SUMMER INTERNSHIP PROGRAM

At

NATIONAL HEALTH MISSION, RAJASTHAN

From 12/05/2025 TO 21/07/2025

A REPORT BY

ABHAY MISHRA

(MBA HOSPITAL AND HEALTH MANAGEMENT)

Roll no-1891

2024-26

under the Mentorship of

DR. ANOOP KHANNA (PROFESSOR)

Government of Rajasthan
National Health Mission, Rajasthan
Department of Medical, Health & FW, Swasthya Bhawan, Jaipur
Tel.No.0141-2229108, Email ID: spm_raj.nrhm@yahoo.com

No. F 2 (153) NHM/SPM/2025/ 877 Dated: 22.7.2025

CERTIFICATE

This is to certify that **Mr. Abhay Mishra** students of MBA-Hospital & Health Management and Healthcare Analytics for Summer Training IIHMR, Jaipur Has successfully completed his Summer Training for Internship at NHM, Rajasthan from **12th May to 21st July 2025.**

His performance was found good. We extend him good wishes for a bright and successful career ahead.

Mission Director
NHM

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that **Mr. Abhay Mishra** of academic year 2024-26 of **Institute of Health Management Research** has prepared a poster with respect to his summer internship held during May-July 2025.

He has carried out work as per the guidelines. His poster is approved for presentation.

Date: 25/7/2025

Dr. Anoop Khanna

Professor

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141-3924700, 2791431- 32, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

Assessment The Preparedness of Public Health Facilities (District Hospitals) to Implement A Risk Management System (RMS)

ABHAY MISHRA (Roll No. 1891)

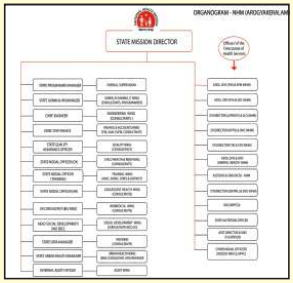
MENTOR - DR. ANOOP KHANNA (Professor)

NHM

The National Health Mission (NHM) comprises two parts: National Rural Health Mission (NRHM) initiated on April 12, 2005, and National Urban Health Mission (NUHM) which began on May 1, 2013. While NRHM works on healthcare improvements in rural regions, NUHM targets health service delivery in urban areas, particularly for low income slum dwellers

Vision & Mission

Ensure that everyone has access to fair, inexpensive, high-quality healthcare services that are accountable and sensitive to the needs of the populace, particularly the weak and disadvantaged. With a focus on marginalized communities, a reduction in newborn and maternal mortality rate, the promotion of illness prevention and management, the building of healthcare systems, and the prioritization of vulnerable groups, NHM's mission is to provide everyone with inexpensive, high-quality healthcare services



RESEARCH QUESTION

To what extent government district hospitals in Rajasthan are prepared to implement an effective Risk Management System (RMS) in accordance

Primary Objective

To assess the preparedness of public health facilities (District Hospitals) to implement a Risk Management System (RMS).

Secondary Objectives

1.To conduct a comparative analysis of the risk management systems between certified and non-certified healthcare facilities

2.To identify infrastructural, administrative, and human resource gaps related to RMS.

Research Methodology

Study Design: This cross-sectional and interventional study evaluates risk management preparedness in selected district hospitals under the 2024 NQAS guidelines. It uses checklists, surveys, and staff interviews to assess IPC implementation and identify key challenges

Study Area and Sample: 10 district Hospitals (DH) located in 10 districts of 4 Zones.

Study Population : Medical Officers, Nursing Staff, and Support Staff working at the selected DHs

Tools for Data Collection

a. NQAS Checklist (Pre-Defined Explanatory checklist)
b. Google Form-based Survey
c. Online Interviews (through virtual mode)

Intervention Plan

a. Development and Sharing of Risk management Guidelines
b. Awareness and Training Sessions
c. Feedback Loop

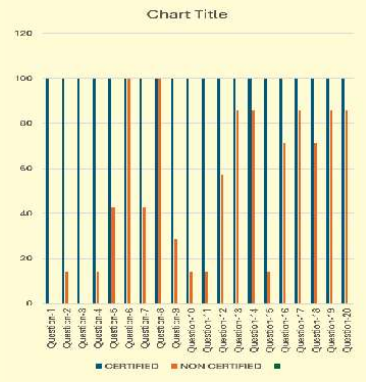
DATA ANALYSIS

Quantitative Analysis: Scoring of checklist data , comparison using percentages and trend visualization.

Qualitative Analysis: Thematic categorization of staff responses to identify systemic and behavioral gaps.

TOPICS	Qs	Yes %	No %	Total %
RISK MANAGEMENT COMMITTEE	Q-1	60%	40%	100
	Q-2	70%	30%	100
EMERGENCY INCIDENT	Q-3	10%	90%	100
	Q-4	60%	40%	100
RISK MANAGEMENT SCALE	Q-5	100%	0%	100
	Q-6	60%	40%	100
PATIENT SAFTY	Q-7	100%	0%	100
RISK REGISTER AND REPORT AND RCA	Q-8	50%	50	100
	Q-9	50	50	100
	Q-10	40	60	100
STAFF AND SURVILLANCE	Q-11	80	20	100
	Q-12	90	10	100
	Q-13	90	10	100
AUDIT AND 24*7 SERVICES	Q-14	50	50	100
	Q-15	80	20	100
	Q-16	100	0	100
MOCK DRILLS AND ELECTRICTY SAFETY	Q-17	90	10	100
	Q-18	80	20	100
GAS CYLENDER AND FLAMMABLE SUBASTANCE	Q-19	90	10	100
	Q-20	90	10	100

Theme	Frequency (out of 10 DHs)
Policy and Documentation Gaps	7\10
Training and Awareness	6\10
Human Resource Constraint	6\10
Infrastructure Limitations	5\10
Monitoring & Reporting Issue	4\10
Emergency Preparedness Gaps	4\10
Communication Barrier	5\10
Budget & Resource Allocation	4\10



Risk Management Preparedness Score (Overall)

- **High Preparedness Areas**: Patient safety, 24×7 service delivery, electrical safety, staff deployment.
- **Moderate Preparedness Areas**: Committee formation, risk scale use, audits.
- **Low Preparedness Areas**: Emergency response systems, RCA, SOP documentation, training programs.

