CHAPTER 8

Adequacy and effectiveness of Regulatory Mechanisms

8 Chapter *Adequacy and effectiveness of Regulatory Mechanisms*

Audit Objective: Whether adequate monitoring and regulatory systems had been put in place and had been effectively followed, for ensuring delivery of quality healthcare to the public.

Under the National Quality Assurance Scheme, there was no roadmap for attaining national standards, within any measurable timeframe. Due to inadequate numbers of meetings having been held, as well as and non-discussion of quality scores by the State and the district level committees, corrective actions had not been planned. A considerable number of health facilities had not furnished 'Key Performance Indicator' (KPI) information. The KPI dataset, reported by the health facilities, were also not discussed.

Maternal deaths had remained unreviewed, contradicting the facts claimed by the State. The State level Task Force had not followed the prescribed mechanism of centrally reviewing maternal deaths. Child deaths were not been reviewed in the State, at any level.

8.1 National Quality Assurance Scheme (NQAS)

The Ministry of Health & Family Welfare, GoI, in order to support and facilitate a sustainable quality assurance programme for the public health system in the country, framed (2013) guidelines under NHM, for Quality Assurance, which were adopted by the State in 2014. The guidelines introduced a scoring system, against a set of standards, indicators and other measurable elements, for continuous internal assessment, to be carried out by the facility itself at least once in a quarter, followed by preparation and implementation of an action plan, for bridging the observed gaps.

A State Level Quality Assurance Committee (SQAC) was to be formed, to oversee quality assurance activities across the State and ensure regular and accurate reporting of various Key Performance Indicators (KPIs). The SQAC was to develop a roadmap for achieving the national standards; ensure orientation and training; conduct six-monthly review meetings; and define targets/ road maps, for corrective actions, on review of the quality scores of the public health facilities of the State. The Committee's review reports were to be uploaded onto the State's website.

A State Quality Assurance Unit (SQAU) was to act as a working arm of the SQAC. With the same terms of reference as the SQAC, the SQAU was to develop a plan for quality assurance, at each level of health institution, in a phased manner; develop a field travel plan for visits to districts; and compile and collate the monthly data received from the districts in regard to the KPIs.

At the district level, District Quality Assurance Committee (DQAC) and District Quality Assessment Unit (DQAU), were to carry out similar functions.

District Quality Assessment Teams (DQTs) were to be formed, at each District Hospital (DH), for carrying out internal assessment of the DH and the health institution below the DH level, under the scheme. Once the DQT had completed these assessments, the DQAC and SQAC were to ensure external assessments

of all facilities, were carried out, on a quarterly and bi-annual basis, by the District and State assessors. This process was to continue, till the SQAC assessors had certified the attainment of quality standards at the hospital. Thereafter, the DQTs were to maintain the standards.

Review of records and replies showed that no comprehensive road map had been devised by the SQAC, for attaining the national standards, within any measurable timeframe.

In regard to the trainings conducted by the SQAC, no details of the year-wise trainings conducted and the number of participants, had been provided by the Health & Family Welfare Department, GoWB, though sought for. An analysis of the funds approved by GoI, for the purpose of imparting Quality Assurance trainings, during the audited period, and the utilisation of the same, revealed significant non-utilisation of the funds, as shown below:

Table 8.1: Utilisation of GoI funds for training on Quality Assurance

(₹ in lakh)

Financial Year	OB	Budget Allotted, as per Record Of Proceedings	Expenditure	CB
2016-17	**--**	479.98	103.04	**376.94**
2017-18	**376.94**	0.00	19.52	**357.42**
2018-19	**357.42**	83.53	12.49	**428.46**
2019-20	**428.46**	70.73	17.83	**481.36**
2020-21	**481.36**	4.19	6.80	**478.75**
2021-22	**478.75**	56.80	18.48	**517.07**
Total		**695.23**	**178.16**	

*Source: Records furnished by H&FW Department; *Financial Management Report*
Note: OB as of April 2016, if any, has been ignored, for the purpose of this analysis

Non-utilisation of 74.37 *per cent* of the GoI grants, by the SQAC, was indicative of the fact that the targets for training of staff, had remained grossly unachieved, under the scheme.

