2014

Baseline Assessment Report

National Quality Assurance Standard

[Belonia Sub Divisional Hospital, Tripura]

Assessment period – 6th and 7th August 2014

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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 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
- Operation Theatre
- 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. The facility did not have disaster management plan in place.

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. 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.

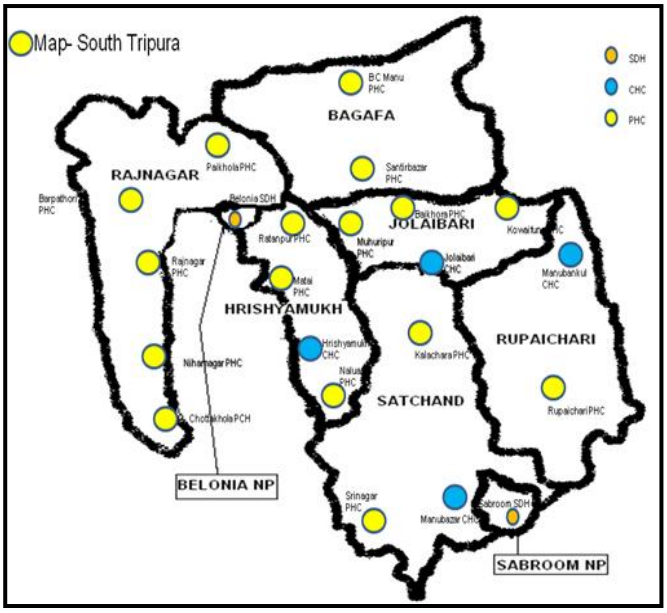
<table>
<tr><th colspan="4">Hospital Quality Score Card –Belonia Sub-divisional Hospital</th></tr>
<tr><td>Accident & Emergency
50.24%</td><td>OPD
52.78%</td><td>IPD
55.07%</td><td>Paediatrics
48.64%</td></tr>
<tr><td>Labour Room

56.92%</td><td colspan="2" rowspan="2">Hospital Score

47.19%</td><td>Operation Theatre
52.56%</td></tr>
<tr><td>Maternity Ward
55.22%</td><td>General Administration
35.79%</td></tr>
<tr><td>Mortuary
36.95%</td><td colspan="2">Auxiliary Services
31.69%</td><td>Pharmacy
41.92%</td></tr>
<tr><td></td><td>Laboratory
40.65%</td><td>Radiology
40.03%</td><td></td></tr>
</table>

BACKGROUND

South Tripura District is a newly formed district declared on June 2012. The District comprises with 3 Sub Division namely Belonia, Santirbazar and Sabroom. It has 1 Municipal Council, 2 Nagar Panchayat, 8 nos Block and 169 Gp/ADC villages. Total Population of South District is 444516. There are 3(three) principal hill ranges in South Tripura District namely South Baramura , Deotamura hill and a part of Atharamura hill range. Deotamura is the principal hill range of South Tripura District having a length of 85 Km. and forms the boundary between Amarpur and Udaipur Sub-Division.



The principal rivers flowing through the district are, Gumti, Muhuri and Feni. The river Gumti originates from the range connecting the Longtharai and Atharamura. It is more than 64 km. long and has a catchment area of 1014 sq.km. and it flows westwards through hillocks and plains of Belonia sub-division till it enters Bangladesh. The river Feni forms the natural boundary between the South Tripura District and Bangladesh.

Belonia Sub Divisional Hospital is only fully functional FRU of this district with 100 bedded facility including different services. It has clinical, diagnostic and ancillary services. It has a 01 MO in-charge and along with 08 Medical officers including specialists of O & G , Pediatric & trained LSAS. It has 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 fixed day sterilisation services starting from inception of FRU at Belonia and more than 400 cases LL and 45 NSV are done till date. C-section facility is also available at Belonia SDH.

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, RNTCP, IDSP, RBSK, JSSK, JSY, ILEP, HMIS & MCTS)

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

Bed distribution

The Belonia Sub Divisional Hospital Indoor is 100 bedded distributed in 6 Blocks.

S. No.	Ward	No of beds
1	Emergency Block	06
2	Maternity Block	11
3	Male Block (New)	25
4	Female Block(New)	25
5	Children Block	16
6	Male & Female Block (Old)	17
Total bed capacity		100

Manpower Status (Regular+ Contractual)

S.N	Speciality	Numbers
1	General Duty Medical Officers	6
2	Medicine specialist	0
3	Gynaecologist	1
4	Paediatrician	1 (Trained)
5	Anaesthetist	1 (Trained)
6	Pathologist	0
7	Dental Surgeon	1
8	Ayurvedic MO	1
9	Homoeo MO	1
10	Staff Nurses	26
11	Pharmacist	5
12	Laboratory technician	4
13	Radiographer	1
14	Ophthalmic Assistant/ Refractionist	1
15	GDA	14
16	SCA	3
17	Asst Hospital administrator	1
18	HMIS assistant(SDH)	1
19	ASHA programme manager	1
20	Malaria technical supervisor	1
21	Sub-divisional accounts cum data assistant	1
22	Adolescent Counsellor	1
23	Pharmacist (Allopathy, RBSK)	1
24	STLS	1
25	ICTC Counsellor	1
26	STI/RTI Counsellor	1
27	Laboratory technician	1

Hospital Performance

Type of services	Performance			
	Jan'14	Feb'14	Mar'14	April'14
No of OPD cases	4549	4530	5116	4008
No of IPD cases	594	563	760	738
No of Deliveries				
Normal Delivery	62	48	56	49
Caesarean section	0	3	2	5
Major surgeries	0	0	0	0
Minor Surgeries	0	0	0	0

DEPARTMENTAL GAPS

1. Accident and emergency department

Emergency Score Card		
	Emergency Score	**50.24**
	Area of Concern wise Score	
A	Service Provision	**64.28**
B	Patient Rights	**52.77**
C	Inputs	**56.47**
D	Support Services	**57.69**
E	Clinical Services	**67.67**
F	Infection Control	**39.81**
G	Quality Management	**2.43**
H	Outcome	**11.11**

Gaps

- Facility for emergency Surgical Procedures, emergency Ophthalmology procedures, emergency psychiatric procedures etc not available in the department.
- Radiology services, laboratory investigations, ECG etc not available 24x7. These services are available during OPD hours only.
- Police post not available in the hospital premises.
- Signages in the department were found poor. Departmental signage was found displayed but not prominent, directional signages, staffs on duty, display of list of services provided by the department, important contact numbers, patient rights and responsibilities, IEC 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 (complaint box was not available, whom to contact in case of complaint was not displayed and record of actions taken to resolve complaint).
- 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 get free services.
- The space available in the room is not adequate. Dressing/injection room need renovation. Only one observation bed was available.
- Basic patient amenities- waiting area, seating arrangement, cold drinking water, separate toilet etc were not provided.
- The department do not have layout & demarcated areas as per functions.
- Minor OT, shaded porch for ambulance etc not available.
- No intercom facility.
- The department do not have functional linkage with Major OT, ICU, labour room, Indoors and laboratories which are located in separate block.
- Non structural components eg, fixtures and furniture like cupboards, cabinets, and heavy equipments, hanging objects are not properly fastened and secured.
- 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.
- Staffs were not trained on Triage & mass casualty management, BLS/ALS, patient safety, biomedical waste management, infection control & hand hygiene etc. Only few staffs are trained as confirmed by the staffs on duty.
- Emergency drug tray was not maintained in the department.
- 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 as well as ambulance.
- The facility does not have any system for inspection, calibration, testing and annual maintenance of equipments.
- Empty and filled cylinders were not labelled.
- Records of expiry and near expiry medicines were not maintained in the department.
- Stock & expenditure register for drugs and consumables were not maintained in the department as all the patients after primary treatment are sent to IPD wards.
- The facility doesn't have any set procedures for handling mass situation and violence in emergency.
- Assessment criteria of different kind of medical emergencies are not defined.
- 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.
- 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. No disaster plan available.
- Registers/records were identified but not numbered.
- Advices in discharge summary were not complete. All the instructions were not written.
- Ambulance is not appropriately equipped for BLS/ALS.
- There is no log book and checklist implemented for daily maintenance of ambulance.
- Consent is not taken before blood transfusion.
- No standard procedure available for removal of life sustaining treatment as per law
- No provision for 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.
- Antiseptic solution was not available in the department during visit.
- Personal protective kit for infectious patients not available.
- Standard protocol for decontamination of instruments & procedure surfaces need to be followed and should be strictly 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. Staffs were not aware on how to prepare cleaning solution. Concentrations of cleaning/disinfectant agent solution need to be monitored.