GAP FINDINGS

- **Audit and Monitoring**: Only 50% conduct routine audits
- **Underreporting Culture**: Fear-based culture is limiting open incident reporting
- **Missing SOPs & Tools**: Many hospitals lack standard SOPs and risk communication tools
- **Emergency Response Gap**: lack a structured emergency response system framework
- **Training Deficit**: Many facilities show lack of competency in risk reporting.

SUGGESTION

Implement a **"No-Blame Culture"** policy.

Utilization of anonymous reporting tools or drop-boxes

Strengthening the RMS system in the institution by a trained RMC officer

Establish a small RMS room with digital monitoring tools

LEARNING FROM INTERNSHIP

- Learned about the organizational framework and quality assurance systems of NHM.
- Used primary surveys to gather and analyze primary data.
- Examined the level of preparedness for risk management in district level hospitals.
- Diagnosed inadequacies in standard operating procedures (SOPs) and the systems for responding to emergencies.

Importance of Internship - NHM Rajasthan

1. Put MBA theory to practice in actual healthcare environments.
2. Acquired practical skills in quality and risk management.
3. Enhanced skills in research, data analysis, and reporting.
4. Developed confidence through the interaction with healthcare clinicians.

Acknowledgement

I would like to express my sincere gratitude to Dr. Amit Yadav, Mission Director, NHM for his invaluable guidance and support throughout the course of my internship.

I would like to start by expressing my gratitude to Dr. Lokesh Chaturvedi, SPM NHM, Dr. Rommel Singh, Additional Director (Planning) and Project Director, Ayushman Arogya Mandir, and Quality Assurance, for his invaluable advice, wisdom, and unwavering support. His insight and experience enabled me to give this research direction and significance.

I am also extremely grateful to Dr. Saurabh Vijay, Additional State Programme Manager, whose encouragement and real-world advice helped me stay grounded and concentrated. Her assistance had a major impact on the phases of data collection and analysis.
I would especially like to thank my faculty mentor, Dr.Anish Sinha , for his patience, insightful guidance, and steadfast support during this process. I was able to approach this work with both academic rigour and a reflective mindset, thanks to his mentoring. His direction during times of uncertainty was greatly appreciated; his faith in my abilities gave me the courage to keep moving forward.
Additionally, I want to express my gratitude to the whole staff at the National Health Mission in Jaipur for their collaboration and for creating a stimulating and challenging learning environment.
Lastly, to my family and friends—your belief in me, emotional support, and constant encouragement gave me the strength to stay motivated and see this journey through. This work would not have been possible without you.

-ABHAY MISHRA

Report (Weekly)
Name of the Organisation: NHM RAJASTHAN ,JAIPUR
Area/ Department/ Project of Summer Internship Program: NQAS(QUALITY)
Name of the Student: ABHAY MISHRA
Roll no: 1891 Stream: MBA HOSPITAL AND HEALTH MANAGEMENT
Week no: 1 From:12 MAY 2025 To 17 May 2025

Activity Done	**12th May 2025 (Monday)** Joining Formalities and Introduction and Submitted the joining letter to the department and Attended introductory session with **SPM Sir**. **13th May 2025 (Tuesday)** Orientation Program – Day 1 FPP (Family Planning Program), Immunization, RBSK (Rashtriya Bal Swasthya Karyakram), RKSK (Rashtriya Kishor Swasthya Karyakram, IAP, ASHA Program, Quality Assurance,NTCP (National Tobacco Control Program),Oral Health and Rabies Program **14th May 2025 (Wednesday)** Orientation Program – Day 2 NPPCF (National Programme for Prevention and Control of Fluorosis), AAM , Maternal Health, Child Health, NTEP (National Tuberculosis Elimination Programme),IDSP (Integrated Disease Surveillance Programme), NPHCE/NPNCD (Non-Communicable Disease Programs) **15th May 2025 (Thursday)** Departmental Guidelines and New Project Overview Attended session by the **NQAS Department Officer,** Received detailed implementation guidelines for facilities at the following levels:District Hospital (DH),Community Health Centre (CHC), Primary Health Centre (PHC), Sub-Centre (SC) Introduction to the **New Project 2024**, which includes: .Risk Management in healthcare settings .Integrated Public Health Laboratories (IPHL) **16th May 2025 (Friday)** Research Work -Collected and reviewed **15–20 research papers** related to **Risk Management in Health and Hospital Settings**. Data Compilation and Prepared an **Excel sheet** compiling data of winners at different healthcare levels: District Hospital (DH), Community Health Centre (CHC),
Linking theory (Classroom learning) with practice at your organisation	I reviewed the actual functioning of the NHM subject and organization, and the research method chapter helped me a lot to find out the outcomes of the risk management topic
Gaps identified on the working area.	Without any understanding of the actual office work, and after experiencing a long waiting time just to meet the officer, theoretical details seems more complex when compared to the practical requirements of the job. And the large data are very complex
Suggestions for improvement	Actual feedback from superiors in the internship Better time management and actual data practise set

