates in selecting, integrating and using data.

IMS-3. Every medical record has does not have unique identifier. Organization does not policy identifies those authorized to make entries in medical record. Entry in the medical record are not named, signed, dated and timed. The author of the entry cannot be identified. The contents of medical record are not identified and documented. The record does not provide a complete, up-to-date and chronological

account of patient care. No provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.

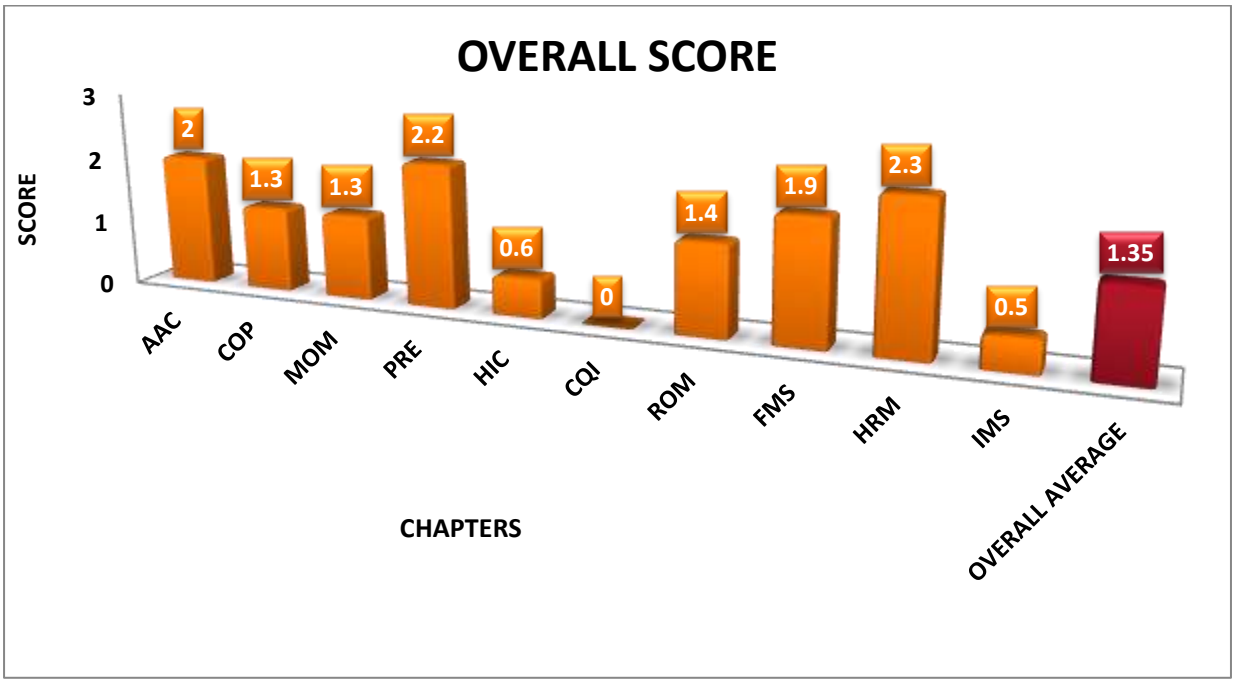
IMS-4. When patient is transferred to another hospital, the medical record does not contain the date of transfer, the reason for the transfer and the name of the receiving hospital. The medical record does not contain a copy of the discharge summary duly signed by appropriate and qualified personnel. Care providers do not have access to current and past medical record.

IMS-5. Documented policies and procedures are not in place for maintaining confidentiality, integrity and security of records, data and information.

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

IMS-7.. The organization does not carry out review of medical records to find out the timeliness, legibility and completeness of medical records. Appropriate corrective and preventive measures are not undertaken.

Overall average score of all Chapters



Analysis

1. Pre-accreditation entry level:

Conditions for qualifying to this award are as below:

- All the regulatory legal requirements should be fully met.
- No individual standard should have more than two zeros.
- The average score for individual standard must not be less than 5.
- The average score for individual chapter must be more than 5.
- The overall average score for all standards must exceed 5.

