Measuring the compliance to NABH standards for SCHO utilizing Gap analysis as per self-assessment toolkit

A dissertation submitted in partial fulfillment of the requirements for the award of

Post Graduate Diploma in Health and Hospital Management

By

Dr. Sudesh Lamoria

Roll No: PG/08/055



International Institute of Health Management Research

New Delhi

1st Feb-1st May, 2010

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Dr. Sudesh Lamoria

Under the Guidance of

Ms. Archana Joshi
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International Institute of Health Management Research

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Date

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Abstract

Small healthcare organizations are those having bed strength between 20 to 50 beds and are in possession of supportive and utility facilities that are appropriate and relevant to the service being provided by the organization.

Accreditation is the commitment to quality enhancement through out the whole of the healthcare system involving all professionals and service groups. The focus of accreditation is on continuous improvement in the organizational and clinical performance of health services, not just the achievement of certificate or award or merely assuring compliance with minimum acceptable standards.

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

Methodology: - A comparative study of existing position of organization and NABH standards. Data source are secoundary data of the hospital facility. Standard formats have been developed and compilation of scattered data has been done. Hypothesis and problem statement was formed on the basis of literature review.

Major findings: - Gap analysis report shows the major findings like how many % services are fully available, partially available and not available.

Figure of % complition of NABH Chapters

Name of chapter	Total O.E	NC	PC	FC	Scoring	% of completion
Access, Assesment and Continuity of Care (AAC)	35	11	18	6	150	42.85
Care of Patient (COP)	47	26	20	1	110	23.40
Management of Medication (MOM)	27	16	11	0	55	20.37
Patient Rights and Education (PRE)	28	14	14	0	70	25
Hospital Infection Control (HIC)	30	19	11	0	55	18.33
Continous Quality Improvement (CQI)	25	14	11	0	55	22
Responsibility of Management (ROM)	14	4	10	0	50	35.71
Facility Management and Safety (FMS)	22	14	7	1	45	20.45

Human Resource Management (HRM)	30	9	18	3	120	40
Information Management System (IMS)	36	19	17	0	85	23.61
Total	294	146	137	11	795	27.04

Gap analysis as per NABH standards shows that the hospital is only 27.04% prepared for the accreditation application. As per NABH standards, eligibility for application is only when there is 70% preparedness on part of the hospital. Structural part is 30.27% ready, Process part 26.01% ready and Outcome part is 12.50% ready.

Hypothesis at the commencement of the study:

1. The organization is ready for accreditation.

As per NABH compliance the organization is only 27.04% ready for accreditation. The gap areas are around 70%.

Conclusion: - The study shows that the management is working for NABH accreditation and a consultant for gap analysis has been hired. I, as a hospital administrator helped the external agency in conducting a facility survey which is the basis of gap analysis. The gap analysis result shows that the hospital is only 27.04% ready for accreditation application and as per norms it requires 70% preparedness. This shows that more efforts are required for the accreditation application. Process documentation needs to be focused upon. Improvement in structures and process would lead to better results.

ACKNOWLEDGEMENTS

I would like to express my heartfelt thanks to Ms. Archana Joshi, Director, Deepak Foundation for giving me this opportunity in beginning of my career.

I would also like to give my profound thanks to Sangeeta Tikyani Madam and Yashvir agency for involving and guiding me for the gap analysis process.

I would like to express my profound thanks to Human Resources department for their support in data collection.

I also thank Dr. Nitish Dogra, Assistant Profesor, IIHMR New Delhi for their support and guidance.

I also thank full to Dr. Manisha Pawar, Gynecologist, and Resident Medical Officer, Dr. Ujwala Patil for their support.

I also thank Miss Nidhi Shendurnikar and Kandarp Talati for their valuable support.

Last but not least I would like to express my sincere and profound thanks to all my staff members including the nursing and paramedical staff, housekeeping staff for their cooperation. It would have been difficult to complete this study without their encouragement.

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List of Abbrevations:-

1. IPHS- indian public health standards
2. NABH- national accreditation board of hospital and healthcare providers
3. CSSD- central strile supply department
4. OT- operation theater
5. QCI- quality counicl of india
6. SMCS- safe motherhood and child survival
7. IMR- infant mortality rate
8. MMR- maternal mortality rate
9. BCC- behavior change communication
10. EmTF- emergency transport facility
11. CEmONC- comprehansive emergency obstetric and newborn care
12. GIDC- gujarat industrial development corporation
13. ICDS- intigrated child development scheme
14. ANC/PNC- antenatal care/ postnatal care
15. MHU- mobile health unit
16. VHSC- village health and senitation committee
17. NRHM- national rural health mission
18. PHC/CHC- primary healthcare center/ community healthcare center
19. RCH- reproductive child health
20. ANM- axulliary nurse midwife
21. ASHA- accreditated social health activist
22. EC- exicutive committee
23. SHCO- small health care organisation
24. NGO- non governmental organisation
25. MTP- medical termination of pregnancy
26. RTI/STI- reproductive tract infection/ sexual transmitted infection
27. RNTCP- revised national tuberculosis control programme
28. NPCB- national programme for control of blindness
29. NVBDCP- national vector born disease control programme
30. AYUSH- ayurveda yoga unani sidha and homiopathy
31. MIS- management information system
32. BOR- bed occupancy rate
33. BTR- bed turnover ratio
34. ALOS- average length of stay
35. OP/IP- optpatient/ inpatient

Internship report

1.1 Introduction to organisation and its profile[i]:-

1.1.1 History: - Brief Profile of the Organization

Deepak Foundation is a corporate social responsibility of Deepak Group of Industries (Deepak Fertilizers and Petrochemicals Corporation Limited and Deepak Nitrite Limited). The Foundation was set up in early eighties by Shri C.K. Mehta, to provide quality health care services to the families of the industrial workers at *Nandesari* industrial area. The initiative that initially catered to 30 surrounding villages has now evolved into a full fledged Foundation covering all 1548 villages of *Vadodara* District in Gujarat, India. The Foundation, through its multifaceted programs reaches out to a nearly 2 million population to provide services in various development sectors through Public Private Partnership (PPP).

Vision: Empowering women in rural and tribal areas by providing livelihood & health care opportunities.

Mission: Creating an enabling and sustainable environment among rural communities. We envisage a world; free of distress, disease, deprivation, exploitation & subjugation, thus ensuring the overall well being of the family, society & community with special focus on women and children.

Goals

- **Promote practices for safe motherhood and child survival**
- **Make available health and pre-school education services**
- **Ensure sustainable livelihood for underprivileged communities**
- **Provide disaster relief and rehabilitation services**

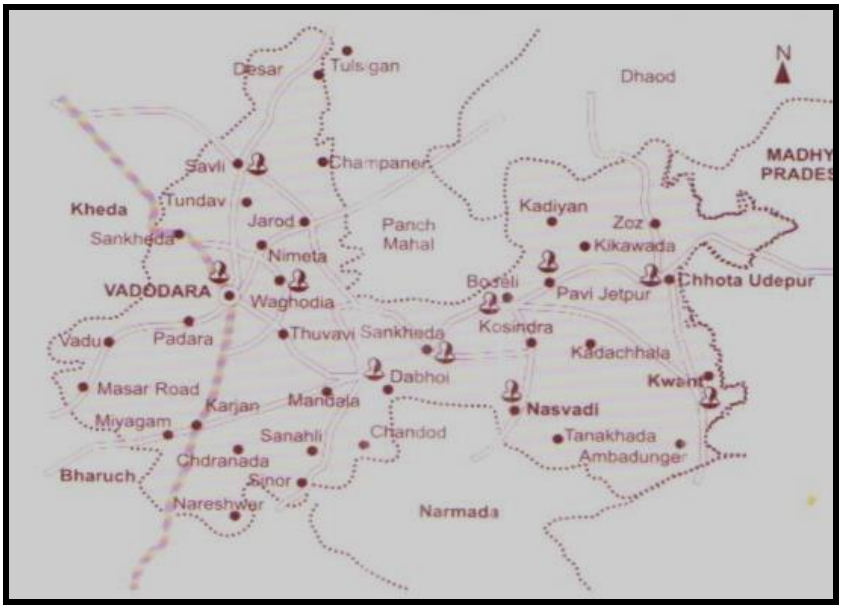
Organizational Structure and Capacity:

1.1.1. The organizational structure of the Foundation is designed to assist smooth functioning of various departments and project activities. The strength of the Foundation lies in its diverse workforce comprising of professionals from varied backgrounds such as demography, health, nutrition, economics, journalism, human development and family studies, extension and communication, and information technology. The implementation of project activities is carried out by coordination among different departments like Research and Evaluation, Training and Monitoring, Documentation & Public Relations, Accounts Team, Human

Resources Department and a field network spread in the 12 blocks of *Vadodara* district.