- 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, sharps not done, transportation of wastes in covered trolley not done, staffs not aware on mercury spill management 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).
- 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 indicators.

2. Out-patient Department

Gaps:

Out-patient Department Score Card		
	Out-patient department Score	**52.78**
	Area of Concern wise Score	
A	Service Provision	**50**
B	Patient Rights	**61.53**
C	Inputs	**61.03**
D	Support Services	**83.33**
E	Clinical Services	**66.17**
F	Infection Control	**43**
G	Quality Management	**14.63**
H	Outcome	**3.44**

- Functional General Surgery Clinic, Ophthalmology Clinic, ENT Clinic , Orthopaedic Clinic, Skin & VD Clinic, Psychiatry Clinic, Physiotherapy Unit not available
- The facility does not provide services for Super specialties, as mandated
- Functional IYCF clinic not available
- TMT services not available
- The facility does not provide services under National Leprosy Eradication Programme as per guidelines
- Counselling centre for Suicide prevention not available
- No dedicated Geriatric Clinic
- Functional NCD clinic not available
- The facility does not provide services under National health Programme for deafness
- Layout/floor directory not displayed
- List of OPD Clinics not available
- Names of doctor on duty not displayed and updated
- Important numbers like ambulance not displayed
- Enquiry Desk with dedicated staff not available
- No Separate Female general OPD
- Wheel chair or stretcher for easy Access to the OPD not available

- Ramps with railing not available
- Disable friendly toilet not available
- Privacy at the counselling room not maintained
- Patient rights and responsibilities not displayed
- The facility does not ensure timely reimbursement of financial entitlements and reimbursement to the patients
- Adequate waiting area not available
- Seating arrangement in waiting area not available
- Sub waiting area for separate clinics not available
- Patient calling system not available
- Functional toilets not available
- Public telephone booth not available
- Clean and dirty utility room not available
- No demarcated trolley/wheelchair bay
- Functional telephone and Intercom Services not available
- Non structural components not properly secured
- The facility has no plan for prevention of fire
- The facility does not have adequate fire fighting Equipment
- No system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation
- The staff has been provided required training / skill sets on bio-medical waste management, infection control and hand hygiene and patient safety.
- Emergency Drug Tray not maintained at injection room & immunization room
- The facility has not established system for maintenance of critical Equipment
- All the measuring equipments/ instrument not calibrated
- Drugs stored in containers/tray/crash cart not labelled
- Records for expiry and near expiry drugs not maintained for drug stored at department
- There was stock out of drugs
- Hospital does not have sound security system to manage overcrowding in OPD
- Patient History not recorded
- Provisional Diagnosis not recorded
- A few Patient were consulted in Standing Position
- No screening clinic for initial assessment of the patients
- No procedure for follow up of old patients
- Facility has not established procedure for handing over of patients during departmental transfer
- No procedure for consultation of the patient to other specialist with in the hospital
- Facility does not ensure that drugs are prescribed in generic name only
- A copy of Prescription not kept with the facility
- No procedure of rational use of drugs
- The facility does not have disaster management plan in place
- Clinics not provided with the critical value of different tests
- At ANC clinic, auscultation for foetal heart sound, breast examination not done. Counselling not done for recognizing danger sign of labour and birth preparedness
- Staff not aware of how to minor and serious advise events (AEFI)
- Staff do not know what to do in case of anaphylaxis
- Triage, Assessment & Management of newborns having emergency signs not done as per guideline

- Management of children presenting with fever, cough/ breathlessness not done as per guideline.
- Management of children with severe acute Malnutrition not done as per guidelines
- Management of children presenting diarrhoea not done as per guideline
- Facility does not provide service under National Leprosy Eradication Program as per guidelines
- Facility does not provide service under Mental Health Program as per guidelines
- Geriatric Care not provided as per Clinical Guidelines
- Facility does not provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines
- No weekly reporting of Presumptive cases on form "P" from OPD clinic
- Facility does not provide services under National program for prevention and control of deafness
- No provision of Periodic Medical Checkups and immunization of staff
- No regular monitoring of infection control practices
- Alcohol based Hand rub, antiseptic Solutions not available
- Hand washing Instruction at Point of Use not displayed
- Non-adherence to 6 steps of Hand washing
- Facility does not ensure adequate personal protection equipments as per requirements
- Non-compliance to correct method of wearing and removing the gloves
- Facility does not ensure standard practices and materials for decontamination and cleaning of instruments and procedures areas
- Sitting arrangement in TB clinic not as per guideline
- Facility does not ensures standard practices followed for cleaning and disinfection of patient care areas
- Facility does not ensure segregation of Bio Medical Waste as per guidelines
- Puncture proof box not available
- 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
- No designated departmental nodal person for coordinating Quality Assurance activities
- OPD Patient satisfaction survey not done on monthly basis
- 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 (Proportion of follow-up patients, No of ANC done per thousand, ICTC OPD per thousand, ART patient load per thousand, ARSH OPD per thousand, Immunization OPD per thousand) ; equity indicator (Proportion of BPL patients); efficiency indicator; clinical care & safety indicator & service quality indicators (Patient Satisfaction Score, Waiting time at registration counter, Waiting time at ANC Clinic, Waiting time at general OPD, Waiting time at paediatric Clinic, Waiting time at surgical clinic, Average door to drug time) on monthly basis.

3. Labour Room

Gaps

Labour room Score Card		
	Labour Room Score	**56.92**
	Area of Concern wise Score	
A	Service Provision	**76.66**
B	Patient Rights	**64.28**
C	Inputs	**64.0**
D	Support Services	**64.15**
E	Clinical Services	**77.04**
F	Infection Control	**53.62**
G	Quality Management	**2.5**
H	Outcome	**0**

- HIV positive delivery cases & assisted delivery cases were not managed at the facility.
- Eclampsia/Pre eclampsia cases were mostly referred.
- Points of care diagnostic services (for HIV, Hb%, Random blood sugar) were not available.
- Poor signage – internal sectional signage, directional signage, restricted area signage, service provision in Labour room, 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.
- Dedicated receiving area, examination area, pre delivery, post delivery observation room, eclampsia room, septic labour room with NBCC, dirty utility room, store etc not available.
- Dedicated nursing station within or proximity of labour room was not available. One nursing station was located adjacent to Paediatric ward for Labour room, maternity ward & paediatric ward.
- 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.
- The staffs were not given required training eg. Only 2 staffs were trained on NSSK, Biomedical waste management etc.
- Emergency tray was available but on labelling expiry date was not mentioned.
- All the required items were not arranged in Episiotomy tray & Baby tray.
- MVA/EVA & PPIUCD tray was 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 all 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, ID band or foot print record is not kept.
- No provision of Centralized /local piped Oxygen and vacuum supply.
- Delivery table - stir ups not available, mattress, mackintosh not in good condition.
- 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.
- 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.
- Delivery note & baby note- complete details not mentioned.
- All the registers/records were identified but not labelled & numbered.
- Staffs were not aware of disaster plan & their roles & responsibilities in case of disaster.
- Consent is not taken before blood transfusion.
- MCP card was not updated.
- 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. Hand washing Instruction at Point of Use was not displayed.
- 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 procedure surfaces & handling of soiled & infected linen.
- There is no procedure to ensure the traceability of sterilized packs.
- 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

Gaps

- Dedicated Septic ward & eclampsia room not available as renovation was going on but those cases are kept separately in the area adjacent to ward.
- Visitors' policy not implemented, visiting hours for patient attendants, list of drugs available, IEC for post partum counselling not displayed in the department.
- Most of the IEC material (Kangaroo

Maternity Ward Score Card		
	Maternity Ward Score	**55.22**
	Area of Concern wise Score	
A	Service Provision	**78.57**
B	Patient Rights	**67.94**
C	Inputs	**66.42**
D	Support Services	**67.30**
E	Clinical Services	**71.07**
F	Infection Control	**46.93**
G	Quality Management	**4.25**
H	Outcome	**0**

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)
- 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).
- The ward was found congested. Available space was not adequate as per the case load.
- Attached Toilets/bathrooms were not available.
- Dedicated nursing station for maternity ward was not available. One nursing station was located adjacent to Paediatric ward for Labour room, maternity ward & paediatric ward.
- No intercom facility.
- 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.
- Uterotonic 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) were 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.
- 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.
- Different diet (Diabetic diet, low salt diet etc) is not provided as per the nutritional need of patients.
- The assessment criteria for different clinical conditions are not defined and measured in assessment sheet.
- No referral slip used, mentioned in discharge certificate.
- 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.
- Registers/records were not identified & numbered
- Follow up note was not mentioned in the discharge sheet. Discharge summary is not given to LAMA cases.
- Staffs not aware of disaster plan.