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

2. Pre-accreditation progressive level:

Conditions for qualifying to this award are as below:

- All the regulatory legal requirements should be fully met.
- No individual standard should have more than two zeros.
- The average score for individual standard must not be less than 5.
- The average score for individual chapter must be more than 6.
- The overall average score for all standards must exceed 6.

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

3. Accredited:

Conditions for qualifying for accreditation are as below:

- All the regulatory legal requirements should be fully met.
- No individual standard should have more than one zero to qualify.
- The average score for individual standards must not be less than 5.
- The average score for individual chapter must not be less than 7.
- The overall average score for all standards must exceed 7.

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

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

1) There are individual standards with more than two zero.
2) There are many standards having average score less than 5.
3) There are many individual chapters having average score less than 5.
4) Overall average of all the standards does not meet the criteria as it is less than 5.

With the above analysis it is clear that the hospital fails to fulfil the pre-accreditation entry level criteria.

RECOMMENDATIONS

1. Dedicated manpower should be posted on immediate basis that includes: **EMO, Gynaecologist, Radiologist, Pathologist, Dietician, Trained and qualified Nurses, OT Technicians** as per NABH standards.
2. **A well-equipped laboratory with Semi-automatic and Automatic lab equipment's and Separate sample collection area** should be made available and scope of services should be increased since all the tests are not performed in present laboratory setup.
3. **Setup of SNCU should be made functional by providing well trained nurses with all equipment's of SNCU.**
4. **Well-equipped Labour Complex should be designed including Separate labour rooms with one labour table each, , Post Op –Pre Op room, Septic room , appropriate Doctors and Nurses changing room along with toilets and new born corner.**
5. **OT complex should be designed with proper Zoning of OT having Pre-Operative and post-operative rooms, scrub area, Doctors and nurses changing room and HVAC system.**
6. **There should be restricted entry along with provision for privacy and safety to the patients in the labour room.**
7. **Essential equipment & Accessories such as crash cart, dressing trolley, Beds, Defibrillator, Monitor, Intubation Set, Emergency tray** should be made available in most of the patient care areas.
8. **Manifold system for supplying medical gases to OT, Labour room, SNCU and wards should be designed.**

9. **Since ICU is not present,** ICU should be designed and facility should be stated as soon as possible.

10. It is recommended that there should be separate counters for registration, enquiry, and admission and for differentially able patients.

11. **UHID should be generated** at the registration counter for every patient.

12. There should be uniform signage system displaying all necessary information bilingually on boards to be visible and understandable by general public.

13. Relevant licenses and statutory requirements to be obtained on immediate basis.

14. Existing cylinders to be refilled and updated. The Hospital should follow recommendation of Local Fire Division.

15. Patient charter having patient's rights and responsibilities should be displayed according to NABH norms.

16. **Arrangement for treatment of infected liquid waste should be done.**

17. **Adequate resources should be provided for BMW and infection control.**

18. Infection control measures and practices should be initiated inside the hospital.

19. All the staff should be sensitized and given periodic training on bio medical waste practices.

20. **Ward staff and housekeeping should be provided with Personal Protective Equipment (PPE).**

21. Turnaround Time should be defined and documented for diagnostic services.

22. External Quality Assurance for diagnostic services should be started.

23. Provision for tests not available inside the hospital should be present.

24. Surveillance programme in high risk area should be initiated and feedback regarding growth, infection rates, and trends should be provided to respective units.

25. A dedicated Centralized sterilization unit should be recommended for better infection control practices since autoclaves are kept separately in all departments with no channelized system of sterilization.

26. Medical Record Department with proper functional flow should be designed having sufficient number of racks.

27. Dedicated Security staff should be made available in sufficient number for safety of patients as well as hospital staff.

28. Equipment should be calibrated and history cards must be maintained.

29. Pest Control measures should be started as it was not seen anywhere.

30. Laundry/ Linen Management should be started.

31. Layout of kitchen should be done as per standards and dietician should be posted.

32. There should have Biomedical engineering and Maintenance.

CONCLUSION:

The analysis shows that there are many gaps in the hospital as per NABH norms. Documentation and implementation is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. There are different stages of accreditation which needs to be fulfilled by the organization. As of now the hospital does not fulfills the criteria for entry level according to which no standard must have more than two zero and the average score of individual standard must not less than 5 and the average score for individual chapter must be more than 5.we conducted gap analysis to analyze the present status of the hospital and concluded that the hospital fails at entry level as there are standards HIC, CQI and IMS having score even less than 1.rest all other standards are having score less than 5 .therefore these are the areas which require greatest attention. Thus the hospital is presently not prepared for pre – assessment and requires great effort and focus on the weak points so as to cover the gaps and to be prepared for getting NABH accreditation.

