2014

Baseline Assessment Report

National Quality Assurance Standard

Khowai District Hospital, Tripura

Assessment period – 4th and 5th August 2014

Assessors - Ms. Asha Kumari & Ms. Sanyukta Kashyap

Report prepared by - Ms. Asha Kumari & Ms. Sanyukta Kashyap

INDEX

EXECUTIVE SUMMARY

Providing quality of care is the prime objective of each hospital. After so many years of successful implementation of various health programmes under National Rural Health Mission, now the focus is on creating an inbuilt and sustainable quality for public health facilities which not only delivers good quality but is also so perceived by the client. It is said, what can't be measured, can't be improved. Regular assessment of health facilities by their own staff and state and action-planning for traversing the observed gaps is the only way in having a viable quality assurance programme in Public Health. In view of that, baseline assessment survey as per National Quality Assurance Standards of all the departments of Khowai District Hospital was done by RRC-NE quality team.

Departments assessed-

- Out-patient department
- In-patient department
- Maternity ward
- Pediatrics ward
- Labour room
- Accident & emergency department
- Laboratory
- Pharmacy
- Radiology department
- General administration
- Auxiliary services
- Mortuary

The hospital has sufficient infrastructure in terms of OPD, Accident & Emergency and diagnostic facilities but was not adequately maintained. Seepage, cracks, chipping of plasters was observed in inpatient wards, window panes and other fixtures were not intact. Basic amenities for patients and attendants like proper sitting arrangements, separate toilets were not provided. Although all the inpatient wards had attached toilet facility but the toilets were in extremely poor condition (dirty muddy floor, broken water taps).Bed side locker, mattresses, bed linen and other accessories were not found in good condition in inpatient wards. Record maintenance throughout the hospital was found good. The facility has a disaster management plan in place but the roles and responsibilities of the staff were not defined.

The facility doesn't have any infection control program (for prevention and measurement of hospital associated infection), internal & external quality assurance program, established system of periodic review (as internal assessment, medical & death audit and prescription audit, corrective & preventive action to fulfil gaps observed during audits) in place. Biomedical waste management, disinfection of instruments & equipments need to be improved. Disposables and consumables were not available in adequate quantity. Patients had to buy most of the consumables and disposables from outside. Expired drugs were found in most of the department. Standard practice of mopping and scrubbing (unidirectional) not followed. Brooms were used for cleaning in patient care areas. The facility does not use any method and or tool for quality improvement in services. The facility does not measure any productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.

<table>
<tr><th colspan="4">Hospital Quality Score Card – Khowai District Hospital, Tripura</th></tr>
<tr><td>Accident & Emergency
55.85%</td><td>OPD
53.40%</td><td>IPD
50%</td><td>General Administration
35.79%</td></tr>
<tr><td>Labour Room
56.83%</td><td colspan="2" rowspan="3">Hospital Score
45.03%</td><td>Auxiliary Services
35.03%</td></tr>
<tr><td>Maternity Ward
52.16%</td><td>Paediatrics
47.83%</td></tr>
<tr><td>Mortuary
11.68%</td><td>Laboratory
37.87%</td></tr>
<tr><td></td><td>Pharmacy
38.78%</td><td>Radiology
40.43%</td><td></td></tr>
</table>

BACKGROUND

Khowai District is a newly formed district declared on the 10th of January 2012. In the month of July 2014, the sub-divisional hospital was declared as District Hospital, with the SDMO as the in-charge. The lush green and fertile Khowai valley is covered by Barmura hill range in its western part and Atharamura hill range in the eastern part and sustained by Khowai River and its abundant river source which glide quietly to the neighbouring Bangladesh. The district population is about 3, 70,793. The population covered by Khowai Sub-divisional hospital is 68,936. Khowai district has its tribal people and rich cultural history, especially in the field of drama. Even now the life and society of Khowai is synonymous with cultural activities and trends that inspire the whole of Tripura.

Khowai district hospital is a 105 bedded hospital with various departments providing various services. It has clinical, diagnostic and ancillary services. The SDMO is the Head of the hospital. It has an MO in-charge and along with eight Medical officers including specialists in Medicine, Gynaecologist and Paediatric specialist. It has its nursing and other para-medical staffs, management staffs, GDA and SCA staffs providing services.

The Hospital has both IPD and OPD services. It also organises L.L camp once in every month from this 2014 and already 174 cases are done till date. The Hospital will shortly start caesarean sections in Khowai.

Scope of services-

- Accident and Emergency
- Out- patient door
  - General Medicine
  - Obstetrics and Gynaecology
  - Paediatric
  - AYUSH
  - Dental care
  - RNTCP
  - ICTC
  - ARSH
  - Eye testing
- In-patient door
- Operation Theatre
- Labour room
- New Born Stabilization Unit
- Blood Storage
- Radiology (X-Ray and USG)
- Pharmacy
- Laboratory
- General Administration
- Auxiliary Services
- Tele- medicine
- RSBY

- National Programmes run under NHM (NVBDCP, IDSP, RBSK, JSSK, JSY, IMLEP, HMIS & MCTS)

- Community services under NHM- VHND, Health camps, RBSK, Eye camps, IEC activities.

Bed distribution

The Khowai District Hospital Indoor is 105 bedded distributed in 5 Blocks.

S. No.	Ward	No of beds
1	Emergency Block	20
2	Maternity Block	14
3	Male Block	36
4	Female Block(1)	14
5	Female Block(2)	21
Total bed capacity		105

Manpower Status (Regular+ Contractual)

S.N	Speciality	Numbers
1	General Duty Medical Officers	6
2	Medicine specialist	1
3	Gynaecologist	1
4	Paediatrician	1
5	Anaesthetist	1
6	Pathologist	1
7	Dental Surgeon	2
8	Ayurvedic MO	2
9	Staff Nurses	34
10	Pharmacist	2
11	Laboratory technician	3
12	Radiographer	1
13	Ophthalmic Assistant/ Refractionist	1
14	GDA	17
15	SCA	6
16	Asst Hospital administrator	1
17	HMIS assistant(SDH)	1
18	ASHA programme manager	1
19	Malaria technical supervisor	1
20	Sub-divisional accounts cum data assistant	1
21	Adolescent Counsellor	1

22	Pharmacist (Allopathy, RBSK)	1
23	STLS	1
24	ICTC Counsellor	1
25	STI/RTI Counsellor	1
26	Laboratory technician	1
27	Pharmacist (Allopathy, store)	1

Hospital Performance

Type of services	Performance			
	Jan'14	Feb'14	Mar'14	April'14
No of OPD cases	4352	4352	3488	3488
No of IPD cases	748	748	890	886
No of Deliveries				
Normal Delivery	103	99	114	100
Caesarean section	0	0	0	0
Major surgeries	0	0	0	0
Minor Surgeries	0	0	0	0
X-Ray	284	305	315	337
USG	Not done due to non availability of trained person	11	12	In April Machine was out of order(In May the no was 15)
Lab test	150	150	133	175

DEPARTMENTAL GAPS

1. Accident and emergency department

The department is located in the main building near entrance having same entry and exit as OPD. The department has one room for doctor consultation, dressing, injection etc and a 16 bedded ward for admission of patients is located adjacent to the room. Only initial treatment is given in the department, for any procedure or surgery patients are sent to the respective department.

Emergency Score Card		
	Emergency Score	**55.85**
	Area of Concern wise Score	
A	Service Provision	**57.14**
B	Patient Rights	**66.66**
C	Inputs	**66.47**
D	Support Services	**67.94**
E	Clinical Services	**68.53**
F	Infection Control	**50.92**
G	Quality Management	**4.87**
H	Outcome	**5.55**

Gaps-

- Facility for emergency Surgical Procedures, emergency Ophthalmology procedures, emergency ENT procedures, emergency psychiatric procedures etc not available in the department.
- Radiology services, laboratory investigations etc not available 24x7 basis. These services are available during OPD hours only.
- Signages in the department were found poor. Departmental signage was found displayed but not prominent, directional signages, display of list of services provided by the department, important contact numbers, patient rights and responsibilities etc were not displayed.
- To collect evidence of sexual assault, forensic kit not available. No protocols /guidelines for collection of forensic evidence in case of rape victim.
- Separate toilets for male and female not available. Disable friendly toilet not available.
- Male and female observation areas were not demarcated.
- Consent is not taken for invasive emergency procedures.
- Grievance redressal mechanism not in place (although complaint box was available in the department but whom to contact in case of complaint was not displayed and record of actions taken to resolve complaint was also not maintained).
- Patients sometimes have to spend on drugs, consumables & diagnostic tests (whatever facilities or drugs are not available in the facility). Free emergency consultation is not given to all the BPL patients, only those exempted by MS.
- Clean and dirty utility room not available.
- Buffer beds for handling mass causality and disaster were not available.
- Non structural components eg, fixtures and furniture like cupboards, cabinets, and heavy equipments, hanging objects are not properly fastened and secured.
- Shaded porch for ambulance not available.
- Corridors at emergency are not broad enough for easy movement of stretcher and trolley.
- Functional linkage between emergency and other departments such as Labour room, Major OT, ICU, indoor, laboratories is not proper. Hospital layout is not properly planned. Departments are not located adjacent to each other as per the functions.
- No fire safety measures (installation of fire extinguisher, clearly visible fire exit plan, competent staffs to operate fire extinguisher in case of any disaster) taken in the department.