Plan for the next week	Checklist of DH and selection of a topic in risk management and excel sheet of winners at the level of PHC and SC

Week no: 2 ***From:19th May 2025 To 24th May 2025***

Activity Done	**19th May 2025 (Monday)** Data Compilation and preparation of an **Excel sheet** compiling data of winners at different healthcare levels: primary health centre **20th May 2025 (Tuesday)** Continuously doing this same work for sub centre And select any three objectives for my project in research review **21st May 2025 (Wednesday)** "Mera Aspataal" data was not available for winner selection so all data are to be set at only 85 percentage of total value of all DH,CHC,PHC,SC and must be necessary that after doing this that all the hospital should be more than 70 percentage. **22nd May 2025 (Thursday)** Prepare a final excel sheet and select eco friendly winner at the basis of eco friendly score of DH and CHC and compile this data with final sheet. **23rd May 2025 (Friday)** Recheck all data to submit and review all conditions to finalize the excel data sheet.
Linking theory (Classroom learning) with practice at your organisation	As I studied research methods chapter so I was able to find out the objectives for my project and DH, CHC, PHC, SC knowledge in hospital and health services.
Gaps identified on the working area.	Actual spelling of district names and block names were wrong and made it hard to be searched in excel vast data. And district number increased from 34 to 50 which made the data overlapped.
Suggestions for improvement	Excel data could be managed more precisely by administration. New district data could be managed separately in a better way.
Plan for the next week	Prepare a power point presentation of all extracted excel data to present to the committee.

Week no: 3 **From:26th May 2025 To 31st May 2025**

Activity Done	**26th May 2025 (Monday)** Prepared power point presentation on winning awards for public health facilities and submitted it to senior officer and data analyst. Filtered state certify list and checked manually. **27th May 2025 (Tuesday)** Kayakalp and state certify list were cross checked and the facilities included in kayakalp list was pointed out and NIN ID were written to the PHC centre. **28th May 2025 (Wednesday)** Prepare a list of assessors based on zone and some condition for the assessment of DH and PHC and SC centre and blacklisted the name that do not work properly. **29thMay 2025 (Thursday)** Government holiday **23rd May 2025 (Friday)** My objective was finalized, which is "preparedness of public health facilities for implementation of risk management system".
Linking theory (Classroom learning) with practice at your organisation	To arrange or do classification according to different types of methods and ranking
Gaps identified on the working area.	Data are not properly arranged and the availability of assessors are not confirmed. Due to the different portals' data, they are not integrated
Suggestions for improvement	Integrated data must be available, and certification data for all centres must be compulsory, and non-certified centres are assessed to improvement
Plan for the next week	Find out checklist data for project objective and how to prepare e-notesheet .

Week no: 4 **From:2nd june 2025 To 7th june 2025**

Activity Done	2nd june 2025 (Monday) A well-structured synopsis and detailed summary of my project work and research, reviewed and approved by my mentor 3rd june 2025 (Tuesday) A complete excel sheet was prepared to represent the total savings and expense on all type of activities in NHM 4 june 2025 (Wednesday) AFTER NPCC final QA and kayakalp PIP 2024-25 cosolidated sheet was prepared. 5 june 2025 (Thursday) Questions are prepared for" preparedness of risk management in district hospital" 6 june 2025 (Friday)

	PCTS id was updated in nqas national and state certify excel sheet
Linking theory (Classroom learning) with practice at your organisation	Library search papers helpd me a lot to fine out some points and e-library was very helpful
Gaps identified on the working area.	Different persons create different spellings for names so at a large scale all data is available but difficult to check or choose any specific things
Suggestions for improvement	All budjet must be more differentiated and monthly report must be prepared to finalize all savings easily
Plan for the next week	To prepare a raw structure for dashboard and select any 10 DH facilities to study

Week no: 5 From:9th JUNE 2025 To 14TH June 2025

Activity Done	Work Summary: 9th June – 13th June 2025 9th June 2025 (Monday) The *Assessment Transfer List* was revised with necessary changes. A set of 40 questions for the District Hospital (DH) survey was finalized and prepared. 10th June 2025 (Tuesday) The SNOPS Officer selected 10 District Hospitals for my research study. Official permission was granted to visit and conduct surveys in these identified hospitals. 11th June 2025 (Wednesday) The NIN ID was updated in the assessment data of District Hospitals (DH), Community Health Centres (CHC), and Sub-Centres (SC). 12th June 2025 (Thursday) The sanctioned NQAS Incentives for FY 2024–25 were updated to include the newly formed district in the system. 13th June 2025 (Friday) Responses for the NQAS State Assessment 2024–25 were reviewed to ensure complete data upload. Additionally, the set of 40 survey questions was reviewed and approved by my mentor for the research project.