The Department in its reply (February 2024) offered no response in this regard.

8.1.1 Lack of review through SQAC meetings

The Committee had to conduct review meetings at six-monthly intervals. However, against the normative 12 meetings, which had fallen due in the period audited, minutes of only four State level SQAC/ SQAU meetings could be produced before Audit, as detailed below:

Table 8.2: Minutes of SQAC/ SQAU meetings

Committee	Date of meeting	Issues discussed in the meeting
State Quality Assurance Committee (SQAC) (formed on 14.01.2014)	08.07.2015	The importance and strengthening of the fumigation procedure, planned training programme for infection control measures, implementation of uniform signage system across all hospitals, quality of diet supply to indoor patients with proper dress code, training on hygiene, antibiotic policy to be implemented at the State level *etc.*
	22.06.2017	Removal of solid waste by rubberised mops, nursing personnel to be properly trained about dismantling the laparoscopes, removing blood clots meticulously and proper sterilisations. One team at each DH/ SDH/ SGH was to monitor for quality of diet supplied and one dietician was to be engaged, for different medical colleges, One internal quality assurance was to be developed in respect of the Medical College Pathology or Bio-chemistry Department and Mercury spill, management kits to be maintained at Hospitals, in all wards and user areas *etc.*

Committee	Date of meeting	Issues discussed in the meeting
	27.07.2021	Implementation of LaQshya in all the Medical College and Hospitals, building an IT-based patient information system, where all details of mothers be generated from a single portal, for the reduction of referral rate and implementation of referral audit, to assess the cause of all referrals and take preventive measures from all types of hospital.
State Quality Assurance Unit (SQAU) (formed on 28.04.2015)	05.04.2016	Developing a field visit plans to the districts, by the members of the SQAU, Meetings at the district level (DQAC and DQAU) being more regular and timely, lists of non-functioning equipment of hospitals undergoing quality assurance to be collected in a format that would be finalised by the Ophthalmology Dept., State officers nominating experts, specifically for training programmes organized at district hospitals in the evening slots, Orientation of DQAC and DQAU, sharing field visit reports on quality assessment and discussing the way forward for improving services.

Source: SQAC/ SQAU meetings State level

It may be seen from **Table 8.2** that, not only had very few SQAC/ SQAU meetings been held, but also, in none of the meetings had the assessed scores of the public health facilities been reviewed by SQAC. Thus, defining of targets/ road maps for taking corrective action, on review of quality scores, had not been done at the State level.

In reply, the Department stated (February 2024) that two SQAC meetings had been conducted in the year 2023 and regular SQAC meetings are being conducted now. No details/ documents in support, however, have been provided.

As per norms, DQAC meetings were to be conducted on a quarterly basis. It was, however, observed that only 28 DQAC meetings had been conducted, instead of 116, in the selected districts, with a shortfall of 75.86 *per cent* in conducting DQAC meetings.

Table 8.3: Conduct of DQAC meetings in the selected districts

District	DQAC meetings to be conducted as per norms (2016-22)	Target for conducting DQAC meeting (2016-22)	No. of meetings conducted	Shortfall percentage
Bashirhat Health District	20 (As the health district was formed in F/Y 2017-18)	20	7	65
Jalpaiguri	24	12	8	66.66
Paschim Medinipur	24	0	2	91.66
Purulia	24	24	3	87.5
Uttar Dinajpur	24	24	8	66.66
Total	**116**	**80**	**28**	**75.86**

Source: DQAC/ DQAU meetings of test-checked District

In reply, Department while acknowledging (February 2024) the fact regarding inadequate DQAC meetings, stated that in the year 2023, 60 DQAC meetings had been conducted across districts. No documentary evidence, however, was provided.