- Security guard not available. Shortage of housekeeping staffs.
- Staffs were not trained on Triage & mass casualty management, BLS/ALS, patient safety etc
- Dressing tray was not kept ready
- Hospital ambulance doesn't have any monitoring equipments and required medicines.
- Resuscitation equipment, Glucometer, HIV rapid diagnostic kit etc were not available in the department.
- The facility does not have any system for inspection, calibration, testing and annual maintenance of equipments.
- Expired medicine was found in the department.
- Empty and filled cylinders were not labelled.
- Records of expiry and near expiry medicines were not maintained in the department.
- Although the stock register of drugs and consumables was found in the department but expenditure record were not maintained.
- The facility doesn't have any set procedures for handling mass situation and violence in emergency.
- License for ambulance could not be produced during visit.
- No established criteria defined for admission through emergency department
- Assessment criteria of different kind of medical emergencies are not defined.
- Nursing records were not filled properly. Complete details were not provided. TPR chart, intake output chart etc were not found in some of the case sheets.
- Cardiac monitor/multi parameter was not used for monitoring of critical patients.
- Drugs are not prescribed under generic name only.
- Relevant standard treatment guidelines were not available at the point of use.
- The facility does not have drug formulary.
- High alert drugs are not identified in the department.
- No system of taking declaration from LAMA patients.
- The department does not have any implemented system of sorting the patients. Triage area is not marked. Triage protocols, emergency protocols (management in case of head injury, snake bite, poisoning etc) were not displayed.
- Ambulance is not appropriately equipped for BLS/ALS.
- There is no log book and checklist implemented for daily maintenance of ambulance.
- The department doesn't have any defined criteria for medico-legal cases.
- No standard procedure available for removal of life sustaining treatment as per law
- No provision for active & passive culture surveillance on regular basis in the department.
- There is no set procedure for immunization & periodical medical checkups of the staffs.
- No hospital antibiotic policy available.
- Hand washing instruction (six steps of hand washing - preferably in local language) above the sink was not found displayed. Adherence to hand washing steps was also not found.
- Compliance to correct method of wearing and removing gloves needs to be monitored.
- Facility need to ensure separation of general traffic from patient traffic.
- Standard practice of mopping and scrubbing (unidirectional) not followed. Brooms were used for cleaning in patient care areas.
- Emergency department doesn't have any defined list of infectious diseases requiring special precaution and barrier nursing.
- Biomedical waste management – not adhering to color coding of bins & bags as per guideline, disinfection of liquid waste is not done transportation of wastes in covered trolley, staffs not aware on mercury spill management, what to do in case of needle stick injury etc
- The department doesn't have any internal & external quality assurance program in place.

- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for receiving the patient in emergency, triaging, for taking consent, for initial screening of patient, nursing care, documented procedure for admission and transfer of the patient to ward, for Handling medical records, for maintaining records in Emergency, to handle brought in dead patient, for storage, handling and release of dead body, for storage and replenishing the medicine in emergency, for equipment preventive and break down maintenance).
- All the relevant work instructions/clinical protocols were not found displayed.
- The facility doesn't have established system of periodic review as medical & death audit and prescription audit
- Quality policy and quality objectives are not defined.
- The facility does not measure all productivity indicators (only no. of emergency cases, no. of trips per ambulance maintained), efficiency indicator, clinical care & safety indicator & service quality (LAMA rate, Absconding rate – overall, not department wise) indicators.

2. Out-patient Department

Out-patient Department Score Card		
	Out-patient department Score	**53.40**
	Area of Concern wise Score	
A	Service Provision	**49.01**
B	Patient Rights	**71.79**
C	Inputs	**63.63**
D	Support Services	**73.80**
E	Clinical Services	**66.36**
F	Infection Control	**46**
G	Quality Management	**7.31**
H	Outcome	**10**

Gaps

- General surgery, Paediatric, Orthopaedic, ENT, Psychiatry, IYCF clinics not available
- TMT services not available
- The facility does not provide services under National Leprosy Eradication Programme, Mental Health Programme, and National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) and National Programme for the health care of the elderly.
- Layout/floor directory not displayed
- List of OPD Clinics not available
- Names of doctor on duty not displayed
- No enquiry desk with dedicated staff
- No separate Female general OPD
- No separate toilets for male and female
- Non-availability of Breast feeding corner
- Disable friendly toilet not available
- Patient rights and responsibilities not displayed
- Complaint box was available but the process for grievance redressal and whom to contact not displayed
- The facility does not ensure timely reimbursement of financial entitlements and reimbursement to the patients
- No sub waiting area for separate clinics, no adequate waiting area, sitting arrangement not available in the waiting area.

- Patient calling system not available.
- Public telephone booth not available.
- Trolley/wheelchair bay not demarcated
- Functional telephone and Intercom Services not available
- Fire exits are neither clearly visible nor the routes to reach exit are clearly marked
- Expiry date for fire extinguishers not displayed on extinguishers and the due date for next refilling was not mentioned
- Staff not competent for operating fire extinguisher
- Non structural components not properly secured
- OPD building has a few temporary connections and loosely hanging wires.
- Staffs have not received training on infection control and hand hygiene, patient safety, preparing cleaning solution as per standard procedure, cleaning of patient care area with detergent solution, mercury spill management
- Emergency Drug Tray not maintained at injection room & immunization room
- Functional Instruments/Equipments for Gynae and obstetric not available.
- Equipment for storage for drugs not available.
- No system of timely corrective break down maintenance of the equipments
- All equipments were not covered under AMC including preventive maintenance
- All the measuring equipments/ instrument were not calibrated
- Drugs stored in containers and tray were not labelled
- Records for expiry and near expiry drugs were not maintained for drug stored at department
- No screening clinic for initial assessment of the patients
- No established procedure for follow-up/ reassessment of Patients
- No procedure to monitor the quality and adequacy of outsourced services on regular basis.
- Provisional Diagnosis not recorded
- Patient consulted in standing position
- No established procedure for day care admission
- Facility does not have an established procedure for handing over of patients during departmental transfer
- No established procedure for consultation of the patient to other specialist with in the hospital
- No system of follow up of referred patients
- Drugs not prescribed under generic name
- A copy of Prescription not kept with the facility
- No procedure of rational use of drugs
- Any adverse drug reaction that occurs not recorded
- Register/records were identified but not numbered
- Role and responsibilities of staff in disaster not defined
- For antenatal care, facility does not maintain records on blood pressure, respiratory rate, pallor, oedema, icterus, abdominal palpation for foetal growth, foetal lie, auscultation for foetal heart sound, breast examination.
- Line listing of pregnant women with moderate and severe anaemia not done.
- Staff not aware of how to minor and serious advise events (AEFI)
- Counselling of pregnant women not done as per standard protocol and gestational age (recognizing danger signs of labour, breast feeding, arrangement of referral transport, birth preparedness and family planning)
- No procedure for Periodic medical checkups and immunization of the staff
- No regular monitoring of infection control practices

- Triage, Assessment & Management of newborns having emergency signs not done as per guidelines.
- Management of children presenting with fever, cough/ breathlessness not done as per guidelines
- Management of children with severe acute malnutrition, diarrhoea not done as per guidelines.
- Doctors not aware of Hospital Antibiotic Policy
- Non- compliance to correct method of wearing and removing the gloves
- Decontamination of operating & Procedure surfaces not done according to standard protocols.
- Proper Decontamination of instruments after use not done
- Non- adherence to 6 steps of Hand washing
- Masks not available
- Staff not aware of how to make chlorine solution
- High level Disinfection of instruments/equipments not done as per protocol
- Cleaning equipments (like broom) used in patient care area
- Non- Availability of plastic colour coded plastic bags
- Puncture proof box not available
- Staff not aware of contact time for disinfection of sharps
- All the Staff do not know what to do in condition of needle stick injury
- Transportation of bio medical waste not done in close container/trolley
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for registration, documented procedure for patient calling system in OPD clinic, documented procedure for receiving of patients in clinic, documented procedure for OPD consultation, documented procedure for investigation, documented procedure for prescription & drug dispensing, documented procedure for nursing process in OPD, documented procedure for patient privacy & confidentiality, documented procedure for conducting, analysing patient satisfaction survey, documented procedure for equipment management and maintenance in OPD, documented procedure for Administrative and non clinical work at OPD, documented procedure for No Smoking Policy in OPD, documented procedure for duty roaster, punctuality, dress code and identity for OPD staff).
- No designated departmental nodal person for coordinating Quality Assurance activities
- Patient Satisfaction surveys not conducted at periodic intervals
- Facility does not have established system for use of check lists in different departments and services
- The facility does not conduct periodic internal assessment
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have established system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure any productivity indicator, clinical care & safety indicator & service quality indicators.