Linking theory (Classroom learning) with practice at your organisation	As an MBA student, I applied theoretical knowledge of risk management and quality assurance in real-world healthcare settings. Classroom concepts like strategic planning, data analysis, and stakeholder management were implemented during hospital assessments. This practical exposure deepened my understanding and strengthened my decision-making skills.
Gaps identified on the working area.	Lack of standardized documentation and data entry across departments was a key gap identified in the working area.
Suggestions for improvement	1. Implement regular training sessions for staff on standardized data entry and documentation protocols. 2. Develop and enforce uniform templates and checklists to ensure consistency across departments.
Plan for the next week	Finalize only 15 questions for survey and google form

Week no: 6 From: 16 JUNE 2025 To 20 June 2025

Activity Done	**Work Summary: 16th – 20th June 2025** **16th June 2025 (Monday):** The NQAS checklist and guidelines were reviewed once again to enhance the preparedness of the risk management system in district hospitals. **17th June 2025 (Tuesday):** All data were thoroughly reviewed and approved by the SNOP Officer. The assessment list was updated accordingly. **18th June 2025 (Wednesday):** PAC and PERA were requested by PHS Ma'am. Additional activities such as verification of the linen change register, citizen charter, etc., were conducted to prepare a consolidated file indicating the availability status of these items in each facility. **19th June 2025 (Thursday):** Based on the findings, facilities lacking proper registers were instructed directly by the DPM. The Quality Cell also personally contacted all District DPMs, instructing them to update the necessary records and submit proof immediately. **20th June 2025 (Friday):** All responses were printed and submitted. Following this, a meeting was scheduled by the Mission Director, NHM Jaipur, which will now be conducted every three months.

Linking theory (Classroom learning) with practice at your organisation	I linked theoretical knowledge gained in the classroom with practical experience at my organisation by applying quality assurance guidelines, participating in risk management assessments, and contributing to real-time data verification and facility evaluation processes.
Gaps identified on the working area.	Gaps were identified in the working area, including incomplete documentation, irregular maintenance of registers, and lack of timely data updates.
Suggestions for improvement	1.Ensure regular monitoring and timely updating of all mandatory registers and documentation. 2.Conduct periodic training sessions for staff to enhance compliance with quality assurance protocol
Plan for the next week	Google form was circulated among selected district hospitals

Week no: 7 From: 23 JUNE 2025 To 27 June 2025

Activity Done	***Work Summary: 23rd June – 27th June 2025*** ***23rd June 2025 (Monday):*** *Responses were received from the selected district hospitals, and virtual permission for the survey was granted by the department. Discussions were held to address the actual issues and concerns.* ***24th June 2025 (Tuesday):*** *PAC PERA responses were organized district-wise and paginated for submission. A hard copy of the compiled responses was also prepared.* ***25th June 2025 (Wednesday):*** *The next phase of the project involved contacting selected district hospital facilities to obtain compliance data in response to the next PERA. This included collecting total OPD and IPD numbers, bed occupancy rates, and the number of registration counters.* ***26th June 2025 (Thursday):*** *Some facilities did not provide complete compliance data with photographic evidence. Therefore, calls were made to the respective DPMs and CHMOs for follow-up.* ***27th June 2025 (Friday):*** *For research purposes, all collected data was compiled in an Excel sheet. It was then cleaned, refined, and arranged into a consolidated file for final use.*

Linking theory (Classroom learning) with practice at your organisation	*Theoretical concepts learned in the classroom, such as health system management, risk assessment, and data analysis, were effectively applied during fieldwork in district hospitals through survey design, compliance evaluation, and data consolidation*
Gaps identified on the working area.	*Some facilities lacked timely compliance submissions, complete documentation, and photographic proof, indicating a gap in communication and adherence to standard reporting protocols*
Suggestions for improvement	*Establish a standardized reporting format with clear timelines to ensure timely and complete data submission from all facilities*
Plan for the next week	*New project will be given .*

Week no: 8 From: 30 JUNE 2025 To 4 July 2025

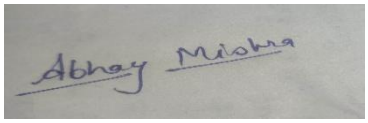
Activity Done	***Work Summary: 30th June – 4th July 2025*** • ***30th June 2025 (Monday):*** *Data interpretation and analysis for the Risk Management Project was completed. A virtual meeting was conducted with the district hospital management to verify the ground reality.* • ***1st July 2025 (Tuesday):*** *Certified facilities were cross-checked with the facilities uploaded on the official portal.* • ***2nd July 2025 (Wednesday):*** *Preparation of a consolidated sheet for the compiled district-wise committed unspent balance for the financial year 2024–25 was initiated.* • ***3rd July 2025 (Thursday):*** *The amounts listed under Serial No. 175 and Serial No. 176 for all districts were consolidated and rechecked.* • ***4th July 2025 (Friday):*** *There were some discrepancies in the reported amounts. All DPMs were contacted to confirm the figures with an authorized letter for clarity.*

Linking theory (Classroom learning) with practice at your organisation	*Classroom learning on risk management, healthcare policies, and data analysis was practically applied during fieldwork at the district hospital. Real-time exposure to audits, budgeting, and inter-department coordination helped bridge the gap between theory and practice.*
Gaps identified on the working area.	*Limited coordination and irregular meetings of the risk management committee were observed. Incomplete documentation and lack of updated financial data across districts also indicated operational gaps*
Suggestions for improvement	*Limited coordination and irregular meetings of the risk management committee were observed. Incomplete documentation and lack of updated financial data across districts also indicated operational gaps*
Plan for the next week	*Kayakalp budjet will be formed with budjet sheet*

Week no: 9 From: 7 JULY 2025 To 11 July 2025

Activity Done	**Work Summary: 30th June – 4th July 2025** • **7th July 2025 (Monday):** The sanctioned amount was revised based on the final meeting discussions with AMD. • **8th July 2025 (Tuesday):** The virtual district-level meeting was finalized and successfully conducted for all approved districts. • **9th July 2025 (Wednesday):** Bed occupancy rates for certain districts were calculated, and the burden on healthcare facilities was assessed. • **10th July 2025 (Thursday):** The compiled report and project report were submitted to the Additional State Programme Officer. • **11th July 2025 (Friday):** A blood donation camp and health programme function were organized, presided over by the Health Minister of Rajasthan.

