NABH: A Gap Analysis of Process of Accreditation

By

Richa Sharma

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2016-2018

The IIHMR University, Jaipur

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CERTIFICATE

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Richa Sharma, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Rungta Hospital, Jaipur from 19-02-2018 to 18-05-2018.

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.

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"NABH: A gap analysis of process of accreditation"** and submitted by Dr. Richa Sharma, Enrollment No. 0518 (Five hundred n eighteen) under the supervision of Dr. Neetu Purohit for award of MBA in Hospital and Health of the University carried out during the period from 19-02-2018 to 25-05-2018 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Richa

Signature

Richa Sharma

HM21

Hospital

ACKNOWLEDGEMENT

First, I would extend my profound gratitude to the almighty, who helped me to accomplish all my tasks well on time. I would like to thank all the people who contributed their valuable time and support without which my study would have been incomplete.

My special vote of thanks to **Ms. Reena Verma** (Head HR) who gave me the opportunity to pursue my summer training in Rungta Hospital (Jaipur). I consider myself fortunate to work under **Mr. SC Tiwari(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. Neetu Purohit.** Under his guidance and motivation, I was able to conduct my study. I am thankful for all the support provided.

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INTRODUCTION

Hospital accreditation is defined as " the process of self-assessment & external assessment through Peer followed in health care organizations for accurately assessing their level of quality , standards and performance in comparison to already established standards and to implement ways for continuous improvement.

There is very dynamic Health system in India which works or operates in an environment with fast economical, technical and social changes. In the past there are many examples of compromised patient care, negligence, scarcity or inadequacy of resources with inefficient facilities, lack of information and unwanted medical interventions. On the other hand it consists of different types of healthcare organizations and institutions delivering different levels of care not only to the local population but also to foreigners who visit India for medical treatment (Medical Tourism). Such being the case, assuring quality in healthcare services becomes a mandate and receiving an accreditation is the only answer to it. It is the single most approach for improving the current standards of the hospitals.
The level of confidence and faith of the people in hospitals can be increased through accreditation since it ensures that the accredited healthcare organization practices and delivers continuous quality services and also functions in the best interests of all patient's. The primary goal of the accreditation is to ensure that the hospitals not only perform evidence based practices but also give importance to access, affordability, efficiency, quality and effectiveness of healthcare.

In the recent times demand for quality in healthcare services has risen due to various market forces such as medical tourism, insurance, corporate growth and competition. As a result of these the expectations of the consumer for best in quality has also risen, which has indeed lead to the introduction of national and international accreditation bodies to act as a quality assurance mechanism, thus enhancing customers access to better healthcare services. National

Accreditation Board for Hospitals and Healthcare Providers (NABH) defines Hospital Accreditation as a public recognition by a national or international healthcare accreditation body, of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organizations level of performance in relation to the standards."

DEFINITIONS

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.

Accreditation Assessment is the evaluation process for assessing the compliance of an organization with the applicable standards for determining its accreditation status.

Objective Element is that component of standard which can be measured objectively on a rating scale. The acceptable compliance with the measurable elements will determine the overall compliance with standard.

Objective is a specific of a desired short-term condition or achievement includes measurable end-results to be accomplished by specific teams or individuals within time limits.

Standard is a statement of expectation that defines the structure and process that must be substantially in place in an organization to enhance the quality of care.

NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTHCARE PROVIDERS

- NABH Standards for hospitals, 4th Edition, December 2016 has been released . This standard has been accredited by International Society for Quality in Healthcare (ISQua). The approval of ISQua authenticates that NABH standards are in consonance with the global benchmarks set by ISQua. The hospitals accredited by NABH will have international recognition. This will provide boost to medical tourism .
- The standards provide framework for quality assurance and quality improvement for hospitals. The standards focus on patient safety and quality of care. The standards call for continuous monitoring of sentinel events and comprehensive corrective action plan leading to building of quality culture at all levels and across all the functions .
- The 10 chapters in the standard reflect two major aspects of healthcare delivery i.e. patient centered functions (chapter 1-5) and healthcare organisation centered functions (chapter 6-10).

Patient Centered Standards

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

Organisation Centered Standards

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

ACCREDITATION PROCESS

1. Self-Assessment
2. Application for accreditation
3. Pre - Assessment visit
4. Final Assessment of hospital
5. Issue of Accreditation Certificate
6. Surveillance
7. Re assessment

SELF ASSESSMENT

Prepare a definite plan of action towards NABH accreditation. Appoint a person responsible for coordinating all activities related to accreditation. Obtain a copy of NABH standards and implement those standards in the healthcare organization. Obtain a self-assessment tool kit and conduct self-assessment through that kit atleast three months before submission of application form and should have compliance with those standards.

APPLICATION FOR ACCREDITATION

Obtain the NABH application form from the NABH office. Fill the form and submit the form. Make payment of accreditation fees.

PRE ASSESSMENT VISIT

A Principal assessor and assessment team is appointed by NABH. After completion of application form, all documents and Self-assessment tool kit.the objective of Pre Assessment by NABH is to check

- The preparedness of hospital for the Final assessment by NABH for accreditation
- Commitment to the quality goals and accordance with the standards laid down by NABH
- To see the documentation system of the hospital.

FINAL ASSESSMENT

NABH appoints a new assessment team with the principal Assessor same as for the pre assessment. Number of assessors depends upon number of beds of the Hospital and services. All documents and processes are reviewed by the Assessment team. All Non compliances of pre assessments are assessed again for the compliances. Corrective action ns reviewed. NABH give a final assessment report.

LEVEL ACCREDITATION

1. **ENTRY LEVEL ACCREDITATION**
   All the legal and regulatory requirements should be completed. No individual standard should have more than two zeros. The average score for individual standard must not be less than 5. The average score for individual chapter must be more than 5. The overall average score for all standards must exceed 5.
   Validity period is minimum of 6 months to max 18 months. Cannot apply for assessment before 6 months.

2. **PROGRESSIVE LEVEL ACCREDITATION**
   All legal and regulatory requirements should be fully met. No individual standard should have more than two zeros. The average score for individual standard must not be less than 5. The average score for individual chapter must be more than 6.The overall average score for all standards must exceed 6. Validity period of minimum 3 months to max of 12 months. HCO Cannot apply for assessment before 3 months

3. **ACCREDITATION**
   All the Legal and regulatory requirements should be fully met. No individual standard should have more than one zero to qualify. The average score for individual standards must not be less than 5.The average score for individual chapter must not be less than 7. The overall average score for all standards must exceed 7. Validity period is 3 years

SURVEILLANANCE AND RE-ASSESSMENT

Surveillance is done once in three years after getting accreditation after final assessment. Surveillance is a kind of check that the organization is sticking to NABH standards. Surveillance is generally planned after 18 month of accreditation.

To apply for renewal of accreditation , the organization need to apply at least 6 month before expiry of validity.

IMPORTANCE OF ACCREDITATION

- Earlier there have been many cases of poor patient care, availability of less resources, negligence, lack of information, poor facilities etc leading to poor patient satisfaction and poor patient management but due accreditation by National Accreditation board for Hospital and healthcare HCO are bound to follow standards and quality assurance in Hospital

BENEFIT OF ACCREDITATION

- Leading to provision of more safer and protected surroundings to the patient in the Hospital.
- Only Hospitals accreditated by NABH are allowed to have empanelment with Third Party Administrators leading to more patients
- NABH is mainly to protect rights and responsibilities of patients and hospital employees
- Provides regular training and development to the employees leading to more employee satisfaction
- It enhances the level of patient Care
- Medical tourism

NEED FOR THE STUDY

- Hospitals are the very important and the services provided by Hospitals are most vital part of society. Healthcare sector is a very hot sector in terms of economic returns due to which many large and small facilities are coming up. Leading to the decrease in standard of care. Standardization of services for similar care to all patients as per their requirement was the demand of market. This will ensure better quality of care to the patient and will also reduce burden on facilities and staff. Mortality and morbidity in hospitals are mainly due to less standardization of care but accreditation has bound the hospital to provide standardize care to the patient leading to the reduction in mortality and morbidity.

- NABH accreditation process is periodic review Hospitals maintain the standards as per NABH during NABH assessors visit but after visit maintain same quality standards seems difficult.