3. Labour Room

Labour room Score Card		
	Labour Room Score	**56.83**
	Area of Concern wise Score	
A	Service Provision	**83.33**
B	Patient Rights	**50.0**
C	Inputs	**66.66**
D	Support Services	**59.43**
E	Clinical Services	**79.08**
F	Infection Control	**55.07**
G	Quality Management	**2.5**
H	Outcome	**0**

Gaps

- No c-section services as the OT was not functional.
- HIV positive delivery cases were not managed at the facility.
- USG machine was found out of order.
- Points of care diagnostic services (for HIV, Hb%, Random blood sugar) were not available.
- Departmental signage, directional signage, restricted area signage, service provision in Labour room, entitlements under JSY, JSSK, staffs on duty, contact details of referral transport etc not displayed. Signage and other information are not displayed in local language.
- No enquiry desk available.
- Screens between two labour tables to maintain visual privacy were not placed.
- No provision of taking general consent before delivery/at the time of admission.
- No grievance redressal mechanism (Availability of complaint box and display of process for grievance re redressal and whom to contact).
- All the services are not cashless for JSSK beneficiaries as pregnant women sometimes need to spend on drugs, consumables, diagnostics etc whatever is not available in the facility. The patients who have RSBY card, they only get reimbursed for any other expenditure.
- Patient amenities such as attached toilet/bathroom, hot water facility etc not available.
- Dedicated receiving area, examination area, pre delivery, post delivery observation room, eclampsia room, septic labour room with NBCC, dirty utility room etc not available.
- No intercom facility.
- Non structural components eg, fixtures and furniture like cupboards, cabinets, and heavy equipments, hanging objects are not properly fastened and secured.
- No fire safety measures (fire extinguisher not placed, fire exit plan not available) taken in the department. Staffs are not trained for such disasters.
- No female security staff available.
- Emergency tray was available but items were not found labelled.
- Baby tray & PPIUCD tray were not kept ready, though all the items were found in the department.
- MVA/EVA tray not available.
- Resuscitation instruments for Newborn Care as well as adult were not available.
- Although timely corrective break down maintenance of equipments are done but the facility does not have system for inspection, testing, maintenance of equipment. Annual Maintenance Contract/Comprehensive Maintenance Contract for equipments not available.
- Empty and filled cylinders not labelled. Expiry/near expiry record of drugs not maintained in the department. No drug expenditure record maintained.
- No security arrangement. Female security staff not available.
- For newborn identification, foot print record is not kept.
- Although delivery table was found in good condition but stir ups not available.

- There is no provision of gowns for mother & sterile drape/baby blanket for baby.
- Complete labour details (Time of start, frequency of contractions, time of bag of water leaking, colour and smell of fluid and baby movement) & detailed physical examination report (Recording of Vitals , shape & Size of abdomen , presence of scars, foetal lie and presentation. & vaginal examination) not recorded in all case sheet.
- Referral in register not maintained in the department.
- Patient vitals were not recorded and monitored for all the cases.
- All the relevant standard treatment guidelines were not available except few GOI guidelines at the point of use. Drugs were prescribed under brand name.
- The facility doesn't have any drug formulary.
- High alert drugs are not identified in the department.
- Every Medical advice and procedure was accompanied with date and signature but time not mentioned.
- There is no procedure for reporting and recording of adverse drug reaction.
- Consent is not taken before blood transfusion.
- No system of recording and reporting of blood transfusion reaction incidences.
- APGAR score not maintained for all the cases.
- The facility needs to monitor infection control program for prevention and measurement of hospital associated infection (No swab culture test done, no periodic medical checkups & immunization of staffs, regular monitoring of infection control program by the committee).
- Alcohol based hand rub not available.
- Elbow operated taps not available.
- Shaving is done during part preparation/delivery case which is not recommended nowadays. Adherence to 6 steps of hand washing & correct method of wearing sterile gloves & removing gloves etc need to be ensured.
- Elbow length gloves for obstetrical purpose use were not available.
- Personal protective equipment eg.caps, heavy duty gloves & gum boots for housekeeping staffs were not available.
- The staffs do not strictly adhere to standard practices of disinfection and sterilization of instruments and equipments.
- The facility needs to ensure standard practices are followed for the cleaning and disinfection of patient care areas. Standard practice of mopping and scrubbing (unidirectional from inside out) not followed. Brooms were used for cleaning in patient care areas. Three bucket system mopping not followed anywhere in the facility.
- Fumigation/carbolization on regular basis not done.
- Biomedical waste management need to be improved (segregation as per the guideline, disinfection of sharps & liquid waste before disposal, transportation of biomedical wastes in closed trolley, make staffs aware on mercury spill management, what to do in case of needle stick injury etc)
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for receiving and assessment of the patient of delivery, documented procedure for Emergency obstetric care, documented procedure for management of high risk pregnancy, documented procedure for rapid initial assessment, documented procedure for requisition of diagnosis and receiving of the reports, documented procedure for intra partum care, documented procedure for immediate post partum care, documented essential newborn care, documented procedure for neonatal resuscitation, documented procedure for admission, shifting and referral of the patient, documented procedure for arrangement of intervention for labour room, documented

procedure for blood transfusion, documented procedure for distinguish between newborn death and still birth, documented procedure for environmental cleaning and processing of the equipment, documented procedure for maintenance of rights and dignity of pregnant women, documented procedure for record maintenance including taking consent.).

- Work instructions/protocols not displayed in the department.
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- No established system of periodic review as internal assessment, audits, corrective and preventive actions on the gaps identified during assessment etc.
- The facility does not measure all productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.

4. Maternity Ward

Maternity ward had 14 beds. The facility has one gynaecologist available. 10 GNMs were managing both Labour room as well as maternity ward. Ante natal & post natal cases were kept in same ward. Average case load in the ward is 114-115/month.

Maternity Ward Score Card		
	Maternity Ward Score	**52.16**
	Area of Concern wise Score	
A	Service Provision	**60.71**
B	Patient Rights	**53.84**
C	Inputs	**60.71**
D	Support Services	**53.84**
E	Clinical Services	**73.52**
F	Infection Control	**56.12**
G	Quality Management	**4.25**
H	Outcome	**0**

Gaps

- C-section services not available in the facility.
- Dedicated Septic ward & eclampsia room not available.
- Poor signage system-Numbering of rooms, internal sectional signage, directional signage were not available.
- Visitors' policy not implemented, visiting hours for patient attendants, entitlements under JSY, JSSK, contact details of referral transport not displayed in the department.
- List of drugs available were displayed in/near the ward but quantity & expiry date were not mentioned.
- Most of the IEC material (Kangaroo care, family planning, Post natal advice, PCPNDT etc) were not displayed.
- No enquiry desk, no breast feeding corner, no disable friendly toilets were available in the department.
- No system of maintaining privacy & dignity of patients (availability of screen at examination area, curtains at windows, patients dressed/covered while shifting etc)
- General consent of patient is not taken before admission.
- No grievance redressal mechanism (availability of complaint box and display of process for grievance redressal and whom to contact).
- All the services are not cashless as pregnant women sometimes need to spend on drugs, consumables, diagnostics etc whatever is not available in the facility.
- Toilets/bathrooms were not found clean.

- Basic amenities such as separate toilets for visitors, adequate shaded waiting area etc. were not available.
- No intercom facility.
- Separate pre partum & post partum wards not available.
- Non structural components (fixtures and furniture like cupboards, cabinets, and heavy equipments, hanging objects) were not properly fastened and secured.
- No fire safety measures (fire extinguisher not placed, fire exit plan not available) taken in the department. Staffs are not trained for such disasters.
- RMNCH+A counsellor, security guard not available.
- The staffs have not been provided required training/skill sets such as Infant and young Child Feeding (IYCF) practices, patient safety etc.
- Uterotonic drugs, hypertensive drugs & some of the consumables for newborn care were not available in the stock.
- Emergency drug list was not standardised in the department.
- Point of care diagnostic instruments (Glucometer, HIV rapid diagnostic kit etc) was not available.
- Resuscitation kit (both adult & baby) was not available.
- The facility does not have any system for inspection, testing, maintenance and calibration of equipment.
- Empty and filled cylinders were not labelled.
- Expenditure register of drugs and consumables were also not found. Records for expiry and near expiry drugs were not maintained for drug stored in the department.
- Visiting hours were not fixed for patients attendants.
- Cleanliness of the patient care areas & toilets need to be improved as dirts, cobwebs & seepage in ward were observed.
- Condemned items & stray animals were seen in the unit.
- There are no defined/established criteria for initial clinical & nutritional assessment of patients. No such records/formats seen. Records of physical examination were inadequate as evident from patient case sheets.
- The hospital doesn't have standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients.
- Nursing notes were not maintained. Patient vital records were also not monitored & recorded. No TPR chart, intake output chart etc. available.
- Relevant standard treatment guidelines, drug formulary were not available at the point of use. Drugs were prescribed in brand name not under generic name as evident from patient records. High alert drugs were not identified.
- Follow up note was not mentioned in the discharge sheet. Discharge summary is not given to LAMA/referral cases.
- Consent is not taken before blood transfusion.
- There is no established procedure for monitoring and reporting transfusion complication.
- Mothers & new born stay for minimum 48 hours after delivery is not ensured.
- The facility doesn't have any infection control program in place for prevention and measurement of hospital associated infection (monitoring to observe signs of HAI, no periodic medical checkups & immunization of staffs, no hospital antibiotic policy etc.)
- Adherence to 6 steps of hand washing was also not found.
- Proper handling of Soiled and infected linen to be ensured.

