NABH: A GAP ANALYSIS OF PROCESS OF ACCREDITATION

By

NISHANT LAXKAR

Dissertation submitted for the partial fulfillment of the
MBA Hospital and Health Management

Academic year, 2016-2018

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

NABH: A GAP ANALYSIS OF PROCESS OF ACCREDITATION

By

NISHANT LAXKAR

Dissertation submitted for the partial fulfillment of the
MBA Hospital and Health Management

Academic year, 2016-2018

Jeevan Rekha Hospital, Jagatpura, Jaipur, Rajasthan

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

TO WHOMSOEVER MAY CONCERN

This is to certify that Nishant Laxkar, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at JEVEEN REKHA HOSPITAL, Jaipur from 20-02-2019 to 21-05-2019.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dr. P. R. Sodani
Pro-president
The IIHMR University, Jaipur

Asso. Professor
30.5.19
The IIHMR University, Jaipur

JEEVAN REKHA
SUPERSPECIALITY

जीवन रेखा
Critical Care and Trauma Hospital
Research and Training Institute, Jaipur
(A Unit of Dr. M.N. Tandon Memorial Charitable Trust)

Date: - 21.05.2019

WHOM SO EVER IT MAY CONCERN

This is to certify that Mr. Nishant Laxkar student of The IIHMR University, JAIPUR has successfully completed his training in our hospital, under the supervision of Ms.Vijay Shree. He has undertaken a project AN EVAULATION OF THE APPROPRIATENESS OF AMBULANCE RESPONSES IN JEEVAN REKHA CRITAICAL CARE & TRAUMA HOSPITAL, JAIPUR. The period of his involvement in the aforesaid project was from 20th February to 21st May 2019.

We wish him all the best in his future endeavors.

Manager Human Resources

Jeevan Rekha Superspeciality, Jeevan Rekha Critical Care & Trauma Hospital,
S-24, Jeevan Rekha Marg, Central Spine, Mahal Yojna, Near Akshay Patra, Jagatpura, Jaipur - 302025
Ph.: 0141-5155050, 2988288 • Mob. : 8003399996, Email - info.jrsh@gmail.com • web : www.jrsh.co.in

ACKNOWLEDGEMENT

For the writing of this report, I owe a debt to my predecessors, professors, friends & all the staff of Jeveen Rekha Hospital. My deep appreciation goes to them. I happily share the credit of the report with all these.

My special vote of thanks to VIJAY SHREE (Head HR) who gave me the opportunity to pursue my dissertation in Jeevan Rekha Hospital. I consider myself fortunate to work under DIWANSHU SIR (Hospital Administrator). He gave enormous encouragement and support for my research work. He extended valuable guidance which helped me to gain newer insights for my study.

I would also like to mention here that this study would not have been possible without the support of my mentor **Dr. Mohan Bairwa.** Under his guidance and motivation, I was able to conduct my study. I am thankful for all the support provided.

INTRODUCTION

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

Accreditation is self-assessment and external peer review process used by the healthcare organizations to accurately assess their level of performance in relation established standards and to implement ways to continuously improve the healthcare system

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

INDEX

Executive Summary

Accreditation is a versatile tool to ensure equity in delivering of healthcare services and in-turn meeting the increasing aspirations of people. Given the vast differences in availability of resources to haves and have not, Private vs. Public, North vs. South, healthcare delivery available to the less fortunate is likely to be adversely affected.

Hence, the demands of good governance dictate that the core values of health care service delivery are equitable regardless whether services are provided to a prince or pauper. This ideal state of affair can be achieved by the institution of a quality management system that focuses on compliance with the Accreditation standards of Entry Level **NABH.** The standards for compliance are dynamic and seek to raise the bar continually; as well as to remain contemporary and applicable to the situation obtaining in a region.

The Jeevan Rekha Hospital ,Jaipur has taken a step in the right direction to ensure that the Hospital performs their designated and sustainable role in the community in delivering of quality service to the people.

The Consultants, Jaipur shall put all efforts to see to it that Jeevan Rekha Hospital ,Jaipur complies with the Accreditation standards of the NABH.