LITERATURE REVIEW

Gap analysis of a Multispeciality Hospital in Bhadurgarh as per NABH standards

The study is non- experimental, descriptive and observational which is done in two parts i.e. present status of the department and compliance against NABH standards. All available services were compared against the set standards and scoring was done on a scale of 1 to 10 using NABH toolkit. Primary data was collected through unstructured interviews in which convenient sampling was done and observation was also included. Secondary data was collected from the records of various departments. As of now the hospital fulfills the criteria for entry level according to which no standard must have more than two zero and the average score of individual standard must not less than 5 and the average score for individual chapter must be more than 5 (1)

Gap analysis of a Multispeciality Hospital in Delhi as per NABH standards

The study provided the data which shows the gap between the existing services and the standards of NABH in different departments of the hospital. Primary data was collected through observation, discussion with staff and patients of the staff and secondary data was collected from hospital records in the form manuals, policies and procedure guidelines. Apparently, a self-assessment toolkit i.e. a checklist is used and corrective, preventive actions are recommended to reduce the gaps. The study revealed that the average score as per NABH was 8.8 which makes the hospital eligible for appearing for final assessment, as minimum score required was 7.The area of concern lies with implementation of policies and procedures as documentation part was up to the mark. The hospital had maximum of structural gaps i.e 44 % followed by process i.e. 43 % and then outcome gaps i.e. only 13 % .The utilization rate of departments were moderate with OPD 36.2% & OT 40.4% .The hospital fulfilled all the four criteria, that were there was no standard which is having more than one zero score, the average score for individual standard was not less than 5 and average score for individual chapter was not less than 7. (2).

OBJECTIVES OF THE STUDY

- To identify gaps in the structure, process and outcome.
- To identify the non-compliances and gaps of current services with respect to four patient centric standards of NABH 4th edition
- Compare the gaps with the non-compliances of Final assessment of the hospital

- To suggests the required alterations in structure, processes and outcomes to reduce the non-compliances in surveillance

RESEARCH METHODOLOGY

Research question

What are the current gaps and compliances of hospital on four patient centric standards as compared to gaps and compliances of same standards at the time of final assessment for NABH accreditation?

Study Design

Descriptive and Observational study

Study Location

Rungta Hospital, Malviya Nagar , Jaipur , Rajasthan

Departments:
OPD
Laboratory
Radiology and Imaging
ICU
NICU
Wards
CSSD
Laundry
OT
Housekeeping
Pharmacy
Blood Storage etc

Data Collection tool

Self- assessment toolkit of 4th edition of NABH
Checklists

Data collection techniques

Primary Data:

Interviews with the Hospital staff
Direct Observation

Interview with the patients of Hospitals

Secondary Data

Hospital policies and Manuals

Records and HMIS of Hospital

Study Time

12 weeks which includes preparing and filling checklist, Self-assessment tool kit and compiling data, gap analysis and final report completion.

COMPLIANCE CHECK AS PER NABH

TABLE: 1.1 STATUTORY REQUIREMENTS

S.No.	License/Certificate	Status
	General	
1	BMW Management and Handling Authorization	Available
2	Registration under Clinical Establishment Act (or similar)	**NA**
3	Registration with Local Authorities	Not Available
	Facility Management	
4	Fire (NOC)	Available
5	License for Diesel storage	**NA**
6	License to Store Compressed Gas	
7	Registration for Boiler	
8	Sanction/License for Lifts	
	Radiology	
9	Registration for Modality License to operate (CT/IR)	
	Stallion-20 (G-XR-10582)	Available
	DX-300 (Fixed) (G-XR-30237)	Available
	C-Arm (Surgico-60D HF) (G-XR-32392)	Available
10	RSO Level I	**NA**
	Nuclear Medicine	
11	License to Operate Nuclear Medicine Lab	**NA**
12	License to procure Radioactive Material (Diagnostic/Therapy)	
13	RSO Level II	
	Radiation Oncology	
14	License to operate Radiation Therapy Department	**NA**

15	License to procure source/radioactive material	
16	RSO Level III	
	Clinical departments	
17	Blood Bank	**NA**
18	License for MTP	Available
19	Transplantation Registration	**NA**
	Pharmacy	
20	Drugs-Bulk license	**NA**
21	Drugs-Retail license	Available
22	Narcotic license	Applied
	Miscellaneous	
23	Canteen/ F & B license	Available
24	License for Possession and Use of Methylated Spirit, Denatured spirit and Methyl alcohol	**NA**
25	License for Possession of Rectified Spirit and ENA	Available
	Any Other	
26	NOC under Pollution Control Act	Available
27	Vehicle Registration Certificates	Available
28	License for transformers	**NA**
29	NOC for Generator Set	**NA**
30	Registration with MCI	Available
31	Registration with NCI	Available
32	PNDT for all Ultrasounds	Available
33	Income Tax Act, 1951	Available
34	Coompanies Act, 1956	Available
35	RC (Pharmacy), Raj VAT Act 2003	Available
36	RC (Hospital), Raj VAT Act 2003	Available
37	RC (Pharmacy), Raj VAT Act 2003	Available
38	Housekeeping MoU	Available

TABLE : 1.2 SINAGES

Sinages	Displayed	Bilingual	Pictorial	Remarks
	(Yes/No/NA)	(Yes/No/NA)	(Yes/No/NA)	
CITIZEN CHARTER	Yes	yes	No	Pictorial to be displayed
MISSION	Yes	No	NA	
VISSION	Yes	No	NA	

PATIENTS RIGHTS AND RESPONSIBILITIES	No	No	No	
SCOPE OF SERVICES	Yes	No	NA	
TARRIF LAW	No	No	NA	
DOCTOR'S LIST WITH SPECIALITIES	Yes	No	No	
OPD SCHEDULE OF DOCTORS	Yes	No	Yes	OPD schedule shown on television
BIOHAZARDS SYMBOLS	Yes	No	Yes	Partially
FIRE EXIT PLAN	Yes	No	Yes	
FLOOR DIRECTORY	Yes	No	No	
WASH ROOMS	Yes	No	No	
AMBULANCE PARKING AREAS	No	No	No	
DRINKING WATER	No	No	No	

TABLE: 1.3 IDENTIFIED GAPS

OUT PATIENT DEPARTMENT

STRUCTURAL	• Sinages displayed are not bilingual • Privacy of patient during examination is a issue due to the opaque glass cabins • In some cabins hand washing facilities not available • Hand washing area not available in the procedure room
PROCESS	• Complete data not captured in the HMIS of the hospital • Separate registration not done for Camp patients
OUTCOME	• Patient satisfaction • Waiting time of OPD Patient • OPD Utilization is not monitored

INTENSIVE CARE UNIT

STRUCTURAL	• Isolation Ward is inside the ICU

	• No changing room for the staff • No proper Exit • Some Oxygen pannels not working from long time
PROCESS	• Verbal order policy not followed properly • Doctors handover is not proper there is not doctors handover format • Hand hygiene compliance is only 70-80%
OUTCOME	• Very few patients in the ICU • ICU utilization rate is not properly monitored

AMBULANCE SERVICES

STRUCTURAL	• All medicines and equipment not available in the ambulance • No ambulance checklist is available • Maintenance of Oxygen cylinder is not done • Equipment calibration is not done
PROCESS	• No proper communication between Nursing staff, reception and ambulance driver • None of the nursing staff is designated the responsibility of ambulance
OUTCOME	• TAT for ambulance is not monitored • Ambulance is not checked before sending to transfer of patient.

