COMPLIANCE REPORT – INSPECTION HELD ON 12th April 2016

Sr. No	OBSERVATION		COMPLIANCE
1	Deficiency of faculty is 8.57 % as detailed in the report. (i.e. 9 faculties are short.) **Details:-** Pharmacology- Assoc.Professor -01 General medicine- Asst.Professor-01 Paediatrics -Professor -01 Paediatrics- Assoc.Professor -01 Psychiatry- Asst.Professor -01 Orthopaedics-Asst.Professor- 01 Ophthalmology-Assoc.Professor -01 OBG-Professor -01 Dentistry-Professor -01		Truly speaking the 8.57% shortfall in faculty strength should not be considered as a deficiency, since it is coming well within the total permissible & allowed Norms / MSR. However, we would like to specify that on date 12-04-16 : **(a)** Actual deficiency was only 2 vacant posts (Assoc. Prof. Pediatric-1 & Asst. Prof. Psychiatry-1) out of the Total 105 as required under MSR. Now Dr. Arun M. Kooli is newly appointed Assoc. Prof. Pediatrics, joined on Dt. 02-05-16. Photocopy of his Declaration Form etc are enclosed. **(b)** 7 doctors had taken Pre-granted leaves from Dean. Hence they were not available on assessment date. But even the leave applications of 3 faculty due to sickness were ignored by Assessors and not counted. New Appointment of One Assoc. Prof. in Ophthalmology & One Asst. Professor, Psychiatry will be made shortly. The Declaration Form, Appointment Order and Joining report of New Faculty Dr. Arun M. Kooli is enclosed. ***Annexure -I***
2	Shortage of residents is 11.47% as detailed in the report. (i.e. 08 residents are short.) **Details:-** Gen. Medicine – Senior Resident -03 TB & chest – Senior Resident -01 Dermatology – Senior Resident -01 Psychiatry – Senior Resident -01 Orthopaedics – Senior Resident – 01 Anesthesiology – Senior Resident-01		Truly speaking the 11.47% shortage in Residents should not be considered as a deficiency, since it is coming well within the total permissible & allowed Norms / MSR. However, we would like to clarify that : On Assessment date 12-04-16 **(a)** Actual deficiency of SR was NIL. **(b)** 7 Sr. Residents of various departments were on Pre-granted leaves from Dean. Hence they were not available on assessment date. One S.R. in Gen. Medicine was not accepted as SR by the Assessor making the total deficiency to 8 SR. But even the applications of one SR who was on Leave due to sickness was ignored by Assessors and not counted. All those 7 SR who were on Pre-granted Leave have now resumed duty. New Appointment of One SR in Gen. Medicine will be made shortly.

3	OPD attendance was 723 on day of assessment against requirement of 800.		The City & District of Kadapa was in the grip of severe heat-wave at that time. Many heat related deaths were also reported. Documentary Evidence of Newspaper cuttings are annexed. ***Annexure – II.*** Hospital OPD, IPD, Bed Occupancy, Casualty etc are affected due to such incidental events. However, our OPD timings are from 9 am - 4 pm. But Assessor wanted the Computer Generated OPD Attendance Data from MRD for the period 9 am - 2 pm only. Data given was 723. But the Actual OPD Attendance for that day from 9 am - 4 pm OPD timings was 849. We showed this end of day computer generated data to Assessor at 4.05 pm. which he has not mentioned in report. Therefore our OPD attendance of Assessment Date 12-04-2016 fulfills the Requirements of Norms/MSR and there was No deficiency. The Photocopy of Assessment day Census is enclosed. ***Annexure – IV.***
4	Bed occupancy was 72.76% on day of assessment.		Because of heat wave that severely affected Kadapa as stated in item **3** above, many patients (more than 15) requiring treatment for Dehydration were already admitted in Medicine ward. One assessor visited the Medicine ward at 10 am and saw them in the bed, but did not count the admissions of these 15 Dehydrated Patients (who were in bed and taking IV treatment at that time) while computing his figure of 342 saying that these patients are having minor complaints. Whereas, Our Professors of Medicine had found the same 15 patients sent from Casualty to be fit for admission and to be given IV treatment indoors. These 15 patients ought to have been counted for bed occupancy. When these 15 are counted for the bed-occupancy figure would be 342+15=357 that is 75.95% This fulfils the Norms. Our Ethics does not allow us to decline admission to any such patient who is clinically sick and requires indoor treatment. Our record of actual bed occupancy shown to Assessors at 12 Noon on Assessment Day was 392 out of 470. i.e. 83.40 % Therefore no deficiency in Bed Occupancy existed on 12-04-2016. This noting of deficiency should be deleted by Council. The Photocopy of the Assessment day Censes is enclosed. ***Annexure –III.***
5	There is mismatch in IPD data provided by institute (392 out of 470 beds) & observed by assessors (342 out of 470)		Our Computer Generated Data of IPD from the MRD showed to Assessor was 392 out of 470. Assessor declined to accept our 50 Indoor Patients but accepted only 342. He considered this as a mismatch between his own hasty calculation and the data generated by our fully computerized MRD.