To conclude, the actions to be taken for compliance with the Accreditation standards of NABH at Jeevan Rekha Hospital ,Jaipur are likely to impact the delivery of healthcare services positively, ensuring quality services, efficient outcomes with economy, risk management with patients, staff and visitors safety and above all equity in healthcare services for all the citizens.

AIM & OBJECTIVES

AIM:

To ensure Jeevan Rekha Hospital ,Jaipur to accredited by the "National Accreditation Board" for Hospitals & Healthcare Providers "NABH"

OBJECTIVES:

a. The existing service delivery standards to assessed of the Jeevan Rekha Hospital ,Jaipur (Rajasthan)

b. To identify the baseline level of all quality indicators (Structure, Process and Outcome).

c. To propose alterations in the Structural designs of the facilities to meet its required requirement. Review of facilities including building and associated aspects i.e. "Fire fighting systems".

d. To lay down Standard Operating Procedures for various activities.

e. To Train the Key Personnel in these processes.

f. To review the Outcome.

g. To obtain NABH accreditation

TASKS:

- To perceive the existed level of healthcare delivery system by discussion with policy makers and senior officers and other stake holders.
- To review the secondary data type available – "Bed Occupancy Rate", "OPD Attendance", "No. of Discharges", "Average Length of Stay" etc.
- To have a sensitization workshop for policy makers and officials of the Surya Hospital, Jaipur.
- To suggest any basic minimal civil structural alteration, if required.
- To study the equipment and instrument functionality, maintenance and calibration of the same.
- To identify senior and potential trainers from within the facilities.
- To conduct training of trainers of various facilities.
- To assist in organizing Training Program for all personnel.
- To observe and analyse the effectiveness of such training by carrying out patient satisfaction survey, employee satisfaction surveys and hospital utilization rates coupled with analysing the healthcare service indicators.
- To assist to create signage, work instructions, manuals etc. necessary for the facilities.
- To facilitate carrying out internal audit as per NABH standards for the Hospital.
- To assist in carrying out the self assessment as per NABH standards.

- To assist in submitting application for the Accreditation.

INTRODUCTION

"Jeevan Rekha Superspeciality Hospital is basically resides in Jagatpura, Jaipur(rajasthan). The development of the institute reflects our commitment to filling the large gap that exists between demand and availability of Emergency and Critical Care Services in Rajasthan state in general and Jaipur in particular. Lethal road traffic accidents, Poisoning, Burns, epidemics like Malaria, Dengue, Scrub Typhus and Swine Flu in our state have become major killers. We resolve to serve the young, the old, the child, the neonate and a pregnant woman and all economic strata of the society. We are committed to providing such required modern medical and health services at most resonable cost. The services will be 24X7, by most handled trained doctors backed by motivated, which able nursing and other paramedical staff."

"Through the uninterrupted, training & research, we are aim to create the difference to outcome in those critically sick patients. The Adoption of the recent-most protocols, it adherence to international designs and recommendations reflects our hunger and desire to offer the best to people we serve."

a) "24 x 7 Dedicated services
b) 150 beds, world class facility
c) Medical professionals with international recognition
d) Green building
e) State of art equipment with advanced technology
f) Dedicated to all critical sicknesses of adults, neonates, pediatrics, obstetrics, trauma, surgical & burn patients
g) Hospital subscribes to 100% HAVC requirements, guidelines of ISCCM and international recommendations in terms of space per bed
h) Equipment installation for Level I critical care
i) Best patient safety norms
j) Encompasses 50000 Square feet space. It's intelligent framework
k) Allows optimization and utilization of space and resources
l) ICU on Wheels "The State of Art" Ambulances equipped with ventilator & multipara monitors
m) Well equipped modular OTs with laminar flow
n) Ideal for Neurosurgery, Joint Replacement & Advance Laparoscopic Surgeries
o) Research, teaching and training hub

Scope:

- To evaluate the following aspects at the Jeevan Rekha Hospital, Jaipur for their compliance with NABH standards:
  - Manpower
  - Equipment
  - Licenses
- To carry out a gap analysis between desired and existing level.
- To suggest recommendations for streamlining the processes.
- To assist the Jeevan Rekha Hospital, Jaipur in charting the further course of action which will lead to compliance with accreditation standards of the NABH and institutionalization of a quality management system, leading further to a continuous quality improvement plan.
- To plan the activities for action subsequent to the Gap analysis.