- The facility needs to ensure standard practices are followed for the cleaning and disinfection of patient care areas. Standard practice of mopping and scrubbing (unidirectional from inside out) not followed. Brooms were used for cleaning in patient care areas.
- Isolation and barrier nursing not practiced for septic cases.
- Biomedical waste management- proper colour coding of bags & bins were not followed. Segregation was also not done as per the guideline. Sharps were not disinfected before disposal. Staffs were not aware what to do in case of needle stick injury. Transportation of biomedical waste is done in open trolley. Staffs not aware on mercury spill management.
- Patient satisfaction surveys were not being conducted.
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for receiving & initial assessment of the patient in maternity ward, documented procedure for admission, shifting and referral of pregnant mother, documented procedure for shifting the mother to Labour room, documented procedure for requisition of diagnosis & receiving of the reports, documented procedure for preparation of the patient for surgical procedure, documented procedure for transfusion of blood in maternity ward, documented procedure for maintenance of rights and dignity of pregnant women, documented procedure for record Maintenance including taking consent, documented procedure for discharge of the patient from maternity ward, documented procedure for post natal inpatient care of mother, documented procedure for post natal inpatient care of newborn, documented procedure for environmental cleaning and processing of the equipment, documented procedure for counselling of the patient at the time of discharge, documented procedure for arrangement of intervention for maternity ward, documented procedure for sorting, cleaning and distribution of clean linen to patient, documented procedure for providing free diet to the patient as per their requirement, documented procedure for end of life care.)
- Work instructions/clinical protocols were not found displayed.
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have any established system of periodic review as internal assessment, audits for identification of the gaps, corrective and preventive actions to fulfil the gaps.
- Quality objectives for maternity ward were not defined.
- The facility doesn't have an established system of measuring indicators (productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators) on monthly basis.

5. Paediatrics Ward

Paediatrics Department Score Card		
	Paediatrics department Score	**47.83**
	Area of Concern wise Score	
A	Service Provision	**50**
B	Patient Rights	**75**
C	Inputs	**48.41**
D	Support Services	**62.26**
E	Clinical Services	**62.75**
F	Infection Control	**43**
G	Quality Management	**2.32**
H	Outcome	**0**

Gaps

- No dedicated paediatric ward in the facility.
- Isolation ward not available
- Indoor Management of severe acute malnutrition, meningitis, acute respiratory infections, Chikungunia, JE, Accidental poisoning, Paediatric Tuberculosis.
- The facility does not provide services under National health Programme for deafness.
- Departmental directional signages not adequate
- Visiting hours and visitor policy not displayed
- IEC Material on Breast feeding, immunization schedule and Zn, ORS, nutrition and hand washing etc. not displayed.
- Screens were not available for providing adequate visual privacy.
- General Consent not taken before admission, except surgery, O&G cases
- Information about the treatment not regularly shared with patients or attendants
- Complaint box not available.
- Toilets not clean, broken taps, dirty floor.
- Free diagnostics not available for all the patients, no free drop back services.
- Patient party spends on purchasing diagnostics, drugs or consumables from outside.
- Other expenditure occurred by the patient party not reimbursed from hospital.
- No separate toilet for visitors.
- No patient/ visitor Hand washing area.
- Non-availability of examination room, treatment room, doctor's duty room, dirty room and play room.
- Functional telephone and intercom not available.
- Cupboards and cabinets not properly secured.
- Windows do not have wire meshwork.
- Fire exits not clearly marked.
- Fire extinguishers not installed.
- The staff has not been provided training on facility based immunization, IYCF practices, IMNCI training and patient safety.
- Department did not have antibiotics (except cefotaxime) and resuscitation consumables (Nasogastric tube 10 FG, suction catheter, uncuffed tracheal tube and oropharyngeal tube)
- Emergency drug tray not maintained.
- Equipments and instruments for monitoring and examination (stadiometer, infantometer, glucometer and BP apparatus with paediatric cuff) not available.
- All equipments not covered under AMC including preventive maintenance.
- Measuring equipments like BP apparatus, thermometers not calibrated.
- Equipment for sterilization and disinfection (boiler) not available in the ward.
- Drugs stored in containers, tray not labelled.

- Stock level not updated daily.
- Expired drugs present
- Empty and filled cylinders not labelled.
- Records for expiry and near expiry drugs not maintained for drug stored at department.
- No practice of calculating and maintaining buffer stock in paediatric ward; no established system of timely indenting of consumables and drugs at nursing station. Indenting done verbally at the pharmacy.
- There was stock-out of drugs.
- Illumination of patient care area not adequate.
- Visiting hours are not fixed.
- Side railings have not been provided to prevent fall of patient.
- Identification band for children below 5 years not available.
- Cleanliness of the wards needs to be improved upon including surfaces of fixtures and furniture.
- A few junk material found in the ward.
- Linen not changed every day.
- No established procedure for admission of patients
- No established procedure for handing over of patients during departmental transfer
- No established procedure for consultation of the patient to other specialist within the hospital
- Patient history and provisional diagnosis not recorded
- Facility does not have functional referral linkages to lower facilities.
- No system of follow up of referred patients.
- Nursing Handover register not maintained; handover not given bed side.
- Patient vitals not monitored and recorded periodically.
- No procedure for rational use of drugs
- High alert drugs available in department not identified.
- Maximum dose of high alert drugs neither defined nor communicated.
- No process to ensure that right doses of high alert drugs are given.
- Any adverse drug reaction not recorded.
- No records of calculation chart for fluid and drug dosages, drip rate and volume.
- Standard Format for bed head ticket/ Patient case sheet (TPR chart, IO chart, growth chart) not available.
- Registers identified but not numbered.
- Discharge summary not given to LAMA patients.
- Counselling not done regularly to mother on correct treatment and feeding of the child at home, when to return for follow-up care and immunization.
- Declaration is not taken from LAMA patient.
- Staffs were not aware of disaster plan; roles and responsibilities of staffs in disaster not defined.
- Any major or minor blood transfusion reaction not recorded
- Death note (including efforts done for resuscitation) not noted in patient record
- Assessment Protocols (Airway, Breathing, Circulation, Coma, Convulsion, and Dehydration) not available.
- Triage Protocols not available
- Staff not aware and do not practice ETAT protocols
- ETAT checklist not available
- Differential diagnosis algorithm (Management of children presenting with fever, cough/ breathlessness) not available.

- Weight chart not maintained.
- Assessment of dehydration not done as per protocols
- No procedure to report cases of Hospital acquired infection.
- No procedure for periodic medical check up of the staff
- No regular monitoring of infection control practices
- Doctors not aware of Hospital Antibiotic Policy
- Non- availability of alcohol based hand rub
- Hand washing Instruction not displayed anywhere.
- Non adherence to 6 steps of hand washing.
- Staff aware when to hand wash but not practised.
- All mothers do not practice hand washing with soap
- Non- Compliance to correct method of wearing and removing the gloves.
- Antiseptic solution not available
- Decontamination of operating & Procedure surfaces, instruments not done as per standard guidelines.
- No proper handling of Soiled and infected linen.
- Staff not aware of making chlorine solution
- Staff is not trained for spill management, preparing cleaning solution as per standard procedure, standard practice of mopping and scrubbing not followed, cleaning equipments (broom) used in patient care areas, isolation and barrier nursing procedure not followed for septic cases.
- Puncture – proof box not available.
- Sharps not disinfected before disposal; Staff not aware of contact time for disinfection of sharps
- Transportation of bio medical waste not done in close container/trolley.
- Staff not aware of mercury spill management.
- The facility doesn't have any established system for patient and employee satisfaction survey.
- The facility doesn't have any internal & external quality assurance program in place.
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented Procedure for receiving and initial assessment of the patient, documented procedure for reassessment of the patient as per clinical condition, documented procedure for admission, shifting and referral of children, documented procedure for emergency triage assessment and treatment, documented procedure for assessment and management of Emergency signs, documented procedure for Management of fever, cough, breathlessness, diarrhoea and malnutrition, documented discharge process for paediatric patient, documented procedure for transfusion of blood in maternity ward, documented procedure for requisition and reporting of diagnostics, documented procedure for end of life care, documented procedure for discharge of the patient, documented procedure for environmental cleaning and processing of the equipment, documented procedure for arrangement of intervention for Paediatric ward, documented procedure for sorting, cleaning and distribution of clean linen to patient, documented procedure for providing free diet to the patient as per their requirement).
- Work instruction/protocols not displayed.
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility has not established any system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.