8.1.2 State level Assessments not done

As per the records provided by the State Department, State level assessments had been carried out (under NQAS) for only 20 health facilities[183] (15 in 2019

[183] *Jalpaiguri DH, Kalimpong DH, Siliguri DH, Rajgunj RH, Mirik BPHC, Jashodanga RH, MR Bangur DH, Vidyasagar SGH, Katwa SDH, Durgapur SDH, Bolpur SDH, Suri DH, Balurghat DH, Gangarampur SDH, Tarakeswar RH, Silbarihat PHC, Oodlbari RH, Kalna SDH, Jangipara RH, Joypur BPHC*

and 5 in 2021), against the 1,382 health facilities[184] in the State (from the PHC level, up to the DH level), during the period checked by audit. Out of these, 12 health facilities had obtained National Certification.

The Department eventually accepted the shortfall by stating (February 2024) that it has conducted 1,053 State level Assessments of MCHs to Sub-centres under NQAS including assessments under LaQshya & MusQan scheme in 2023. However, no document in support was provided.

8.1.3 Monitoring of Key Performance Indicators (KPI)

The State Department issued an order, in March 2015, that, as part of the Quality Assurance programme under NHM, all hospital authorities of the State were to collect and collate critical data from their various departments, calculate certain performance indicators and monitor them on a monthly basis. These identified Key Performance Indicators (KPIs), were to be reported to the DQAC and SQAC, for monitoring, on a monthly basis and addressing the gaps in performance.

Review of the records however, revealed that none of the 916 PHCs, only 329 out of 348 BPHCs/ RHs, one of the 40 other decentralised/ teaching hospitals, 10 of the 42 Super Speciality Hospitals and none of the Medical College Hospitals of the State, has reported the KPI data, during the test-checked year 2021.

Moreover, the SQAC, as discussed above, had not met, to review the dataset reported by the health facilities and nor had it discussed the KPIs in its meetings. Thus, the purpose of the scheme had remained unfulfilled.

In the test-checked districts/ units, it was observed that internal assessment had not been carried out at 37 of the 38 test-checked SCs. It had not been done in 14 PHCs (out of 19 PHCs), in five CHCs (out of the seven CHCs whose data was available) and one SDH (Islampur), out of five test-checked DH/ SDHs. External assessments had been carried out in only seven PHCs and one CHC, out of the eight health facilities whose internal assessments had done ***(Appendix 8.1 to 8.3)***.

The State Government, in its reply, stated (December 2023) that all the facilities have been requested to conduct internal assessments after forming facility level Quality Improvement/ Assurance Teams. Shortage of manpower has been sited as one of the reasons for not conducting the assessments. After completion of internal assessments, external assessments of the eligible facilities would be carried out.

The Department subsequently stated (February 2024) that Quality Assurance Teams have now been constituted and internal assessments are carried out in every tier of facility. It was also stated that all facilities except 718 PHCs are now reporting in KPI portal. No documentary evidence, however, has been furnished by the Department.

8.1.4 Patient Satisfaction Surveys and Medical & Death Audits

The Health Department stated that: (i) Patient Satisfaction Surveys (PSSs), of OPD and IPD patients, are conducted across all facilities and (ii) medical and death audits are also conducted for all deaths across the State.

[184] *DH: 18 + SDH: 36+ SGH:24 + Other Hosp.: 40 + RH/ BPHC: 348 + PHCs: 916 = 1382 Health facilities*

In the 19 test-checked PHCs, Patient Satisfaction Surveys had not been conducted at 16 PHCs. While none of the test-checked PHCs had carried out death audits, medical audits had also not been conducted in 18 of the test-checked PHCs ***(Appendix 8.2)***. Patient Satisfaction Surveys had not been conducted in five of the 10 test-checked CHCs. Neither Medical Audits, nor Death Audits, had been conducted in any of the test-checked CHCs ***(Appendix 8.3)***. Medical audits had never been conducted in Islampur SDH and Raghunathpur SDH.

In reply, State Government stated (December 2023) that communications will be made to conduct PSS in the bedded PHCs. Medical audit is only conducted in PHCs undergoing State Certification under NQAS. No comments in respect of non-conduct of such audits in other facilities were made.

The Department in its further reply (February 2024) stated that Patient Satisfaction Survey, medical audits and death audits have been rolled out in all tiers of facilities from 2023 onwards. This, however, was not mentioned by the Department in its reply in December 2023. No documentary evidence was also furnished in support by the Department.

