Chapter - I

Performance audit of four major Public Hospitals in Delhi

A performance audit of the functioning of four major public hospitals in Delhi was conducted to assess their performance in terms of providing proper medical care by efficient use of available resources and infrastructure. The hospitals reviewed were Lok Nayak Hospital (LNH) and Deen Dayal Upadhyay Hospital (DDUH) under the Government of Delhi, Hindu Rao Hospital (HRH) under the Municipal Corporation of Delhi and Charak Palika Hospital (CPH) under the New Delhi Municipal Council. The performance audit covered the entire functioning of the four hospitals and brought out *inter alia* the following:

Highlights

The Budgetary and expenditure controls in the hospitals were inadequate leading to persistent savings under Plan heads and overpayment of electricity charges of Rs.6.23 crore in two hospitals.

(Paragraphs 1.6.1 & 1.6.3)

There were shortages in medical, para-medical and nursing staff in all the four hospitals that impaired their capabilities to render timely and efficient patient care. Despite a continuous overall increase in patient load in most of the hospitals, no exercise had been carried out to fill in the critical vacancies and review the adequacy of the sanctioned strength.

(Paragraphs 1.7.1 & 1.7.2)

There was overcrowding in the wards of indoor patients due to increased patient load without corresponding increase in bed strength and medical staff. There were abnormal delays in conducting diagnostic tests and surgeries resulting in increased waiting time and backlog.

(Paragraphs 1.8.1 & 1.8.2)

The casualty and emergency departments did not receive the necessary attention and priority in terms of infrastructure, supplies and manpower. Consequently, these were not adequately equipped to ensure proper emergent medical aid to the patients.

(Paragraph 1.9)

The procurement, installation and commissioning of 72 *per cent* of the medical equipment was delayed, hampering rendition of

prompt and quality medical care to the patients. Against the laid down norms, LNH and HRH accepted from the suppliers medicines and vaccines valuing Rs. 1.04 crore with reduced shelf life.

(Paragraph 1.10)

More than 50 *per cent* usage of ambulances in the four hospitals was for purposes other than patient care. The ambulances in LNH and CPH were also not equipped with essential equipment for basic life support.

(Paragraph 1.12)

Three out of four hospitals could not make available 19 to 26 *per cent* of the essential life-saving drugs and medicines to the patients suffering from serious diseases including the terminally ill patients, though such essential drugs and medicines were required to be stocked by the hospitals at all times.

(Paragraph 1.13)

Efforts to augment the facilities in two hospitals were affected by inordinate delays in execution of works resulting in cost escalation of Rs. 3.43 crore. Possession of a building for a 140 bedded Trauma-cum-Emergency Block in DDUH could not be taken by the hospital management even two years after its completion and investment of Rs. 7.78 crore.

(Paragraph 1.14)

The management and handling of bio-medical waste in the hospitals was deficient. There was lack of proper segregation and handling of bio-medical waste in LNH and HRH in contravention of the Bio-Medical Waste Rules 1998, thereby increasing risk of infection.

(Paragraph 1.15)

The functioning of Hospital Infection Control Committees for prevention and control of hospital associated infections was deficient and the patient grievance redressal mechanism was weak.

(Paragraph 1.16)

Summary of main recommendations

- *For efficient management of the financial resources, the department should exercise effective control over payments of various charges and ensure early adjustment of contingent advances including the pending ones. Persistent savings under plan head needs to be avoided.*

- *The hospital and departmental authorities should undertake a manpower review to assess the actual requirement of manpower hospital-wise and take effective steps to fill in the critical vacancies so that the ability of the hospitals to offer the full range of intended medical care services is not hindered.*

- *The department should review and strengthen medical infrastructure facilities across all government and municipal hospitals to reduce the waiting time of the patients for various investigations and surgeries as well as tackle the problem of overcrowding due to increasing patient load.*

- *The system of procurement of equipment and medicines need to be streamlined to cut down delays so as to ensure that the benefits in terms of enhanced patient care accrue from the investments made.*

- *Procurement and stock management of drugs and medicines should be such as to ensure availability of essential drugs at all times. Stock registers must be maintained at the ward and OT levels to guard against pilferages and wastages.*

- *The department should take immediate action to ensure strict adherence and conformity with the Bio-Medical Waste (Management and Handling) Rules 1998.*

1.1 Introduction

While medical care facilities in the National Capital Territory (NCT) of Delhi are provided by various agencies under the administrative control of the Union or NCT Government, the major share of health care facilities is provided by hospitals of the Government of Delhi and the two municipal bodies. The quality of health care provided in these hospitals has been a matter of public concern and interest and the Government of Delhi has identified improvement of health care facilities as one of its primary areas of interest. A performance audit was undertaken of four major public hospitals in Delhi, viz. Lok Nayak Hospital (LNH) and Deen Dayal Upadhyay Hospital (DDUH) which are under the Government of Delhi, Hindu Rao Hospital (HRH) under the Municipal Corporation of Delhi (MCD) and Charak Palika Hospital (CPH) under the New Delhi Municipal Council (NDMC). These four hospitals together have a bed strength of 3,227 which constituted 32 *per cent* of the total bed strength of public hospitals under the Government of Delhi and the municipal bodies. The hospitals provide medical facilities for outdoor as well as indoor patients in all major specialties viz. medicine, pediatrics, surgery, orthopedics, gynecology, eye care, ENT, dental care, etc. along with round the clock casualty and emergency services.