1.1.2. Location:-

Figure 1: Map of Vadodara District



1.1.3. Programs:-

Currently, the key implementation projects of the Foundation are:

- **Safe Motherhood and Child Survival Project (SMCS):** A Public-Private Partnership initiative undertaken to reduce infant and maternal mortality in *Vadodara* district.

- **Kawant Livelihood Project (KALP):** Public-Private Partnership initiative undertaken to improve the socio-economic status of households in one tribal block of *Vadodara* district.

- **Integrated Child Development Scheme (ICDS):** A Public-Private Partnership for provision of integrated health and nutrition services to underprivileged poor children and mothers.

- **Deepak Medical Foundation :**

The Foundation started humbly with setting up of **Deepak Medical Foundation**, a 15-bedded hospital, to serve the families of industrial workers in Gujarat Industrial Development Corporation (GIDC) area at Nandesari, Vadodara. Subsequently the hospital services were spread to around 30 villages in a catchments area spreading around 16 square kilometers.

In 1981, a clinic was established in Nandesari with the aim of providing maternal and child care services. The services were provided by a medical and paramedical staff to those who would approach the hospital. Besides hospital services, various health camps were organized by the trust hospital to reach out to the communities who had limited access to the hospital.

In 1985, a Mobile Dispensary cum Ambulance was started to take healthcare services to the doorsteps of people living in the remotest areas. With its advent, gradually the outreach activities were made available in each of the villages. It was ensured that the health needs of the all population groups were addressed like sexual health problems of the industrial workers, reproductive health needs of the adolescents and newly married couples, health and nutrition needs of children below five years through the Integrated Child Development Services (ICDS) scheme

One of the most important features of the hospital is its linkages with the Integrated Child

Development Services (ICDS) program. Deepak Foundation has been assigned the responsibility of supervision and running of 40 *Anganwadi* Centers in the catchment area surrounding the GIDC area at Nandesari.

Staff of DMF at Nandesari

- Gynecologist
- Resident Medical Officer
- Pharmacist
- Laboratory technician
- Nurses
- Ayyahs and Ward boys

Services offered by DMF hospital

- 24-hour medical services
- Ambulance service for DMF as well as for outside emergency patients
- Specialist consultation in Obstetrics and Gynecology
  - Antenatal and postnatal check-ups
  - Treatment of Gynecological disorders
  - Family planning services including counseling, distribution of suitable contraceptives, and Tubectomy
- Consultation in Pediatrics and Neonatology
  - Child health care with special focus on immunization
- Consultation in Ophthalmology and cataract surgeries
- Laboratory facilities (hemoglobin, blood group, semen, urine and other examinations)
- Sonography facility
- Care and guidance to men and women in matters related to reproductive health and sexually transmitted infections with emphasis on HIV/AIDS prevention
- Health related training to outreach workers
- Camps for awareness generation and screening of diseases

Figure 2: Staffing and services of DMF

The hospital today is well equipped with an **operation theater, oxygen cylinder, USG machine, well equipped labour room, ICU ward and ambulance** for 24 hours to provide emergency transport to the patient. The integrated

packages of services are rendered by around 30 staff members. Recently DMF has been recognized by the Government of Gujarat for providing services under the *Chiranjeevi Yojana,* endorsing the initiative of PPP. In this scheme, services during delivery are provided free of cost to pregnant women belonging to Below Poverty Line (BPL) families.

1.2. Area of engagement:-

A. General management: -

i. Looking after the general management for routine smooth functioning of all the departments of hospital and staff.

ii. Monitoring the function of staff members and providing suggestions for improvement.

iii. Guiding them for systematic process of working.

iv. Preparing various data collection formats for proper collection of data and easy retrieval of the same.

v. Coordinate with head office for reporting of data and general management issues; also for arrangement of well organised meetings and training programs.

vi. To resolve grievance of both patient and staff members.

vii. Motivate the staff for proper documentation of work and also provide them with the basic formats for documentation.

viii. Making monthly salary statement of all the employees and maintaining their leave cards.

ix. Providing data to government agencies on time in given formats.

x. Tracking attendance and Incoming-Outgoing time of employees.

xi. Orient the other agency visitor's about the services and facilities at the hospital.

B. Programs:-

- ICDS project: -
  - i. Coordinate with ICDS team for Anganwadi Health Check-up camps arrangement.
  - ii. Coordinate with Medical Officer for Health Check-up camps.
- SMCS project: -

i. Coordinate with the ASHA's training team for scheduling the lectures of medical related topics; mainly gynecological topics.
ii. Orient them about the facilities provided by the hospital and cost of treatment.
iii. Coordinate with the Head Office to ensure that they appropriate data is being received on a daily basis for the Horoscope project.

- Quality Improvement Program: -
  i. Monitoring of proper Bio-Medical Waste segregation.
  ii. Train the housekeeping staff for proper methods of Moping and motivate them for using protective measures.
  iii. Motivating the nursing staff for practice of personal protective methods.

1.3. Task Performed:-

- Preparing job profiles of the hospital employees.
- Preparing the Excel format for data collection of OPD, IPD (mainly Obstetric cases like- No. of delivery conducted in a day, type of delivery, etc.) and daily census.
- Train the staff in data entry and motivate them to use computer.
- Implement census filling system at mid night on daily basis from 1st of April.
- Prepare various registers (like- Indoor register, round book for daily ward round, discharge register, etc.) for proper documentation of basic data and train the staff for the same.
- Complete the old IPD records of last financial year. Collection of scattered IPD and OPD data and compile it in standard format.
- Prepare the Hospital Statistics for the last financial year.
- Calculate the key performance indicators for the last financial year and present the same in the Executive Committee (EC) meeting.
- Compile the full financial year data and present it in EC meeting.
- Document the existing policies and procedures like registration, admission, discharge.

1.4. Learnings:- Major learning during internship are-

- The first thing I learnt in this internship is keen observation because with out it a manager is not able to get hiden information which may affect the smooth functioning of an organisation.
- Learn how the theoretical practices are implemented in practical workings.
- Importance of team work and its effect in better productivity in an organization.
- How to coordinate with government agencies and authorities.
- How minor things can affect our performance.
- How to control anger; because it is the biggest enemy of a manager.
- How to manage human resources.

Dissertation report

Chapter 1:- Introduction

Small healthcare organization are those having bed strength between 20 to 50 beds and are in possession of supportive and utility facilities that are appropriate and relevant to the service being provided by organization[ii].

For specialty centers bed strength is not mandatory; which reflect requirement of MD/MS or equivalent qualification personnel[iii].

Deepak Medical Foundation (SHCO) is run by an NGO. It has the specialty of Obstetrics and Gynecology care. The Organization provides services to mothers and children.

Although the organization has facilities but these are not properly managed because the focus of all superior persons working with this setup is on the clinical side. The person performing the administrative function doesn't have the knowledge of healthcare organizations functioning. Clinical work is going in smooth way but due to lack of knowledge of medical setup functions, the administrative functions are affected. Work is not evaluated due to lack of documented policies and improper records.

Problem Statement:-

- Major problem is lack of documented Standard operating procedures- the reason behind being stipulated time period of doctors and change of records according to their wish. Improper management is also one of the reasons.
- Unqualified staff is also a problem area- the staff working with the organization is experienced but not qualified. Staffs including pharmacist and front desk assistant are not properly trained in work which they execute.
- Lack of acceptance of responsibilities and team sprit- the main reason behind it is also the improper guidance and training.

Because of the above problems and the mandatory requirement of NABH for every hospital or Healthcare providers (as per government guidelines); the organization hired an external agency named Yashvir, for gap analysis.