OBSERVATIONS, ANALYSIS, RECOMMENDATIONS:

- The observations are classified as follows:
  - Structural
    - Physical Facilities
    - Manpower
    - Equipment
    - Licenses
  - Processes
    - Policy and Procedures
  - Outcome
    - Secondary Data

SIGNAGE SYSTEM

There are number of signage showing the various departments and utilities like drinking water, toilets, different OPDs etc at appropriate places. It is recommended that the signage should be at least in bilingual i.e. English & local language (Hindi).

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)
Citizen Charter	NO	NO	NA
Mission	NO	NO	NA
Vision	NO	NO	NA
Patients Rights and Responsibilities	NO	NO	NA
Service Available	YES	NO	NA
Complaint Redressal box	NO	NO	NA
Tariff List	NO	NO	NA
Doctors list along with their Specialities and Qualifications	NO	NO	NA
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	NO	NO	NA
Biohazard Symbols	NO	NO	NO
Fire Exit Plan	NO	NO	NO
Floor Directory	NO	NO	NO
Departmental Signages	YES	NA	NA
Wash Rooms (Handicap)	YES	YES	NO
Toilets	YES	NO	NO
Ambulance Parking Area	NO	NO	NO
Drinking Water	YES	YES	NO
Health Education Related Signages (HIV & Immunization)	NO	NO	NO
SCOPE of Gynae Dept.	NO	NO	No
Scope of Pedia Dept.	NO	NO	NO

Statutory requirements:

Licenses	Status *(A / NA)	Available YES/NO
1. Building Permit (From the Municipality)./RENT Deed	A	TBC
2. No objection certificate from the Chief Fire officer.	A	TBC
3. License under Bio- medical Management and handling Rules, 1998.	A	TBC
4. No objection certificate under Pollution Control Act.	A	TBC
5. Income tax PAN.	A	TBC

6. Permit to operate lifts under the Lifts and escalators Act.	NA	NA
7. Narcotics and Psychotropic substances Act and License.	A	TBC
8. Sales Tax Registration certificate.	A	TBC
9. Vehicle registration certificates for Ambulances.	A	TBC
10. Retail drug license (Pharmacy)	A	TBC
11. Air (prevention and control of pollution) Act, 1981 and License	A	TBC
12. Radiation Protection Certificate in respect of X-Ray equipments from AERB	A	TBC

TBC- To be checked

A = Applicable

NA = Not Applicable

SERVICES & REQUIREMENTS:

GROUP A: CLINICAL SERVICES	
OBSTETRICS & GYNAECOLOGY	PEDIATRICS
CRITICAL CARE	NEONATOLOGY
INTENSIVE CARE UNIT	OUT PATIENT DEPARTMENT
GROUP B: CLINICAL SUPPORT SERVICES	
RADIOLOGY & IMAGING	LABORATORY
• USG	• HAEMATOLOGY
	• Biochemistry
DIETETICS & NUTRITION	• Serology
GROUP C: SUPPORT SERVICES	
1. MAINTENANCE	6. HOUSEKEEPING SERVICES
• CIVIL WORKS	7. GAS MANIFOLD ROOM
• WATER	8. PHARMACY & MEDICAL STORE
• ELECTRICITY	9. SECURITY
• AC	10. KITCHEN- OUTSOURCED
• LIFT	11. CSSD
2. LAUNDRY	12. CENTRAL STORE
3. BIOMEDICAL EQUIPMENT DEPARTMENT	13. BIOMEDICAL WASTE MANAGEMENT - OUTSOURCED
4. MEDICAL RECORDS	14. ADMISSION, REGISTRATION & DISCHARGE
5. AMBULANCE SERVICE- OUTSOURCED	

OUTPATIENT DEPARTMENT

The outpatient department block is located at 4th Floor. Drinking water facilities are available in all the OPD blocks. There are waiting areas for the patients in all OPD blocks. The doctors' name, their specialty, qualifications, are displayed in the form of signage.