Recommendation:

19. The H&FW Department may ensure conduct of regular meetings, by the State Level and District Level Committees, for discussion on the information received as Key Performance Indicators (KPIs), from the health facilities, for identifying and plugging gaps, for maintaining the healthcare services at an optimal level.

8.2 Maternal and Child Death Reviews

8.2.1 Maternal Death Review (MDR)

Maternal Death Review (MDR) is an important strategy for improving the quality of obstetric care and reducing maternal mortality and morbidity. The importance of MDR lies in the fact that it provides detailed information on various factors relating to the health care facilities at the district, community, regional and national levels, that need to be addressed, to reduce maternal deaths. GoI had requested the State (2010) for issuing a GO, making MDR mandatory, by involving District Collectors in the maternal death review process and making the CMOH responsible for reviewing all maternal deaths.

The State Government, in line with the central norms, had issued guidelines in this regard, in July 2010. Two methods of investigation were adopted for every maternal death, *viz.* Community-Based Maternal Death Review (CBMDR) and Facility-Based Maternal Death Review (FBMDR). CBMDR is a technique, wherein the family members, relatives, neighbours or other informants and care providers are interviewed and asked for a narrative, to elicit information on the events leading to the death of the mother during pregnancy (in their own words), to identify the medical and non-medical (including socio-economic) factors responsible for the death of the mother. FBMDR, on the other hand, aims to identify various delays causing maternal deaths in the health facilities and to enable the health system to take corrective measures, at various levels.

Every district was supposed to have a committee for maternal death reviews. The District MDR Committee had to review all the maternal deaths in the district, once every month, on a pre-fixed date. The MDR committee under the

CMOsH, was to receive two types of MDR reports. One was the CBMDR, from the block medical officers, based on the verbal autopsy[185] conducted by the ANM in regard to the area of residence of the deceased mother. The other was the FBMDR, from the Nodal Officer/ ACMOH, for MCHs/ DHs/ SGHs/ SDHs/ RHs/ BPHCs/ PHCs/ Sub-Centres and other private and decentralised Hospitals. However, CBMDR was to be taken up mandatorily for all deaths that had occurred in the specified geographical area of the deceased's residence, irrespective of the place of death, be it at home, facility or in transit.

The District MDR Committee was to prepare reports, in the form of Case Summaries, of all the maternal deaths reviewed by the Committee and share the findings with the DM. The DM would then have the option of reviewing, in detail, a sample of these deaths, in the quarterly meetings (DQAC meetings). The minutes of the meetings were to record the corrective measures discussed by the Committee, for being taken in at the community level, and at the facility level, as also the issues needing intervention at the State level, with timelines.

A State level Task Force (SLTF), headed by Principal Secretary H&FW Department, also was to be constituted. It was to meet once in six months, to review the analyzed data at the State level. This was to be followed by feedback to the districts and action at the State level, if any. SLTC was also to discuss the actions taken on the minutes of the last meeting and make recommendations to Government, for policy and strategy formulation. Every year, an annual maternal death review report for the State was to be prepared and a dissemination meeting was to be organized, to sensitize the various service providers and managers.

The list of districts, having MDR Committees, under the chairmanship of the CMOHs and the District Maternal Child Health Officers (DMCHOs), as the nodal officers, were not furnished to Audit, though asked for.

Further, the number of monthly meetings conducted by the District MDR Committees, as furnished in the reply given by H& FW Department, was unrealistic, as shown below:

Table 8.4: Number of meetings conducted by the District MDR Committee

Financial Year	Number of meetings conducted	Remarks
2016-17	1,240	Had all 27 districts (including the health districts) of the State conducted the monthly review meetings regularly, the maximum number of meetings would have been 324 (27 x12) in a given year. Therefore, these number of meetings, as furnished in the reply, seems unrealistic.
2017-18	1,126	
2018-19	786	
2019-20	756	
2020-21	967	
2021-22 *(Upto January)*	773	

Source: Reply of West Bengal State Health Samity

The Department in its reply accepted (February 2024) the fact of erroneous supply of information and stated that the number shown against the column of meetings were actually the number of maternal deaths reviewed by the District MDR Committee. Number of monthly meetings conducted by District MDR Committees, however, was not provided.