Objectives of the study:-

1. Find out the Gap's in Structure, process and outcome of healthcare organization for accreditation process.
2. Collection of scattered data and calculate the key performance indicators.

Literature survey:-

Accreditation is the commitment to quality enhancement through out the whole of the healthcare system involving all professionals and service groups. The focus of accreditation is on continuous improvement in the organizational and clinical performance of health services, not just the achievement of certificate or award or merely assuring compliance with minimum acceptable standards[iv].

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

NABH introduction[v]:-

National Accreditation Board for Hospitals & Healthcare Providers, is a body of Quality council of India and asses the quality of care provided by the hospitals and healthcare providers.

NABH standards for hospitals have been prepared by Technical Committee of NABH and contain complete set of standards for evaluation of hospitals for grant of accreditation. The standards provide framework for quality assurance and quality improvement for hospitals.

Figure 3. Structure of QCI

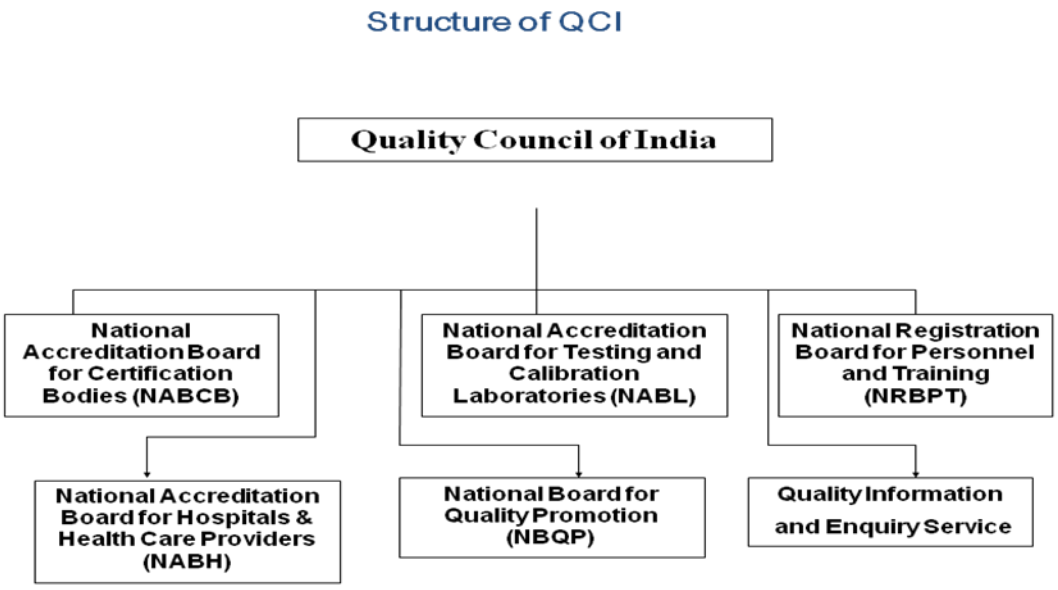
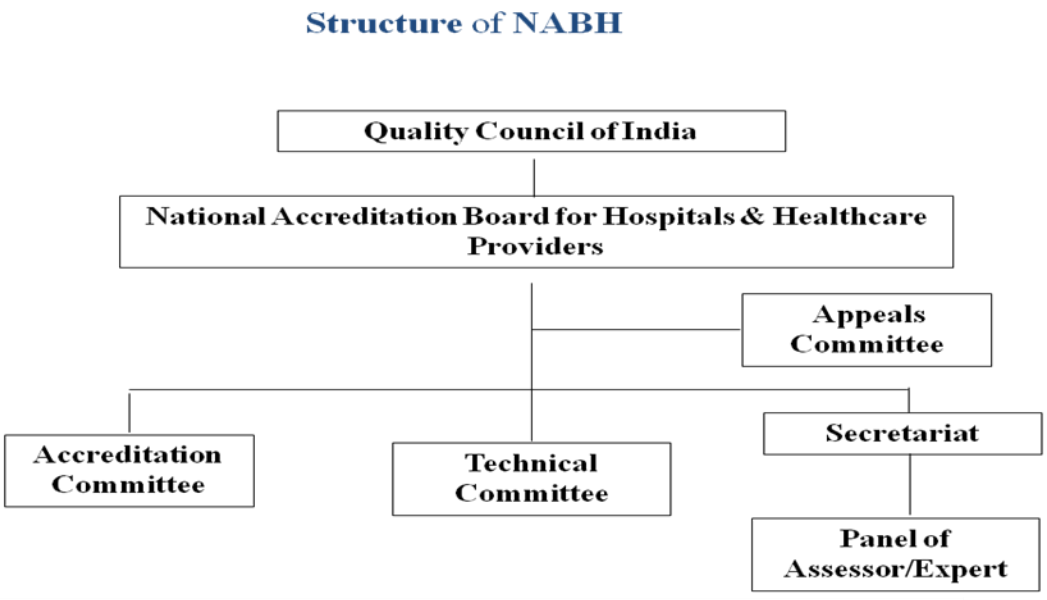


Figure 4. Structure of NABH



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Accreditation[vii]

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

Standard

It is a statement that defines the structures and processes that must be substantially in place in an organization to enhance the quality of care.

Objective Element [viii]

It is a measurable component of a standard.

Acceptable compliance with objective elements determines the overall compliance with a standard.

NABH Standards contain:

- 10 chapters
- 63 standards
- 294 objective elements

Table 1: NABH Chapters with standards and Objective element

Patient Centered Standards	Standards	Objective Elements
1. Access, Assesment and Continuity of Care (AAC)	7	35
2. Care of Patient (COP)	10	47
3. Management of Medication (MOM)	6	27
4. Patient Rights and Education (PRE)	5	28

5. Hospital Infection Control (HIC)	6	30
Organisation Centered Standards		
6. Continuous Quality Improvement (CQI)	5	25
7. Responsibility of Management (ROM)	3	14
8. Facility Management and Safety (FMS)	5	22
9. Human Resource Management (HRM)	9	30
10. Information Management System (IMS)	7	36

Benefits of NABH Accreditation[ix]:-

- By this providers can demonstrate the commitment to quality care and patient safety.
- Hospital can demonstrate that the services are provided by competent doctors and Para- medical staff.
- It will stimulate continuous improvement of the system for quality patient care and safety.
- It will help in the drastic reduction in a variety of medical and surgical errors, reduction in injuries to staff, reduction in injuries to patients and ensure safe medication administration and care.
- It streamlines all the areas.

It enables the hospital to have proper inter disciplinary co-ordination, internal and external reporting system, effective system for credentialing medical and Para- medical professionals and develop a system for professional training and development of staff.

Gap Analysis[x]: - Quality management system and the Accreditation process in compliance with standards, is a tool for quality assurance and quality improvement for hospitals which in turn help ensure quality healthcare services, standardized output, and aim for the best outcome possible. Spin offs of the system include economy, effectiveness, leadership amongst peer institution, confidence of the citizens in the establishment, and a culture of team work with a focus on service quality.

The Quality Council of India is an autonomous body under the Government of India; which has the National Accreditation Board for Hospitals and Health Care Providers (NABH) amongst several other boards under its fold. The NABH standards place emphasis on patient, staff, visitor and environment safety, infection control, and quality of care[xi].

Gap analysis is a tool that helps an organization to compare its actual performance with its potential performance. At its core are two questions: "**Where are we**?" and "**Where do we want to be**?"

Gap analysis shows the existing position of the organisation and also shows the gap areas where the organisation requires improvement. Gap analysis shows the gaps in 3 sections-

1. **Gaps in Structure and Process**: - Process gaps are identified by the policies and procedures. The most important part in this is documentation of the preformed work as per organisation policies. NABH standards guide about the process part of the hospital.