IDENTIFIED GAPS

STRUCTURAL	• Citizen Charter, Patient rights & responsibilities and NABH signages were not displayed. • Scope of Paediatrics & High risk Obstetrics Care were not defined & displayed in bilingual. • Doctors' name, qualifications, speciality, OPD days & timings were not displayed in bilingual.. • OPD records are not being stored uniformly for future referral.
PROCESS	• No SOP available for the department. • Content of assessment for the outpatients are not defined. • No standardized format used for initial assessment of OPD patients as per NABH standards • Housekeeping services for the toilets needs strengthening. • Staffs are not uniformly aware of the services provided by the hospital.
OUTCOME	• Waiting time of OPD patients is not being monitored. • OPD utilization is not done. • Out patient satisfaction is not being carried out.

Recommendations:

- Citizen Charter, Patient Charter, Scope of Paediatrics & High Risk Obstetrics Care and other signages need to be displayed in bilingual.
- Scope of Service of the hospital need to be defined & displayed in bilingual at the entrance of the hospital.
- Fire exit route map need to be displayed in the OPD block.
- Red & Black colour bins with respective colour plastic bags with biohazard label should be used uniformly.
- SOP for the department needs to be developed. Staff needs to be trained periodically and their training records needs to be documented.
- The housekeeping services need to be strengthened particularly cleaning of toilets.
- Waiting time of Outpatient needs to be monitored.
- Outpatient satisfaction index needs to be monitored and evaluated monthly.
- OPD utilization rates needs to be analysed.

REGISTRATION, ADMISSION & BILLING COUNTERS

IDENTIFIED GAPS

STRUCTURAL	• Citizen Charter, Patient rights & responsibilities and signages for registration counter were not displayed in bilingual. • Fire exit & fire escape routes are not displayed.
PROCESS	• No SOP is available for the department. • Tariff book with date of effect is not available. • Service available policy is not available. • Policy on Non availability of beds is not available. • Staffs are not trained on these policies.
OUTCOME	• No monitoring of waiting time for registration.

Recommendations:

- Citizen Charter, Patient rights & responsibilities and signages for registration counter should be displayed in bilingual.
- Fire exit & fire escape routes should be displayed.
- Documented SOP needs to be developed.
- Tariff book with date of effect needs to be prepared & documented.
- Service available policy needs to be developed.
- Policy on Non availability needs to be developed.
- Staffs should be trained on these policies.
- Waiting time for registration needs to be monitored.

AMBULANCE SERVICES

The HCO has outsourced the ambulance services

Recommendations:

The HCO needs to ensure that the ambulance meets all statutory requirements viz. Registration, license of driver, insurance, emission check.

a) The ambulance needs to be equipped with adequate equipments viz. Ventilator, defibrillator, multi-parameter, suction apparatus, cervical collar, splints, scoop, stretcher, spine board, ambu bag and emergency kit.
b) The equipments need to be calibrated & checked on daily basis.
c) A checklist for all emergency drugs needs to be made available and they should be checked daily and prior to dispatch.
d) The ambulance should have a proper communication system (mobile phone).
e) The ambulance should have a portable Fire extinguisher available in the patient cabin.

CASUALTY DEPARTMENT

The casualty department is located on ground floor. It has 2 beds. There is no triage area for sorting the patients as per the severity, Patient privacy needs to be considered.

IDENTIFIED GAPS

STRUCTURAL	• No earmarked triage area. • No standard Crash cart inventory available. • Disaster cupboard with all emergency drugs, items are not available. • Calibration of equipments was not evident. • Fire exit and fire escape route signages were not displayed. • 24 hours casualty service board not displayed at the entrance. • No spillage kit available..
PROCESS	• Staffs are not trained uniformly in BLS and/or ALS, triaging and handling of emergencies during disaster. • No documented SOP for the casualty department. • No documented SOP for the Medico Legal cases. • No structured format available in the department for initial assessment. • Clinical protocols are not defined for handling of emergencies. • Liquid soap to be made available instead of soap bars. • Material safety data sheet is not available in the department.
OUTCOME	• Time for initial assessment of nurses and doctors in the casualty department are not monitored.