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   Date: 27-03-2014

Annexure

(A) Checklist:

OPD

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

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

25	**OPD patient satisfaction survey**		√	

AMBULANCE

Sl. No	**Description**	**Yes**	**No**	**Remarks**
Structure				
1	**Adequate communication system exists in ambulance**		√	
2	**Required equipments (stetho, sphygmo, suction app, defib, monitor, oxygen cylinder) are available in the ambulance.**		√	**Only oxygen cylinder**
3	**Required medicines are available in the ambulance.**		√	
4	**Is Vehicle license available?**	√		
5	**Is driver license present?**	√		
6	**Maintenance of the medical gas (oxygen) to 90% of the total capacity.**		√	
7	**Calibration of Equipments present**		√	
PROCESS				
8	**Is staff trained in BLS**		√	
9	**Is Medication and equipment checklist maintained**		√	

10	**Is infection control practices followed**		√	

LABORATORY

Sl. No.	Check points	Yes	No	Remarks
STRUCTURE				
1	**Is laboratory present in hospital?**	√		
2	**Specify the functional units of laboratories present in the hospital**		√	**Only Hematology unit present,BT,CT, TLC,DLC,VDRL, Blood Sugar,Blood urea, urine albumin, urine routine**
3	**Is there continuous water supply to this unit?**	√		
4	**Is adequate drainage system present in this unit?**	√		
5	**Is there provision for hand washing facility in this unit?**	√		
6	**Is there provision of personal protective devices for staff?(if yes mention the name)**	√		**Not used**
7	**Is the staff licensed and competent in knowledge and skill?**	√		
8	**Is there separate area available for sample collection?**		√	
9	**Is pathologist available?**		√	**Pathologist is to be posted**

10	**Are BMW bins are present in the department?**		√	
11	**Is there power back up facility available**	√		
12	**Is the scope of services defined**		√	
13	**Is maintenance of laboratory equipments done?**		√	
14	**Are laboratory equipments calibrated?**		√	
15	**Is laboratory staff aware about the safety precautions while handling samples?**		√	
16	**Is laboratory staff taking necessary precautions while handling samples?**		√	
17	**Is BMW segregation done as per BMW guidelines?**		√	
18	**Is critical results defined, reported, and documented.**		√	
19	**Is surveillance for lab test being carried out**		√	
20	**Is EQAS being monitored**		√	
21	**Laboratory reports are signed by Pathologist.**		√	
22	**Is labeling of sample done?**		√	
23	**Is time frame defined for dispatching lab reports?**		√	
24	**Is turnaround time for lab reports monitored?**		√	

25	**Is MOU available for outsourced tests**		√	**No test is outsourced**
26	**Is temperature monitoring of refrigerator is done?**		√	
OUTCOME				
27	**Number of reporting errors per 1000 investigations**		√	
28	**% of reports having clinical correlation with provisional diagnosis**		√	
29	**% of adherence to safety precautions**		√	
30	**% of redo's**		√	

WARDS

SL.NO	**Check points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	**Is Medical Gas Facility available in the ward?**		√	
2	**Are basic facilities for staffs present (toilet/ drinking water)?**		√	
3	**Is needle cutter present in each ward?**	√		**1 needle cutter present in each ward**
4	**Emergency crash cart is present in the ward?**		√	
5	**Color coded BMW bins are present in each ward?**		√	