2. **Gaps in outcome[xii]**: - These gaps are shown in hospital's performance level in various categories. These gaps also show the popularity of hospital in the locality and the quality of care provided by the hospital.
    - Bed occupancy rate: - Bed occupancy rate is the percentage of official beds occupied by hospital inpatients for a given period of time. In general the greater the occupancy rate, the greater the revenues for the hospital.

      $$BOR=\frac{\text{Total no. of inpatient service days for a given period x 100}}{\text{Total no. of inpatient bed count days for the same period}}$$

    - Bed Turnover Ratio: - It is a measure of hospital utilization. It includes the number of times each hospital bed changes occupants.

      $$BTR=\frac{\text{Total no. of discharges (including deaths) for a given time period}}{\text{Average Bed count for the same period}}$$

- Average length of stay: - Length of stay is calculated for each patient after he or she is discharged from the hospital. It refers to the no. of calender days from the day of patient admission to the day of discharge. The total length of stay divided by the no. of patients discharged is the Average Length of Stay.

  ALOS= Totel Length of stay for a given period
  Total no. of discharges (including deaths) for the same period

- L.S.C.S rate: - It shows that how many percent deliveries conducted by operative procedure.

  LSCS rate= Total no. of C-section performed in a given period of time
  Total no. of women who delivered in the same period of time Including C-sections

- Out patient- In patient ratio[xiii]:- It shows the ration between outpatient and inpatient. It indicates that how much indoor facility of a hospital is popular in community.

  OP/IP ratio= Total no. of Out door patient in a given period of time
  Total no. of indoor patient in the same period of time

Basic terms used in hospitals[xiv]:-

- **Hospital inpatient:** - A person who is provided room, board and continuous general nursing services in an area of the hospital where patients generally stay at overnight.

- **Hospital newborn inpatient:** - An infant born in the hospital at the beginning of the current inpatient hospitalization. New borns are usually counted separately because their care is so different from that of other patients.
- **Inpatient hospitalization**:- The period in a person's life when they are an inpatient in a single hospital with out interruption except by possible intervening leavies of absance.

- **Inpatient admission:-** The formal acceptance by a hospital of a patient who is to be provided with room,board and continuous nursing services in an area of the hospital where patients generally stay outnight.
- **Inpatient discharge:-** the termination of a period of inpatient hospitalization through the formal release of the inpatient by the hospital. This designation includes patients who are discharged alive (by physician order), who are discharged against medical advice, or who died while hospitalized.
- **Hospital outpatient: -** A hospital patient who receive services in one or more of the outpatient facilities when not currently an inpatient or home care patient. An outpatient may be classified as either emergency outpatient or a clinic outpatient

Gap analysis provides a foundation for measuring investment of time, money and human resources required to achieve a particular outcome.

Chapter 2:- Research Methodology

Research Problem: - Management of the organization shows interest in Accreditation of the hospital under the Small Health Care logo. For Accreditation the basic requirement is to assess the existing position of the hospital in comparision with the NABH stsndards and for fullfilment of this requirement Gap Analysis is the basic tool. It shows the actual vs potential of the hospital as per NABH standards and the gap areas.NABH standards give importance to documentation. On the basis of comparision of actual position of the hospital and NABH standards the hypothesis is as follows-

1. The organization is ready for accreditation.

Research design: -

- General methodology used for data collection was the secondary data review and the comparative study of the existing vs potential.
- The data source is secondary data collected from the medical and nursing records and the standard copy received from Yashvir agency. NABH requires proper data of each and every procedure. I collected these data's from the patient's indoor records and the old nursing and OPD registers. Here all the data's are in scattered form and also incomplete. No standard or formal format is available to compile the data. I first prepared a standard format for collection of data in excel sheet and implemented it at registration counter and nursing station both. I collected full year data on one on one basis; because these data's are the base for hospital performance. Depiction of performance indicators is not possible without this and comparison with standards is also not possible. This part is most time consuming because of the need for cross verification.

- Data analysis on the basis of quantitative method for satisfying the hypotheses. Find out the preparation percentage of organisation in each section- structure, process and outcome. I give each standard that is compliance to NABH standards full marks; partially compliance gets half mark and no compliance gets zero mark as per the guidelines of NABH and guidance of Yashvir agency. NABH standrds are the combination of Structuer, Process and Outcome standards.

Chapter 3:- Results and Findings:-

The initiation for the gap analysis shows the interest of management towards the accreditation award achievement. For the fulfillment of this objective, the management appointed Yashvir Agency for primary step that is Gap analysis; I was a part of this team for facility servey of the hospital and preparing the hospital statistics.

Gap analysis shows the lacking areas which requires improvement for Accereditation award application. NABH standards give the comprehensive format of structure, process and outcome.

Self Assesment Tool kit

Compliance to the requirement: 10
Partial compliance to the requirement: 5 (if any of the sample is found to be noncomplying out of total samples selected)
Non-compliance to the requirement: 0

Table 3: Assessment of Access, Assessment and Continuity of care

Elements		Scores (0/ 5/ 10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)		
AAC.1: The organization defines and displays the services that it can provide.		
A	The services being provided are clearly defined.	5
B	The defined services are prominently displayed.	0
C	The staff is oriented to these services.	10
AAC.2: The organization has a documented registration, admission and transfer process.		
a.	Process addresses registering and admitting out-patients, in-patients and emergency patients.	5
b.	Process addresses managing patients during non availability of beds.	5

c.	Patients are accepted only if the organization can provide the required service.	5
d.	Process addresses mechanism for transfer or referral of patients who do not match the organizational resources.	5
AAC.3 Patients cared for by the organization undergoes an established initial assessment.		
a.	The organization defines the content of the assessments for the out-patients, in-patients and emergency patients.	0
b.	The organization determines who can perform the assessments.	5
c.	The organization defines the time frame within which the initial assessment is completed.	0
d.	The initial assessment for in-patients is documented within 24 hours or earlier.	5
AAC.4 Patient care is continuous and all patients cared for by the organization undergo a regular reassessment.		
a.	During all phases of care, there is a qualified individual identified as responsible for the patient's care who coordinates the care in all the settings within the organization.	5
b.	All patients are reassessed at appropriate intervals.	10
c.	Staff involved in direct clinical care document reassessments.	5
d.	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	10
AAC.5 Laboratory services are provided as per the scope of the hospital's services and adhering to best practices.		
a.	Scope of the laboratory services are commensurate to the services provided by the organization.	10
b.	Adequately qualified and trained personnel perform and/ or supervise the investigations.	5
c.	Procedures guide collection, identification, handling, safe transportation, processing and disposal of specimens.	0
d.	Laboratory results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.	5

e.	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	5
f.	Laboratory personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.	5
g.	Quality assurance for laboratory should be as per accepted practices and also include periodic calibration and maintenance of all equipments.	0
AAC.6 Imaging services are provided as per the scope of the hospital's services and adhering to best practices.		
a.	Imaging services comply with legal and other requirements.	5
b.	Scope of the imaging services are commensurate to the services provided by the organization.	5
c.	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	10
d.	Imaging results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.	10
e.	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
f.	Imaging personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.	5
g.	Quality assurance for Radiology services should be as per accepted practices and also include periodic calibration and maintenance of all equipments.	5
AAC.7 The organisation has a defined discharge process.		
a.	Process addresses discharge of all patients including Medico-legal cases and patients leaving against medical advice.	5
b.	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice).	0
c.	Discharge summary contains the reasons for admission, significant findings, investigation results, diagnosis, procedure performed (if any), treatment given and the patient's condition at the time of discharge.	0
d.	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.	0

e.	Discharge summary incorporates instructions about when and how to obtain urgent care.	0
f.	In case of death the summary of the case also includes the cause of death.	0
Total		150

Table 4: compliance of AAC

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
35	11	18	6	150

Gaps:

- Services are not clearly defined.
- Defined services are not displayed.
- No policy and procedures are documented.
- No assessment policy present.
- No maintenance policy for equipments.
- Discharge summary is not given to patients.