EMERGENCY SERVICES

STRUCTURAL	• There is no separate entry for Emergency • Emergency signage is not visible from the road • Not all monitors are working
PROCESS	• Fumigation of Emergency not done since 2 years • Staff not trained in ACLS
OUTCOME	• Patients sometimes are directly transferred to ICU

LABORATORY

STRUCTURAL	• Proper Zoning for different sub sections of laboratory not available
PROCESS	• Samples are not properly send after collection
OUTCOME	• Lab in charge is not clear for calculating % of staff adhering to safety precaution

RADIOLOGY AND IMAGING

STRUCTURAL	• No changing room for the patient
PROCESS	• TAT is not followed • HMIS not there for radiology department • Improper patient queue management
OUTCOME	• Quality indicators are not monitored properly

WARDS

STRUCTURAL	● Crash cart is not monitored regularly ● No changing room for Nursing staff ● No separate toilets for staff
PROCESS	● BMW is not segregated at the point of generation ● Handing over of doctors not done properly no handover form available ● Housekeeping staff does not work up to the mark
OUTCOME	● Poor patient satisfaction

OPERATION THEATER

STRUCTURAL	● No post operating room ● No proper zoning ● All equipments are not calibrated ● AHU are not working
PROCESS	● Surgeries are not done as per schedule ● BMW is not properly segregated
OUTCOME	● Indicators not maintained properly ● OT utilization rate is not monitored

PHARMACY

STRUCTURAL	• No proper areas i.e receiving, segregation and storing are there • No Formulary is followed • Some staff are not qualified enough to handle the pharmacy
PROCESS	• Medication errors record are not maintained • Pharmacy in charge is not aware of formulary • No analysis is done in maintaining the stocks in pharmacy
OUTCOME	• Dead stock • Percentage of local purchase, Percentage of drug return and Reorder level are not monitored

DATA ANALYSIS 1

TOTAL GAPS: 56

Structural Gaps: 24

Process Gaps: 18

Outcome Gaps:14

FIG: 1.1

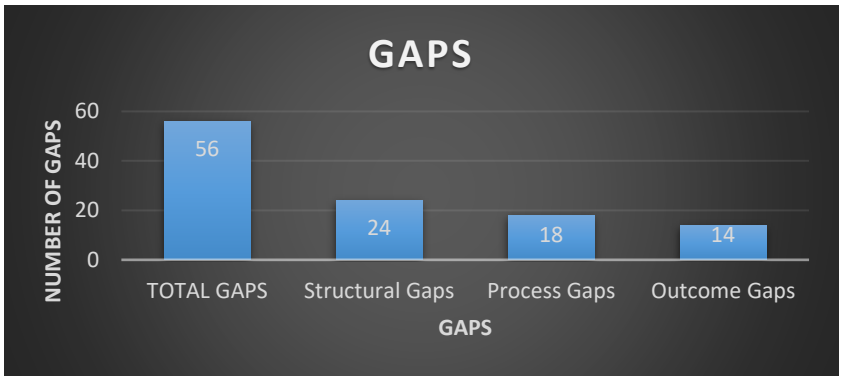

Figure shows gaps in structure, process and outcomes of hospital

CHAPTER 1: ACCESS ASSESSMENT AND CONTINUITY OF CARE (AAC)

TABLE: 1.4

Standard	Score
AAC1	7.5
AAC2	8.5
AAC3	7
AAC4	8.5
AAC5	9.1
AAC6	9.5
AAC7	9
AAC8	8
AAC9	9.5
AAC10	9.1
AAC11	8.75
AAC12	8.33
AAC13	9
AAC14	8.6
Average	8.6

FIGURE: 1.2

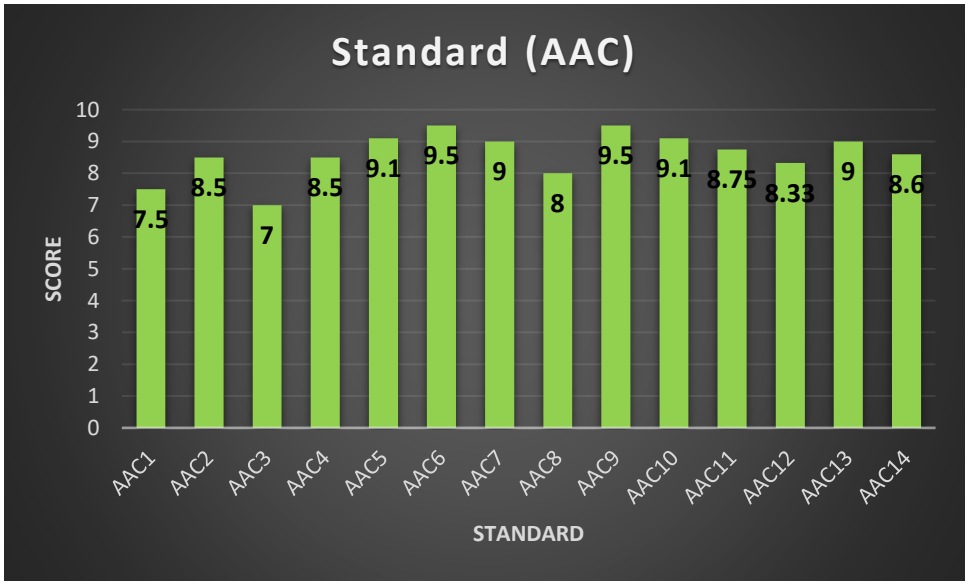

Figure shows average scoring in individual standards in Chapter AAC Self-assessment tool kit

INTERPRETATION

AAC-1

- Scope of services are and the services not in the scope are displayed in citizen charter bilingually (Hindi and English)
- All diagnostic and treatment facilities in consonance with need of the community are present except MRI, Nuclear medicine etc.
- All staff is not aware of scope of services or services not in the scope of Hospital.
- There is a demand of Cath lab , as many patients having cardiac emergencies are referred from the Hospital due to unavailability of facility.
- MRI facility is not available.
- Nuclear Medicine not there in despite of increase burden of Cancer

AAC-2

- All staff are not aware of services provided by hospital
- Staff is not even completely aware of policies and procedure for registering and admitting patient in the Hospital
- Registering form is not up to the mark lags many important parameters

AAC-3

- There is no staff dedicated for the Ambulance
- There is no policy regarding the staff responsible for during transfer / referral of Patient
- There is no nursing staff trained in advanced CPR
- Doctors are never found to accompany any patient in the ambulance even unstable patient too.

AAC-4

- Only one dietician is there in the hospital so some time in case of her unavailability assessment is not done by dietician within time frame.
- Initial assessment by nursing staff is done with in 30min and initial assessment by Doctor is done with in 1 hour .
- Initial assessment is documented within 24 hours
- Nutritional assessment is also done within 24 hours
- Diet is planned by dietician according to the patients condition.
- Care plan is documented and counter signed by the Consultant
- But it the desired outcome of the care plan was not documented.

AAC-5

- Based on initial assessment of patient and established plan of care, reassessments are performed and documented throughout the care process and at follow-up appointments.
- Reassessment is done for both OPD and IPD patients.

- Reassessments is performed to determine a patient's response to care/treatment and when there is a significant change in a patient's condition or a change in diagnosis.
- Reassessment is done by both Clinician in charge and nursing staff
- Reassessment in ICU is done in every shift or as per the requirement of the patient
- Consultant also reassess the patient as per the need of patient but at least once daily.
- Reassessment is documented in the form of Nursing and Doctor progress sheet.

AAC-6

- The laboratory provides all tests as per the scope of services required by the hospital to know the clinical picture of the treating patient.There are various sections in the laboratory.

✓ Clinical Pathology

✓ Serology

✓ Biochemistry

✓ Hematology

- The infrastructure is not proper as it does not have separated sections for all sub sections of lab.
- Laboratory shall possess the staff that are suitably qualified and trained to carryout laboratory tests.
- Sample collection is carried out on 24 hours basis either in the sample collection room (for OPD) or Phlebotomist collects samples from bedside forpatients admitted in the hospital.
- Proper handling and handling is done properly.
- TAT for various tests are maintained and results are given in standard format.
- Critical results are intimidated to the concerned consultant as early as possible and register is maintain to keep the record
- Lab test outsourced from another lab but the quality is assured by random visit of lab, Quality certified lab only is chosen and there tests are also verified for quality check.

AAC-7

- Regular quality indicators and calculated and analysed to have a check on the quality assurance of Laboratory.

- Lab shall participate in external quality assurance scheme with CMC Vellore (for biochemistry) and AIIMS (for hematology).

- Calibration is done strictly as per the recommendations of the equipment manufacturer.

AAC-8

Hospital safety program is focused in to entire hospital, staff, patients and visitors in general and in specific to

- Infection control
- Emergency and disaster preparedness
- Laboratory safety-general
- Occupational health and safety
- Chemical Safety
- All laboratory staff shall be vaccinated for Hepatitis B.
- Staff many times in the lab found to be without PPE and they also do not segregate the waste as per BMW 2016 rule.