6	**Is there a nursing station in the ward?**	√		
7	**Is there adequate number of nurses in each shift?**		√	**2 nurses in each shift**
8	**Racks are present to store linen?**		√	
9	**Wash basin is present in each ward.**	√		
10	**PPE is provided in each ward?**	√		
11	**Is staff aware of the admission process?**	√		
12	**Does the cleaning of the department take place?**	√		
13	**Are the vitals of the patient checked every day?**		√	
14	**Administration of medication is done by qualified nurse?**	√		
15	**Indent of medicines and other items is placed by nurses regularly?**		√	
16	**PPE is used by the nurses?**		√	
PROCESS				
17	**Are the BMW segregated at the point of generation?**		√	
18	**Does the nurse on duty record the details of the patient in the BHT**		√	

	on a daily basis?			
19	**Are the nurses trained in BLS(CPR)**		√	
20	**Is infection control practices being followed**		√	
21	**Is bio medical waste management practice followed**		√	
22	**Is the staff aware about transfer IN/OUT system**		√	
23	**Is cost estimate for treatment provided to the patient/attendant**	**NA**	**NA**	
24	**Is discharge process defined and documented?**		√	

LABOUR ROOM/EMERGENCY

Checklist for Labor Department				
Si. No	**Description**	**Yes**	**No**	**Remarks**
INFRASTRUCTURE				
1	**Are there separate areas demarcated for septic and aseptic deliveries?**		√	
2	**Does the Labour room have a toilet facility?**	√		

3	**Are number of Labour tables present appropriate for the daily load?**	√		
4	**Is continuous water available for the unit?**	√		
5	**Does the Labour Room have a hand washing facility?**	√		
6	**Is scrubbing area present for the Labour Room staff?**		√	**No scrubbing area, Only wash basin**
7	**Is the fire fighting system available in the unit?**	√		
8	**Is the changing room available for the doctors and nurses?**	√		
9	**Is there a continuous power back up for Labour Room?**	√		
10	**Is the Labour Room having a demarcated New Born Care Area with the appropriate equipments?**		√	
11	**Does the Labour Room have any sterilization equipment?**		√	**Boiler is present**
12	**Are there Disposable Delivery Kits in required quantities?**		√	
13	**Does the Labour Room have a Crash Cart?**		√	

14	**Is there an ECG monitor?**		√	
15	**Does the Labour Room have adequate Oxygen supply as per demand?**	√		
16	**Is the staff provided with the Personnel Protective Devices/ Equipments?**		√	
17	**Does the Labour Room have round the clock coverage by Trained Nurses/ Mid wives for conducting supervised deliveries?**		√	**2 nurses in morning shift** **2 nurses in evening shift** **1 nurse in night shift**
18	**Are there screens for privacy?**	√		
19	**Are there Cusco's vaginal speculum (each of small, medium and large size); Sim's vaginal speculum – single & double ended - (each of small, medium and large size); Anterior Vaginal wall retractor; Sterile Gloves; Sterilized cotton swabs and swab sticks in a jar with lid; Kidney tray for keeping used instruments; Bowl for antiseptic solution; Antiseptic solution: Chlorhexidine 1% or Cetrimide 2% (if povidone iodine solution is available, it**	√		

	is preferable to use that); Chittle forceps; Proper light source / torch			
PROCESS				
20	**Are Bio Medical Waste Management followed?**	√		
21	**Are Work Instructions prominently displayed?**	√		
22	**Does the Labour Room Register have a record of referred cases?**		√	
23	**Is the part preparation of the patient done before the operation?**		√	
24	**Are the number of Labour Room instruments counted before and after use?**		√	
25	**Are Partograms used for all patients?**		√	

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

OT

S. No.		**Yes**	**No**	**Remarks**
STRUCTURE				
1	**Is HVAC System present inside OT**		√	
2	**Is proper Zoning concept followed(Clean zone, protective zone, sterile zone, and disposal zone)**		√	
3	**Is the number of OT tables present in the hospital appropriate for the daily load**		√	

4	**If any OT has got more than one OT table**	√		
5	**Does the OT have a hand washing facility**	√		
6	**Is the firefighting system available in the unit**		√	
7	**Is continuous water available for the unit?**	√		
8	**Is the changing room available for the doctors and nurses**		√	
9	**Is there a continuous power back up for OT**	√		
10	**Does the OT have a crash cart**		√	
11	**Does the OT have defibrillator**		√	
12	**Does the OT have an ECG monitor**		√	
13	**Does the OT have oxygen supply**	√		
14	**Does the OT have shadow less OT light**	√		
15	**Is the staff provided with the personnel protective devices**	√		
16	**Is scrubbing area present for the OT staff**	√		
PROCESS				
17	**Is the consent for the surgery and anesthesia taken from the patient**	√		
18	**Is the OT list prepared**		√	
19	**Is the OT booking being done**		√	
20	**Is the preparation of patient done before**		√	**Not in OT**