Table 5: Assessment of Care of Patient

Chapter 2: CARE OF PATIENTS (COP)	
COP.1: Care of patients is uniform and is guided by the laws and regulations. X	

A	Care delivery is uniform when similar care is provided in more than one setting.	5
B	Care delivery includes special needs of vulnerable patients (elderly, children, physically and/ or mentally challenged).	0
C	The care and treatment orders are signed, named, timed and dated by the concerned doctor.	0
D	The care plan is countersigned by the clinician in-charge of the patient within 24 hours.	0
E	Evidence based medicine and clinical practice guidelines are adopted to guide patient care whenever possible.	0
COP.2: Emergency services including ambulance are guided by documented procedures and applicable laws and regulations.		
A	Documented procedures address care of patients arriving in the emergency including handling of medico-legal cases.	5
B	Documented procedures also guides the triage of patients for initiation of appropriate care.	0
c	Staff is trained on the procedures for care of emergency patients.	5
D	Admission or discharge to home or transfer to another organization is also documented.	5
E	Ambulance is appropriately equipped and manned by trained personnel.	5
F	In the ambulance, there is a checklist of all equipment and emergency medications which is checked on a regular basis.	0
COP.3: Documented procedures guide the care of patients requiring cardio-pulmonary resuscitation.		
A	Documented procedures guide the uniform use of resuscitation throughout the organization.	0
B	Staff providing direct patient care is trained and periodically updated in cardio-pulmonary resuscitation.	0
C	Events during cardio-pulmonary resuscitation are recorded.	0
COP.4: Documented procedures define rational use of blood and blood products.		
A	The transfusion services are governed by the applicable laws and	5

	regulations.	
B	Informed consent is obtained for donation and transfusion of blood and blood products.	5
C	Procedure addresses documenting and reporting of transfusion reactions.	0
COP.5: Documented procedures guide the care of patients in the Intensive care and high dependency units.		
A	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	0
B	Care of patients is in consonance with the documented procedures.	0
C	Adequate staff and equipment are available.	0
COP.6: Documented procedures guide the care of obstetrical patients.		
A	The organization defines the scope of obstetric services.	5
B	Obstetric patient's care includes regular ante-natal check ups, maternal nutrition and post-natal care.	5
C	The organization has the facilities to take care of neonates.	5
COP.7: Documented procedures guide the care of pediatric patients.		
A	The organization defines the scope of its pediatric services.	0
B	Provisions are made for special care of children by competent staff.	0
C	Patient assessment includes detailed nutritional, growth, and immunization assessment.	5
D	Procedure addresses prevention of child/ neonate abduction and abuse.	0
E	The children's family members are educated about nutrition, immunization and safe parenting.	0
COP.8: Documented procedures guide the care of patients undergoing parenteral sedation.		
A	The person administering and monitoring sedation is different from the person performing the procedure.	5
B	Patient's vital parameters are monitored during and after sedation and are discharged/ transferred once they are stable.	5

C	Equipment and manpower are available to rescue patients from a deeper level of sedation than that intended.	5
COP.9: Documented procedures guide the administration of anesthesia.		
a.	There is a documented procedure for the administration of anesthesia.	0
b.	All patients for anesthesia have a pre-anesthesia assessment by a qualified individual.	0
c.	The pre-anesthesia assessment results in formulation of an anesthesia plan which is documented.	0
d.	An immediate preoperative re-evaluation is documented.	0
e.	Informed consent for administration of anesthesia is obtained by the anesthetist.	5
f.	Anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anesthesia.	0
g.	Each patient's post-anesthesia status is monitored and documented.	0
h.	A qualified individual applies defined criteria to transfer the patient from the recovery area.	0
i.	All adverse anesthesia events are recorded and monitored.	0
COP.10: Documented procedure guide the care of patients undergoing surgical procedures.		
a.	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	5
b.	An informed consent is obtained by a surgeon prior to the procedure.	5
c.	The documented procedure addresses the prevention of adverse events like wrong site, wrong patient and wrong surgery.	0
d.	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	10
e.	A brief operative note is documented prior to transfer out of patient from recovery area.	5
f.	The operating surgeon documents the post-operative plan of care.	5

g.	The operation theatre is adequately spaced, equipped and monitored for infection control practices.	5
	Total	110

Table 6: Compliance of COP

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
47	26	20	1	110

Gaps:

- No written and monitoring process for adverse event.
- No recovery area is available.
- Basic Pediatric care facility is not available.
- Staff is not trained in any kind of emergency procedure.

Table 7: Assesment of Management of Medication

Chapter 3: MANAGEMENT OF MEDICATION (MOM)	

MOM.1: Documented procedures guide the organization of pharmacy services and usage of medication.		
A	Documented procedure shall incorporate purchase, storage, prescription and dispensation of medications.	5
B	These comply with the applicable laws and regulations.	0
C	The hospital has a list of medications appropriate for the patient's and organization's resources.	5
D	Sound alike and look alike medications are stored separately.	5
E	Beyond expiry date medications are not stored/ used.	0
F	Documented procedures address procurement and usage of implantable prostheses.	0
MOM.2: Documented procedure guide the prescription of medications.		
A	The organization determines who can write orders.	5
B	Orders are written in a uniform location in the medical records.	5
C	Medication orders are clear, legible, dated, named and signed.	0
D	Procedure addresses verbal orders and is implemented.	0
E	The organization defines a list of high risk medication.	0
MOM.3: Documented procedure guide the safe dispensing of medications.		
A	This includes a procedure for medication recall.	5
B	Medications are checked prior to dispensing, including the expiry date to ensure that they are fit for use.	5
C	High risk medication orders are verified prior to dispensing.	0
MOM.4: There are defined procedures for medication administration.		
A	Medications are administered by those who are permitted by law to do so.	5
B	Patient is identified prior to administration.	5
C	Prior to administration medication order including dosage, route and timing are verified.	5

D	Prepared medication is labelled prior to preparation of a second drug.	0
E	Medication administration is documented.	5
f	A proper record is kept of the usage, administration and disposal of narcotics and psychotropic medications.	0
G	The procedure addresses patient's self administration of medications and medications brought from outside the organization.	0
MOM.5: Patients are monitored for adverse drug events after medication administration.		
A	Adverse drug events are defined.	0
B	Adverse drug events are documented and reported within a specified time frame.	0
C	Adverse drug events are collected, analyzed by the treating doctor and practices are modified (if necessary) to reduce the same.	0
MOM.6: Documented procedures guide the use of medical gases.		
A	Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases.	0
B	Procedures address the safety issues at all levels.	0
C	Appropriate records are maintained in accordance with procedures and legal requirements.	0
	Total	55

Table 8: Compliance of MOM

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
27	16	11	0	55

Gaps:

- The organization does not define a list of high risk medication.

- Adverse drug events are not defined.
- Prepared medication is not labeled prior to preparation of a second drug.
- No documented procedure for procurement, handling, storage, distribution, usage and replenishment of medical gases.

Table 9: Assessment of Patient rights and education

Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)		
PRE.1: The organization protects patient and family rights during care and informs them about their responsibilities.		
A	Patient and family rights and responsibilities are documented.	0
B	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	5
C	Staff is aware of their responsibility in protecting patients and family rights.	0
D	Violation of patient and family rights is recorded, reviewed and corrective/ preventive measures taken by the organization's leaders.	0
PRE.2: Patient rights support individual beliefs, values and involve the patient and family in decision making processes.		
A	Patient rights include respect for personal dignity and privacy during examination, procedures and treatment.	5
B	Patient rights include protection from physical abuse or neglect.	5
C	Patient rights include treating patient information as confidential.	0
D	Patient rights include refusal of treatment.	5
E	Patient rights include obtaining informed consent before carrying out procedures.	5
F	Patient rights include information and consent before any research protocol is initiated.	5

G	Patient rights include information on how to voice a complaint.	0
h.	Patient rights include information on the expected cost of the treatment.	5
i.	Patient has a right to have an access to his/ her clinical records.	0
PRE.3: A documented policy for obtaining patient and/ or families consent exists for informed decision making about their care.		
A	General consent for treatment is obtained when the patient enters the organization.	0
B	Patient and/ or his family members are informed of the scope of such general consent.	0
C	The organization has listed those situations where informed consent is required as per national guidelines.	0
D	Informed consent includes information on risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.	5
E	The policy describes who can give consent when patient is incapable of independent decision making.	0
PRE.4: Patient and families have a right to information and education about their healthcare needs.		
A	Patients and families are educated to make informed decisions pertaining to plan of care, preventive aspects, possible complications, the expected results and costs at the time of admission.	5
B	When appropriate, patient and families are educated about the safe and effective use of medication and the potential side effects of the medication.	0
C	Patient and families are educated about diet and nutrition.	5
D	Patient and families are educated about immunization.	5
E	Patient and families are educated about preventing infections.	0
F	Patients are taught in a language and format that they can understand.	0
PRE.5: Patient and families have a right to information on expected costs.		