- The facility does not measure any productivity indicator, clinical care & safety indicator & service quality indicators.

6. Indoor Patient Department

The In Patients Department was 105 bedded distributed in 5 blocks – emergency, maternity, male and female blocks (2). Indoor services for isolation ward, general surgery, burn ward, ophthalmology, orthopaedics, psychiatry, dialysis and physiotherapy were not available in the facility. Indoor treatment of TB patients who require hospitalization not provided. Nursing services were available 24x7.

Indoor-patient Department Score Card		
	Indoor-patient department Score	**50**
	Area of Concern wise Score	
A	Service Provision	**38.88**
B	Patient Rights	**64.47**
C	Inputs	**51.53**
D	Support Services	**53.92**
E	Clinical Services	**65.47**
F	Infection Control	**43.87**
G	Quality Management	**21.79**
H	Outcome	**0**

Gaps

- Layout/floor directory not displayed.
- Visiting hours and visitor policy not displayed.
- List of services available and user charges - not displayed.
- List of drugs available neither displayed nor updated.
- Relevant IEC material, user charges (if any) not displayed at wards
- Disable friendly toilet not available
- Male attendants allowed to stay at night in female ward
- Examination/ Dressing of patient not done in enclosed area
- No two patients are treated on one bed but in the female IPD it was observed that both patient and attendant were sleeping in the same bed.
- No established procedures for taking informed consent before treatment.(General consent is taken only for surgery cases)
- Patient not informed periodically about clinical condition and treatment been provided
- Patient party had spent on purchasing a few drugs and consumables from outside
- Functional toilets were not clean and not available as per strength and patient load of ward
- Patient/ visitor Hand washing area not available.
- No separate toilets for visitors
- Non- availability of Examination room, treatment room, doctor's duty room and dirty room.
- Functional telephone and Intercom Services, TV for entertainment and health promotion not available.
- Cupboards, cabinets, heavy equipments not properly secured.
- IPD building has a few temporary connections and loosely hanging wires
- Windows do not have wire meshwork
- Fire exits are neither clearly visible nor the routes to reach exit are clearly marked.
- Fire extinguishers not installed in the facility.
- Non – availability of security services.

- Staffs have not received training on infection control and hand hygiene, patient safety, preparing cleaning solution as per standard procedure, cleaning of patient care area with detergent solution, mercury spill management.
- Nursing staff skilled for maintaining clinical records but the system for record maintenance was messy and haphazard.
- Standard practice of mopping and scrubbing not followed
- Non availability of drugs acting on CVS, CNS/PNS, dressing material and antiseptic lotion, respiratory system and hormonal preparation.
- Emergency drug tray not available.
- Equipments (like refrigerator, drug trolley, dressing trolley) for storage for drugs not available.
- All equipments were not covered under AMC including preventive maintenance
- All the measuring equipments/ instrument were not calibrated
- No established procedure for forecasting and indenting drugs and consumables
- Expiry drugs found (For instance- QDH X 15 in male ward)
- Drugs stored in containers and tray were not labelled
- Empty and filled cylinders were not labelled
- There was stock-out of drugs.
- Narcotic and psychotropic drugs not identified and therefore not stored in lock and key
- Records for expiry and near expiry drugs were not maintained for drug stored at department
- Condemned material found at the ward
- Linen were not changed every day
- No procedure to monitor the quality and adequacy of outsourced services on regular basis
- Patient history and provisional diagnosis not recorded.
- No established procedure for handing over of patients from one department to other department
- No established procedure for consultation of the patient to other specialist with in the hospital
- No system to follow up of referred patients
- Nursing Handover register not maintained; hand over not given bed side
- Patient vitals not monitored and recorded periodically.
- The facility does not ensure that drugs are prescribed in generic name only
- No procedure for rational use of drugs
- High alert drugs were not identified
- Any adverse drug reaction occurred not recorded
- Standard Format for bed head ticket/ Patient case sheet (TPR chart, IO chart) not available
- Discharge summary not given to LAMA patients
- Declaration not taken from LAMA patients
- Although staffs have some idea about the disaster plan; roles and responsibilities of the staff not defined.
- Nursing station not provided with the critical value of different tests
- Consent not taken from patient before blood transfusion
- Death note does not include notes on efforts done for resuscitation in patient record
- No procedure to report cases of Hospital acquired infection
- No procedure for Periodic medical checkups of the staff
- No regular monitoring of infection control practices
- Doctors not aware of Hospital Antibiotic Policy
- Hand washing Facility not available at Point of Use

- Hand washing Instruction at Point of Use not displayed.
- Non-adherence to 6 steps of Hand washing
- Antiseptic Solutions, alcohol based hand rub not available
- Non-compliance to correct method of wearing and removing the gloves
- Decontamination of operating & Procedure surfaces not done according to standard protocols.
- Proper Decontamination of instruments after use not done
- Staff not aware of how to make chlorine solution
- High level Disinfection of instruments/equipments not done as per protocol
- Non- Availability of plastic colour coded plastic bags
- Staff not aware of contact time for disinfection of sharps
- All Staff were not aware of what to do in condition of needle stick injury
- Transportation of bio medical waste not done in close container/trolley
- The facility doesn't have any established system for patient and employee satisfaction survey.
- The facility doesn't have any internal & external quality assurance program in place.
- The facility has not established system for use of check lists in different departments and services
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for receiving and initial assessment of the patient, documented procedure for admission, shifting and referral 0f patient, documented procedure for requisition of diagnosis and receiving of the reports, documented procedure for preparation of the patient for surgical procedure, documented procedure for transfusion of blood, documented procedure for maintenance of rights and dignity of Patient, documented procedure for record eminence including taking consent, documented procedure for counselling of the patient at the time of discharge, documented procedure for environmental cleaning and processing of the equipment, documented procedure for sorting, and distribution of clean linen to patient, documented procedure for end of life care).
- Work instruction/protocols not displayed.
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have established system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure any productivity indicator, clinical care & safety indicator & service quality indicators.

7. Laboratory Services

The laboratory provides services for Haematology, Bio chemistry & Clinical Pathology tests. It is open from 8 am – 1 pm & 4-6 pm.

Laboratory Score Card		
	Laboratory Score	**37.83**
	Area of Concern wise Score	
A	Service Provision	**50.0**
B	Patient Rights	**50.0**
C	Inputs	**42.24**
D	Support Services	**47.82**
E	Clinical Services	**60.34**
F	Infection Control	**49.07**
G	Quality Management	**8.62**
H	Outcome	**0**

Gaps

- Emergency lab services are not available.
- Microbiology, cytology, histopathology & serology lab test facilities were not available.
- Facilities for skin smear examination not available in the facility.
- Restricted area signage, internal sectional signage, timing for collection of sample and delivery of reports etc not displayed outside the department. Updated list of services were available but not found displayed.
- Printed formats for lab reporting were not available.
- No grievance redressal mechanism.
- No empanelled lab for JSSK beneficiaries for tests (not available within the facility).
- Space available for carrying out lab tests was not sufficient. Sample collection, testing, reporting etc everything done in a single room.
- Patient amenities such as sitting arrangement in sub waiting area, patient calling system at lab etc were not available.
- Intercom facility not available.
- The department didn't ensure unidirectional flow of services.
- Non structural components eg, heavy equipments, hanging objects are not properly fastened and secured.
- No fire safety measures (fire extinguisher not placed, fire exit plan not available) taken in the department. Staffs are not trained for such disasters.
- No pathologist & microbiologist available. Shortage of cleaning staffs. No security arrangement.
- Staffs have not been provided required training/skills eg. Bio Medical waste Management, Infection control and hand hygiene, Training on Internal and External Quality Assurance, Laboratory Safety etc.
- Emergency drug tray not maintained.
- BP apparatus, Stethoscope not available at sample collection area.
- Semi/fully auto analyser not available in the department. Refrigerator was also not available for storage of samples and reagents.
- Although the facility has a system of timely corrective break down maintenance of equipments but system for inspection, testing, maintenance and calibration of equipment not available. Annual Maintenance Contract/Comprehensive Maintenance Contract for all the equipments not available.