			Those 50 patients were physically present in hospital wards, seen present in the wards by the assessor but, they were not counted by him bringing down our Hospital Statistics of IPD and Bed Occupancy. Our Computer Generated Data should be considered valid and accepted. No deficiency or mismatch existed.
6	Casualty: patients admitted in casualty were not of serious nature. There were only 8 patients comprising of watering of eye, Nasal injury, Hypoglycaemia, Diarrhoea, Generalized weakness, Acute pneumonia, COPD & Diabetic neuropathy.		Many stressed patients prefer to come directly to Casualty in order to get an immediate attention to their illness without waiting in OPD Our 24 Hour Casualty Attendance on that day was 74. Even Non-Serious patients who want immediate medical attention can come directly to our casualty wherefrom they are either sent for admission to respective wards or discharged or even sent to OPD but, this is done only after proper clinical examination. We do not consider any illness as "Not of Serious nature" unless proper clinical examination & investigations are done. Some cases like Nasal injury, Hypoglycemia, Diarrhea, Generalized Weakness, Acute Pneumonia, COPD & Diabetic Neuropathy coming for treatment can anytime become serious if not attended in proper time. His comment should not be considered as a technical opinion of deficiency and therefore, should be removed / ignored by Council.
7	Many patients in wards were admitted for minor complaints which would not merit admission.		Just like Government Hospitals our hospital is also offering full-free services to all poor and down trodden people from rural back ground. Such patients utilize our services for various types of minor and major complaints. We do not send away or deny proper medical attention to any patient in OPD or IPD whether having Minor or Major complaints. Whether a patient merits admission or not is decided by clinical specialists only after due clinical examination and when they suspect a medical problem. Our Ethics does not allow us to decline admission to such patients who are clinically sick and require indoor treatment. Therefore this comment should not be treated as a deficiency and should be removed / ignored by the Council.
8	ICUs: Patients admitted in ICUs did not require intensive care. In SICU, there were 2 patients of Appendicectomy, 1 of Fistulectomy, 1 of Incisional hernia repair who did not merit admission in ICU. None of the patients in ICUs was on ventilator.		On Assessment day, in SICU there were 2 patients of Appendicectomy, 1 of Fistulectomy, 1 of Incisional hernia repair with a clinical condition of shock, peritonitis and profuse bleeding which required intensive care and therefore were in SICU as per the decision of treating Surgeons. The Assessor has made a hasty opinion on these 4 patients during his visit in SICU and without examination of these 4 Post-surgical patients. Therefore this comment should not be treated as a deficiency and should be removed / ignored by the Council. Ventilator is very much available in SICU and it is used whenever