A	There is uniform pricing policy in a given setting (out-patient and ward category).	5
B	The tariff list is available to patients.	0
C	Patients are educated about the estimated costs of treatment.	5
D	Patients are informed about the financial implications when there is a change in the patient condition or treatment setting.	5
	Total	70

Table 10: Compliance of PRE

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
28	14	14	0	70

Gaps:

- Staff is not aware of patients and family rights.
- The tariff list is not available to patients.
- Patient charter is not available.
- Patients are not informed about their rights.

Table 11: Assessement of Hospital infection control

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)

HIC.1: The organization has a well-designed, comprehensive and coordinated Hospital Infection Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.		
A	The hospital has an infection control committee.	0
B	The hospital has a designated individual for infection control activities.	0
C	The hospital infection control programme is documented.	0
HIC.2: The hospital has an infection control manual, which is periodically updated and conducts surveillance activities.		
A	The manual identifies the various high-risk areas.	0
B	It outlines methods of surveillance in the identified high-risk areas.	0
C	Surveillance activities are appropriately directed towards the identified high-risk areas.	0
D	It focuses on adherence to standard precautions at all times.	0
E	Equipment cleaning and sterilisation practices are included.	5
F	Laundry and linen management processes are also included.	5
G	Kitchen sanitation and food handling issues are included in the manual.	0
H	Engineering controls to prevent infections are included.	0
I	Scope of surveillance activities incorporates tracking and analyzing appropriate infection rates.	0
J	Feedbacks regarding these rates are provided on a regular basis to medical and nursing staff.	0
HIC.3: The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees.		
A	Hand washing facilities in all patient care areas are accessible to health care providers.	5
B	Compliance with proper hand washing is monitored regularly.	0
C	Isolation/ barrier nursing facilities are available.	0
D	Adequate gloves, masks, soaps, and disinfectants are available and used correctly.	5

E	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	0
HIC.4: There are documented procedures for sterilisation activities in the hospital.		
A	There is adequate space available for sterilization activities.	5
B	Regular validation tests for sterilisation are carried out and documented.	0
C	There is an established recall procedure when breakdown in the sterilisation system is identified.	0
HIC.5: Statutory provisions with regard to Bio-Medical Waste (BMW) management are complied with.		
A	The hospital is authorised by prescribed authority for the management and handling of Bio-Medical Waste.	5
B	Proper segregation and collection of Bio-Medical Waste from all patient care areas of the hospital is implemented and monitored.	5
C	The organization ensures that Bio-Medical Waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	5
D	Bio-Medical Waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	5
E	Requisite fees, documents and reports are submitted to competent authorities on stipulated dates.	5
F	Appropriate personal protective measures are used by all categories of staff handling Bio-Medical Waste.	0
HIC.6: The infection control programme is supported by hospital management and includes training of staff and employee health.		
A	Hospital management makes available resources required for the infection control programme.	5
B	It conducts pre-induction sensitisation programme for appropriate categories of staff before joining concerned department(s).	0
C	It also conducts regular ‘in-service’ training sessions for all concerned categories of staff at least once in a year.	0
	Total	55

Table 12: Compliance of HIC

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
30	19	11	0	55

Gaps:

- Infection control committee does not exist.
- No in-service training system exists.
- Bio-Medical Waste treatment facility is in worst condition.
- Employees are not aware about proper hand washing technique.
- Staff is not trained in standard precautions.

Table 13: Assessement of Continuous quality improvement

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)

CQI.1: There is a structured quality improvement and continuous monitoring programme in the organization.		
A	The organization develops, implements, maintains and document quality improvement programme.	0
B	There is a designated individual for coordinating and implementing the quality improvement programme.	5
C	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and risk management.	0
D	The designated programme is communicated and coordinated amongst all the employees of the organization through proper training mechanism.	0
E	The quality improvement programme is reviewed at predefined intervals and opportunities for improvement are identified.	0
F	The quality improvement programme is a continuous process and updated at least once in a year.	0
CQI.2: The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.		
A	Organization shall identify the appropriate key performance indicators in both clinical and managerial areas.	5
B	Indicators shall be related to structures, processes and outcomes.	5
C	These indicators shall be monitored.	5
D	Monitoring includes performance of quality improvement activities in diagnostics, ICUs and operation theatres.	0
E	Monitoring includes patient satisfaction which also incorporates waiting time for services.	5
F	Monitoring includes employee satisfaction.	5
G	Monitoring includes safety aspects including adverse events.	5
H	Data collected are used as tools for further improvements	5
I	Monitoring includes data collection to support evaluation of these improvements.	5
CQI.3: The quality improvement programme is supported by the management.		

A	Hospital Management makes available adequate resources required for quality improvement programme.	5
B	Appropriate statistical and management tools are applied whenever required.	5
CQI.4: There is an established system for clinical audits.		
A	Medical staff participates in this system.	0
B	The parameters to be audited are defined by the organisation.	0
C	Patient and clinician anonymity is maintained.	0
D	All audits are documented.	0
E	Remedial measures are implemented.	0
CQI.5: Sentinel events are intensively analyzed.		
A	The organization has identified the appropriate sentinel events.	0
B	The organisation has established processes for intense analysis of such events when they occur.	0
C	Corrective and Preventive Actions are taken based on the findings of such analysis.	0
	Total	55

Table 14: Compliance of CQI

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
25	14	11	0	55

Gaps:

- Quality improvement programme does not exist.

- Clinical audits system is not exist.
- Sentinel events identification system is not exist.

Table 15: Assessement of Responsibilities of Management

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)		
ROM.1: The responsibilities of the management are defined.		
A	The organization has a documented organogram.	5
B	Those responsible for management support quality improvement plans.	0
C	The management defines the rights and responsibilities of employees.	5
D	The organization complies with the laid down and applicable legislations and regulations.	5
e	Those responsible for management address the organization's social responsibility.	0
ROM.2: The organization is managed by the leaders in an ethical manner.		
A	The management makes public the mission statement of the organization.	5
B	The leaders establish the organization's ethical management.	5
C	The organization discloses its ownership.	5
D	The organization honestly portrays the services which it can provide.	5
E	The organization honestly portrays its affiliations and accreditations.	5
F	The organization accurately bills for its services based upon a billing tariff.	5
ROM.3: Leaders ensure that patient safety aspects and risk management issues are an integral part of patient care and hospital management.		

A	The organization has a designated individual(s) to oversee the hospital wide safety programme.	5
B	The scope of the programme is defined to include adverse events ranging from ‘no harm’ to ‘sentinel events’.	0
C	Management ensures internal and external reporting of system and process failures.	0
	Total	50

Table 16: Compliance of ROM

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
14	4	10	0	50

Gaps:

- No quality improvement plan available
- No proper reporting system is available.
- Adverse event recording system is not present.

Table 17: Assessement of Facility management and safety

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)		
FMS.1: The organization is aware of and complies with the relevant rules and regulations, laws and byelaws and requisite facility inspection requirements.		
A	The management is conversant with the laws and regulations and knows their applicability to the organization.	5
B	The management ensures implementation of these requirements.	5
C	There is a mechanism to regularly update licenses/ registrations/ certifications.	0
FMS.2: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.		
A	There is a documented operational and maintenance (preventive and breakdown) plan.	0
B	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	0
C	The provision of space shall be in accordance with the statutory requirements or available literature on good practices.	0
D	Maintenance staff is contactable round the clock for emergency repairs.	5
E	The hospital has a system to identify the potential safety and security risks including hazardous materials.	0
F	Facility inspection rounds to ensure safety are conducted periodically.	0
G	There is a safety education programme for all staff.	0
FMS.3: The organization has a program for clinical and support service equipment management.		
A	The organization plans for equipment in accordance with its services.	5
B	All equipment is inventoried and proper logs are maintained as required.	5
C	Qualified and trained personnel operate and maintain the equipment.	5
D	Equipment are periodically inspected and calibrated for their proper functioning.	0
E	There is a documented operational and maintenance (preventive and breakdown) plan.	0

FMS.4: The organization has provisions for safe water, electricity, medical gas and vacuum systems.		
A	Potable water and electricity are available round the clock.	10
B	Alternate sources are provided for in case of failure and tested regularly.	5
C	There is a maintenance plan for medical gas and vacuum systems.	0
FMS.5: The organization has plans for fire and non-fire emergencies within the facilities.		
A	The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.	0
B	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	0
C	Staff is trained for their role in case of such emergencies.	0
D	Mock drills are held at least twice in a year.	0
	Total	45

Table 18: Compliance of FMS

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
22	14	7	1	45

Gaps:

- Employees are not trained in fire and non fire emergencies.
- No maintenance plan for medical gas.
- No Mechanism to regularly update licenses/ registrations/ certifications.
- Drawings are not available which detail the site layout, floor plans and fire escape routes.