- The department don't have any system to label Defective/Out of order equipments and store appropriately until it has been repaired
- Laboratory does not have any system to update correction factor after calibration wherever required.
- Operating and maintenance instructions/manuals were not available with the users of equipment.
- Reagents & consumables were not properly stored.
- Expired reagent found in ICTC lab. Records for expiry and near expiry reagent were also not maintained.
- Stock and expenditure register were not updated.
- Temperature chart for refrigerator available in ICTC lab were not maintained.
- Entry is not restricted in testing area as all the processes such as sample collection, testing, report despatch everything is done in a single room.
- Cleaning need to be improved in the department.
- Condemned items were found in the department.
- No power back up facility in the department.
- Lab technician were not found wearing apron.
- No referral linkage facility for tests not available at the facility.
- Printed formats for requisition and reporting were not available. Lab registers were not labelled.
- Instructions for collection and handling of primary sample were not communicated to those responsible for collection.
- Laboratory does not have any system to trace the primary sample from requisition form & identity of person collecting the primary sample.
- The department don't have infection control program and procedures in place for prevention and measurement of hospital associated infection (Periodic medical checkups of the staff & immunization not done, Regular monitoring of infection control practices, hospital antibiotic policy not available etc)
- Elbow operated taps not available.
- Non compliance to 6 steps of hand washing.
- Antiseptic solutions were not in the stock.
- Standard practices not followed for cleaning and disinfection of patient care areas- staffs not trained on spill management, unidirectional mopping form inside out not practiced, brooms used in patient care areas.
- Biomedical waste management need to be improved (availability of color coded bins, adhering to color coding of bins, disinfection of sharps before disposal , disinfection of liquid waste before disposal, make staffs aware on mercury spill management, etc)
- No system to take feedback from clinicians and patients.
- The facility does not have defined and established procedures for Emergency Services and Disaster Management.
- Cross Validation of Lab tests are not done. Control charts are not prepared.
- The department doesn't have any established and documented Standard Operating Procedures for some key processes and support services (documented process for Collection and handling of primary sample, documented procedure for transportation of primary sample with specification about time frame, temperature and carrier, documented procedure for acceptance and rejection of primary samples, documented procedure on receipt, labeling, processing and reporting of primary sample for emergency cases, documented procedure for storage of examined samples, documented procedure for repeat tests due to analytical failure,

documented validated procedure for examination of samples, documented critical reference values and procedure for immediate reporting of results, documented internal quality control system to verify the quality of results, documented External Quality assurance program, documented procedure for calibration of equipments, documented procedure for validation of results of reagents, stains, media and kits etc, documented procedure for examination by referral laboratories, documented system for storage, retaining and retrieval of laboratory records, primary sample, Examination sample and reports of results, documented system to control of its documents, documented procedure for preventive and break down maintenance , documented procedure for internal audits, documented procedure for purchase of external services and supplies.)

- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The department do not have established system of periodic review as internal assessment, audits etc.
- Quality policy & objectives were not defined.
- The facility does not measure some productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.

8. Radiology

The department was located in the mid zone of the hospital. The opening hours were 8.00 hrs – 13:00hrs. USG services were not regular; as in January 2014- USG was not done as there was no trained person; in February and March USG cases done were 11 and 12 respectively. Again in April'14 no USG service was available as the machine went out of order.

Radiology Department Score Card		
	Radiology department Score	**40.43**
	Area of Concern wise Score	
A	Service Provision	**50**
B	Patient Rights	**67.50**
C	Inputs	**44**
D	Support Services	**58.49**
E	Clinical Services	**67.64**
F	Infection Control	**28.57**
G	Quality Management	**0**
H	Outcome	**0**

USG services were free for BPL and Indoor patients only. Two X-ray machines of 300 MA and 100 MA were available in the facility. Functional Dental X-Ray machine was not available. CT scan machine was not available.

Gaps

- Special radiography services were not available (Barium Swallow, Barium enema, Barium meal, MMR, Chest)
- Emergency radiology services not available
- Directional signages were not available in the facility.
- Cautionary signage outside the X-Ray department was not displayed. List of services available were not displayed at the entrance.
- Timing for taking X-Ray and collection of reports were not displayed outside the X-Ray department. User charges in r/o X ray services were not displayed at the entrance.
- Reports were not provided to patient in proper printed format.

- Radiology services were not free for pregnant women and infants; it was free only for BPL and Indoor patients.
- Physical layout of X-Ray unit was not as per AERB safety code (room size, unshielded opening for ventilation and natural light, installation and distance of control panel, facility of the processing tanks in the dark room, provision of lead lining in the door and windows, thickness of wall).
- Waiting area not adequate, no sitting arrangement.
- Attached toilet available only with USG, not for X-ray.
- Functional telephone and intercom services were not available.
- Non- structural components not properly secured.
- Electrical installations were not intact.
- The facility has no plan for prevention of fire.
- Fire extinguisher was not installed.
- Radiologist, housekeeping staff and security staff were not available.
- Staffs have not been provided training on radiation safety, infection control, hand hygiene, bio-medical waste management.
- Personal protective equipments like lead aprons were available but not used by the radiographer.
- Emergency drug tray not maintained.
- TLD badges not available.
- All equipments not covered under AMC.
- All the measuring equipments/ instrument not calibrated
- No system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due.
- Fixers and developer not labelled appropriately
- Records for expiry and near expiry chemicals not maintained.
- There is no practice of calculation and maintaining buffer stock chemicals and X-ray films.
- Department does not maintained stock and expenditure register of chemicals and X-ray films.
- Warning light not provided outside X- ray room and it's been used when unit is functional.
- Protective gloves not provided to relative of the child patient who escort the child for X ray examination.
- No Exhaust fan in the dark room
- Junk material found in the USG room.
- X ray department does not have registration from AERB, layout approval, type approval of equipment with QA test report for X ray machine, Radiological safety officer (RSO) approved by competent authority
- Technician and support staff did not adhere to their respective dress code
- X ray department does not have a Radiological safety officer (RSO) approved by competent authority
- Facility does not have an established procedure for handing over of patients during transfer to X-Ray department
- Women in reproductive age not asked for pregnancy (LMP) before X-ray. Notice in local language not displayed at entrance of X ray department asking every female to inform radiographer/radiologist whether she is likely to be pregnant
- Standard format (reporting formats) not available in the department
- Radiology records were not indexed
- The facility does not have disaster management plan in place.
- USG department does not have a system in place to label the USGs

- X ray and USG department does not have a system in place to take X-ray of patients in case of Emergency.
- Instructions to be followed by patient for USG not displayed in local language at reception
- Necessary Instruction for taking X ray and its processing were not displayed at work station.
- There was no provision of periodic medical checkups of staff.
- There was no regular monitoring of infection control practices.
- Staff is not trained and do not adhere to standard hand washing practices; hand washing Instruction were not displayed anywhere in the department.
- Alcohol based hand rub not available.
- Decontamination of operating & Procedure surfaces were not followed according to required standard practices.
- Staffs were not trained for spill management, preparing cleaning solution as per standard procedure.
- Standard practice of mopping and scrubbing not followed.
- Segregation of Bio Medical Waste not as per guidelines.
- Disposal of Fixer and Developer not according to guidelines.
- Work instructions for segregation and handling of Bio-medical waste not displayed.
- The facility doesn't have any established system for patient and employee satisfaction survey.
- The facility doesn't have any internal & external quality assurance program in place.
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for process of taking and handling X ray, documented procedure for acceptance and rejection of X ray taken, documented procedure for receipt, labelling , Processing and reporting of X ray, documented procedure for taking X ray in emergency conditions, documented procedure for quality control system to verify the quality of results, documented procedure for repeat X ray, documented procedure for storage, retaining and retrieval of department records, and reports of results, documented procedure for preventive and break down maintenance, documented procedure for purchase of External services and supplies, documented procedure for inventory management, documented procedure for upkeep management of department, documented procedure for radiation safety of staff , patients and visitors).
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have established system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure any productivity indicator, clinical care & safety indicator & service quality indicators.

9. Pharmacy

Pharmacy Department Score Card		
	Pharmacy department Score	**38.78**
	Area of Concern wise Score	
A	Service Provision	**83.33**
B	Patient Rights	**55.88**
C	Inputs	**54.46**
D	Support Services	**44.61**
E	Clinical Services	**40.62**
F	Infection Control	**14.28**
G	Quality Management	**0**
H	Outcome	**0**

The drug dispensing counter was in the OPD area and services were available in the OPD hours. Timings for dispensing counter of pharmacy were displayed. Services under national health programmes like NVBDCP, RNTCP, NACP were available. However drugs under NLEP were not available in the facility.