[185] *The verbal Autopsy technique involves interviews of family members, relatives, neighbours or other informants and care providers, for eliciting information on the events leading to the death of the mother during pregnancy/ abortion/ delivery/ after delivery and recording/documenting, in their own words, the medical and non-medical (including socio-economic) factors involved in the death of the mother.*

As per norms, each maternal death, in the State, was to be reviewed, by following the CBMDR and FBMDR mechanism. However, records showed that a considerable number of maternal deaths had remained unreviewed, as shown below:

Table 8.5: Review of maternal deaths

Financial Year	Maternal Deaths occurred at				Maternal Deaths Reviewed	
	Home	Health care Facilities	In transit	Total Maternal Deaths	CBMDR	FBMDR
2016-17	90	1,121	97	1,308	818	779
2017-18	64	1,170	91	1,325	667	790
2018-19	44	1,038	86	1,168	734	673
2019-20	28	898	100	1,026	689	625
2020-21	58	1,040	108	1,206	785	746
2021-22	37	918	82	1,037	654	761
Total:	**321**	**6,185**	**564**	**7,070**	**4,347**	**4,374**

Source: NHM data (State level)

As evident from **Table 8.5**, there was a shortfall of almost 39 *per cent* (only 4,347 deaths had been reviewed, against the total of 7,070 deaths) in respect of CBMDR whereas in respect of FBMDR a shortfall of 29 *per cent* (only 4,374 deaths were reviewed against 6,185 deaths at health care facilities) was noticed.

In reply, the Department stated (February 2024) that in 2022-23, 87 *per cent* of FBMDR and 73 *per cent* of CBMDR were conducted and thrust is given to achieve 100 *per cent* FBMDR and CBMDR.

However, FBMDR in respect of 13 *per cent* maternal deaths and CBMDR in respect of 27 *per cent* of maternal death still remained unreviewed.

The status of review, in the five (5) selected districts showed that a considerable number of maternal deaths had remained unreviewed, as below:

Table 8.6: Review of maternal deaths in the test-checked districts

Financial Year	Maternal Deaths occurred at				Maternal Deaths Reviewed	
	Home	Health care Facilities	In transit	Total Maternal Deaths	CBMDR	FBMDR
2016-17	23	150	13	186	168	63
2017-18	18	121	20	159	131	50
2018-19	14	139	14	167	109	38
2019-20	7	135	21	163	114	63
2020-21	13	167	27	207	154	99
2021-22	11	170	31	212	182	117
Total:	**86**	**882**	**126**	**1,094**	**858**	**430**

Source: NHM data (State level)

Thus, though the State level figures showed almost equal figures for CBMDR and FBMDR, figures of the test-checked districts showed that only 430 (48.75 *per cent*) of the 882 institutional deliveries had been reviewed by the facilities where the deaths had taken place. A considerable number of deaths had remained unreviewed for CBMDR also.

Further, in the nine test-checked DHs/ SDHs/ MCHs, out of 495 deaths, only 242 deaths had been reviewed by these health care facilities, leaving 51.11 *per cent* deaths unreviewed.

In regard to the formation of the State Level Task Force (SLTF) and convening of six-monthly review meetings, with the aim of reducing maternal mortality, it

was observed that, though the SLTF had been formed (2014), the data of only two meetings (one in August 2014 and one in April 2022) could be produced to Audit. However no minutes, of these meetings, were produced. Further, some documents (pertaining to 2019-2022) were produced before Audit, showing intermittent action having been taken, in regard to the increasing trend of maternal deaths in some districts/ health institutions, including field visits and issue of directions. However, the prescribed mechanism of centrally reviewing the CBMDR and/ or FBMDR, at the State level, to identify gaps, prepare of action plans and execute them, had not been followed.

In reply (February 2024), while admitting the fact, the Department did not furnish any reason for not holding the meeting at prescribed interval. It was further claimed that weekly review of maternal deaths has been undertaken for last two years.

No annual MDR report had been prepared, at the State level, for any of the years covered under audit. Further, no dissemination meetings had been organised, in any year, to sensitize the various service providers and managers.