Table 19: Assessement of Human resource management

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)		
HRM.1: The organization has a documented system of human resource planning.		
A	The organization plans and maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	5
B	The organization verifies the antecedents of the potential employee.	5
HRM.2: The staff joining the organization is socialized and oriented to the hospital environment.		
A	Each staff member is appropriately oriented to the organization's mission, policies and procedures.	5
B	Each staff member is made aware of his/her rights and responsibilities.	5
C	All employees are educated with regard to patients' rights and responsibilities.	0
HRM.3: There is an ongoing programme for professional training and development of the staff.		
A	A documented training and development policy exists for the staff.	0
B	All staff is trained on the risks within the hospital environment.	0
C	Staff members can demonstrate and take actions to report, eliminate/	0

	minimize risks.	
D	Training also occurs when job responsibilities change/ new equipment is introduced.	0
E	Feedback mechanisms for assessment of training and development programme exist.	0
HRM.4: An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.		
A	The appraisal system is documented.	10
B	All employees are aware of the system of appraisal.	10
C	Performance is evaluated based on pre-defined criteria which the employee is aware of.	5
D	Performance appraisal is carried out at pre defined intervals and is documented.	10
HRM.5: The organization has a well-documented disciplinary and grievance handling procedure.		
A	A documented procedure with regard to these is in place.	5
B	The documented procedure is known to all categories of employees in the organization.	5
C	The disciplinary procedure is in consonance with the prevailing laws.	0
D	The redress procedure addresses the grievance.	5
E	Actions are taken to redress the grievance.	5
HRM.6: The organization addresses the health needs of the employees.		
A	Health problems of the employees are taken care of in accordance with the organization's policy.	5
B	Occupational health hazards are adequately addressed.	0
HRM.7: There is documented personal record for each staff member.		
A	Personal files are maintained in respect of all employees.	5
B	The personal files contain personal information regarding the employee's qualification, disciplinary background and health status.	5

C	All records of in-service training and education are contained in the personal files.	5
D	Personal files contain results of all evaluations.	5
HRM.8: There is a process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications.		
A	Medical professionals permitted by law, regulation and the hospital to provide patient care without supervision is appointed.	5
B	Medical professionals admit and care for patients as per the laid down policies and authorisation procedures of the organization.	0
C	The services provided by the medical professionals are in consonance with their qualification, training and registration.	5
HRM.9: There is a process to identify job responsibilities and make clinical work assignments to all nursing staff members commensurate with their qualifications and any other regulatory requirements.		
A	The clinical work assigned to nursing staff is in consonance with their qualification, training and registration.	5
B	The services provided by nursing staff are in accordance with the prevailing laws and regulations.	5
	Total	120

Table 20: Compliance of HRM

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
30	9	18	3	120

Gaps:

- No training and development policy exist.
- No feedback mechanisms exist.
- Employees are not educated with regard to patients' rights and responsibilities.

Table 21: Assessement of Information Management System

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)		
IMS.1: Documented procedures exist to meet the information needs of the care providers, management of the organization as well as external agencies that require data and information from the organization.		
A	A documented procedure exists to meet the information needs.	5
B	The documented procedure is in compliance with the prevailing laws and regulations.	5
C	The organization contributes to external databases in accordance with the law and regulations.	5
IMS.2: The organization has processes in place for effective management of data.		
A	Formats for data collection are standardized.	5
B	Necessary resources are available for analyzing data.	5
C	Documented procedures are laid down for timely and accurate dissemination of data.	0
D	Documented procedures exist for storing and retrieving data.	5
IMS.3: The organization has a complete and accurate medical record for every patient.		
A	Every medical record has a unique identifier.	5
B	Organisation identifies those authorized to make entries in medical record.	5
C	Every medical record entry is dated and timed.	5

D	The author of the entry can be identified.	5
E	The contents of medical record are identified and documented.	5
IMS.4: The medical record reflects continuity of care.		
A	The record provides an up-to-date and chronological account of patient care.	5
B	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	5
C	Operative and other procedures performed are incorporated in the medical record.	5
D	When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.	5
E	The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel.	0
F	In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.	0
G	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	0
H	Care providers have access to current and past medical record.	5
IMS.5: Documented procedures are in place for maintaining confidentiality, integrity and security of information.		
A	Documented procedures exist for maintaining confidentiality, security and integrity of information.	0
B	Documented procedures are in consonance with the applicable laws.	5
C	Documented procedures incorporate safeguarding of data/ record against loss, destruction and tampering.	0
D	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	0
E	A documented procedure exists on how to respond to patients/ physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.	0

IMS.6: Documented procedures exist for retention time of records, data and information.		
A	Documented procedures are in place on retaining the patient's clinical records, data and information.	0
B	The procedures are in consonance with the local and national laws and regulations.	0
C	The retention process provides expected confidentiality and security.	0
D	The destruction of medical records, data and information is in accordance with the laid down procedure.	0
IMS.7: The organization regularly carries out medical records audit.		
A	The medical records are reviewed periodically.	0
B	The review uses a representative sample based on statistical principles.	0
C	The review is conducted by identified care providers.	0
d	The review focuses on the timeliness, legibility and completeness of the medical records	0
E	The review process includes records of both active and discharged patients.	0
F	The review points out and documents any deficiencies in records.	0
G	Appropriate corrective and preventive measures undertaken are documented.	0
	Total	85

Table 22: Compliance of IMS

No. of objective elements	Non compliance	Partial compliance	Full compliance	Scoring
36	19	17	0	85

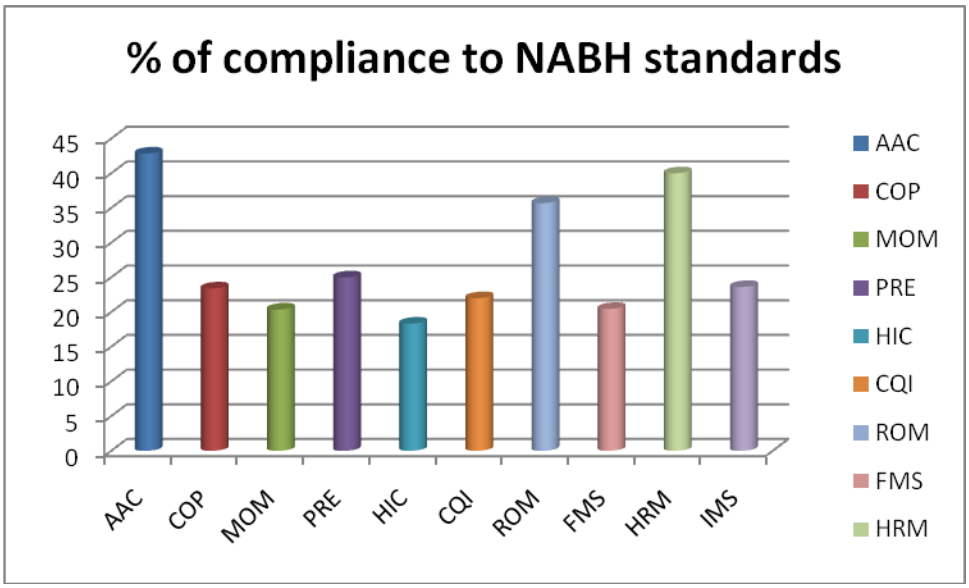
Gaps:

- No MIS system is available.
- Storage of medical records is not secure.
- Discharge summury is not provided to patients.
- The organization does not carry out medical records audit.
- No documented procedures are in place for maintaining confidentiality, integrity and security of information.