Gaps

- Generic Drug store was not operational 24X7
- Directional signage's not displayed
- List of drugs available not displayed at pharmacy
- Status of availability of drugs not updated daily
- User charges in r/o services not displayed at entrance of generic drug store
- No separate queue for male and female at dispensing counter
- Local purchase of stock out drugs/ Reimbursement of expenditure to the beneficiaries not available
- Pharmacy does not have sitting arrangement for patients
- Functional telephone and Intercom Services not available
- Lack in the unidirectional flow of goods in the pharmacy (Receipt and Inspection area at one side and issue area on the other side)
- Pharmacy does not have a plan for safe storage and handling of potentially flammable materials.
- Windows of the pharmacy do not have wire meshwork.
- No fire extinguishers installed in the pharmacy (dispensing counter and store)
- Security staff not available.
- Staffs have not received training on inventory management, rational use of drugs, prescription audit.
- Bin cards were not available in the facility and the staffs were also not skilled for maintaining bin cards. The estimation of the requirement, proper storage of drugs and maintaining pharmacy records were based on experience.
- Drugs acting on central/Peripheral Nervous system, respiratory system, Hormonal Preparation remain mostly unavailable.
- All equipments were not covered under AMC.
- No system of timely corrective break down maintenance of the equipments
- No established procedure for forecasting and indenting of drugs
- All the shelves/racks containing medicines were not labelled in pharmacy and drug store
- Product of similar name and different strength not stored separately
- Heavy items not stored at lower shelves.
- Drug store and pharmacy has no system of inventory Management
- Drug store has no system to inform the patient care areas about near expiry/expired drugs
- Physical verification of inventory not done periodically

- Drugs stored at floor and adjacent to wall
- Facility does not use bin card system
- Reorder level not defined for each category of drugs
- Drugs not categorized as vital, essential and desirable
- Work instruction for storage of vaccines not displayed at point of use
- Drug store has no inventory management software
- ILR and deep freezer does not have functional alarm system
- Thermometer in ILR not in hanging position
- There was no license for storing spirit
- Staff not aware of Hold over time of cold storage equipments
- Pharmacists did not adhere to their respective dress codes.
- No procedure for secure storage of narcotic and psychotropic drugs
- Toilets not clean
- Facility does not provide list of drugs available to different departments as per essential drug list
- There was no system of conducting periodic prescription audit to ensure that only generic drugs are prescribed
- Hospital does not have its own drug formulary based on EDL
- List of high risk drugs was not available in the pharmacy
- Pharmacy records were not indexed.
- The facility does not have disaster management plan in place
- There was no provision of periodic medical checkups and immunization of staff
- Pharmacists were not aware of Hospital Antibiotic Policy
- Segregation of Bio Medical Waste not done as per guidelines
- Disposal of expired drugs not done as per state guidelines
- The facility doesn't have any internal (Physical verification of the inventory by Pharmacist/hospital manager at periodic intervals) & external quality assurance program (Periodic and random sampling of the drugs for Quality Assurance) in place.
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for indent the drugs and items from district drug warehouse, documented procedure for local purchase of drugs/ generic drug stores, documented procedure for reception of drugs and items, documented procedure for storage of drugs, documented procedure for dispensing of medicines at Pharmacy, documented procedure for indenting the drugs to patient care area, documented procedure for issue of the drugs in emergency condition, documented procedure for maintenance of temperature of ILR/Deep freezer /refrigerators, documented procedure for maintaining near expiry drugs at store and pharmacy, documented procedure for rational use of drugs and prescription audit, documented procedure for storage of narcotic and psychotropic drugs, documented procedure for periodic random check and quality testing of drugs).
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have established system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure any productivity indicator, clinical care & safety indicator & service quality indicators.

10. Auxiliary Services

The facility provides services under dietary, laundry (outsourced), maintenance services and disposal services. Although the facility provides housekeeping services there was inadequate manpower (only 4 sweepers). The disposal service was in-house but was not proper. The facility lacked in providing functional security services and medical record department.. Departmental signages were not available for the support service departments.

Auxiliary Score Card		
	Auxiliary Score	**35.03**
	Area of Concern wise Score	
A	Service Provision	**80**
B	Patient Rights	**81.25**
C	Inputs	**38.09**
D	Support Services	**49.18**
E	Clinical Services	**59.37**
F	Infection Control	**32.5**
G	Quality Management	**3.44**
H	Outcome	**0**

Gaps

- The support services department were not connected with intercom
- Only one Complaint box was available in the facility (at SDMO office) and display of process for grievance re addressal and who to contact not displayed.
- Dietary department does not have demarcated and dedicated area for various activities
- The flow of goods and services in laundry service was not uni-directional
- Equipments in wet areas like Kitchen was not equipped with ground fault protection and not designed for wet conditions
- Although, the facility has sufficient fire exit to permit safe escape to its occupant at time of fire; fire exits were neither clearly visible nor the routes to reach exit were clearly marked.
- Dietary Department does not have a plan for safe storage and handling of potentially flammable materials.
- Fire Extinguishers were not installed for the support services department.
- Non- availability of Dietician, washer man, Data Entry operator for MRD.
- The staffs have not been provided required training on bio-medical waste management, medical record management and infection control management.
- Laundry staff was not adequately skilled for segregating and processing of soiled and infectious linen.
- Consumables like caps, gowns, gloves were available at the dietary department but not used by the staff.
- Refrigerator was not available for storage of drugs, other edible perishable items
- The facility does not have an established system for maintenance of critical equipment
- Up to date instructions for operation and maintenance of equipments were not available with staff.
- Cleanliness of the floors, walls, roof, roof tops, sinks patient care and circulation areas needs to be improved
- No power back up
- Hospital does not have Special diet schedule for the critical ill patients suffering from Heart Disease, Hypertension, Diabetes, Pregnant Women, diarrhoea and renal patients
- Distribution of the food was not done in covered food trolleys; however utensils were covered during distribution.

- Department does not maintain stock and expenditure register in Kitchen. No procedure for calculating and maintaining buffer stock in kitchen.
- Linen department does not have a separate trolley for distribution of clean linen and collection of dirty linen
- Linen are not transported into leak proof containers /bags
- Linen department does not have a system of sorting of different category of linen (except OT linen)
- Linen department does not have procedure for sluicing of soiled, infected and fouled linen
- There is no procedure for condemnation of linen.
- No system to check pilferage of linen from ward
- All register/records were identified but not numbered.
- Medical record department does not have a system to check for completion of records, no procedure for destruction of old records
- Medical record department does not have a system for ICD coding /indexing the records.
- There is no Provision of Periodic Medical Checkups and immunization of staff
- Facility does not have established procedures for regular monitoring of infection control practices
- Hand washing Instruction were not displayed at point of use; no adherence to 6 steps of hand-washing.
- Layout of the department not conducive for the infection control practices
- Cleaning and decontamination of food preparation surfaces needs to be improved.
- Decontamination of heavily soiled linen needs further monitoring and supervision.
- Staffs were not trained for spill management, preparing cleaning solution as per standard procedure.
- Standard practice of mopping and scrubbing were not followed, broom were used in patient care areas.
- Stray animals outside the kitchen.
- Segregation of Bio Medical Waste not done as per guidelines
- Staffs were not aware what to do in condition of needle stick injury
- Liquid waste was not disinfected before disposal.
- The facility doesn't have any established system for patient & employee satisfaction survey.
- The facility doesn't have any internal & external quality assurance program (daily round by hospital authority, inspection, audits, monitoring through checklist etc) in place.
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented procedure for indexing of the records in MRD, documented procedure for receiving, compiling, and maintaining records, documented procedure for issuing of the records, documented procedure for retention of records, documented procedure for pest and rodent control, documented procedure for diet schedule, documented procedure for calculation of diet required in wards, documented procedure for procurement of food items, documented procedure for preparation and distribution of food, documented procedure to check the quality of food provided to the patient, documented procedure for disposal of remaining food, documented procedure for cleaning of kitchen and utensils, documented procedure for checkups of kitchen workers at defined intervals, documented procedure for collection, sorting and cleaning of linen, documented procedure for sluicing of the blood/ body fluid stained linen, documented procedure for distribution of linen in all patient care area, documented procedure for physical verification of the linen for cleanliness or torn out, documented procedure for condemnation of linen, documented procedure corrective and preventive maintenance of laundry

equipments, documented procedure for duty hours-security staff, documented procedure for control of incoming and outgoing items- security dept., documented procedure for visiting hours in patient care area, documented procedure for fire safety in hospital-security dept., documented procedure for electrical safety, documented procedure for training and drills of security staff).

- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have established system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure any productivity indicator, clinical care & safety indicator & service quality indicators.