Recommendations:

1. Earmarked triage area is required.
2. Crash cart should be arranged uniformly as per defined checklist.
3. Disaster cupboard with all emergency drugs, triage bands & required items to be made available.
4. All equipments need to be calibrated.
5. Fire exit and fire escape route signage need to be displayed.
6. 24 hours casualty service board to be displayed at the entrance.
7. Spillage kit to be made available in the department.
8. Staffs are to be trained uniformly in BLS and/or ACLS, triaging and handling of emergencies during disaster.
9. Documented SOP for the casualty department needs to be developed.
10. Documented SOP for handling of Medico Legal cases needs to be developed.
11. Structured format to be made available in the department for initial assessment.
12. Clinical protocols need to be defined for handling of emergencies.
13. Liquid soap to be made available instead of soap bars.
14. Time for initial assessment of nurses and doctors in the casualty department are to be monitored.
15. Mock drill for disaster management needs to be conducted.

LABORATORY

IDENTIFIED GAPS

STRUCTURAL	• Scope of the department is not displayed at the entrance. • Digital thermometers were not available in refrigerators. • Sample Collection chair was not available. • Duty hours of Pathologist not defined. • BMW management Needs to be strengthen with sample discard facilities. • Fire exit & fire escape route were not displayed in the department. • Calibration of equipments was not evidenced. • Spillage kit was not available.
PROCESS	• No documented SOP for Laboratory. • No documented quality assurance and lab safety manual. • Staffs are not trained in lab safety measures and proper segregation & disposal of BMW. • Surveillance of test results is not carried out regularly. • Critical results are not defined and documented. • Turnaround time for all test are not being monitored. • List of outsourced tests are not displayed & documented. • Material Safety Data Sheet is not available for chemicals kept in the lab. • Temperature of fridge is not being monitored. • Work instructions for all equipments were not available. • EQAS and IQC program were not evidenced.
OUTCOME	• Turnaround time for investigations are not defined and measured. • Safety & quality for laboratory not defined & measured (No. of reporting errors/1000 investigations, percentage of Redo's, percentage of reports correlating with clinical diagnosis.

Recommendation:

- Scope of the department need to be defined & displayed at the entrance.
- Fire exit & fire escape route are to be displayed in the department.
- Adequate no. of fire extinguisher to be made available in the department.
- Calibration of equipments needs to be carried out at regular intervals.
- Spillage kit to be made available.

- Documented SOP for Laboratory needs to be developed.
- Documented quality assurance and lab safety manual needs to be developed.
- Staffs need to be trained in lab safety measures and proper segregation & disposal of Bio-Medical Waste.
- Surveillance of test results needs to be carried out regularly.
- Critical results are to be defined and documented.
- Turnaround time for all test needs monitoring.
- List of outsourced tests to be displayed & documented.

RADIOLOGY AND IMAGING DEPARTMENT

The USG department is located in OPD area.

IDENTIFIED GAPS

STRUCTURAL	• Scope of Radiology & Imaging department is not displayed at the entrance. • Radiation hazard signages are not prominently displayed in all appropriate locations. • Fire exit & fire escape signage is not displayed in the department. • Radiation is hazardous to pregnant women were not properly displayed. • Emergency medicine kit was not found in Radiology Department.
PROCESS	• Documented SOP for the department is not available. • Quality assurance & safety manual are not available. • Staffs are not trained uniformly on radiation safety measures. • Health check up of staffs was not evident. • Quality assurance & validation of equipments was not evident. • Surveillance of imaging results is not evident. • Critical results are not defined and intimated. • Turnaround time for investigations is not monitored.
OUTCOME	• No monitoring of quality indicators like number of reporting errors/1000 investigations, percentage of re-dos, percentage of reports correlating with clinical diagnosis, percentage of employees adhering to safety precautions, percentage of contrast related reactions.