In regard to the selected health facilities, in the test-checked districts, it was observed that, as per the information furnished by the facilities, CBMDR of all the Maternal Deaths Reported in the Blocks and FBMDR, in regard to two deaths that had occurred in the health care facilities, had been conducted. However, it was observed that Rudrapur RH, and Sandelerbil RH of North 24 Parganas, had not formed any facility-based MDR Committee, till FY 2021-2022. Thus, deaths had remained unreviewed/ had been improperly reviewed.

Moreover, in respect of Sabang RH, Paschim Medinipur district, two deaths were reported in the block during FY 2016-17 and one death in 2018-19. The hospital authorities admitted that these deaths had occurred on account of lapses in the Government mechanism[186] ***(Appendix 8.3)***.

8.2.2 Child Death Review

Improving child survival and development is one of the key goals of the National Health Mission. Child Death Review (CDR) is a step in this direction. The purpose of this review is to establish a mechanism, through which all child deaths are reported, investigated and accounted for. At the same time, it enables the concerned authorities at the block and district level to take corrective measures for averting such deaths in future.

The H&FW Department had issued guidelines[187] in April 2015, for conducing CDR of children, in the age group of 0 to 5 years. CDR, like MDR, was of two types for every child death, *viz.* Community-Based Child Death Review (CBCDR) and Facility-Based Child Death Review (FBCDR). The mechanism of the review was similar to that of the MDR. In CDR also, the same State Level Task Force was the apex monitoring and reviewing authority.

Scrutiny of records, however, showed that, in disregard of its own formulated guidelines, no child deaths had been reviewed in the State, at any level. There was no documentary evidence of the functioning of the State Level Task Force for child death reviews. Records showed that the State Department had

[186] *Delay in getting transport, sub-standard care in hospital, dearth of blood/ equipment/ drugs, etc.*
[187] *H/ SFWB/ 9D-01-2013/ 4413 dated 02.04.2015*

circulated an order, along with the CDR guidelines, in April 2022, for commencing the review process, from April 2022 only.

In reply, the Department claimed (February 2024) that CDR has been started at the State level as well as facility level since April 2022.

8.3 Other controls

A survey of 38 doctors, conducted by Audit, across the test-checked CHCs, SDHs and DHs, brought out the following facts, which were indicative of the absence of some common regulatory mechanisms:

Table 8.7: Survey of doctors on common regulatory protocols

Issues raised in the Survey	No. of Doctors confirming the issue	Percentage
Registration number of the doctor not being displayed in the clinic, prescription, and receipts	19	50
Manuals on Standard Treatment Guidelines not being available in the doctors' chambers	18	35
Doctors not creating awareness among the patients regarding usage of prohibited drugs and educating them on their side-effects	16	37
Doctor opining that the applicable rules and regulations were not sufficient for regulating the Government health sector	21	49
No monthly meeting held among doctors, to discuss or address the issues faced by the hospital	16	37

Source: Doctor's Survey in the test-checked PHCs & CHCs

Further, another survey of 20 doctors, of the test-checked DHs and SDHs showed the following:

Table 8.8: Survey of 20 doctors of test-checked DHs and SDHs

Sl. No.	Issues raised through surveys	No. of Doctors Surveyed	No. of Doctors confirming the issue	Percentage
1	Doctor was not provided with all required infrastructure in the hospital to examine the patient	20	7	35
2	Doctor had to attend more than 50 patients (OPD/ IPD) on an average in a day	20	5	25
3	Doctor had to attend more than 100 patients (OPD/ IPD) on an average in a day	20	14	70
4	Patient influx was heavy	20	9	45
5	Registration number of the doctor was not displayed in the clinic, prescription and receipts	20	10	50

Source: Doctor's Survey in the test-checked DHs & SDHs

The Department in its reply (February 2024) offered no response in this regard.