AAC-9

- All staff in the radiology are registered on ELORA website .
- There is one RSO recently appointed earlier there were no RSO.
- Results are reported in standardized format.
- MRI not available in the hospital, patients are referred for MRI.
- TAT is not always maintained there are many times delay in result intimation.
- Critical results are reported as early as possible.

AAC-10

- Established quality assurance program but the quality indicators are not verified regularly.
- Periodic calibration and maintenance is done for all equipments
- All staff are qualified enough to work in radiology.

AAC-11

- Imaging safety program is documented
- All staff adhere to all safety precautions
- Radiation monitoring devices are periodically checked
- All radiation related waste are discarded in yellow colour dustbin.
- Regular training are provided to the staff.
- Sometimes proper PPE are not provided to staff ,
- Sinages are displayed as per the AERB guidelines

AAC-12

- Doctors handing over is not proper and there is no documentation regarding doctors handing over and taking over.
- Sometimes patients are transferred without side rails on the stretcher
- Seat belts are not there in the wheel chair
- There are referral forms and case sheets to guide the referral
- There is a mechanism to monitor the clinical intervention appropriateness but it was found not followed

AAC-13

- There is no documented policy for absconding patients
- There was not mentioned in discharge summary about Emergency conditions for which discharged patient should come to emergency immediately after discharge.
- Discharge time was monitored as per the feedback received by Patient welfare officer
- Discharges were not properly planned many times.

AAC-14

- Discharge summary does not have instruction about Emergency conditions in which patient need to report to emergency immediately.
- Cause of death was not appropriate in all discharge summary sometimes discharge summary missed some of prominent cause of death.

CHAPTER 2: CARE OF PATIENT (COP)

TABLE: 1.5

Standard	Score
COP1	8.75
COP2	8
COP3	7.2
COP4	7
COP5	7
COP6	10
COP7	10
COP8	9.3
COP9	8.75
COP10	9
COP11	10
COP12	8.75
COP13	10
COP14	9.09
COP15	8.6

COP17	9
COP18	9.1
COP21	9.1
COP22	9
AVERAGE	8.8

FIGURE: 1.4

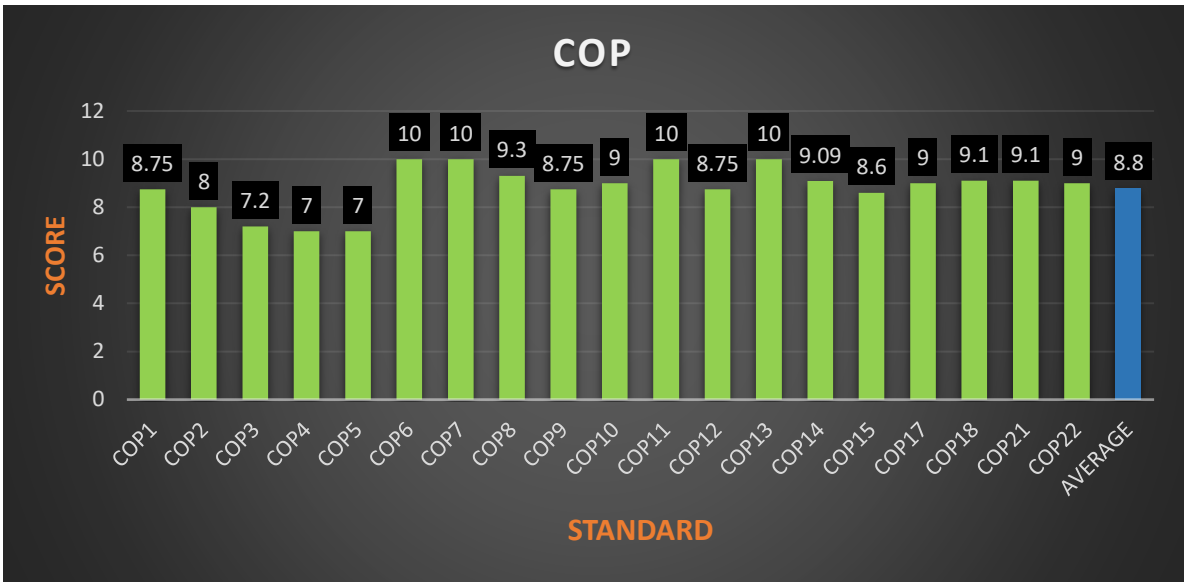

Figure shows average scoring in individual standards in Chapter COP Self-assessment tool kit

COP-1

- Evidenced based medicine guidelines are there but not followed
- Every patient shall be provided with uniform clinical care irrespective of cast, creed, religion, region, paying capacity, category of bed or behavior of patient with staff.

COP-2

- Emergency sinage is not visible from road
- Emergency department does not have separate entry
- Staff are familiar but not trained properly
- Sometime untrained staff is posted in emergency
- The policy for brought dead patients is not followed completely

COP-3

- There is a outsourced ACLS ambulance
- Hospital has a basic life support ambulance only
- There is no checklist for ambulance
- No one dedicated person has given the responsibility of ambulance due to which there has been incidences ambulance went empty without ambulance kit to carry Patient.
- No daily check of emergency drugs is carried out.
- Ambulance driver has a mobile the only means of communication

COP-4

- Hospital staff is not trained to handle mass casualty.
- There is not very good plan for availability of medical supplies , equipment and material during emergency
- Staff need to train on Code yellow

COP-5

- ACLS training certificates of staff has been expired.
- There is a post CPR evaluation form but not filled always
- Post event analysis is not done for all CPRs

COP-6

- Nursing staff is well trained and well versed with their duties
- Equipment for providing nursing care are not in sufficient number.

COP-7

- There is no such checklist to prevent wrong site , wrong patient and wrong procedure but due to less number of operation being carried out such incidences are not found.
- Staff lack training in implementing the policies regarding blood and blood product usage

COP-9

- Staff not trained for the policies of admission and discharge criteria from ICU and HDU.
- Adequate equipment are available but some of them are not in working conditions
- ICU utilization rate is not monitored properly
- Staff is not trained to monitor the ICU utilization rate
- ICU staff except Intensivist in ICU are not trained for ACLS.

COP-10

- Nursing Staff is trained but other staff like GDAs are not trained
- Informed consent not taken from all vulnerable patients.

COP-11

- Maternal nutrition assessment is not separately done for high risk pregnancy cases.

COP-12

- Scope of Pediatrics services are not displayed
- Age specific competencies are not specified by the care givers

COP-13

- Sedation is performed by competent and experienced professionals.

COP-14

- Adverse anesthesia reactions are not recorded as per NABH guidelines

COP-15

- Surgical checklist is not followed.
- Infection control practices is not in consonance with NABH guidelines.
- There is no post-operative room.

COP-17

- Staff receives training regularly regarding care of patients under restraints but compliance is low.
- Many times reasons for restraints are not documented.

COP-18

- Sometimes the pain score is not filled in the patient file.
- Rehabilitative services are absent

COP-21

- Kitchen is not as per the norms
- Food is not prepared under safer manner

COP-22

- Training regarding end of the life care to the staff is not done

CHAPTER 4: PATIENT RIGHTS AND EDUCATION (PRE)

TABLE: 1.6

Standard	Score
PRE 1	8
PRE2	9.5
PRE3	10
PRE4	10
PRE5	8.75
PRE6	10
PRE7	10
PRE8	9.1
AVERAGE	9.2

FIGURE: 1.4

Figure shows average scoring in individual standards in Chapter PRE Self-assessment tool kit

PRE-1

- Patient rights and responsibilities are not displayed
- Families and patients are not informed always about their rights and responsibilities

PRE-2

- Patients privacy during examination in some of OPD chambers is an issue due to the opaque glass chamber.

PRE-4

- Informed consent is mostly taken by nursing staff under the guidance of consultant from the patient or attendant.
- Staff is well versed with informed consent procedure.

PRE-6

- There is a uniform pricing policy in the hospital.
- A relevant tariff list is available to the patient but given on request.