Linking theory (Classroom learning) with practice at your organisation	The theoretical concepts learned in the classroom were effectively integrated into real healthcare practices at the organization, enhancing practical application
Gaps identified on the working area.	The burden assessment of facilities was based mostly on secondary data, with limited on-ground verification
Suggestions for improvement	Improve coordination with districts and use a centralized report system
Plan for the next week	No project will be told for next week

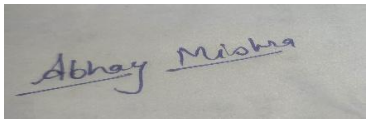


Signature of the Student

Week no: 10 From: 14TH JULY 2025 To 18th July 2025

Activity Done	Work Summary: 14th June – 18th July 2025 14th July 2025 (Monday): Under the National Quality Assurance Program, facilities were to be increased in Bikaner, Jhalawar, and Ganganagar by 12/07/2025. A PDF report was prepared in A4 size. 15th July 2025 (Tuesday): Progress status of the Aspirational Block Programme was prepared, and growth percentage was analyzed. 16th July 2025 (Wednesday): I was absent on this day. 17th July 2025 (Thursday): An order was given to prepare the committed budget sheet. 18th July 2025 (Friday): While preparing the Jaipur dashboard, PCTS codes were missing. The missing codes were identified and added to the dataset.

Linking theory (Classroom learning) with practice at your organisation	Applied classroom knowledge of health program management, data analysis, and quality assurance to real-time tasks like facility assessment, dashboard creation, and progress monitoring in the organization.
Gaps identified on the working area.	Gaps identified in the working area include incomplete or missing PCTS codes in datasets, irregular monitoring of aspirational block progress, delays in updating facility data across districts, lack of uniformity in budget sheet preparation, and inadequate documentation of certain tasks
Suggestions for improvement	Ensure timely data entry, standardize formats, conduct regular progress reviews, update facility data promptly, and maintain proper documentation
Plan for the next week	Final submission of report



Signature of the Student

COMPILE REPORT
Name of the Organisation: NHM RAJASTHAN ,JAIPUR
Area/ Department/ Project of Summer Internship Program: NQAS
Name of the Student: ABHAY MISHRA
Roll no: 1891 Stream: MBA HOSPITAL AND HEALTH MANAGEMENT
Week no: 1 From:12 MAY 2025 To 17 May 2025

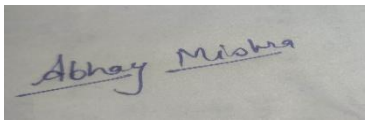
Activity Done	Joining Formalities and Introduction and Submitted the joining letter to the department and Attended introductory session with **SPM Sir**. Orientation Program FPP (Family Planning Program), Immunization, RBSK (Rashtriya Bal Swasthya Karyakram), RKSK (Rashtriya Kishor Swasthya Karyakram, IAP, ASHA Program, Quality Assurance,NTCP (National Tobacco Control Program),Oral Health and Rabies Program Orientation Program – Day 2 NPPCF (National Programme for Prevention and Control of Fluorosis), AAM , Maternal Health, Child Health, NTEP (National Tuberculosis Elimination Programme),IDSP (Integrated Disease Surveillance Programme), NPHCE/NPNCD (Non-Communicable Disease Programs Departmental Guidelines and New Project Overview Attended session by the **NQAS Department Officer,** Received detailed implementation guidelines for facilities at the following levels:District Hospital (DH),Community Health Centre (CHC),

	Primary Health Centre (PHC), Sub-Centre (SC) Introduction to the **New Project 2024**, which includes: .Risk Management in healthcare settings .Integrated Public Health Laboratories (IPHL) Research Work -Collected and reviewed **15–20 research papers** related to **Risk Management in Health and Hospital Settings**. Data Compilation and Prepared an **Excel sheet** compiling data of winners at different healthcare levels: District Hospital (DH), Community Health Centre (CHC), Data Compilation and preparation of an **Excel sheet** compiling data of winners at different healthcare levels: primary health centre Continuously doing this same work for sub centre And select any three objectives for my project in research review"Mera Aspataal" data was not available for winner selection so all data are to be set at only 85 percentage of total value of all DH,CHC,PHC,SC and must be necessary that after doing this that all the hospital should be more than 70 percentage.Prepare a final excel sheet and select eco friendly winner at the basis of eco friendly score of DH and CHC and compile this data with final sheet. Recheck all data to submit and review all conditions to finalize the excel data sheet. Prepared power point presentation on winning awards for public health facilities and submitted it to senior officer and data analyst. Filtered state certify list and checked manually. Kayakalp and state certify list were cross checked and the facilities included in kayakalp list was pointed out and NIN ID were written to the PHC centre. Prepare a list of assessors based on zone and some condition for the assessment of DH and PHC and SC centre and blacklisted the name that do not work properly. My objective was finalized, which is "preparedness of public health facilities for implementation of risk management system". A well-structured synopsis and detailed summary of my project work and research, reviewed and approved by my mentor A complete excel sheet was prepared to represent the total savings and expense on all type of activities in NHM AFTER NPCC final QA and kayakalp PIP 2024-25 cosolidated sheet was prepared. Questions are prepared for" preparedness of risk management in district hospital" PCTS id was updated in nqas national and state certify excel sheet The Assessment Transfer List was revised with necessary changes. A set of 40 questions for the District Hospital (DH) survey was finalized and prepared. The SNOPS Officer selected **10 District Hospitals** for my research study. Official permission was granted to visit and conduct surveys in these identified hospitals. The **NIN ID** was updated in the assessment data of District Hospitals (DH), Community Health Centres (CHC), and Sub-Centres (SC). The sanctioned **NQAS Incentives for FY 2024–25** were updated to include the newly formed district in the system.