- Consent is not taken before blood transfusion.
- All the treatment details, day to day progress, nursing note etc not filled properly. Details were not complete.
- 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.)
- Hand washing facility was not available at the point of use, it was common for Labour room and maternity ward, located adjacent to Labour room. Six steps of hand washing instruction was also not found displayed.
- Adherence to 6 steps of hand washing was also not found.
- Proper handling of Soiled and infected linen & disinfection of procedure surfaces 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

Gaps:

Paediatrics Department Score Card		
	Paediatrics department Score	**48.64**
	Area of Concern wise Score	
A	Service Provision	**62.5**
B	Patient Rights	**60.71**
C	Inputs	**52.38**
D	Support Services	**64.15**
E	Clinical Services	**67.85**
F	Infection Control	**37**
G	Quality Management	**2.32**
H	Outcome	**0**

- Isolation room not available
- Indoor Management of Acute respiratory infections, Chikungunia, JE, paediateric Tuberculosis not available
- The facility does not provide services under National health Programme for deafness
- Departmental signage's not available
- IEC Material not displayed
- General Consent not taken before admission
- Patient not informed about his/her clinical condition and treatment been provided
- Free drop back services, Free patient transport not available
- Patient party spends on purchasing drugs or consumables from outside.
- Patient party spends on diagnostics from outside.
- The facility does not ensure timely reimbursement of financial entitlements and reimbursement to the patients
- Patient/ visitor Hand washing area not available
- No separate toilets for visitors
- No TV for entertainment and health promotion
- Examination room, Treatment room, Doctor's Duty room, dirty room, play room not available
- Functional telephone and Intercom Services not available
- Non structural components not properly secured
- The facility has no plan for prevention of fire
- The facility does not have adequate fire fighting Equipment
- Staff not competent for operating fire extinguisher and what to do in case of fire
- Security staff not available
- Staffs have not been provided required training / skill sets on Facility based immunization, Infant and young Child Feeding (IYCF) practices, IMNCI Training, Biomedical waste management, Infection control and hand hygiene and patient safety.
- Counsellor not skilled in IYCF counselling
- All equipments not covered under AMC including preventive maintenance
- No system of timely corrective break down maintenance of the equipments
- All the measuring equipments/ instrument not calibrated
- Empty and filled cylinders not labelled
- Department does not maintain stock and expenditure register of drugs and consumables
- There was stock out of drugs
- Temperature of refrigerators not kept as per storage requirement and records are maintained
- Side railings have not been provided to prevent fall of patient
- Identification band for children below 5 years not provided
- No security arrangement in Paediatric Ward
- 24x7 running and potable water not available

- Quality of diet provided not checked.
- Clean linens not provided for all occupied bed; linen not changed every day
- Provisional Diagnosis not recorded
- Facility has not established procedure for handing over of patients during departmental transfer
- Advance communication not done with higher centre in case of referrals
- Referral vehicle not being arranged always
- Referral in or referral out register not maintained
- Facility does not have functional referral linkages to lower facilities
- No system of follow up of referred patients
- Nursing Handover register not maintained
- Hand over not given bed side
- Nursing notes not maintained adequately
- The facility does not ensure that drugs are prescribed in generic name only
- No procedure of rational use of drugs
- Any adverse drug reaction not reported
- Fluid and drug dosages calculated according to body weight but no records found (Records-calculation chart)
- Standard Format for bed head ticket/ Patient case sheet not available as per state guidelines
- All register/records not numbered
- Discharge summary not given to patients going in LAMA/Referral
- The facility does not have disaster management plan in place
- Nursing station not provided with the critical value of different tests
- Death note does not include efforts done for resuscitation is noted in patient record
- 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 not done as per guidelines.
- Management of children presenting diarrhoea not done as per guidelines.
- No procedure to report cases of Hospital acquired infection
- No provision of periodic medical check-up and immunization of staff
- No regular monitoring of infection control practices
- Doctors not aware of Hospital Antibiotic Policy
- Alcohol based Hand rub not available
- Hand washing Instruction at Point of Use not displayed
- Non-adherence to 6 steps of Hand washing
- The facility does not ensure adequate personal protection Equipment as per requirements
- Non-compliance to correct method of wearing and removing the gloves
- The facility does not ensure standard practices and materials for decontamination and cleaning of instruments and procedures areas
- Staff not trained for preparing cleaning solution as per standard procedure
- Standard practice of mopping and scrubbing not followed
- Cleaning equipments like broom not used in patient care areas
- Isolation and barrier nursing procedure not followed for septic cases
- Plastic colour coded plastic bags not available
- Segregation of different category of waste not done as per guidelines
- Puncture proof box not available
- Disinfection of sharp not done before disposal

- Staff not aware of contact time for disinfection of sharps
- Staff do not know what to do in condition of needle stick injury
- Transportation of bio medical waste not done in close container/trolley
- Staff not aware of mercury spill management
- No designated departmental nodal person for coordinating Quality Assurance activities
- Patient satisfaction survey not done on monthly basis
- Departmental checklist not used for monitoring and quality assurance
- Staff not designated for filling and monitoring of these checklists
- Standard operating procedure for department has not been prepared and approved
- Current version of SOP not available with process owner
- 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 use any method for quality improvement in services
- The facility does not use any tool for quality improvement in services
- Facility does not measure productivity indicators on monthly basis (Bed Occupancy Rate, Proportion of Mothers given nutritional counselling, No. of paediatric admission per 1000 indoor admission)
- The Facility does not measure equity indicators periodically (Proportion of female patient, LAMA rate for female patient, Proportion of BPL patient)
- Facility does not measure efficiency indicators on monthly basis (Referral Rate, Bed Turnover rate, No. of drug stock out in the paediatric ward, Discharge Rate)
- Facility does not measure Clinical Care & Safety Indicators on monthly basis (No of Newborn / Child Resuscitated, Average length of Stay, Death rate, No of adverse events per thousand patients, % of infants exclusively breastfed from admission to discharge, Time taken for initial assessment, Case fatality rate)
- Facility does not measure Service Quality Indicators on monthly basis (LAMA Rate, Attendant Satisfaction Score)

6. Indoor Patient Department

Indoor-patient Department Score Card		
	Indoor-patient department Score	**55.07**
	Area of Concern wise Score	
A	Service Provision	**61.11**
B	Patient Rights	**72.36**
C	Inputs	**59.23**
D	Support Services	**73.52**
E	Clinical Services	**70.83**
F	Infection Control	**41.83**
G	Quality Management	**2.56**
H	Outcome	**0**

Gaps:

- Ophthalmology indoor services, Orthopaedics indoor services, Psychiatry Indoor services, Indoor Physiotherapy Procedures, dialysis services not available
- Ophthalmic ward, Geriatric ward not available
- Departmental signage's not uniform and user friendly.
- Layout/floor directory not displayed
- Entitlement under different national health program not displayed.
- Male attendants allowed to stay at night in female ward
- Disable friendly toilet not available
- Bracket screens / Curtains not available
- Patient/ visitor Hand washing area not available
- No separate toilets for visitors
- TV for entertainment and health promotion not available
- Examination room, treatment room, doctor's duty room , dirty room not available
- Functional telephone and Intercom Services not available
- The facility has no plan for prevention of fire
- IPD has not installed fire Extinguisher that is Class A , Class B, C type or ABC type
- Expiry date for fire extinguishers not displayed on extinguisher, due date for next refilling not clearly mentioned
- Staff not competent for operating fire extinguisher and what to do in case of fire
- Security staff not available.
- Staffs have not been provided required training / skill sets on bio-medical waste management, infection control and hand hygiene and patient safety.
- Point of care diagnostic instruments not available
- Patient beds with prop up facility not available
- All equipments not covered under AMC including preventive maintenance
- No system of timely corrective break down maintenance of the equipments
- All the measuring equipments/ instrument not calibrated
- Empty and filled cylinders not labelled
- Records for expiry and near expiry drugs not maintained for drug stored at department
- Temperature of refrigerators not kept as per storage requirement and records not maintained
- Narcotic and psychotropic drugs not identified and not stored in lock and key
- Visiting hour not practiced
- No security arrangement in IPD
- Toilets not clean and without functional flush
- 24x7 running and potable water not available
- Patient History not recorded
- Provisional Diagnosis not recorded
- Facility has not established procedure for handing over of patients from one department to other department