CHAPTER 5: HOSPITAL INFECTION CONTROL (HIC)

TABLE: 1.7

Standard	Score
HIC1	7.5
HIC2	7.9
HIC3	8.8
HIC4	10
HIC5	6.25
HIC6	10
HIC7	7.5
HIC8	9
HIC9	8.75
AVERAGE	8.4

FIGURE: 1.5

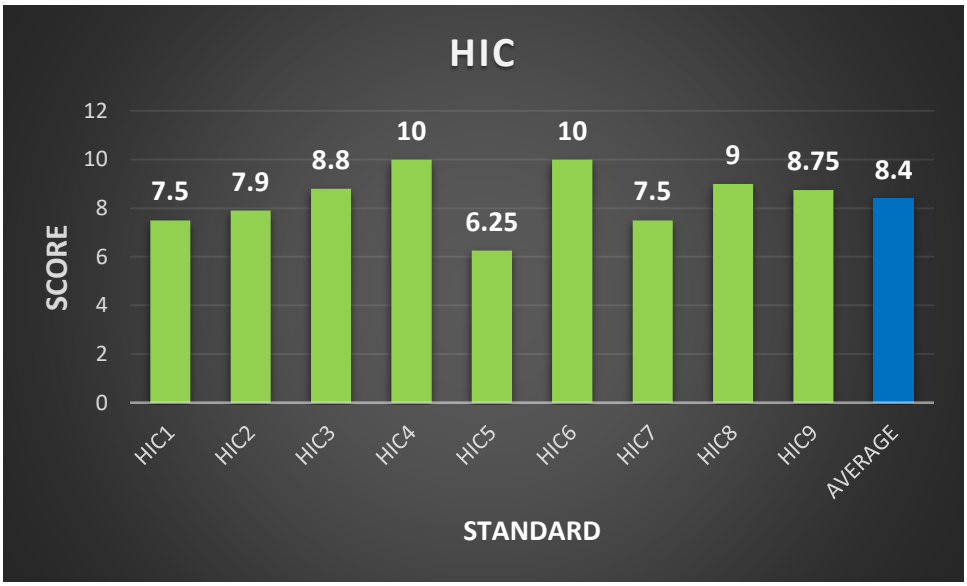

Figure shows average scoring in individual standards in Chapter HIC Self-assessment tool kit

HIC 1

- Updation of infection prevention and control program needed to be done
- Hospital infection control team is non –functional
- Infection control nurse also handles other responsibilities in case of shortageof nursing staff in the hospital.

HIC-2

- Fumigation of Emergency department is not done since two years.
- AHU of ICU are not working properly.
- There is no implementation of antibiotics use and rational use of antimicrobials are not monitored too.
- Housekeeping is found to be less efficient
- Hand hygiene compliance among food handlers is poor.

HIC-3

- The samples collected for surveillance are not validated from other lab
- Data is not verified , it is only discussed among the team members and committee meeting is called if any infection rate is coming beyond the limit.
- Compliance with hand hygiene is on an average around 70-80%

HIC-4

- Surveillance mechanism for Hospital acquired infections must be more strong.

HIC-5

- Proper supply of PPEs should be ensured.
- Procedure room should have provision of hand washing because soiled hands are washed.
- Training on barrier nursing

HIC-7

- Renovation of CSSD
- Proper zoning of CSSD
- Establish recall process when break down in sterilization is found

HIC-8

- Appropiate PPEs should be provided to BMW handlers.

COMPARING THE FINAL ASSESSMENT REPORT WITH THE PRE SURVEILLANACE ASSESSMENT

ACCESS AND ASSESSMENT OF CONTINUITY OF CARE

TABLE: 1.8

NABH FINAL ASSESSMENT REPORT			NABH PRE SURVEILLANCE		
	ACCESS ASSESSMENT AND CONTINUITY OF CARE				
S.No.	**Non-Conformances / Partial Non-conformance**	**Standards & Objective Elements**	**Non-Conformances / Partial Non-conformance**	**Standards & Objective Elements**	**Corrective / Preventive Action Taken**
1			Staff are not oreinted of service provided by hospital	AA1d	Regual training of staff
2			No policies and procedure for managing patient during non availibility	AAC2e	Policy to be made & staff needed to be trained

			of beds		
3	The organization has not defined and documented the content of the initial assessment for the out–patients and emergency patients.	AAC 4a			
4	The plan of care does not include goals or desired results of the treatment, care or service.	AAC 4h	Care plan with desired outcome i.e Document & policy available but staff is not oriented to write desired outcome	AAC4h	Training of staff
5	For in-patients during reassessment the plan of care is not monitored and modified where found necessary.	AAC 5c			
6			The organization lay down the guidelines and implement processes to identify early warning signs of change or deterioration of clinical condition for prompt treatment	AAC5f	policy to be made & staff needed to be trained
7			Safe transportation of sample (sample box not available)	AAC6e	purchase of sample box Training to the staff for safe transportation
8			Lab test are not available within the time frame	AAC6f	Staff training and circular
9	The laboratory quality assurance program does not include EQAS w.r.t Microbiology.	AAC 7a			
10	The HCO has not appointed a RSO; display signages for Radiation Safety are not as per norms; some of the radiation workers are not declared on E-LORA website.	AAC 9a; AAC 11			

	There is no established Radiation Safety Programme.				
11			Surveillance of imaging results are not done	AACd10	
12	Discharge summary does not incorporates instructions about when to obtain urgent care.	AAC 14f	Discharge summary does not incorporates when to obtain urgent care	AAC13f	Circular to residents and format modification
`13			Proper handing over and taking over is not proper of Doctors, no documents regarding their handing and taking over exist.	AAC12d	Format for handing over and taking over for doctors
14			Transfer of patients are not in safe manner(strechers are used without side rails and chairs without belt)	AAC12e	Training of staff
14			No Discharge policy for absconded patients	AAC13b	Policy to be made & staff needed to be trained
15			Discharge time taken is not monitored	AAC13e	Regular Discharge Audits
16	In case of death, the summary of the case does not include the cause of death.	AAC 15g			

STANDARD	**NCS**
Final assessment AAC	8
Pre surveillance assessment AAC	12

FIGURE: 1.6

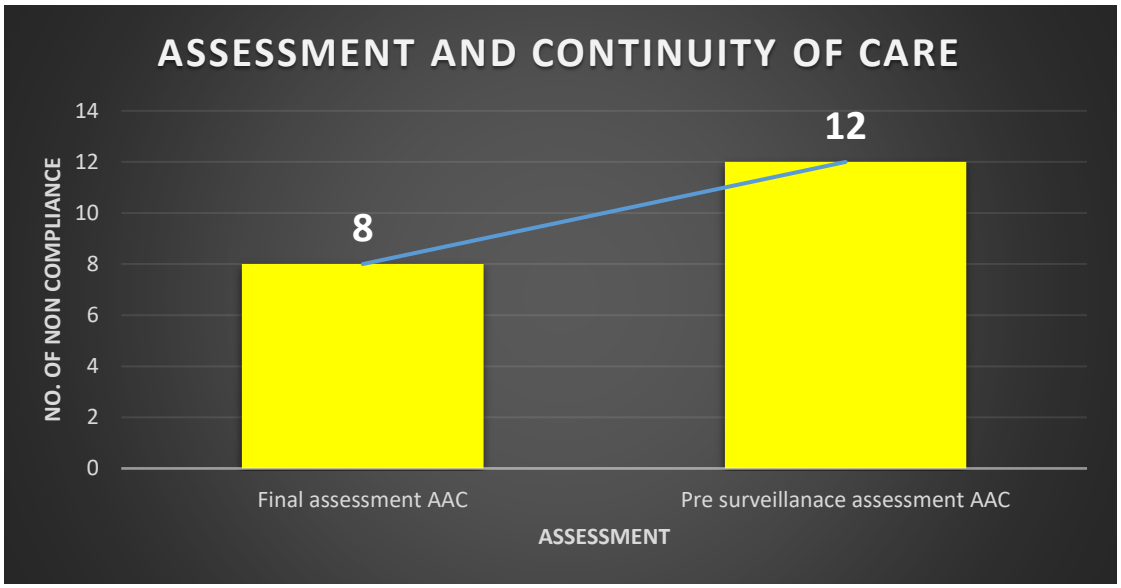

Figure shows rise in the number of non-compliances from final assessment of NABH to Pre surveillance assessment by Hospital

INTERPRETATION

- Non compliances have increased from 8 NCs to 12 NCs out of 96 Objective elements in Access assessment and continuity of care chapter.
- Condition of hospital quality as per NABH standard has deteriorated from Final assessment.
- Many NCs from final assessment report still exist even after the closure report.