	Responses for the **NQAS State Assessment 2024–25** were reviewed to ensure complete data upload. Additionally, the set of 40 survey questions was reviewed and approved by my mentor for the research project. The NQAS checklist and guidelines were reviewed once again to enhance the preparedness of the risk management system in district hospitals. All data were thoroughly reviewed and approved by the SNOP Officer. The assessment list was updated accordingly. PAC and PERA were requested by PHS Ma'am. Additional activities such as verification of the linen change register, citizen charter, etc., were conducted to prepare a consolidated file indicating the availability status of these items in each facility. Based on the findings, facilities lacking proper registers were instructed directly by the DPM. The Quality Cell also personally contacted all District DPMs, instructing them to update the necessary records and submit proof immediately. All responses were printed and submitted. Following this, a meeting was scheduled by the Mission Director, NHM Jaipur, which will now be conducted every three months Responses were received from the selected district hospitals, and virtual permission for the survey was granted by the department. Discussions were held to address the actual issues and concerns. PAC PERA responses were organized district-wise and paginated for submission. A hard copy of the compiled responses was also prepared. The next phase of the project involved contacting selected district hospital facilities to obtain compliance data in response to the next PERA. This included collecting total OPD and IPD numbers, bed occupancy rates, and the number of registration counters.Some facilities did not provide complete compliance data with photographic evidence. Therefore, calls were made to the respective DPMs and CHMOs for follow-up. For research purposes, all collected data was compiled in an Excel sheet. It was then cleaned, refined, and arranged into a consolidated file for final use Data interpretation and analysis for the Risk Management Project was completed. A virtual meeting was conducted with the district hospital Certified facilities were cross-checked with the facilities uploaded on the official portal. Preparation of a consolidated sheet for the compiled district-wise committed unspent balance for the financial year 2024–25 was initiated. The amounts listed under Serial No. 175 and Serial No. 176 for all districts were consolidated and rechecked. There were some discrepancies in the reported amounts. All DPMs were contacted to confirm the figures with an authorized letter for clarity Under the National Quality Assurance Program, facilities were to be increased in Bikaner, Jhalawar, and Ganganagar by 12/07/2025. A PDF report was prepared in A4 size. Progress status of the Aspirational Block Programme was prepared,

	and growth percentage was analyzed. An order was given to prepare the committed budget sheet. While preparing the Jaipur dashboard, PCTS codes were missing. The missing codes were identified and added to the dataset. Under the National Quality Assurance Program, facilities were to be increased in Bikaner, Jhalawar, and Ganganagar by 12/07/2025. A PDF report was prepared in A4 size. Progress status of the Aspirational Block Programme was prepared, and growth percentage was analyzed. An order was given to prepare the committed budget sheet.
Linking theory (Classroom learning) with practice at your organisation	Throughout my internship at the National Health Mission, Rajasthan, I had the opportunity to experience how theoretical knowledge transforms into real-world action. Concepts I had previously studied in classrooms—like health policy implementation, program evaluation, data analytics, and quality assurance—became clearer when I saw them in action on the ground. Working on projects such as the Risk Management System, NQAS, Kayakalp, and various national health programs allowed me to understand how structured guidelines are customized and executed at different levels of public health facilities—District Hospitals, CHCs, PHCs, and Sub-Centres. It was eye-opening to witness how policies take shape through coordination between departments, use of data, and timely follow-up. For instance, concepts like healthcare performance indicators, compliance tracking, and stakeholder engagement were no longer just academic terms. I was actively involved in preparing assessment tools, analyzing performance data, reviewing program gaps, and assisting in the verification process through communication with District Program Managers (DPMs) and CHMOs. I also saw how public health planning requires adaptability, especially when data discrepancies arise or documentation is incomplete. This taught me that beyond strategy and planning, effective execution also depends on communication, coordination, and constant review—skills that aren't taught in textbooks but are vital in the real world. This internship bridged the gap between theory and practice by showing me the realities behind policy-level decisions and field-level challenges. It gave me a deeper appreciation for public health systems and how every dataset, report, or assessment tool contributes to improved healthcare delivery for the community.
Gaps identified on the working area.	While working on data validation and risk management assessments, I noticed several gaps in documentation, data consistency, and follow-up processes. Some health facilities lacked updated registers or complete photographic evidence, making it difficult to verify compliance. There were also delays in data submission and a lack of uniform understanding of guidelines across districts. These gaps highlighted the need for better training, clearer communication, and stronger monitoring systems at every level

Suggestions for improvement	Based on my experience, a few practical steps can really help improve the system. First, regular training for hospital staff is important so everyone clearly understands what's expected in terms of recordkeeping and quality standards. Many times, the problem wasn't the lack of effort, but confusion about how to do things the right way. Second, there should be a system to track data updates in real-time. This would avoid last-minute rushes and errors. A simple reminder system or dashboard could help health facilities stay on top of their submissions. Third, better coordination between the district teams and state office is needed. Sometimes delays happened just because people weren't on the same page. Regular virtual check-ins or quick feedback loops can solve this. Lastly, creating a supportive environment where field workers feel comfortable asking questions and reporting issues would make the whole system more responsive and efficient
Key learnings	During my internship, I gained a deeper understanding of how public health systems actually work beyond textbooks. I learned how data is collected, cleaned, and used to make important decisions at different levels—from district hospitals to state health offices. I saw how teamwork, clear communication, and timely follow-ups are just as important as technical knowledge. Working on quality assurance, risk management, and program assessments taught me how small gaps in documentation can affect the big picture. I also learned how to handle large data sets, prepare reports, and present findings clearly to senior officials. Most importantly, I realized that real change in public health requires both planning and strong coordination on the ground. This experience helped me grow not just professionally, but also in terms of confidence and problem-solving.