8.4 Quality Assurance at Medical College and Hospitals

- As per provisions contained in the National Quality Assurance Standards, 2013, and State Govt. order[188] issued in January 2015, a five-member 'Family Planning Indemnity Sub-Committee', is to be formed, from within the District Quality Assurance Committee, to process claims, received from clients, as well as complaints/ claims lodged against surgeons and accredited facilities, as per the manual on the 'Family Planning Indemnity Scheme, 2013'. It was, however observed that no such sub-committee had been formed in RMC&H, during 2016-22. No information in this regard was furnished by the SSKM Hospital authorities.

[188] *Order No. NHM/ 1H-162-2013/ 06 dated 06.01.2015*

- The Quality Assurance Committee (QAC)[189], formed at RMC&H, had not conducted any quarterly review meetings, to take corrective measures and define targets and roadmaps, during the period covered under Audit. Quality Assurance Units[190], working arms of the QAC, had also not been formed.
- No Quality Team, with the Superintendent of the hospital as the head, had been formed of the RMC&H.
- Social Audit, through Rogi Kalyan Samity[191], had not been conducted, during the entire period of Audit.

The Department in its reply (February 2024) offered no response in this regard.

8.5 IT System at the SSKM Hospital

(i) Patients were being registered at emergency and OPD ticket counter, based on HMIS online software module after coming to the hospital. Though an online registration system was in operation, it is again to be validated at the hospital counter.

(ii) A system-developed registration number (**RG number**) was being generated against each registered patient. This number also served as the unique identity code for that particular patient.

(iii) Though it was possible to obtain the status of vacant beds online, at any point of time, in the HMIS system, this practice was not followed. In the absence of real-time vacancy position of beds, patient service was suffering.

(iv) The Store Management Information System (SMIS)[192] was being used to manage the stock position of various medicines and consumables, at the medicine and surgical store of the hospital. However, this system was not followed at different wards and OPD *etc.*, where the records of consumption of medicines and consumables were maintained manually. As a result, obtaining the status of availability of medicines and consumables, in the hospital as a whole, on a real-time basis was not possible.

The Department in its reply (February 2024) offered no response in this regard.

8.6 Maintenance of Medical Records at SSKM Hospital

(i) Preservation of medical records is required for future case reference, in connection with various court cases, processing insurance claims *etc.* It is used for research purposes also.

(ii) The process of keeping medical records of the Hospital, in a digitized form, had started since 2011, for the period 2009 onwards. Digitized records pertaining to 2017 were not available, due to reason(s) not stated on records.

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[189] *Quality Assurance Committee is responsible for monitoring the quality assurance efforts*

[190] *Quality Assurance Unit is to act as working arm of the Quality Assurance Committee to implement the directions of the QAC.*

[191] *RKS or Rogi Kalyan Samity is a registered society which acts as a group of trustees for the hospitals to manage the affairs of the hospital.*

[192] *SMIS stands for Store Management Information System. It is an online inventory management system of drugs, equipment and consumables in all secondary and tertiary tier hospitals in West Bengal. District Reserve Store at the district handles SMIS operation for all primary tier hospitals in a district.*

(iii) Medical reports of patients, including clinical test reports, BHTs[193], doctors' advice *etc.* were available in digitized form however, no case notes/ case narration were maintained.

(iv) As per provision of Order no. SBHI/ 2D-4/ 2016/ 259/ 1(33) dated 31.08.2016, OPD records, like case sheets and registration books, were to be disposed of after a period of five years. However, no OPD records either in hard copy or in soft copy were being preserved in the hospital.

(v) In case of requirement, records were retrieved on the basis of the discharge dates or expiry dates or Patient Admission numbers printed on the BHT. However, no unique identity (AADHAAR or any such number developed by the IT system) was attached with each individual patient.

(vi) Copies of medical records were not available in the Hospital's portal. There was no system of records which could make available online, to the patient or his/ her relatives after ensuring the patients' identity, through due technical process.

The Department in its reply (February 2024) offered no response in this regard.

Recommendation:

20. The H&FW Department may ensure that all maternal deaths are reviewed, for detection of the underlying causes and take remedial measures for minimising maternal mortality in the State. The H&FW Department may also ensure immediate commencement of reviews of the child deaths in the State.

[193] *'BHT' stands for Bed Head Ticket. It contains all the relevant data relating to the treatment of patient such as advice/test prescribed, findings etc. in a chronological order.*