Recommendations:

- Scope of Radiology & Imaging department need to be displayed at the entrance.
- Radiation hazard signages should be prominently displayed in all appropriate locations.
- Fire exit & fire escape signage needs to be displayed in the department.
- Emergency Medicine kit must be available
- Radiation is hazardous to pregnant women needs to be displayed.
- Lead aprons, thyroid shields & gonad shields should be periodically tested.
- Documented SOP for the department needs to be developed.
- Quality assurance & safety manual needs to be developed.
- Staffs need to be trained uniformly on radiation safety measures.
- Health check up of staffs must be conducted on regular basis.
- Quality assurance & validation of equipments must be carried out periodically.
- Surveillance of imaging results need to be documented.
- Critical results should be defined and intimated.
- Turnaround time for investigations needs regular monitoring.

OPERATION THEATRE

There are total three operation theatres are present in hospital.

IDENTIFIED GAPS

STRUCTURAL	• Equipments in the operation theatres are not calibrated. • Surgeons, anesthetist, technician & nurse do not have TLD badges. • Spillage kit is not available. • Fire exit and fire escape routes are not displayed.
PROCESS	• No documented SOP for the Operation theatre, informed consent, anaesthesia, sedation, restraints, pain management, wrong patient & wrong site surgery and surgical services. • Surgical safety checklist is needs modification • Quality assurance programme is defined and monitored. • Proper record of narcotic drug usage is not found. • Temperature is not monitored for fridges. • Infection control practices needs to be strengthened. • No documented SOP is available for use of implants.
OUTCOME	• Re-exploration rates & rescheduling of procedures are not monitored. • No monitoring of anaesthesia related events like percentage of modification of anaesthesia plan, percentage of unplanned ventilation following anaesthesia, anaesthesia related adverse events and anaesthesia related mortality rate.

Recommendations:

- Equipments in the operation theatres need to be calibrated.
- Surgeons, anesthetist, technician & nurse should have TLD badges.
- Spillage kit is required to be kept in the theatre.
- Fire exit and fire escape route must be displayed in the department.
- Documented SOP for the Operation theatre, informed consent, anaesthesia, sedation, restraints, pain management, wrong patient & wrong site surgery and surgical services needs to be developed.
- Surgical safety checklist should be made available.
- Quality assurance programme needs to be defined and monitored.
- Proper record of narcotic drugs usage needs to be maintained.

WARDS

The hospital has wards categorized as female general ward, male general ward. Hand wash basin doesn't have signages of hand washing; soap bars are available instead of liquid hand wash. Towels are used instead of tissue paper. Handwashing stations are not available at nursing stations

IDENTIFIED GAPS

STRUCTURAL	• No spillage kit is available. • Fire exit and fire escape routes are not displayed in the ward areas. • Equipments are not calibrated. • Weight machine is not calibrated.
PROCESS	• No documented policy and procedure for CPR, Ration use of blood & blood components, informed consent, blood transfusion, referral, transfer, discharge, care of vulnerable patients, pain management, verbal orders, high risk medication, safe dispensing of medication, patient monitoring after medication, self administration of medicines, medicines brought from outside, adverse drug events, storage of medicines, sound alike & look alike medicines, ward management, nursing services in wards, and linen management. • Age specific competency of staff taking care of paediatric patients is not evident. • Look alike and sound alike drugs are not stored separately. • High risk medication is not stored under single lock & key. • Material safety data sheet is not available. • Staff is not trained uniformly.
OUTCOME	• No monitoring of time taken for discharge. • No monitoring of medication errors, ADR, accidental removal of tubes & catheters, strip & falls, sentinel events.

Recommendations:

- Spillage kit needs to be made available.
- Grab bars to be fixed in all toilets.
- Fire exit and fire escape routes need to be displayed in the ward areas.
- Equipments are to be calibrated.
- Weight machines need to be calibrated.
- Scope of paediatric service if any need to be displayed in bilingual.
- Documented policy and procedure for CPR, Ration use of blood & blood components, informed consent, blood transfusion, referral, transfer, discharge, care of vulnerable patients, use of chemotherapy drugs, pain management, verbal orders, high risk medication, safe dispensing of medication, patient monitoring after medication, self administration of medicines, medicines brought from outside, adverse drug events, storage of medicines, sound alike & look alike medicines, ward management, nursing services in wards, and linen management needs to be developed.
- Age specific competency of staff taking care of paediatric patients need to be done.
- Look alike and sound alike drugs should be stored separately.
- High risk medication is recommended to be stored under single lock & key.
- Material safety data sheet to be made available
- Time taken for discharge needs to be monitored."