Signature of the Student

Approved by the IIHMR University's Mentor

On the last day of every week Saturday -) report in the above format should be submitted to the faculty mentor. Submission of total 10 reports in 10 weeks is compulsory. Each report should not be more than 2 pages.

Research Question: To what extent government district hospitals in Rajasthan are prepared to implement an effective Risk Management System (RMS) in accordance with National quality standards?

Objectives

Primary Objective:

- To assess the preparedness of public health facilities (District Hospitals) to implement a Risk Management System (RMS).

Secondary Objectives:

- To conduct a comparative analysis of the risk management systems between certified and non-certified healthcare facilities
- To identify infrastructural, administrative, and human resource gaps related to RMS.
- To evaluate the availability of risk management policies, SOPs, and training programs

Research Methodology

1. **Study Design:**

This is a **cross-sectional and interventional study** designed to evaluate preparedness of risk management in district hospitals practices in selected district hospitals under the risk management guidelines 2024 initiative in NQAS. The study combines quantitative assessment (using structured checklists and surveys) with qualitative insights (through staff interviews) to provide a comprehensive understanding of IPC implementation and challenges.

2. **Study Area and Sample:**

The study will be conducted across **10 district Hospitals (DH)** located in **10 districts of 4 Zones**. These DHs have been selected purposively under the NQAS Risk management guidelines 2024 evaluation status.

Geographic Coverage: 10 districts in the state.

Selection Criteria: DHs with prior quality evaluation or poor performance indicators.
Availability of staff willing to participate in intervention activities.

3. **Study Population:**

Medical Officers, **Nursing Staff**, and **Support Staff** working at the selected DHs

Approximately **2–4 respondents per DH** are expected to participate in interviews and surveys.

4. **Tools for Data Collection:**

a. NQAS Checklist (Pre-Defined Explanatory checklist)

A structured tool developed by the Ministry of Health and Family Welfare, Government of India, focusing on parameters like cleanliness, hygiene, waste management, infection control, and facility upkeep.

b. Google Form-based Survey

Designed questionnaire covering quality checklist knowledge ,challenges faced, and adherence to protocols.

Administered to DH staff anonymously to ensure honest feedback.

c. Online Interviews (through virtual mode)

Semi-structured interviews with Medical Officers and select staff to gather qualitative insights.

Conducted via phone or video conferencing tools.

5. Intervention Plan

A series of supportive interventions will be implemented based on the pre-assessment findings:

a. Development and Sharing of Risk management Guidelines

Simple, practical infection prevention protocols customized for DHs.

b. Awareness and Training Sessions

Conducted online to sensitize staff about NQAS checklist and risk management guidelines 2024

c. Feedback Loop

Mid-point feedback session to reinforce weak areas and motivate improvement.

6. Post-Intervention Evaluation

The same **NQAS checklist** will be used to reassess IPC practices after intervention.
Additional feedback will be collected to understand perceived changes and ongoing challenges.

7. Data Analysis

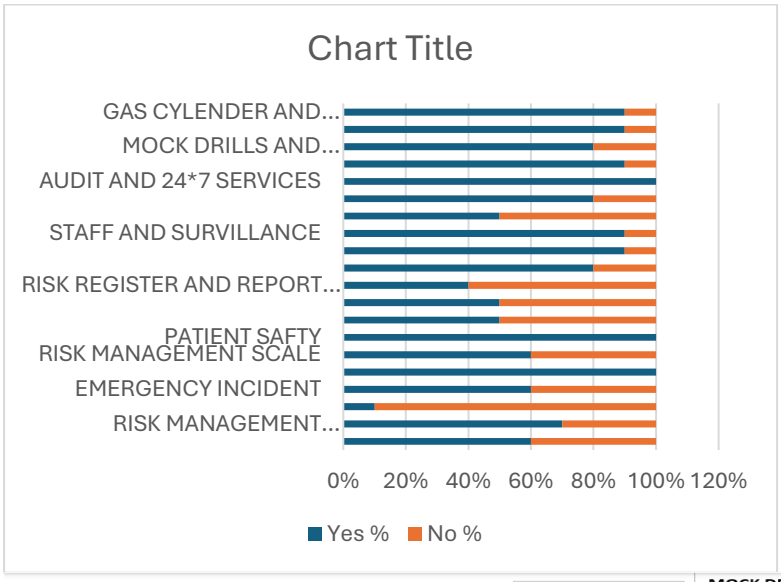
Quantitative Analysis: Scoring of checklist data (pre and post), comparison using percentages and trend visualization.