CARE OF PATIENT

TABLE 1.9

NABH FINAL ASSESSMENT REPORT			PRE SURVEILLANCE REPORT		
	CARE OF PATIENT				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken
1	The organization has not adopted evidence based medicine and clinical practice guidelines to guide uniform patient care.	COP 1d			

2	Policies and procedures to address handling of medico-legal cases is not as per legal requirements.	COP 2b			
3			Staff need to be train on procedures Emergency services	COP2f	Training to staff
4			No policy on patient brought dead on arrival of hospital	COP2j	Policy and training to staff
5			Ambulance space is not marked	COP3a	Ambulance area has to be marked
6			Ambulance is not properly equipped	COP3c	Purchase of all equipment as per checklist
7			Ambulance is not checked on daily basis	COP3e	a Nursing staff should give dedicated responsibility of Ambulance
8			Checklist is not followed for ambulance	COP3f	
9			Emergency medicine are not checked prior to dispatch for cases	COP3g	
10			Employees are not trained in Code yellow	COP4a	Code yellow training and mock drills
11	Staff providing direct patient care are not found to be trained and periodically updated in cardio pulmonary resuscitation.	COP 4b	Staff providing direct patient care are not found to be trained and periodically updated in cardio pulmonary resuscitation.(Certificate expired)	COP4b	BLS and ACLS trainings
12			Availibility of medical supplies, equipment and material during emergency	COP4c	Policy and training to staff

13	A post-event analysis of all cardio-pulmonary resuscitations is not done by a multidisciplinary committee.	COP 4d	A post-event analysis of all cardio-pulmonary resuscitations is not done by a multidisciplinary committee.(not done)	COP4d	Regular committee meetings
14			No corrective and preventive measures based on Post event analysis are done	COP4e	CAPA should be prepared and followed
15	Nursing services do not reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	COP 5b			
16	Documented guidelines for various clinical procedures are not evidenced.	COP 6a	Documented guidelines for various clinical procedures are not evidenced.	COP7a	Guidelines for various clinical procedures
17			Staff is not trained for blood and blood product related policies	COP7h	Training of staff
18	Staff is not trained to apply admission and discharge criteria for its intensive care and high dependency units.	COP 8c	Staff not trained on admission and discharge criteria from ICU and HDU	COP9c	Trainings of residents
19	Policies and procedures for the care of elderly, children, physically and/or mentally challenged are not documented and are in accordance with the prevailing laws and the national and international guidelines. The HCO does not have licence under the Mental Health Act.	COP 9a			OUT OF SCOPE
20	The organization has not defined and displayed whether high risk obstetric cases can be cared for or	COP 10b			

	not.				
21			All staff are not trained in care of vulnerable patients	COP10e	Training to staff
22	The organization has not defined and displayed the scope of its Pediatric services.	COP 11b	No display of scope of pediatric services	COP12b	Scope of pediatric services
23			No age specific competency of care givers for children	COP12d	
24	The pre-anaesthesia assessment does not result in formulation of a documented anaesthesia plan.	COP 13c			
25	Documented policies and procedures to prevent adverse events like wrong site, wrong patient and wrong surgery are not evidenced - practice of filling of surgical safety checklist needs to be strengthened, site marking is not always done.	COP 14d			
26			The type of anesthesia and anesthetic medication used are not documented in patient record	COP14i	Circular to anesthetist and training to nursing staff of OT
27			Adverse anesthesia events are not monitored	COP14k	
28			Patient, personnel and material flow does not confirm to infection control(There is no direct route of instrument from CSSD & nursing staff keep on coming from OT during	COP15h	Circular to ICN and CSSD staff

			procedure)		
29	The quality assurance program of operation theatre does not include daily monitoring of humidity and temperature are not evidenced.	COP 14k	Quality assurance of OT does not include post fumigation culture to lab from outside hospital for controls	COP15k	Search NABL lab start the process
30	Patients with pain are not found to undergo detailed assessment and periodic re-assessment.	COP 16c			
31	Care in the rehabilitative services is not found to include functional assessment and periodic re-assessment.	COP 17c			
32			Training regarding restraints is not regular and staff is not updated in control and restraint techniques	COP17e	Training of staff
33			patient and family are not educated on various pain management techniques	COP18f	Training of NursingStaff
34			Food handling is not very safe manner	COP21e	Regular audits and training
35			Training on end of life care needed	COP22e	Training of staff

STANDARD	**NCs**
Final assessment COP	15
Pre surveillance assessment COP	26

FIGURE : 1.7

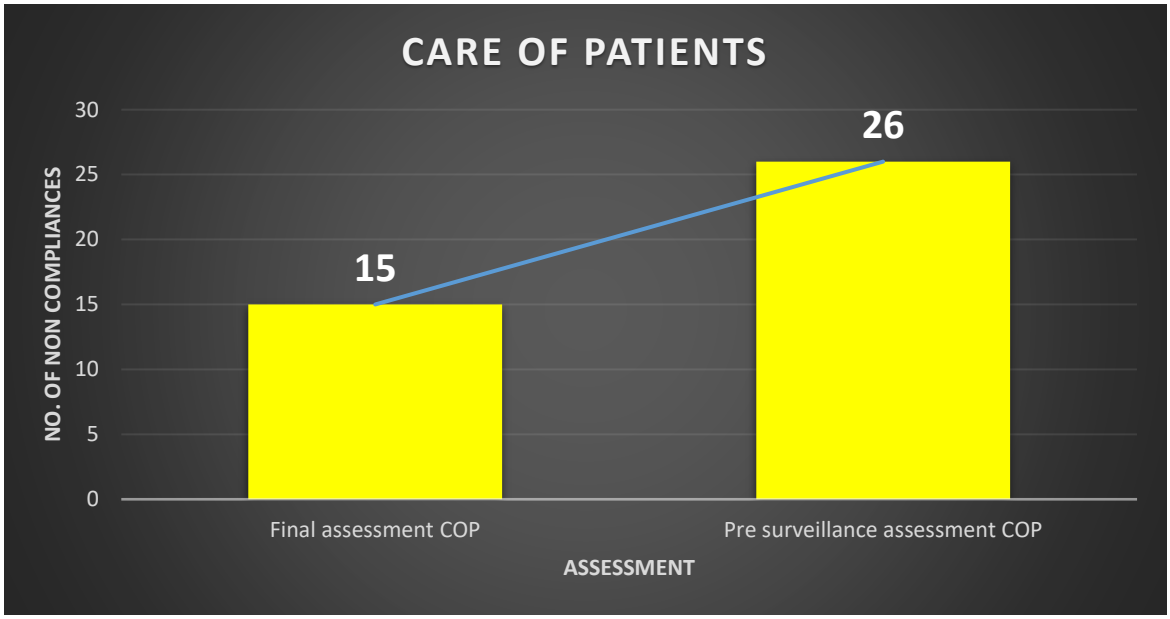

Figure shows rise in the number of non-compliances from final assessment of NABH to Pre surveillance assessment by Hospital

INTERPRETATION

- Non-Compliances again have raised from 15 to 26 NCs
- All most double NCs before NABH Surveillance as compare to Final assessment report
- Around 8 NCs are same as in final assessment.