			the clinical condition of patient requires it.
9	On random checking in Paediatrics ward, some patients had minor complaints not requiring admission.		On date 12-04-2016, there were 49 admitted patients in Pediatrics wards out of 60 beds. Patients having fever, diarrhea and vomiting require admission for investigations and observations which is done on the basis of the clinical judgment made by the treating Pediatricians to rule out the type of dengue fever dehydration etc. We do not send away or deny proper medical attention to any child in OPD or IPD whether having Minor or Major complaints. Hence some children with apparently minor complaints are also admitted so that our MBBS students get properly trained to distinguish, detect and compare the prognosis, signs and symptoms and clinical course of minor illnesses vis a vis those with major illness on the basis of investigative reports and thereby develop clinical skills and acumen in hospital wards. This is an essential part of Clinical training. Many major diseases in children often begin with minor complaints which we do not ignore. Therefore this comment should not be treated as a deficiency and be removed / ignored by the Council.
10	There were very few postoperative or trauma patient admitted in general Surgery or Orthopaedics ward, Majority of patients in Orthopaedics ward comprised of Osteoarthritis, Backache, Hemiplegia, Spondylitis not meriting admission. In Surgical ward, majority of patients comprised of abdominal pain, renal colic, Hemorrhoids, Gastroenteritis. Patients diagnosed as having hernia or Hydrocele did not have such condition in clinical examination. In other surgical branches there were very few post- operative patients.		On Assessment day, due to extreme summer and heat-wave conditions in Kadapa during that week, there were less number of scheduled planned surgeries which is an incidental event beyond our control, however 15 major and 21 minor surgical operations were done. We have not inflated our data which is fully computer generated. Such a situation is not always the case and variations in patient demographics do occur daily in every hospital of the country. But our Hospital being a teaching & training Institute for future doctors. We admit patients for all types of Surgical Orthopedic, ENT, Ophthalmological and OBG treatments as per the sound clinical judgment and advice of senior faculty. Only those which merit admission are taken indoors for further treatments after due investigations. Since surprise Assessment was in progress, some planned surgeries were also postponed to next date which further caused the diminished number of surgical work on that day.
11	There are some fake patients records as under. a) 2 Patients with same name & registration numbers were found to have been admitted on different days with different disgnosis such as Renal Colic & Epigastic hernia in the same ward, with overwriting on case paper. b) On random verification of O.T records, there was record of 2 patients operated for Hysterectomy on 06/04/2016		**(a)** No Fake patient were admitted in hospital on the assessment day and our Records were Not Fake. Neither our data is inflated. Our Ward Nominal Records show that there were two entries (1) and (2) of separate patients both having same name Mary and it is also in same hand writing. But all other details are completely different as follows : **(1)** Mary, r/o Pattasanghatipally, Kadapa, 30 Yrs, F. Unit-I, IP No. 108798, OP No. 857120, DOA : 11/04/16, DOD : 26/04/16 ; Diagnosis : Renal Colic. **(2)** Mary, r/o R. R. Pally, Kadapa, 39 Yrs, F. Unit-II, IP No. 108902, OP No. 857975, DOA : 12/04/16, DOD : 27/04/16; Diagnosis : Epigastric Hernia.

	(Shankaramani Regn#108497 & Rihana 108514): however post-operative gross specimens were not available in the laboratory though the register showed receipt of same.		Some overwriting seen was actually only a correction of transcription error made during writing on the case paper. **(b)** A total of 13 Post-Operative Gross Specimens were verified in laboratory by the Assessor on 12-04-2016. Gross specimens of the 2 operated patients on 06-04-2016 were actually available in the laboratory and also shown to Assessor by our Professor of Pathology namely Dr. Phani kumar. The Blocks Prepared and Reporting dispatched are also available in laboratory for verification. Photograph of the 2 Gross Specimens is enclosed in ***Annexure -VI*** Hence this deficiency pointed out did not exist.
12	There was no record of any Gynaecological Surgery after 06/04/2016 in O.T register.		For OBG, the regular/routine OT days are every Wednesdays and Fridays only. For Emergencies and selective cases we do the Gynecological surgeries 24 x 7 x 365 in the Emergency OT as and when required. Date 06-04-2016 was Wednesday but on Friday, 08 -04-2016 it was a Gazetted Govt. Public Holiday for Ugadi (Telugu New Year day) in Andhra Pradesh. Therefore all the Regular Planned Gynecological surgery cases were postponed to next OT date i.e 13-04-2016 (Wednesday) and therefore no record from 07/04/16 to 12/04/16 was made in OT Register. However All emergency cases like Caesarian Section etc, were conducted round the clock on all dates. Our daily Average of LSCS is 2 of which Assessor has noted and verified one LSCS performed before 1.00 pm and another during rounds 1 patient was in Labour. Hence this deficiency pointed out did not exist.
13	Other deficiencies as pointed out in the assessment report.		Other deficiencies as pointed out in the main report if any are already rectified.