11. General Administration

General Administration Score Card		
	General administration department Score	**35.79**
	Area of Concern wise Score	
A	Service Provision	**40.90**
B	Patient Rights	**46.05**
C	Inputs	**41.74**
D	Support Services	**52.34**
E	Clinical Services	**36.20**
F	Infection Control	**18.42**
G	Quality Management	**0**
H	Outcome	**4.34**

Gaps

- Functional disaster management unit, functional Intensive care unit, Post Partum unit, NRC , District Early Intervention Centre (DEIC), geriatric ward/, CCU , CT scan not available
- District apex group not formed
- Hospital does not have a system for immediate reporting of any disease outbreak to authorities
- Non- Availability of security services, Housekeeping services.
- Community representative not consulted while revising or expanding the scope of service.
- Hospital lay out with location and name of the departments not displayed at the entrance.
- Hospital has not established directional signage
- List of departments not displayed
- Signage's not pictorial
- Services not available were not displayed
- Availability of administrative services like handicap certificate, death certificate services not displayed.
- Processing time for issuing documents and Medical records not displayed
- Mandatory information under RTI not displayed
- Citizen charter does not include rights of patients, responsibilities of patients and visitors, standards and quality of services provided; does not mention services available on payment if any, information about person and place avail Information and assistance, cycle time for critical processes.
- A dedicated facilitation counter/rogi sahayata Kendra not available
- Information regarding services available at the counter not displayed
- Hospital does not have defined policy for non discrimination according to gender
- Ramps not provided with slip resistance surface

- Warning blocks have not been provided at beginning and end of the ramp and Stairs
- Facility does not conduct periodic Access Audits
- Hospital does not have defined policy for providing disable friendly services
- Parking area not earmarked for People with disabilities
- Symbol of Access not displayed at the facilities available for people with disabilities
- Hospital does not have defined policy for maintenance of privacy of patients
- Hospital does not have defined policy for taking consent.
- No affirmative actions to ensure that vulnerable sections can access services
- Staff not regularly sensitized about rights and responsibilities of the patient
- Hospital has not defined policy for grievance redressal mechanism
- There was no defined frequency of collecting complaints from complaint box
- Records of patient complaints suggestion not maintained
- Hospital has no established policy for providing all diagnostics free of cost
- There was no system of removal of old notices and updating the notice board
- No public toilet for visitors, stay facility for attendants not available.
- Separate cafeteria for patients and their relatives not available
- The facility does not ensure the seismic safety of the infrastructure
- The facility does not ensure safety of electrical establishment
- The facility does not have plan for prevention of fire
- Periodic Training not provided for using fire extinguishers
- There was no system to maintain records of down time of equipments
- Hospital does not measure illumination at different area of the hospitals
- Estimation of power consumption of different department of hospitals not done
- Hospital does not have dedicated sub-station for electrical supply
- Colour of gas pipeline and Gas Cylinder not as per standards
- Alarm system has not been provided to indicate any abnormal pressure change
- There was no procedure for prompt replacement of empty cylinders with filled cylinders
- Entry to Manifold room not prohibited
- Staffs have not been provided training on staff safety, measuring hospital performance indicators, facility level quality assurance.
- Hospital has no policy for regular competence testing as per job description.
- Hospital has no process for proper disposal and prevention of unintended use of expired drugs
- Hospital does not have policy to change linen
- Visitor policy not in place.
- The facility has not established procedures for management of activities of Rogi Kalyan Samitis
- The facility has not established procedures for community based monitoring of its services
- The facility does not have requisite licences and certificates for operation of hospital and different activities
- Facility does not have established policy for co ordination and handover during interdepartmental transfer
- No functional telemedicine centre
- Committee against sexual harassment not constituted at the facility
- Staffs have not been provided awareness training on Gender issues
- Facility does not have a closed drainage system.
- Facility does not have an annual maintenance plan or its infrastructure
- The facility has no established procedures for pest, rodent and animal control
- Facility does not measure hospital associated infection rates

- Hospitals does not periodically test the quality of water from the source (municipal supply, bore well etc) for bacterial and chemical content
- Chlorination of water not done as per requirement
- Noiseless generator for power backup not available
- Backlog in payment to beneficiaries as per their entitlement under different schemes due to non-submission of the vouchers and JSY form
- The facility does not ensure the adherence to dress code as mandated by its administration / the health department (I-Cards, name plate)
- No established system for contract management for out sourced services, no periodic review of quality of outsourced services
- No established procedure for continuity of care during interdepartmental transfer
- Infection control committee not constituted at the facility.
- Hospital has neither defined nor established an antibiotic policy
- No system for reporting needle sticks injuries.
- The facility does not have a quality team in place
- Patient Satisfaction surveys are not conducted at periodic intervals.
- The department doesn't have any internal & external quality assurance program in place.
- The department doesn't have any established and documented Standard Operating Procedures for all key processes and support services (documented system for Internal audits at defined intervals, documented procedure for control of documents and records, documented procedure for defining Quality objectives, documented procedure for action planning, documented procedure for training and CMEs of hospital staff at defined intervals, documented procedure for monthly review meeting).
- The facility does not map its key processes to make them more efficient by reducing non value adding activities and wastages.
- The facility doesn't have established system of periodic review as internal assessment, audits, corrective and preventive action on the gaps identified during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure all the productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.

12. Mortuary

Mortuary service was not available 24x7. Dead bodies are kept till the relatives take over the bodies. Unclaimed bodies are kept until disposal is arranged by police.

Gaps

- No facility for pathological post mortem
- No uniform and user-friendly signage system
- Religious and cultural preferences of patients and attendants not taken into consideration while delivering services
- No ramp/level ground for easy access of stretcher to mortuary/ post mortem room

Mortuary Department Score Card		
	Mortuary department Score	**11.68**
	Area of Concern wise Score	
A	Service Provision	**60**
B	Patient Rights	**36.36**
C	Inputs	**15.85**
D	Support Services	**10**
E	Clinical Services	**11.76**
F	Infection Control	**6.97**
G	Quality Management	**0**
H	Outcome	**0**

- Patient amenities not provided
- Departments does not have layout and demarcated areas as per functions
- No infrastructure for intramural and extramural communication
- Deep freezer for storage as per load not available
- Department does not ensures safety of electrical establishment
- Fire extinguishers not installed
- Specialist/MO do not conduct autopsy as per state norms. It is done by the police or grade IV staff.
- Staffs have not been provided training on infection control and hand hygiene, bio-medical waste management.
- Staffs not skilled for preservation of dead bodies in the mortuary
- The department does not have adequate consumables at point of use. Instruments were all rusted.
- Plastic bins for fixing specimens not available
- Equipment & instruments for examination & monitoring of patients, Cutting Instruments trays, Cabinets for storage of dead bodies, equipments for cleaning, equipment for sterilization and disinfection, Post mortem table, cupboard, counter for delivery of reports, table for preparation of reports chair not available
- No established procedure for inventory management techniques
- No adequate illumination level at patient care areas
- Dirty and unhygienic conditions inside the mortuary
- No policy of removal of condemned junk material
- No established job description as per govt guidelines
- No procedure to ensure that staff is available on duty as per duty roster
- No standard procedures for conducting post-mortem, its recording and meeting its obligation under the law
- No Provision of Periodic Medical Check-up and immunization of staff
- Regular monitoring of infection control practices not done
- Hand washing facilities not provided at point of use
- Staff not trained in hand washing practices and they do not adhere to standard hand washing practices
- The facility does not ensure standard practices and materials for decontamination and cleaning of instruments and procedures areas
- Standard operating procedures not available
- The facility does not measure all the productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.

RECOMMENDATIONS

1. Facility level Quality team should be constituted & monitoring & review meetings should be organised at regular intervals. New members should be oriented on Quality Management system and their roles & responsibilities.
2. All the departmental gaps mentioned above need to be closed.
3. Operation theatre should be made functional at the earliest.
4. Internal & external quality assurance should be implemented throughout the hospital.
5. Internal assessment of different departments, infection control audits, review meeting, RKS meeting etc. should be done at regular interval and actions should be taken to fulfil the gaps observed.
6. Although signages were available but directional signages & internal sectional signages to be placed wherever required. The signages should be in both languages – English as well as local language.
7. Basic amenities for patients' attendants should be provided such as shaded waiting area, proper sitting arrangements, drinking water facility, separate toilet etc.
8. Biomedical waste management should be improved (Proper segregation, adherence to colour coding as per the guideline, use of liners in bins, disinfection of wastes before disposal, reporting of needle stick injury, awareness on spill management & mercury spill management etc.)
9. Although PEP is available in the facility but most of the staff were not aware of the same; and did not know what to do in-case of needle stick injury.
10. Infection control practices to be implemented throughout the hospital and monitoring should be done at regular interval by hospital authority.
11. Provision of periodic medical check-up and immunization of the staff should be made available.
12. Patient satisfaction survey should be conducted at periodic intervals.
13. Required licenses & authorization should be obtained from authorized agency such as authorization for biomedical waste management, NOC for fire safety, AERB approval for X-ray room layout etc.
14. Condemnation policy should be made and condemned items should be removed from departments.
15. Disinfection of furniture, accessories, instruments & equipments should be done as per the standard protocol.
16. Key performance indicators should be maintained & monitored on monthly basis.