Table 23: Comparison of NABH compliance: -

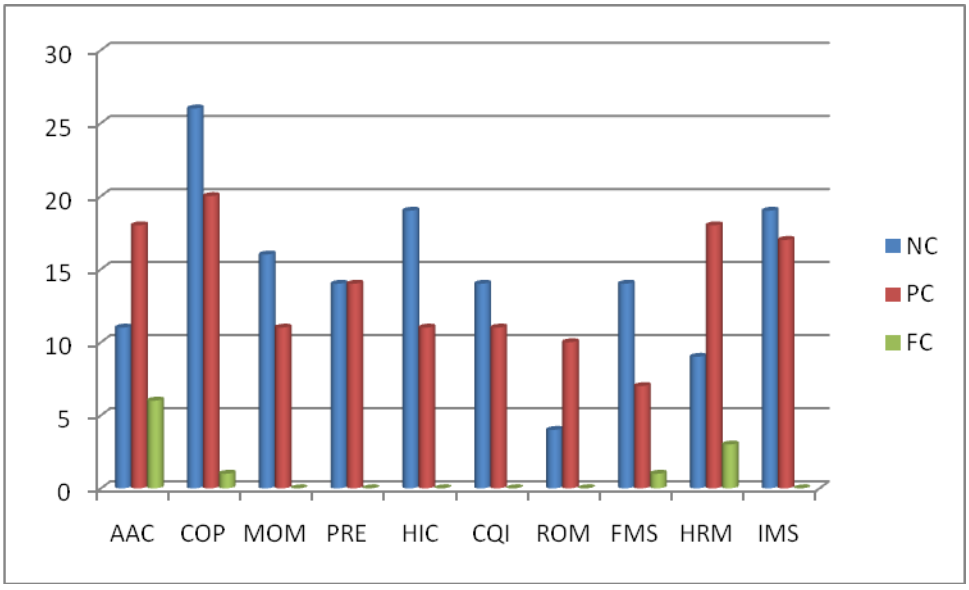
Name of chapter	Total O.E	NC	PC	FC	Scoring	% of complition
Access, Assesment and Continuity of Care (AAC)	35	11	18	6	150	42.85
Care of Patient (COP)	47	26	20	1	110	23.40
Management of Medication (MOM)	27	16	11	0	55	20.37
Patient Rights and Education (PRE)	28	14	14	0	70	25
Hospital Infection Control (HIC)	30	19	11	0	55	18.33
Continous Quality Improvement (CQI)	25	14	11	0	55	22
Responsibility of Management (ROM)	14	4	10	0	50	35.71
Facility Management and Safety (FMS)	22	14	7	1	45	20.45
Human Resource Management (HRM)	30	9	18	3	120	40
Information Management System (IMS)	36	19	17	0	85	23.61
Total	294	146	137	11	795	27.04

Graph 3: % of Compliance to NABH standards (Reference table no. 8)



Graph 3 refelects the % compliance to various objective elements of the particular chapter based on the scoring of 0,5,10 already maintained in methodology section.

Graph4: compliance to objective elements of NABH standards (Reference table no. 8)



Graph 4 refelects the extent (NC, PC, and FC) of compliance to the objective elements of NABH standards.

Gap analysis as per NABH standards shows that the hospital is 27.04% prepare for the accreditation. As per NABH standards when hospital is 70% ready for accreditation then eligible for apply for application.

As per NABH compliance the organisation 27.04% ready for accreditation Application; is not satisfied the hypothesis that"The organisation is ready for accreditation" of the study.

Table 24: Key performance indicators (year 2009-2010)

Month	ALOS	BOR	BTOR	OP/IP ratio	LSCS rate
April	2.4	35.11	4.9	6.63	8.3
May	2.8	44.73	5.7	6.24	7
June	2.5	24.22	3.7	8.03	16.7
July	2.8	27.09	4	8.80	9.3
Aug.	3.4	50.96	5.9	6.69	24.2
Sep.	3.6	52.22	5.7	7.98	12
Oct.	3.4	43.44	4.3	7.51	12.5
Nov.	2.9	42.67	4.1	8.46	15.6
Dec.	3.2	52.04	4	7.28	18.2

Jan.	3	49.46	4.1	6.91	4.4
Feb.	2.8	65	5.5	5.62	10.4
March	2.8	39.35	4.3	9.20	15.2

Key performance indicators shows that hospital provides quality care; ALOS shows that the infection rate in hospital is very low.BOR and BTOR shows that the resources are adequately utilize and the OP/IP ratio shows that the hospital indoor services are popular in community. LSCS rate of the hospital also match with the IPHS guidelines.

Chapter 4:- Conclusion and Recommendations-

The study shows that the management is willing for NABH accreditation and thus they hired a consultant for gap analysis; I as a hospital administrator helped the external agency in facility survey which is the basis of the gap analysis. Gap analysis showed that the hospital is only 27.04% ready for accreditation application and as per norms it requires 70%. This shows that more efforts are required for the accreditation application. Process documentation needs to be focused upon. Improvement in structures and processes and continuous monitoring of outcome indicators would lead to better results.

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Recommendations:-

- Separate registration and billing counter with help desk should be there at the entrance of the hopital building.
- Proper and separate Laundry and CSSD department.
- Modular OT with 4 zones required.
- Each facility requires separate toilet for staff members.
- Separate room for bio-medical waste disposal in the campus; separate from the sensitive area.
- Medical records required confidentiality and a security system.
- Staff requires proper training for documentation the procedures and patient's counseling
- Hospital requires proper cattle guard system for protection of animal entry.
- Garden in open area for dust control and natural cooling.
- Hospital requires active security guards.
- Hospital requires proper sinage's and facility display system.

- Hospital requires fully functional fire fighting system and disaster management plan; because the hospital is situated in disaster prone area.
- Hospital requires qualified staff for provision of quality services.
- A department for proper counseling of patients; because patients are not aware about their rights and responsibilities.
- Requires proper outreach programs like health camps for increased awareness among the community.
- Hospital requires more number of clinical departments and bed counts as per standards.
- Some of the infrastructural requirements can be fulfilled by modification in existing building.

References:

[i] Deepak medical foundation annual report; www.deepakfoundation.org/annualreport ; (accessed 2nd May , 2010)

[ii] Small health care organisation defination; http://www.qcin.org/nabh/shco/nabh_shco_defination.php; (accessed 1st March, 2010)

[iii] Standards for Small Healthcare Organisation; frist edition; March 2008; QCI Publication.New Delhi

[iv] National Accreditation Board for hospital and Health care providers; guide book; http://www.qcin.org/nabh/shco/nabh_gib.php; (accessed 20th Feb, 2010)

[v] National Accreditation board for hospital and health care providers; introduction; http://www.qcin.org/nabh/intro.php; (accessed 1st March, 2010)

[vi] National Accreditation board for hospital and health care providers; structure; http://www.qcin.org/nabh/structure.php; (accessed 1st March, 2010)

[vii] Presentation:-

Prof. J K Das; National Accreditation for Hospital and Health care providers; NIHFW, New Delhi

[viii] Presentation:-

Prof. J K Das; National Accreditation for Hospital and Health care providers; NIHFW, New Delhi

[ix]Quality management services, NABH section, 2008; www.info@qms.in ; (accessed 4th March,2010)

[x]Gap Analysis introduction; http://en.wikipedia.org/wiki/Gap_analysis ; (accessed 10th March,2010)

[xi] Quality Council of India; index; http://www.qcin.org/nabh/index.php; (accessed 4th March,2010)

[xii] Jones and Bartlett publications; chapter 1; p.12-14 ; http://www.jblearning.com/catalog/9780763750343/; (accessed 15th April, 2010)

[xiii] Punjab health Systems Corporation; hospital indicatior & performance; www.punjabhealth.co.in ; (accessed 15th April, 2010)

[xiv] Jones and Bartlett publications; chapter 1; p.7-11; http://www.jblearning.com/catalog/9780763750343/; (accessed 15th April, 2010)