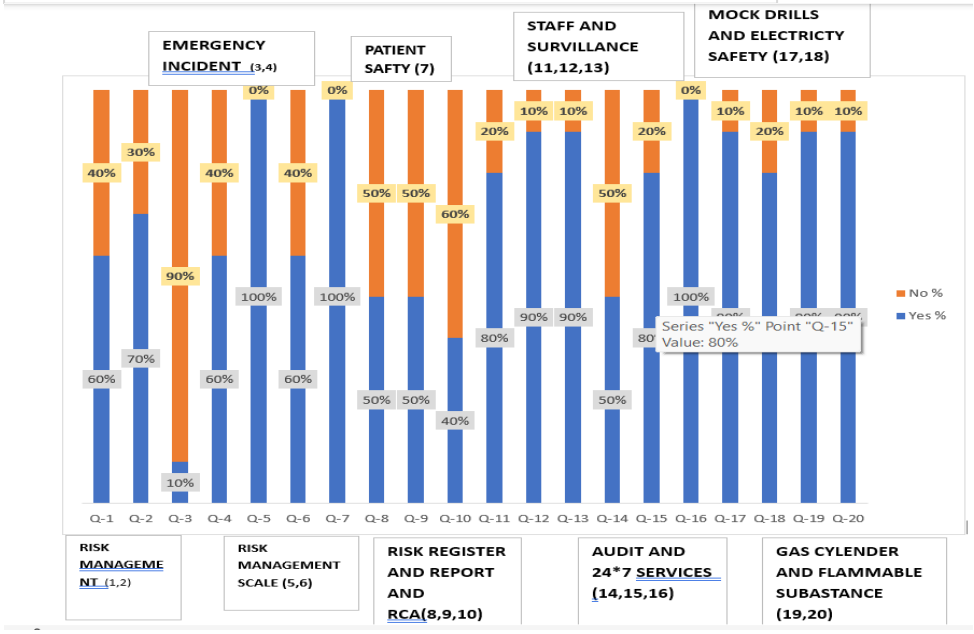
Qualitative Analysis: Thematic categorization of staff responses to identify systemic and behavioral gaps.

Trend Analysis: Improvement patterns across facilities, identification of persistent gaps.

8. Ethical Considerations

Verbal consent will be obtained from all participants.
Anonymity and confidentiality will be maintained.
Data will be used solely for academic and programmatic improvement purposes.





Risk Management Preparedness Score (Overall)

- **High Preparedness Areas**:
  Patient safety, 24×7 service delivery, electrical safety, staff deployment.
- **Moderate Preparedness Areas**:
  Committee formation, risk scale use, audits.
- **Low Preparedness Areas**:
  Emergency response systems, RCA, SOP documentation, training programs.

Results and Gap Findings

6. Results and Gap Findings

The study conducted across 10 district hospitals revealed a growing but uneven level of preparedness for implementing a comprehensive Risk Management System (RMS). While some key areas demonstrate encouraging progress, several operational and structural gaps still hinder full-scale readiness.

Strengths Identified:

One of the most promising findings is the universal adherence to basic patient safety practices, with all hospitals (100%) complying with core safety measures such as hand hygiene, signage, and standard infection control protocols. Additionally, 90% of hospitals had adequate provisions for the safe storage of gas cylinders and flammable substances, reflecting strong compliance in chemical and electrical risk areas.

A positive trend was observed in staff surveillance, deployment, and 24×7 service delivery, with over 85% of facilities maintaining functional staffing patterns and monitoring systems. The use of risk scaling tools (in 80% of hospitals) to assess the severity and frequency of incidents also shows a rising awareness and willingness to prioritize risks effectively. Mock drills and electrical safety checks were conducted routinely in the majority of hospitals, indicating a growing culture of emergency preparedness.

Area of Improvement:

The formation of Risk Management Committees in 65% of hospitals shows a foundational step toward institutionalizing risk governance. Although committee operations in some hospitals were irregular, their existence reflects intent and progress. Moreover, 76% of hospitals conduct internal audits, highlighting an ongoing effort to monitor quality and risk-related indicators.

Many facilities have begun incorporating risk documentation, though inconsistently. About 47% maintained risk registers and carried out root cause analysis (RCA) for adverse events. This partial implementation suggests that district hospitals are transitioning from reactive to proactive risk handling.

Gaps Identified:

Despite these improvements, some critical gaps still need to be addressed. Only 35% of hospitals had a structured emergency response system, with limited readiness for fire, infection outbreaks, or patient surges. Formal training on risk identification and reporting was lacking in 60% of the hospitals, indicating a need for focused capacity building.

Furthermore, the absence of clear Standard Operating Procedures (SOPs), the non-availability of risk communication tools, and the lack of a dedicated RMS officer or nodal point were common concerns. In many hospitals, risk events were underreported due to either a lack of awareness or fear of blame, pointing to a cultural barrier in adopting open reporting mechanisms.

Another noticeable gap was the lack of a dedicated budget for risk management activities, which limits procurement of essential safety tools and the institutionalization of periodic training, audits, and mock drills. Infrastructure gaps such as the absence of RMS rooms, outdated equipment, or poor digital systems for risk tracking, were observed in nearly half of the hospitals.

Conclusion of Findings:

While district hospitals show encouraging growth in patient safety awareness, staffing, emergency preparedness, and partial committee formation, they still face operational, training, and infrastructure-related challenges. The ongoing progress indicates a positive shift toward building safer, risk-resilient public health systems. However, this momentum must be supported with structured policies, trained personnel, strong monitoring mechanisms, and sustainable resource allocation to ensure comprehensive RMS preparedness.

Suggestion

1. Form a Risk Management Committee (RMC) with clearly defined roles and responsibilities.

2. Develop and implement SOPs for risk reporting, emergency handling, and patient safety.

3. Provide regular training to all staff on risk identification, reporting, and response.

4. Establish a non-punitive incident reporting system and maintain a Risk Register

5. Conduct regular mock drills and audits to assess emergency preparedness.

6. Appoint a dedicated Risk Management Officer and allocate necessary resources.

7. Monitor key risk indicators using dashboards or digital systems.

8. Promote a safety culture through regular awareness programs and staff engagement.