MEDICAL RECORD DEPARTMENT

The medical record room location to be defined and needs to have arrangement and storage facility of medical records. One trained manpower needs to deploy in medical record room to maintain medical records as per defined standards & Coding.

INFECTION CONTROL

The hospital does not have Infection control officer, infection control nurse to oversee the infection control practices.

IDENTIFIED GAPS

STRUCTURAL	• Structured surveillance programme is not available. • Hand wash signage is not displayed uniformly in all washing areas. • BMW segregation containers, needle destroyers not available uniformly. • Spill kits are not available.
PROCESS	• No documented infection control manual available. • Soap bars are found in all hand washing areas. • Evidence of Efficacy test for disinfectants is not available. • Induction & In-service training are not provided uniformly to all staffs. • Antibiotic audit is not carried out to ensure adherence to antibiotic policy. • Hand wash monitoring is not carried out regularly. • Staff adherence to standard precautions is not being monitored uniformly. • Equipment cleaning & sterilization practices need to be strengthened. • Hand towels are being used in all hand washing areas.
OUTCOME	• No monitoring of hematoma at puncture site & thrombophlebitis. • No monitoring of HAI rates, hand hygiene compliance rate, environment surveillance programme for High risk areas etc

Recommendation:

- ICO & ICN needs to deploy to oversee the infection control mechanism of hospital.
- Structured surveillance programme needs to be developed.
- Documented infection control manual needs to be developed.
- Soap bars should be replaced with liquid hand wash in all hand washing areas.
- Hand towels to be replaced with tissue paper.
- Efficacy test for disinfectants needs to be carried on regular basis.
- Feedback on Infection rates should be provided to medical & nursing staff (Infection control Bulletin).
- Induction & In-service training should be provided uniformly to all staffs.

INTENSIVE CARE UNIT

IDENTIFIED GAPS

STRUCTURAL	• Crash cart is not arranged as standard inventory and checklist. • Calibration of equipments was not evident. • AMC of critical equipment were not evident. • No fire escape routes displayed in the department. • Restraint for patients is not available. • Toilets do not have grab bars."
PROCESS	• No clinical protocols available in the department. • No documented admission & discharge criteria. • Staffs are not trained to apply these criteria. • No documented quality assurance programme available. • Staffs are not trained in CPR- BLS/ALS. • Sound alike & look alike medicines are not stored separately. • High risk medication list is not available. • Temperature of fridge is not being monitored. • Infection control practices needs to be strengthened. • No documented policies & procedures viz. Restraint, end of life care, non availability of beds, initial & reassessment, CPR, rational use of blood & blood products, blood transfusion, medication administration & documentation, management of medication got from outside, monitoring of patient after medication, ADR, Narcotic drug usage, Antibiotic adherence, care of vulnerable patients etc. • Age specific competency of nurses taking care of paediatrics & neonates is not done. • Care plan and treatment orders are not uniformly signed, named, timed & dated by doctors. • Initial assessment & plan of care are not counter signed by clinician in-charge within 24 hours. • Soap bars are used instead of Liquid hand wash. • Hand towels are used instead of tissue paper.
OUTCOME	Quality indicators are not monitored viz. re-admission rates, re-intubation rates, medication errors, ADR, percentage of accidental removal of tubes & catheters, incidence of hematoma at puncture site etc.