- The facility does not provide appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care (Advance communication is done with higher centre, Facility has no functional referral linkages to lower facilities, no system of follow up of referred patients)
- Treatment chart not maintained
- Hand over not given bed side
- Patient Vitals not monitored and recorded periodically
- No procedure of rational use of drugs
- High alert drugs available in department not identified
- No process to ensure that right doses of high alert drugs are only given
- Standard Format for bed head ticket/ Patient case sheet not available as per state guidelines
- The facility does not have disaster management plan in place
- Nursing station not provided with the critical value of different tests
- Consent not taken before blood transfusion
- Death summary not given to patient attendant quoting the immediate cause and underlying cause if possible
- Death note including efforts done for resuscitation not noted in patient record
- No weekly reporting of Presumptive cases on form "P" from IPD
- No procedure to report cases of Hospital acquired infection
- No provision of periodic medical check-up and immunization of staff
- No regular monitoring of infection control practices
- Facility has not defined and established antibiotic policy
- Alcohol based Hand rub not available
- Hand washing Instruction at Point of Use not displayed
- Non- adherence to 6 steps of Hand washing
- Masks not available
- The facility does not ensure standard practices and materials for decontamination and cleaning of instruments and procedures areas
- Staff do not know how to make chlorine solution
- Staff not trained for preparing cleaning solution as per standard procedure
- Standard practice of mopping and scrubbing not followed
- Cleaning equipments like broom used in patient care areas
- The facility does not ensure segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste not carried out as per guidelines
- Puncture proof box not available
- Disinfection of sharp not done 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
- No designated departmental nodal person for coordinating Quality Assurance activities
- Patient satisfaction survey not done on monthly basis
- Departmental checklist not used for monitoring and quality assurance
- Staff not designated for filling and monitoring of these checklists
- Standard operating procedure for department has not been prepared and approved
- Current version of SOP not available with process owner
- 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.
- Process mapping of critical processes not done
- Non value adding activities not identified
- Processes not rearranged as per requirement
- Internal assessment not done at periodic interval
- The facility does not conduct periodic prescription/ medical/death audits
- Non Compliance neither enumerated nor recorded
- Action plan not made on the gaps found in the assessment / audit process
- Corrective and preventive actions not taken to address issues, observed in the assessment & audit
- Quality objective for IPD not defined
- Staff not aware of quality policy and objectives
- Quality objectives not monitored and reviewed periodically
- The facility does not use method for quality improvement in services
- he facility does not use tools for quality improvement in services
- Facility does not measure productivity indicators on monthly basis (Bed Occupancy Rate of Medical Wards, Bed Occupancy Rate for surgical wards)
- Facility does not measure efficiency Indicators on monthly basis (Referral Rate, Bed Turnover rate, Discharge rate, No. of drugs stock out in the ward)
- Facility does not measure Clinical Care & Safety Indicators on monthly basis (Average length of stay for Medical wards, Average length for surgical wards, Time taken for initial assessment)
- Facility does not measure Service Quality Indicators on monthly basis (LAMA Rate, Patient Satisfaction Score)

7. Laboratory Services

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

Laboratory Score Card		
	Laboratory Score	**40.65**
	Area of Concern wise Score	
A	Service Provision	**56.66**
B	Patient Rights	**69.04**
C	Inputs	**44.91**
D	Support Services	**58.51**
E	Clinical Services	**58.62**

F	Infection Control	**48.14**
G	Quality Management	**6.89**
H	Outcome	**0**

Gaps

- Emergency lab services are not available.
- Microbiology, cytology & histopathology 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.
- No grievance redressal mechanism (Complaint box available but process and contact details not mentioned).
- 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. 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.
- Stock and expenditure register were not updated. Records for expiry and near expiry reagent were not maintained.
- Temperature chart for refrigerator available in lab were not maintained.
- Cleaning need to be improved in the department. Seepage was also observed in the walls of lab.
- Condemned items were found in RNTCP lab.
- Lab registers were not labelled & numbered.
- Staffs were not aware of disaster plan.

- Laboratory does not have any system to record the identity of person collecting the primary sample & to monitor the transportation of the sample.
- The department hasn't defined the retention period and disposal of used 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, Culture surveillance test, Regular monitoring of infection control practices, hospital antibiotic policy not available etc)
- Hand washing Instruction not found displayed. Elbow operated taps not available.
- Adherence to 6 steps of hand washing was also not observed.
- Standard practices not followed for cleaning and disinfection of patient care areas-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 colour coding of bins, disinfection of sharps before disposal , disinfection of liquid waste before disposal, display of work instruction for segregation & handling of biomedical waste, make staffs aware on mercury spill management, etc)
- No system to take feedback from clinicians and patients.
- The department don't have any external & internal quality assurance program in place except RNTCP & NACP lab.
- 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 serv
- ices 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

Radiology Department Score Card		
	Radiology department Score	**40.03**
	Area of Concern wise Score	
A	Service Provision	**75**
B	Patient Rights	**50**
C	Inputs	**46**
D	Support Services	**56.60**
E	Clinical Services	**76.47**
F	Infection Control	**19.64**
G	Quality Management	**0**
H	Outcome	**0**

Gaps:

- Special radiography services not available
- CT scan facility not available
- Departmental signage's are not uniform and user friendly.
- PNDT Notice at USG not displayed
- Cautionary signage outside the X ray department not displayed.
- List of services available not displayed at the entrance
- Timing for taking X ray and collection of reports not displayed outside the X ray department
- Reports provided to Patient not in proper printed format
- Ramp in OPD/ X ray room not available
- Complaint box and display of process for grievance re addressal and whom to contact not displayed
- Radiology services for pregnant women and infant not free.
- Patient party spends on diagnostics from outside.
- Room Size of X ray unit not as per AERB safety code
- Adequate waiting area not available
- Attached toilet facility not available
- Waiting area with sitting facility not available
- Installation of control panel of X ray equipment not as per AERB safety Code
- Distance between control panel and X ray unit not as per AERB safety code
- Functional telephone and Intercom Services not available
- Non structural components not properly secured
- Stabilizer not provided for X-ray machine
- Windows and door in X ray room not provided with lead lining
- Thickness of walls at X room not as AERB safety code
- The facility has no plan for prevention of fire
- Radiology department has not installed fire Extinguisher that is Class A , Class B C type or ABC type
- Expiry date for fire extinguishers not displayed on extinguisher, due date for next refilling not clearly mentioned
- Staff not competent for operating fire extinguisher and what to do in case of fire
- Radiologist not available in the facility.
- Non-availability of house- keeping staff and security staff.
- The staffs have not been provided required training / skill sets on radiation safety, infection control and hand hygiene, bio-medical waste management.
- Personal protective equipments not available
- Emergency Drug Tray not maintained
- Functional Dental X-Ray Machine not available
- Fixtures at lab not available
- No system of timely corrective break down maintenance of the equipments