PATIENTS RIGHTS AND EDUCATION

TABLE: 1.10

NABH FINAL ASSESSMENT REPORT			PRE SURVEILLANCE REPORT		
	PATIENT RIGHTS AND RESPONSIBILITY				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken

1			Patients and families are not explained of their rights and responsibilities	PRE1b	Staff training
2			Staff are not aware of protecting patients and family rights	PRE1d	Staff training
3			Privacy during examination in some of OPD Clinics because of opaque glass walls of OPD clinics	PRE2b	In OPD clinics the site of examination should be concealed
4	Patient and family rights do not include protection from physical abuse or neglect.	PRE 2c			
5	Patient and family rights do not include right to complain and information on how to voice a complaint.	PRE 2g	Patient and family rights do not include right to complain and information on how to voice a complaint.	PRE2h	A patient redressal system needed
6	Documented procedure does not incorporate the list of situations where informed consent is required and the process for taking informed consent.	PRE 4a			
7			**patient and/or family not explained about food drug interaction**	PRE5b	Circular to Dietician and Doctors

8	Patient and/or family are not found to be educated about immunizations.	PRE 5d			
9			Patient and/or family are not explained about preventive healthcare infections	PRE5f	Training to staff
10	There is no evidence of a mechanism to make patient and/or family members aware of the procedure for lodging complaints.	PRE 7b			
11			The hospital does not have any system to monitor and review the implementation of effective communication	PRE8e	

STANDARD	**NCs**
Final assessment PRE	5
Pre surveillance assessment PRE	7

FIGURE: 1.8

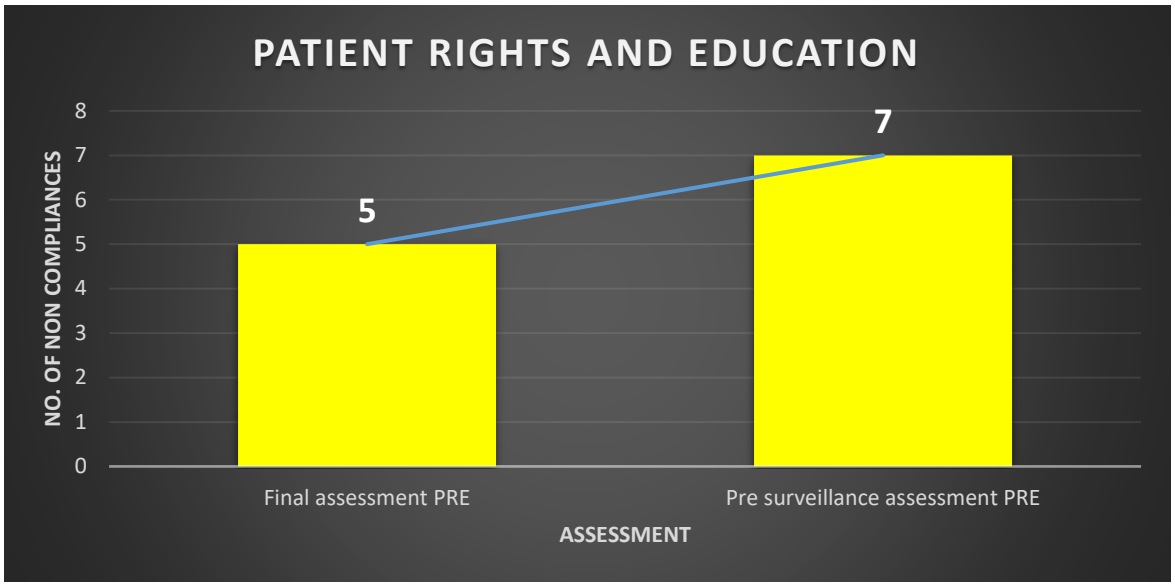

Figure shows rise in the number of non-compliances from final assessment of NABH to Pre surveillance assessment by Hospital

INTERPRETATION

- Patients rights and education NCs have also increased but not much.
- Training and proper patient complaint redressal system can solve many NCs.

HOSPITAL INFECTION CONTROL

TABLE: 1.11

	NABH FINAL ASSESSMENT REPORT		**PRE SURVEILLANCE REPORT**		
	HOSPITAL INFECTION CONTROL				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken
1			Infection control program required updation	HIC1b	Updation required

2			Hospital has a designated infection control officer but JD not attached with the file	HIC1e	Notice to HR department
3	The hospital does not have a designated infection control nurse(s) as part of the infection control team.	HIC 1f	The hospital has designated infection control nurse but JD not attached in the file	HIC1f	Notice to HR department
4			Hospital does not adhere to standard precaution all the times	HIC2b	Training to incharges and regular audits
5	An appropriate antibiotic policy is not found to be established and implemented.	HIC 2g	The organization does not implements the antibiotic policy and no monitoring on rational use of antimicrobials	HIC2h	Circular and antibiotics audit
6	The organisation is not found to have appropriate engineering controls to prevent infections.	HIC 2j	Fumigation machines not working and fumigation is also not effective	HIC2k	Fumigation machine maintenance
7			Food handling and kitchen sanitation issues	HIC2j	Regular audit and training to kitchen staff
8			Housekeeping procedures are not up to the mark	HIC2l	Circular to housekeeping incharge , Checklist for housekeeping & regular audit
9			Surveillance of hand hygiene is poor	HIC3e	Regular training and audits by ICN

10	The organisations actions to prevent and control HAI in patients need to be greatly strengthened - all Oes included.	HIC 4			
11			adequate and appropiate personal protective equipment are not provided	HIC5a	Circular to store and purchase department
12			Hand washing area not present in procedure room of OPD	HIC5b	Report to management for provision
13			Isolation ward is inside the ICU and barrier nursing is followed	HIC5b	Training on barrier nursing
14	Appropriate pre and post exposure prophylaxis is not found to be provided to all staff members concerned.	HIC 5d			
15	The organization has not provided adequate space and appropriate zoning for sterilization activities.	HIC 7a	CSSD is not proper , the organization has not provided adequate space and appropriate zoning for sterilization activities.	HIC7a	Reconstruction of CSSD
16			**Proper issues area is not there in the CSSD**	HIC7b	Reconstruction of CSSD
17	Reprocessing of instruments and equipment is not covered in the sterilization program.	HIC 7c			
18			there is no recall policy implemented for the break down of sterilization	HIC7f	Policy and training to staff

19			appropiate personal protective measures are not used by all staff handling biomedicel waste (Rubber multiutility gloves are not used by Biomedical waste handler)	HIC8e	Training and regular check by Supervisors
20			Shortage of PPE	HIC9a	Proper demand from all departments and audits

STANDARD	NCs
Final assessment HIC	7
Pre surveillance assessment Hic	17

FIGURE: 1.9

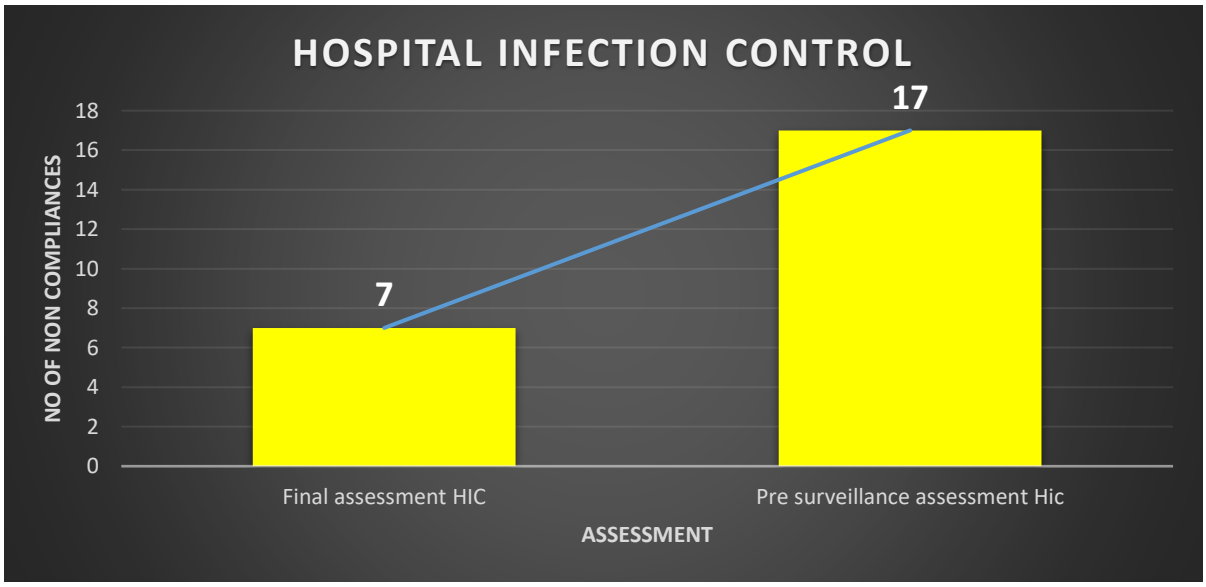

Figure shows rise in the number of non-compliances from final assessment of NABH to Pre surveillance assessment by Hospital

INTERPRETATION

- As per trend line there is a very steep increase in the NCs from final assessment
- This shows that hospital is very negligent about Hospital infection control.