	the operation			
21	**Does the nurse enter the patient details in the OT register**	√		
22	**Are the number of OT instruments counted before and after operation**	√		
23	**Is OT disinfection done after every procedure**	√		
24	**Is the pre anesthesia checkup done by the anesthetists**	√		**Not documented**
25	**Is pre, intra, post-operative notes are documented**		√	
26	**Is infection control practices being followed in OT**		√	
27	**Is pre-operative checklist being followed**		√	
28	**Is bio medical waste management practices being followed**		√	
OUTCOME				
29	**Is % of anesthesia related adverse events being monitored**		√	
30	**% of anesthesia related mortality**		√	
31	**% of modification in plan of anesthesia**		√	
32	**% of unplanned ventilation following anesthesia**		√	
33	**Is % of Surgical site infection rate monitored**		√	
34	**Re Exploration rate**		√	

35	**Re scheduling of surgeries**		√	

TSSU

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

	present? (receipt/Issue)			
11	**Labeling of drums in CSSD takes place?**		√	
12	**Is chemical, biological and bowie-dick test performed**		√	
13	**If recall system of items followed**		√	
14	**If reuse policy for items available**		√	

MEDICAL STORE/PHARMACY

Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	**The racks are available in sufficient number to store the items**		√	
2	**There is adequate ventilation and lighting in the department**	√		
3	**Is there a qualified/ trained personnel available**	√		
4	**Fire detecting &firefighting systems are available at department**		√	
5	**There is no water seepage/ damp in the store**	√		
6	**Verification of stock is done every six months**		√	
7	**There is a receiving area; segregation and**		√	

	storing area			
8	**The items are labeled & arranged at designated place.**		√	
9	**Items such as radiographic films, spirits etc (which are inflammable) are stored in a separate location.**		√	
10	**Inventory recording system is present either computerized or on register**		√	
11	**Frequently used items are arranged and located in most easily accessible area.**		√	
11	**Pest/rodent control measures are regularly under taken**		√	
12	**Lead time in issuing material to the department are recorded**		√	
13	**Stock Turnover details are calculated on a monthly basis.**		√	
14	**If sound inventory control practices followed (ABC/VED/FSN/FIFO)**		√	
15	**Is condemnation policy followed?**		√	
16	**Is there a purchase and condemnation committee in the hospital?**		√	
17	**A comparative list of rates of potential suppliers maintained**		√	
OUTCOME				
18	**% of stock outs**		√	
19	**% of goods rejected before preparation of GRN**		√	

20	**% of variation from procurement process**		√	

MEDICAL RECORDS DEPARTMENT

CHECKLIST FOR MEDICAL RECORDS DEPARTMENT				
S. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	**Is the sufficient space for medical record department available**	√		
2	**Is proper ventilation present in the department**	√		
3	**Is the fire fighting system available in the unit**		√	
4	**Is qualified and trained MRD technician available in the department**		√	
5	**Is table and chair provided to the MRD technician**		√	
6	**Is adequate number of racks available for the storage of records**		√	
PROCESS				
7	**Is the functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing,**		√	

	issuing			
8	**Is ICD coding method used for complete and incomplete files**		√	
9	**Are the MLC cases/dead cases stored separately under lock and key**		√	
10	**Is the retrieval of the records easy**		√	
11	**Is deficiency checklist is followed**		√	
12	**Is MRD Committee available?**		√	
13	**MRD audits is being conducted**		√	
14	**Are the records kept under lock**		√	
15	**If the hospital has retention policy for documents**		√	
16	**Are the forms and formats standardized**		√	
17	**Is the destruction policy for records available**		√	
18	**Is pest control done on a regular basis**		√	
OUTCOME				
19	**Is number of births/deaths monitored**		√	
20	**Is number of diseases notified to the local authority**		√	

21	**% of missing records**		√	
22	**% of records with ICD codification done**		√	
23	**Percentage of medical records not having discharge summary**		√	
24	**Percentage of medical records not having consent form**		√	