- All the measuring equipments/ instrument not calibrated
- No system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due
- Operating instructions and factor charts not available with the equipments
- Fixers and developer not labelled appropriately
- Records for expiry and near expiry chemicals not maintained
- Department does not maintain stock and expenditure register of chemicals and X-ray films
- There was no stock out of x-ray films
- Warning light not provided outside X ray room
- Protective apron and gloves not provided to relative of the child patient who escort the child for X ray examination
- Lead apron and other protective equipments not available with radiation workers
- Temperature control and ventilation in dark room not maintained.
- The facility has no policy of removal of condemned junk material
- Power back up in Radiology and USG room not available
- X ray department does not have registration from AERB.
- X ray department does not have layout approval
- X ray department does not have type approval of equipment with QA test report for X ray machine
- Duplicate copy of Certificate of registration under Form B not displayed inside the department
- X ray department does not have Radiological safety officer (RSO) approved by competent authority
- Technician and support staff do not adhere to their respective dress code
- The facility does not have disaster management plan in place
- No procedure for handling medico legal cases
- Instructions to be followed by patient for USG not displayed in local language at reception
- X ray taking and processing procedure not readily available at work station and staff not aware of it
- Necessary Instruction for taking X ray and its processing not displayed at work station in language understood by staff
- Necessary Instruction for USG Examination not displayed at work station in language understood by staff
- No provision of periodic medical checkups and immunization of staff
- No regular monitoring of infection control practices
- Hand washing Facility at Point of Use not available
- Alcohol based Hand rub not available
- Hand washing Instruction at Point of Use not displayed.
- Non-adherence to 6 steps of Hand washing
- Facility does not ensure adequate personal protection equipments as per requirements
- Staff do not adhere to standard personal protection practices
- Facility does not ensure standard practices and materials for decontamination and cleaning of instruments and procedures areas
- Staff is trained for spill management
- Cleaning of patient care area not done with detergent solution
- Staff not trained for preparing cleaning solution as per standard procedure
- Standard practice of mopping and scrubbing not followed
- Cleaning equipments like broom not used in patient care areas

- Facility does not ensure segregation of Bio Medical Waste as per guidelines
- Facility does not ensure transportation and disposal of waste as per guidelines
- No designated departmental nodal person for coordinating Quality Assurance activities
- No system to take feedback from clinician about quality of services
- Patient satisfaction survey not done on monthly basis
- Internal quality Assurance program not established in Radiology
- Departmental checklist not used for monitoring and quality assurance
- Staff not designated for filling and monitoring of these checklists
- Standard operating procedure for department has not been prepared and approved
- 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).
- Staff not aware of relevant part of SOPs
- Work Instructions not displayed for radiation safety
- Process mapping of critical processes not done
- Non value adding activities not identified
- Processes not rearranged as per requirement
- Internal assessment not done at periodic interval
- Non Compliance neither enumerated nor recorded
- Action plan not made on the gaps found in the assessment / audit process
- Corrective and preventive actions not taken to address issues, observed in the assessment & audit
- Quality objectives for Radiology not defined
- Staff not aware of quality policy and objectives
- Quality objectives not monitored and reviewed periodically
- Facility does not use any method for quality improvement in services
- Facility does not use any tools for quality improvement in services
- Facility does not measure productivity Indicators on monthly basis (X ray done per 1000 OPD patient, X ray done per 1000 IPD patient, Ultrasound done per 1000 OPD patient, Proportion of X ray done at night, No. of dental X ray per 1000 dental OPD)
- The Facility does not measure equity indicators periodically (Proportion of BPL Patients screened)
- Facility does not measure efficiency Indicators on monthly basis (Downtime for critical equipments, turn-around time for X-Ray film development, Proportion of waste of films, Proportion of X ray rejected/repeated, X ray done per radiographer)
- Facility does not measure Clinical Care & Safety Indicators on monthly basis (Proportion of X rays for which report is signed by radiologist, Proportion of scans for which F form is filled out of pregnant women scanned, Examination Demography, Report correlation rate, No of adverse events per thousand patients, No of events of over limit of radiation exposure)

- Facility does not measure Service Quality Indicators on monthly basis (Average waiting time at radiology, Average waiting time at USG, Number of stock out incidences of x ray films).

9. Pharmacy

Pharmacy Department Score Card		
	Pharmacy department Score	**41.92**
	Area of Concern wise Score	
A	Service Provision	**70.83**
B	Patient Rights	**50**
C	Inputs	**54.46**
D	Support Services	**54.61**
E	Clinical Services	**46.87**
F	Infection Control	**28.57**
G	Quality Management	**2.56**
H	Outcome	**0**

Gaps:

- Generic Drug store not operational 24X7
- The facility does not provides services under National Leprosy Eradication Programme as per guidelines
- The facility does not provides services under National AIDS Control Programme as per guidelines
- The facility does not have a uniform and user-friendly signage system.
- Directional signage's not displayed in hospital for easy access to Pharmacy/Generic drug store.
- List of Drugs not available displayed at Pharmacy.
- Status of availability of drugs not updated daily
- Timing for dispensing counter of pharmacy not displayed
- Separate Queue for Male and female not available at dispensing counter
- Complaint box and display of process for grievance re addressal and whom to contact not displayed
- Patient party incurred expenditure on purchasing drugs or consumables from outside.
- No Local purchase of stock out drugs; No reimbursement of expenditure to the beneficiaries.
- Pharmacy does not have patient sitting arrangement as per requirement
- No demarcated area of keeping near expiry drugs
- Functional telephone and Intercom Services not available
- Non structural components not properly secured
- Stabilizer not provided for cold chain room
- Windows of drug store do not have wire meshwork
- Pharmacy has no plan for safe storage and handling of potentially flammable materials.
- Fire exits not visible and routes to reach exit not clearly marked.
- Pharmacy has not installed fire Extinguisher that is Class A , Class B C type or ABC type
- Expiry date for fire extinguishers not displayed on extinguisher, due date for next refilling not mentioned
- Staff not competent for operating fire extinguisher and what to do in case of fire
- Security staff not available
- Staffs have not been provided required training / skill sets on inventory management, rational use of drugs, prescription audit.
- Staff not skilled for maintaining bin cards
- The facility has not established system for maintenance of critical Equipment
- No system of timely corrective break down maintenance of the equipments
- All the measuring equipments/ instrument not calibrated
- Operating instructions for ILR/ Deep Freezers not available at cold chain room

- Staff not trained to forecast the requirement using scientific system
- Sound alike and look alike medicines not stored separately in patient care area and pharmacy
- No separate shelf /rack for storage near expiry drugs.
- Drug store and pharmacy has no system of inventory Management
- No system of periodic random quality testing of drugs
- Physical verification of inventory not done periodically
- Facility does not use bin card system
- Reorder level not defined for each category of drugs
- Drug store does not have inventory management software
- Drugs not categorized in Vital, Essential and Desirable
- ILR and deep freezer has no functional alarm system
- Staff not aware of Hold over time of cold storage equipments
- Narcotic medicines not kept in double lock
- Empty ampoules/strips not returned along with narcotic administration detail sheet
- Hospital has no system to discard the expired narcotic drugs.
- Facility does not maintain the list of narcotic and psychotropic drugs available at facility
- No security arrangement at pharmacy
- The facility has no policy of removal of condemned junk material
- No license for storing spirit
- Pharmacist do not adhere to their respective dress code
- No procedure to monitor the quality and adequacy of outsourced services on regular basis
- No system of conducting periodic prescription audit to ensure that only generic drugs are prescribed
- No procedure of rational use of drugs
- Standard Formats (Bin Cards) not available
- Pharmacy records not indexed
- The facility does not have disaster management plan in place.
- No provision of periodic medical checkups and immunization of staff
- Facility has not defined and established antibiotic policy
- Facility does not ensure segregation of bio medical waste as per guidelines.
- Facility does not ensure transportation and disposal of waste as per guidelines.
- No designated departmental nodal person for coordinating Quality Assurance activities
- Patient satisfaction survey not done on monthly basis
- Periodic and random sampling of the drugs for Quality Assurance not done
- Departmental checklist not used for monitoring and quality assurance
- Staff not designated for filling and monitoring of these checklists
- Standard operating procedure for department has not been prepared and approved
- Department has no documented procedure for indent of drugs and items from district drug warehouse, local purchase of drugs/ generic drug stores, reception of drugs and items, storage of drugs, disposal of expired drugs, dispensing of medicines at Pharmacy, indenting the drugs to patient care area, issue of the drugs in emergency condition, maintenance of temperature of ILR/Deep freezer /refrigerators, maintaining near expiry drugs at store and pharmacy, rational use of drugs and prescription audit, storage of narcotic and psychotropic drugs, periodic random check and quality testing of drugs.
- Work instruction/clinical protocols not displayed
- Process mapping of critical processes not done
- Non value adding activities not identified
- Processes not rearranged as per requirement