FINDINGS

- Staff on reception are found to be not aware of Scope of services provided by hospital.
- Many hospital staff are not aware of services not under the scope of hospital
- Staff on reception are not aware of their responsibilities during announcement of Code Red
- Emergency does not have a separate entry and the sinage of Emergency is not visible from road
- Fumigation of emergency not done since 2 years
- There is already established policy for managing patient during shortage of beds but not all staff is aware of such policy.
- There is no such policy which identify staff responsible during transfer/referral of patient
- Doctors do not document the care plan with desired results.
- Lab does not have proper partition between different sections of lab
- Some of the lab tests are outsourced eg Harmones, tumour marker, Hepatitis marker, PCR, etc
- TAT is maintained for the Radiology department but for lab sometimes delay has been observed
- Lab personals among all PPE they only wear Gloves.
- Critical results are informed immediately to the concerned Doctor on phone within TAT of 15 minutes and all the details are registered in Critical results register.
- Lab were not segregating the BMW according to 2016 rules but after training the segregation was proper.
- No sample box are available to carry the samples from IPD to Lab.
- Lab participate in External quality assurance from CMC Vellore for Biochemistry and AIIMS for hematology
- Clinical correlation for Lab and Radiology department not done as required.
- MSDS lists not updated
- No new equipment is purchased for technological training
- Microbiologist on leave since 5 months and nobody is there for her replacement.
- Biomedical waste management committee is not established in the Hospital.
- No proper handing over and taking over for the residents doctors and no format is established for Handing over and taking over for resident doctors .
- Needle stick injury policy not followed with outsourced staff.
- Discharge summary does not have ICD coding.
- ICD coding is done by MRD on the files after receiving of files .
- Discharge summary does not consolidate guidelines about when to take urgent care.
- Ambulance area is not marked.
- Ambulance is not fully equipped to transfer a patient.
- Checklist for Ambulance is not implemented.
- Driver is trained in BLS
- There is no staff dedicated the responsibility of Ambulance .
- Oxygen cylinders are not checked regularly.

- Ambulance kit was not updated and regularly checked
- Suction apparatus was not there in the ambulance
- Ambulance kit after audit has been updated and kept in Emergency department.
- There is no proper communication between reception staff and Nursing staff about sending of ambulance for carrying patient.
- Code Drills are regularly conducted and classes according to the lacunae found during the drills.
- Doctors are found to be least aware about hospital policies and Disaster management and their roles.
- Regular training for doctors are also implemented but doctors are found to be least interested in attending those trainings.
- Temperature monitor chart must be displayed on the refrigerator but compliance is very low
- List of medicines in the refrigerator are not displayed on the refrigerators
- Food items of staff are found inside fridge during inspection
- Lifts are purchased from a local vendor and safety certificate is not displayed inside the 2 lifts out of three.
- In two lifts instructions are not displayed
- Formulary is formed since 2015 and not revised yet
- Drugs are not sold as per formulary
- Revision of formulary is proposed but due to less interest of doctors revision of formulary has been delayed.
- Antibiotics policy is documented distributed , implemented but not monitored regularly.
- Kitchen there is no different areas available for receiving, storing, Cutting etc
- Kitchen area is very small
- Kitchen workers have very poor compliance with hand hygiene
- Some of items of kitchen are found to be without FSSI mark during audit.
- Kitchen workers are rarely found to use head mask.
- House keeping services are not up to the mark
- Housekeeping checklist are not filled daily
- Complaints of housekeeping are numerous
- OT waste segregation is poor, many complaints come from OT
- No pre and post operating room present
- No changing room is available for ICU and Ward nursing staff
- No changing room available for Housekeeping staff and ward boys/females
- Security guards are found to be less aware of Disaster management plan , but with regular trainings knowledge level has increased.
- Regular briefing is done of security guards and video is recorded.
- Visitor policy is documented but not implemented.
- Daily OPD is on an average around 30-40 patients/day
- IPD on an average 6-8 patients per day
- EPBX sound system does not work properly,
- Announcement is not audible in Admin area, kitchen area ,OT, OPD , Store etc

Preventive and corrective Actions

Reception

- Regular training for front office and reception need to be carried out regarding the scope of services of hospital.
- Regular Training for Codes must be carried out and role of reception has to be explained
- There must be proper communication between reception staff and Emergency regarding Ambulance services.

Licenses

- Drug and narcotics license has to be applied for renewal.

OPD

- Waiting time must be monitored
- TAT must be monitored both for radiology and lab
- Adequate nursing staff must be provided for OPD
- For the privacy of patients during examination must be ensured
- Signages must be bilingual
- For camp patients separate register must be maintaine.d

AMBULANCE SERVICES

- A nursing staff from every shift must be dedicated the responsibility of ambulance
- Daily ambulance must be inspected for oxygen cylinder, suction apparatus and other equipment.
- Ambulance checklist must be checked before transferring any patient
- Ambulance kit must be checked daily for drugs

EMERGENCY DEPARTMENT

- Emergency staff need to be trained for emergency policies
- Signage of Emergency must be placed in such a way to be visible from the road
- Staff need to be trained on Code Yellow and triaging
- Fumigation of Emergency has to be carried out soon
- Regular Fumigation schedule needed to be prepare

LABORATORY

- Lab personal must be trained on spill management and use of PPE
- Lab personal need to attend regular training sessions conducted in hospital on various topics
- Clinical correlation should be done
- Microbiologist should be appointed

RADIOLOGY AND IMAGING

- Regular audits

- Surveillance of the tests done in radiology
- Correlation should be done

OTHERS

- BMW training regular
- Training on SOPs
- Audits regularly

CONCLUSION

- Gaps were observed during the project as per NABH guidelines but these gaps can be removed by little effort of management and employees. Regular training for the staff are going on which can resolve many of the gaps with in the organization. There is a NABH surveillance due for the hospital in month end of MAY,2018. According to the study for four standards no individual standard has ZERO and no individual standard have average below 7.
- Non-Compliances have increased from final assessment Non-compliances. Hospital is going for NABH surveillance and all Non-compliances of final assessment have not closed yet and other non-compliances as per NABH 4th edition are seen. This implies that hospital for NABH accreditation prepare themselves only for the Accessors visit and on routine basis the desired standards are not maintained
- This shows that NABH periodic visits to HCO are not effective in maintaining Quality.

WITH THE ABOVE ANALYSIS HOSPITAL IS FULLFILLING FOR NABH ACCREDITATION

DICUSSION

Accreditation of Hospital is mandatory for Empanelment with various TPAs, ECHS, CGHS etc. To get these Empanelment Hospital try for accreditation and hire consultancies and maintain all standards as per the requirement of standards of NABH but as they get NABH certificate they hospital get all empanelment patient but till NABH surveillance or reassessment which occurs after a gap of at least 18 months, Hospital leave all standards of NABH in fact Hospitals do not at all look after the quality standards it has been observed which is a serious matter to be thought about that whether NABH is playing any role in maintaining quality standards in hospitals or it has only role in introducing quality standards in Hospitals.

RECOMMENDATIONS

- Accreditation of Hospital is mandatory for Empanelment with various TPAs, ECHS, CGHS etc. To get empaneled, hospitals try for accreditation and hire consultants to maintain all standards as per the requirement of standards of NABH. However, when they get NABH certificate, the standards are not adhered to on routine basis.
- By the time, NABH surveillance or reassessment which occurs after a gap of at least 18 months takes place, hospitals do not maintain the desired status. The derive to maintain the standards occur only when there is surveillance. This shows that NABH periodic visits to HCO are not effective in maintaining Quality on a continuous basis. It should be a continuous process so that HCO adhere completely to the desired quality services
- Gaps were observed during the project as per NABH guidelines but these gaps can be removed by little effort of management and employees. Willingness of the

management in terms of implementation and supplies and regular training for the staff can resolve many of the gaps.

LIMITATION OF STUDY

- Data is provided by interview with Staff which can be biased
- The study been subjective depends upon the perception of employees
- Permission and time was limited so the study was conducted only on 4 patient centric standards only

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