Recommendations:

- Crash cart needs to be arranged as per defined standard checklist.
- Calibration of equipments needs to be carried out periodically.
- Fire exit and fire escape routes should be displayed in the department.
- Restraint for patients should be made available.
- Narcotic drugs should be stored in cupboards with double lock & key.
- Grab bars should be fixed in all toilets.
- Digital thermometers should be made available in all medicine refrigerators.
- Documented SOP for ICU/PICU/NICU needs to be developed.
- Clinical protocols needs to be developed & made available in the department.
- Documented admission & discharge criteria should be followed at all times.
- Staffs should be trained to apply these criteria.
- Documented quality assurance programme should be made available.
- Staffs should be trained uniformly in CPR- BLS/ALS.
- Sound alike & look alike medicines should be stored separately.
- High risk medication should be stored under single lock & key.

PHARMACY

The pharmacy is located at OPD. The department is manned by qualified pharmacists for 24 hours

IDENTIFIED GAPS

STRUCTURAL	• No hospital drug formulary. • Fire exit & fire escape routes were not displayed in the department. • Labelling of drugs in pharmacy was not evident (Bar coding). • Arrangement of drugs need to be proper
PROCESS	• No documented SOP for the department like prescription of drugs, high risk medication, safe dispensing of medication, proper storage of drugs, local purchase., procurement of drugs, formulary, procurement of medicines not listed in formulary, look alike & sound alike, medication recall, safe & effective use of medication, etc. • Look alike & sound alike medications are not stored separately. • High risk medication list is not available. • Inventory control mechanism not being followed. • Prescription audit is not being done. • Temperature is not monitored for drugs kept in fridges.
OUTCOME	• No monitoring of indicators like percentage of stock out including emergency drugs, percentage of local purchase, incidence of variation from the procurement process and percentage of goods rejected before preparation of GRN.

Recommendations:

- Hospital drug formulary needs to be developed collaboratively.
- Fire exit & fire escape routes should be displayed in the department.
- Labelling of drugs in pharmacy should be done
- "Documented SOP for the department like prescription of drugs, high risk medication, safe dispensing of medication, proper storage of drugs, storage of narcotic drugs, local purchase., procurement of drugs, formulary, procurement of medicines not listed in formulary, look alike & sound alike, medication recall, safe & effective use of medication etc needs to be developed..

.

HUMAN RESOURCE DEPARTMENT

There is one person available to look after the HR responsibilities. Every staff personal file need to be created. Standard Checklist need to be follow

ENGINEERING & FACILITY MANAGMENT

IDENTIFIED GAPS

STRUCTURAL	• No documented operational and maintenance (preventive and breakdown plan). • Up-to-date drawings, layout and escape route are not maintained. • No maintenance plan for piped medical gas, compressed air and vacuum installation. • Personal Protective Equipments (gloves, shoes, safety goggles) are not available. • Few beds in general ward do not have provision of Side rails. • Stretchers & wheel chairs do not have brakes, straps for restraint, side rails & file holder. • Toilets in the hospital do not have grab bars. • Rubber mats are not placed in front of electrical panel boards for safety during operation. • Danger signs are not available on electrical panel boards. • The hospital premises needs to be kept clean. • Seepage & leakage in hospital needs to be stopped. • Loose & open wires are found throughout the hospital. • Biomedical waste room needs to be modified (4 different room with exhaust and washing facility) • CSSD Zoning needs to be done
PROCESS	• Documented policies and procedures on procuring, handling, storing, distributing and replenishing of medical gas is not available. • Facility inspection rounds by safety & risk management team are not documented. • No documented SOP for the engineering & facility management department. • Water quality test is not done for over head & underground tanks periodically. • Register for terrace access is not available. (It is accessed to everyone). • Register for lift locker room is not available.
OUTCOME	• No response time monitored for the complaints received and analysed for corrective actions. • No monitoring of breakdown time of equipments was evident.

REFERENCES

https://www.iihmr.edu.in/student-dissertation/2011-2013/Gap-Analysis-of-Multispecialty-Hospital-in-Bahadurgarh-as-per-NABH-Norms

https://www.iihmr.edu.in/student-dissertation/2011-2013/Gap-Analysis-of-a-Multispecialty-Hospital-in-Delhi-as-per-NABH-Standards

http://www.nabh.co/H-Doc/hospital.pdf

https://www.slideshare.net/mahboob804/nabh-procedures-and-processes-for-indian-hospitals