- Internal assessment not done at periodic interval
- The facility does not conduct periodic prescription audit
- Action plan not made on the gaps found in the assessment / audit process
- Corrective and preventive actions not taken to address issues, observed in the assessment & audit
- Quality objectives for Pharmacy not defined
- Staff not aware of quality policy and objectives
- Quality objectives not monitored and reviewed periodically
- Facility does not use method for quality improvement in services
- Facility does not use tools for quality improvement in services
- Facility does not measure productivity indicators on monthly basis (Percentage of drugs available against essential drug list for OPD, Percentage of drugs available against essential drug list for IPD)
- The Facility does not measure equity indicators periodically (Expenditure on drugs procured through local purchase for BPL patient)
- Facility does not measure efficiency Indicators on monthly basis (Number of stock out situations in Vital category medicines, Turn Around time for dispensing medicine at Pharmacy, % of drugs expired during the months)
- Facility does not measure Clinical Care & Safety Indicators on monthly basis (Proportion of prescription found prescribing non generic drugs, No of adverse drug reaction per thousand patients, Antibiotic rate, Percentage of irrational use of drugs/over prescription)
- Facility does not measure Service Quality Indicators on monthly basis (Waiting time for Pharmacy Counter)

10. Auxiliary Services

Gaps

- Security services not available 24 X7
- Housekeeping services not available 24X7
- Maintenance services not available 24X7
- Medical record department not available
- Departmental signage for support service department not available
- Complaint box not available and process for grievance re addressal and whom to contact not displayed
- Laundry Department does not have adequate space as per requirement

Auxiliary Score Card		
	Auxiliary Score	**31.69**
	Area of Concern wise Score	
A	Service Provision	**53.33**
B	Patient Rights	**68.75**
C	Inputs	**27.38**
D	Support Services	**50.81**
E	Clinical Services	**65.62**
F	Infection Control	**31.25**
G	Quality Management	**2.58**
H	Outcome	**0**

- Dietary department does not have demarcated and dedicated area for various activities (Layout as per functional flow that is receipt, storage, daily storage, preparation, Cooking area ,Service area, dish washing area, Garbage collection area and administrative area)
- Support services department not connected with intercom.
- Non structural components not properly secured
- Support services departments have a few temporary connections and loosely hanging wires
- Equipments in wet areas like Laundry and Kitchen not equipped with ground fault protection and not designed for wet conditions

- Floors of the Support services slippery
- Building does not have sufficient fire exit to permit safe escape to its occupant at time of fire
- Fire exits not clearly visible and routes to reach exit not marked.
- Dietary Department does not have a plan for safe storage and handling of potentially flammable materials.
- Support services have not installed fire Extinguisher (Class A , Class B C type or ABC type) in adequate number at every strategic points
- Expiry date for fire extinguishers not displayed on any extinguisher; as well as due date for next refilling not clearly mentioned.
- Staff not competent for operating fire extinguisher and what to do in case of fire
- Non-availability of Dietician, MRD technician, data entry operator for MRD.
- Staffs have not been provided required training / skill sets on biomedical waste management, infection control management and medical record management.
- MRD staff not skilled for indexing and storage of medical records.
- Laundry staff not skilled for segregating and processing of soiled and infectious linen.
- Consumables at dietary department (Cap, gowns, gloves, soap for hand washing) not available
- Consumables at laundry department (Detergent and disinfectant, Heavy utility gloves, apron) not available
- Equipments & utensils for Dietary department (Refrigerator, food trolley) not available.
- Equipments for Laundry (Washing machine, drier, iron, separate trolley for clean and dirty linen) not available.
- Furniture and fixtures for laundry department (stand/ hanger for drying of linen, iron table, cupboard) not available.
- Facility has not established system for maintenance of critical Equipment.
- No system of timely corrective break down maintenance of the equipments
- Up to date instructions for operation and maintenance of equipments not available with staff.
- Hospital does not ensure unauthorised entry into dietary department.
- Toilets were not clean, without functional flush.
- Hospital infrastructure not adequately maintained (Window panes , doors and other fixtures not intact)
- The facility has no policy of removal of condemned junk material
- Power back up not available.
- Perishable items not stored in the cold room or refrigerators.
- Distribution of the food not done in covered food trolleys
- Dietary department has no system to check the quality of food provided to patient
- No practice of calculating and maintaining buffer stock in Kitchen
- Department does not maintain stock and expenditure register in Kitchen
- No system to replenish raw food material
- Hospital/ department does not have inventory of total linen available with category wise distribution in every area
- Linen department has no system for periodic physical verification of linen inventory
- Linen department has no separate trolley for distribution of clean linen and collection of dirty linen
- Linen not transported into closed leak proof containers /bags
- Linen department has no system of sorting of different category of linen before putting in to washing machine
- No fix time for collection for dirty linen and supply of clean linen
- No system for verifying the quantity of linen received
- No procedure for condemnation of linen.

- No system to check pilferage of linen from ward
- No designated in charge for MRD department
- All register/records not numbered
- Medical record department has no system for ICD coding /indexing the records
- Medical record department has no system to generate statistics for administrative use
- The facility does not have disaster management plan in place
- No provision of periodic medical checkups and immunization of staff
- No regular monitoring of infection control practices
- Hand washing Instruction at Point of Use not displayed
- Non- adherence to 6 steps of Hand washing
- Facility does not ensure adequate personal protection equipments as per requirements
- Facility does not ensure standard practices and materials for decontamination and cleaning of instruments and procedures areas
- Facility layout does not ensure separation of routes for clean and dirty items in kitchen
- Facility layout does not ensure separation of routes for clean and dirty items in laundry.
- Staff not trained for spill management
- Staff not trained for preparing cleaning solution as per standard procedure
- Standard practice of mopping and scrubbing not followed
- Cleaning of patient care area not done with detergent solution
- Cleaning equipments like broom used in patient care areas
- Surface & fixtures with dust
- Facility does not ensure segregation of Bio Medical Waste as per guidelines
- Facility does not ensure management of sharps as per guidelines
- Staff not aware of what to do in condition of needle stick injury
- Disinfection of liquid waste not done before disposal
- No designated departmental nodal person for coordinating Quality Assurance activities
- Hospital does not have a system to take feed-back regarding quality of diet in documented format. (It is taken verbally)
- Hospital does not have a system to take feed-back regarding cleanliness of linen provided.
- Facility has not established external assurance programs at relevant departments (Kitchen does not have a system of regular external inspection by Municipal/ FDA authorities)
- Departmental checklist not used for monitoring and quality assurance
- Staff not designated for filling and monitoring of these checklists
- Departmental standard operating procedures not available.
- Standard operating procedure for Dietary department has not been prepared and approved
- Standard operating procedure for Laundry Department has not been prepared and approved
- Standard operating procedure for Medical record Department has not been prepared and approved
- Record Department has no documented procedure for indexing of the records, receiving, compiling, and maintaining records, issuing of the records, retention of records, pest and rodent control, diet schedule, calculation of diet required in wards, procurement of food items, preparation and distribution of food, check the quality of food provided to the patient, disposal of remaining food, cleaning of kitchen and utensils, checkups of kitchen workers at defined intervals, collection, sorting and cleaning of linen, sluicing of the blood/ body fluid stained linen, distribution of linen in all patient care area, physical verification of the linen for cleanliness or torn out, condemnation of linen, corrective and preventive maintenance of laundry equipments, duty hours, control of incoming and outgoing items, visiting hours in patient care area, fire safety in hospital, electrical safety, training and drills of security staff.
- Staff not trained and aware of the standard procedures

- Work instructions are displayed at Point of use
- Process mapping of critical processes not done
- Non value adding activities not identified
- Processes are rearranged as per requirement
- Internal assessment not done at periodic interval
- The facility does not conduct periodic prescription/ medical/death audits
- Non Compliance neither enumerated nor recorded
- Action plan not made on the gaps found in the assessment / audit process
- Corrective and preventive action not taken
- The facility does not define its quality objectives periodically and key departments do not have their own objectives
- Quality objectives not monitored and reviewed periodically
- Facility does not use any method for quality improvement in services (PDCA, 5S)
- Facility does not use tools for quality improvement in services (6 basic tools of Quality)
- Facility does measures productivity Indicators on monthly basis (no of cases for which medical audit done, no of cases for which death audit is done, linen index, diet index)
- Facility does not measure efficiency indicators on monthly basis (cycle for laundry services, proportion of special diets)
- Facility does not measure clinical care & safety indicators on monthly basis (Medical Audit Score, Death Audit Score)
- Facility measures Service Quality Indicators on monthly basis (waiting time for getting handicap certificate, waiting time for getting death certificate, patient feedback on cleanliness of linen, patient feedback on quality of food)

11. General Administration

General Administration Score Card		
	General administration department Score	**35.79**
	Area of Concern wise Score	
A	Service Provision	**54.54**
B	Patient Rights	**39.47**
C	Inputs	**45.41**
D	Support Services	**47.98**
E	Clinical Services	**62.06**
F	Infection Control	**12.28**
G	Quality Management	**0**
H	Outcome	**0**

Gaps:

- Functional disaster management unit, Intensive care unit, SNCU, NRC , District Early Intervention Centre (DEIC), CT scan, District Apex Group, ART centre, geriatric ward/Clinic, CCU not available
- Hospital does not have a System for immediate reporting of any disease out-break authorities
- Security services not available
- Medical record services not available
- 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 user friendly and pictorial
- Services not available 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, Complaints and Grievances Mechanism, Mention of Services available on payment if any, person and place avail Information and assistance, Cycle time for Critical Processes.
- Facility has not prepared a comprehensive list of user charges and display at strategic point in the hospital
- Dedicated facilitation counter/rogi sahayata kendra not available
- Information regarding services not available at the counter
- Important contact no not available at the counter
- ASHA help desk not available
- Hospital has not defined policy for non discrimination according to gender
- Hospital has not defined policy to ensure the religious and cultural preferences of the patient
- Hospital has not defined policy to provide barrier free services to patient
- Ramps not provided with slip resistance surface
- Warning blocks have not been provide at beginning and end of the ramp and Stairs
- Facility does not conduct periodic Access Audits
- Hospital has not 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 has not defined policy for ensuring non discrimination on basis of social and economic status of the patient
- No linkages for care , Counselling and Protection of Victims of Violence including domestic violence
- No arrangements for adequate care and post discharge support of Orphan patients including homeless children
- Hospital has not defined policy for maintenance of privacy of patients
- Hospital has not defined the policy for privacy and confidentiality of the patient and condition related with social stigma and vulnerable groups
- Hospital has not defined policy for taking consent.
- Patient rights and responsibilities not displayed
- Staff not regularly sensitized about rights and responsibilities of the patient
- Hospital has not defined policy for grievance redressal mechanism
- No system of periodic review of patient complaints
- No evidence of action taken on complaints
- Action taken not informed to the complainant
- Hospital has not established policy for timely Reimbursement and payment to beneficiaries
- Public toilet for visitors not available
- Dharmshala/stay facility for attendants not available
- No separate cafeteria for patient and their relatives
- No cafeteria/ Recreation room for staff
- Facility does not maintain open area as per floor area ratio mandated by authorities
- No designated person to answer the telephone enquiries
- The facility has not ensured the seismic safety of the infrastructure
- The facility has not ensured safety of lifts and lifts have required certificate from the designated bodies/ board
- The facility has not ensured safety of electrical establishment
- The facility has no plan for prevention of fire

- The facility does not have adequate fire fighting Equipment
- The facility has no system of periodic training of staff , does not conduct mock drills regularly for fire and other disaster situation
- Audiometrician , Dietician, Physiotherapist , Dental Technician , Rehabilitation Therapist , Biomedical Engineer not available
- Facility does not conduct training need assessment periodically for all cadre of staff
- Facility does not have program for continuous medical education for doctors and nursing staff
- Facility has not prepared training calendar as per training need assessment
- Training feedback not taken and records not maintained for training
- Details and Records of training provided not available with unit
- No training on Disaster Management, Cardio Pulmonary resuscitation, staff Safety, Measuring Hospital Performance Indicators, facility level Quality Assurance.
- Hospital has no policy for regular competence testing as per job description.
- Equipments for Facility management not available
- No system to maintain records of down time of equipments
- No system of timely corrective break down maintenance of the for computers and other IT equipments
- Facility does not have contracted agency for calibration of equipments.
- Records of the calibrated equipments not maintained
- Hospital has not implemented scientific inventory management system according to their needs
- Hospital has no policy that there is no stock out of the drugs and consumables at patient care area
- Hospital has no policy for ensuring proper management and restriction of unintended use of narcotic substance and psychotropic drugs as per prevalent law
- Hospital does not periodically measure illumination at different area of the hospitals
- No restriction on entry of vendors and hawkers inside the premise of the hospital
- Hospital does not have visitor policy in place
- Hospital has no policy for restriction of media person inside the hospital
- The facility does not have security system in place at patient care areas
- Staff have not been provided awareness training on Gender issues
- Every department does not have Schedule of cleaning
- Facility does not have a closed drainage system
- Facility does not have an annual maintenance plan for its infrastructure
- Hospital does not have rain water harvesting facility
- Hospital does not have condemnation policy in place
- Hospital has not designated covered place to keep junk/condemned material
- The facility has no policy of removal of condemned junk material
- Pest control measures not evident at facility
- Hospitals does not periodically test the quality of water from the source (municipal supply, bore well etc) for bacterial and chemical content
- RO/ Filters not available for potable drinking water
- Estimation of power consumption of different department of hospitals not done
- Hospital does not have dedicated sub-station for electrical supply
- Hospital has no policy to change linen
- Income tax exemption certificate for donations not available
- Community based monitoring/social audits not done at periodic intervals
- Facility does not communicate updated information on Quality of services
- Facility does not conduct public hearing at regular intervals
- Salaries and compensation not provided to contractual staff on time

- Facility does not provide utilization certificate for funds on time
- The facility does not have requisite licences and certificates for operation of hospital and different activities
- Updated copies of relevant laws, regulations and government orders not available at the facility
- The facility does not ensure the adherence to dress code as mandated by its administration / the health department
- No established system for contract management for out sourced services
- No system of periodic review of quality of outsourced services
- Hospital has no policy for patient hand over during shift change
- Facility has no policy and enabling order for prescribing drugs in generic drug only
- No procedure of rational use of drugs
- Hospital has no policy for retention period for different kinds of records
- Hospital has no policy for safe disposal of records
- The facility does not have disaster management plan in place
- Facility does not have functional infection control committee
- Facility has no provision for Passive and active culture surveillance of critical & high risk areas
- Facility does not measure hospital associated infection rates
- No provision of Periodic Medical Checkups and immunization of staff
- Facility does not have established procedures for regular monitoring of infection control practices
- Facility has not defined and established antibiotic policy
- Facility does not ensure adequate personal protection equipments as per requirements
- No policy for judicious use of personal protective equipments specially sterile gloves
- Staff not trained for preparation of disinfectant solution
- Facility does not ensure adequate and regular supply of colour coded liners
- No system for reporting of needle stick injuries
- Facility does not have secured designated place for storage of Bio Medical waste before disposal
- Facility does not ensure transportation and disposal of waste as per guidelines
- The facility does not have quality team in place
- Patient Satisfaction surveys not conducted at periodic intervals
- Facility does not analyse the patient feedback and root cause analysis not done
- Facility does not prepare the action plans for the areas of low satisfaction
- Facility has not established internal quality assurance program at relevant departments
- Facility has not established external assurance programs at relevant departments
- Facility has not established system for use of check lists in different departments and services
- Hospital has no documented Quality system manual
- Hospital has no Records of distribution of Standard operating procedure
- Hospital has no system for periodic review of the standard procedures
- 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.

Mortuary Department Score Card		
	Mortuary department Score	**36.95**
	Area of Concern wise Score	
A	Service Provision	**70.0**
B	Patient Rights	**63.63**
C	Inputs	**46.34**
D	Support Services	**43.33**
E	Clinical Services	**50.0**
F	Infection Control	**39.53**
G	Quality Management	**0**
H	Outcome	**0**

Gaps:

- No facility for pathological post mortem
- No uniform and user-friendly signage system. Restricted area signage not displayed.
- Patient amenities (adequate waiting area, seating arrangement) not provided.
- Departments does not have layout and demarcated areas as per functions
- Cold room not available.
- Deep freezer for storage as per load not available. Bodies are kept on floor in a separate room.
- Access way connected from hospital to mortuary is not covered.
- Department does not ensures safety of electrical establishment
- Fire extinguishers not installed
- No security arrangement.
- All staffs except few were not trained on infection control, biomedical waste management etc.
- Marble slab is used as a post mortem table. No attached outlet to drain the waste water after cleaning the table.
- 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, cupboard, counter for delivery of reports, table for preparation of reports chair not available
- No established procedure to provide identification tag/wrist band to the body.
- 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

- 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 (documented procedure for death in ward and emergency, documented procedure for storage of the body in mortuary, documented procedure for temperature maintenance in cold store, documented procedure for corrective and preventive maintenance of cold stores, documented procedure for tagging of the dead bodies, documented procedure for maintenance of records, documented procedure sending the bodies for autopsy, documented procedure for hand over the body to deceased relatives, documented procedure for storage and send the viscera/tissue for further investigation, documented procedure for cleaning and upkeep of mortuary and post mortem room)
- The facility does not measure all the productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.

13. Operation Theatre

The Major OT (2 tables) of Belonia SDH is located on first floor of new building having preparation room, Operation theatre, scrub area, NBCC, post-operative room. One Minor OT is also available in ground floor for tubal ligation cases. A separate eye OT is also available, used only for camps.

Operation Theatre Score Card		
	Operation Theatre Score	**52.56**
	Area of Concern wise Score	
A	Service Provision	**34.21**
B	Patient Rights	**62.5**
C	Inputs	**62.92**
D	Support Services	**48.21**
E	Clinical Services	**75.86**
F	Infection Control	**51.85**
G	Quality Management	**2.94**
H	Outcome	**10.0**

Gaps-

- No provision for General surgery, Paediatric surgery, ENT surgeries, Orthopaedic surgery, Oral surgery as the specialists are not available. In gynaecology, only LSCS is done.
- OT services not available 24x7.
- Point of care diagnostic facility (Blood gas, Blood glucose, Rapid HIV testing), C-arm services not available.
- The facility doesn't provide services under National Leprosy Eradication Programme – facility for reconstructive surgery, amputation surgery.
- Internal sectional signages, restricted area signage, doctor/nurses on duty list, OT schedule not displayed.
- Different zones of OT were not marked.
- Screen between two tables not available.
- No grievance redressal mechanism.
- Sometimes patients need to spend on drugs, consumables & diagnostics (whatever services are not available in the facility or items not in the stock)
- Pre-operative room, store room not available. A separate autoclave room is available located outside Operation theatre, adjacent to post-operative room but the room is very compact. There is no space for keeping sterile and unsterile items separately, no racks available. Dirty

utility area is also not available. All the dirty linens are washed in bathroom attached to post-operative room.

- No intercom services.
- Cris cross of infectious & sterile goods as the same corridor is used to carry sterile items & dirty linen.
- Non structural components eg, fixtures and furniture like cupboards, cabinets, and heavy equipments, hanging objects are not properly fastened and secured.
- Joint less tiles were not used to cover wall & floor of the OT. All the windows/ventilators in the OT were not found sealed.
- No fire safety measures (fire extinguisher not placed, fire exit plan not available, trained staffs) taken in the department.
- No security arrangement.
- The staffs were not provided required training such as advance life support, OT management, Infection control & hygiene, biomedical waste management, patient safety.
- Oxytocin was not available in the stock during visit. Stock out incidences of anaesthetic agents was also observed sometimes. Patient need to purchase from outside if required.
- Emergency drug tray was maintained in the OT but only few medicines were kept. All the required emergency drugs and other items were not arranged. No standardised list for items to be kept in emergency tray.
- Point of care diagnostic instruments (Portable X-ray, Glucometer, HIV rapid diagnostic kit, Blood gas analyzer, ultrasound) were not available in the department.
- Paediatric resuscitation equipment was also not available.
- The facility does not have any system for inspection, testing, maintenance and calibration of equipment. Annual Maintenance Contract/Comprehensive Maintenance Contract for all equipments not available. No system for labelling of defective/out of order equipment & store separately.
- Empty and filled cylinders were not labelled. Expiry/near expiry record of drugs not maintained in the department. No drug expenditure record maintained.
- Provision of warning light outside OT is available but it's not used.
- Temperature and humidity level of OT not maintained and records of the same were also not seen.
- No security staff available.
- Seepage, cobwebs, dust etc was observed in some of the areas of OT complex even in OT. Housekeeping need to be improved. There was an opening observed in the ceiling of NBCC area.
- No provision for centralized /local piped Oxygen, nitrogen and vacuum supply. Oxygen cylinders are used.
- Drugs were not prescribed under generic name only as evident from patient records.
- Relevant standard treatment guidelines were not available at the point of use.
- High alert drugs are not identified in the department.
- Every medical advice and procedure is accompanied with date and signature but time not mentioned.
- Complete details of clinical assessment and re assessment were not recorded properly in the BHT. Operation note, anaesthesia note was not recorded for some of the cases as evident from BHT.
- Consent is not taken before blood transfusion.
- No surgical safety check list available to prepare the patient before surgery.
- Staffs were not aware of any disaster plan & their responsibilities in case of disaster.

- Anaesthesia note were not written on patient BHT. During anaesthesia, although patient vitals are monitored but not recorded. No note on post anaesthesia status found.
- APGAR score not maintained for babies.
- The facility doesn't have any infection control program in place for prevention and measurement of hospital associated infection (no swab culture test done, no periodic medical checkup & immunization of staffs, no hospital antibiotic policy, no monitoring of hospital associated infection rate, no monitoring of infection control practices etc.)
- Hand washing instruction (six steps of hand washing - preferably in local language) above the sink was not found displayed. Staffs need to strictly adhere to six steps of hand washing & surgical scrub method.
- Elbow operated tap not available.
- Personal protective kit for infectious patients was not available.
- Record of autoclaving not maintained properly. Loading time, unloading time, temperature, pressure, items etc. need to be mentioned in the record.
- 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) not followed. Brooms were used for cleaning in patient care areas. Three bucket system mopping not followed anywhere in the facility.
- Standard protocol for proper disinfection of operating surfaces/furniture etc need to be followed.
- Biomedical waste management need to be improved (Proper segregation, adhering to color coding – bins as well as bags, display of work instruction for segregation and handling of biomedical waste, disinfection of sharps as per guideline, disinfection of liquid waste, transportation of wastes in covered trolley, make staffs 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 scheduling the surgery and its booking, documented procedure for pre operative procedure, documented procedure for pre operative anaesthetic check up, documented procedure for in process check during surgery, documented procedure for post operative care of the patient, documented procedure for operation theatre asepsis and environment management, documented procedure for OT documentation, documented procedure for reception of dirt packs and issue of sterile packs from TSSU, documented procedure for maintenance & calibration of equipments, documented procedure for general cleaning of OT and annexes.)
- The facility doesn't have established system of periodic review as internal assessment, audit and to take corrective and preventive action to fulfill the gaps observed during assessment.
- Quality policy and quality objectives are not defined.
- The facility does not measure any productivity indicator, efficiency indicator, clinical care & safety indicator & service quality indicators.
-

14. Post partum unit

The hospital doesn't have a dedicated post partum unit. Days for family planning surgeries are fixed. The surgeries and IUCD insertion etc is done in FP OT & Labour room respectively.

Gaps-

- Tubectomy not done.
- No dedicated post partum ward for FP surgeries & abortion clients.
- Compensation for family planning indemnity scheme not displayed.
- Informed consent form for IUD insertion was not available.
- IEC on reproductive rights of clients not displayed.
- Zoning of FP OT was not demarcated.
- Staffs not trained for Laparoscopic surgery/Mini lap.
- No FP counsellor available.
- Emergency contraceptive pills were not in stock.
- Proper decontamination of instruments & operating/procedure surfaces to be ensured.
- Standard operating procedures not available (documented procedure for registration, admission and discharge, documented procedure for initial assessment of the patient, documented procedure for providing appointment/day and date for the surgery, documented procedure for preparation of patient for surgery, documented procedure for IUD insertion, documented procedure for taking consent of the patient for procedure, documented procedure for record maintenance, documented procedure for counselling of the patient, manual for male and female sterilization, manual for Quality assurance for sterilization, standard for various technique of contraception, standard IEC material for patient education and counselling)

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. Internal & external quality assurance should be implemented throughout the hospital.
4. 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.
5. 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.
6. Basic amenities for patients' attendants should be provided such as shaded waiting area, proper sitting arrangements, drinking water facility, separate toilet etc.
7. 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.)
8. 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.
9. Infection control practices to be implemented throughout the hospital and monitoring should be done at regular interval by hospital authority.
10. Provision of periodic medical check-up and immunization of the staff should be made available.
11. Patient satisfaction survey should be conducted at periodic intervals.
12. 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.
13. Condemnation policy should be made and condemned items should be removed from departments.
14. Disinfection of furniture, accessories, instruments & equipments should be done as per the standard protocol.
15. Key performance indicators should be maintained & monitored on monthly basis.