LNH and DDUH function under the administrative control of the Department of Health and Family Welfare of the Government of Delhi headed by the Principal Secretary (Health) while HRH and CPH function under the control of Commissioner MCD and Chairperson NDMC respectively. LNH, DDUH and HRH are headed by Medical Superintendents and CPH is headed by a Director (Health Services) who are assisted by Additional Medical Superintendents.

1.2 Scope of audit

The performance audit covering the period from 2001-02 to 2005-06 was conducted between March and July 2006 with specific focus on areas such as management of financial and manpower resources, development of infrastructure, procurement of equipment/medicines and the quality, economy and effectiveness of patient care.

1.3 Audit objectives

The objectives of the performance audit were:

- to assess the efficiency of utilization of funds;
- to assess the utilisation of manpower and augmentation of resources with reference to the prescribed norms and objectives;
- to assess the economy, effectiveness and quality of patient care provided by the hospitals;
- to assess the economy and effectiveness of the system of procurement and utilization of medical equipment and stores ; and
- to evaluate the adequacy and effectiveness of bio-medical waste management and prevention/control of hospital associated infections.

1.4 Audit criteria

The criteria used for the performance assessment were:

- the extent of utilization of funds with reference to funds budgeted and sanctioned;
- the sanctioned strength of medical staff and norms, if any, prescribed by medical councils;
- the adequacy of infrastructure with reference to patient load; and

- the adherence to norms and procedure for procurement of medical equipment and stores and their utilisation towards patient care and the provisions of the bio medical waste management rules.

1.5 Audit methodology

The audit methodology included:

- scrutiny of the records of the hospitals and the administrative departments concerned;
- analyzing data and evaluating performance with reference to stipulated audit criteria;
- inviting comments of the medical superintendents on the preliminary audit findings along with confirmation of facts and figures; and
- obtaining the views and comments of the administrative departments concerned on the audit observations and the proposed audit recommendations.

Audit Findings

1.6 Financial management

1.6.1 Allocation and utilization of funds

Funds for the government hospitals and plan funds for hospitals under the MCD are allocated by the Department of Health and Family Welfare while funds for the hospital under NDMC are allocated by the Urban Development Department of the Government of Delhi. The allocation and utilization of funds in the four hospitals during the years 2001-02 to 2005-06 were as follows:

Table 1.1: Budget Allocation and Expenditure

(Rs. in crore)

	LNH						DDUH					
Year	Plan			Non-Plan			Plan			Non-Plan		
	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)	Alloca-tion	Actual expen-diture	Excess(+)/S avings(-) (% age)	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)
2001-02	27.05	26.52	(-)0.53(2)	58.71	58.23	(-)0.48(0.8)	18.00	14.12	(-)3.88(21)	23.42	23.23	(-)0.19(0.8)
2002-03	19.40	19.35	(-)0.05(0.3)	63.50	63.45	(-)0.05	16.00	15.14	(-)0.86(5)	24.41	24.25	(-)0.16(0.7)
2003-04	18.25	18.12	(-)0.13(0.7)	60.02	59.93	(-)0.09(0.1)	15.00	11.76	(-)3.24(22)	25.13	25.09	(-)0.04(0.2)
2004-05	30.00	29.88	(-)0.12(0.4)	65.80	65.75	(-)0.05	23.00	19.21	(-)3.79(16)	28.76	28.68	(-)0.08(0.3)
2005-06	46.00	45.88	(-)0.12(0.2)	67.95	67.72	(-)0.23(0.3)	32.00	26.54	(-)5.46(17	29.85	29.56	(-)0.29(1)

(Rs. in crore)

Year	HRH						CPH					
	Plan			Non-Plan			Plan			Non-Plan(*)		
	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)	Alloca-tion	Actual expend-iture	Excess(+)/ Savings(-) (% age)
2001-02	2.80	2.45	(-)0.35(13)	39.71	34.60	(-)5.11(13)	0.50	0.37	(-)0.13(26)	5.00	4.81	(-)0.19(4)
2002-03	2.70	2.15	(-)0.5 5(20)	43.26	39.52	(-)3.74(9)	0.35	0.08	(-)0.27(77)	5.46	6.05	(+)0.59(11)
2003-04	2.10	2.19	(+)0.09(4)	44.27	37.48	(-)6.79(15)	0.51	0.28	(-)0.2(45)	6.09	6.11	(+)0.02(0.3)
2004-05	2.30	2.30	NIL	46.10	36.38	(-)9.72(21)	0.60	0.59	(-)0.01(2)	7.96	8.28	(+)0.32(4)
2005-06	1.55	1.53	(-)0.0 2(1)	57.65	38.98	(-)18.6(32)	0.20	0.19	(-)0.01(5)	7.3 7	8.59	(+)1.22 (16)

(*)Allocation/expenditure under medicines and equipments for the years 2004-06 meant for whole medical sector of NDMC.

While allocated funds were utilized almost fully by LNH, there were persistent savings in DDUH under the Plan head ranging between 16 to 22 *per cent* in all the years except 2002-03. A detailed analysis of the expenditure in DDUH revealed that there were savings of 22 to 98 *per cent* under individual heads like machinery and equipment and computerization of hospital records.

Utilisation of funds in HRH was not very efficient as substantial amounts remained unutilized under Plan heads. In HRH, there were savings of 13 and 20 *per cent* during 2001-02 and 2002-03 respectively under Plan head and in CPH savings were as high as 26 to 77 *per cent* during 2001-04.

Of the four hospitals, HRH could not fully utilize allocations under non-Plan heads.

Such repeated savings reflected poor budgeting practices, inefficient funds management and poor implementation of plan schemes and projects. In fact, the funds which remained unutilized could have been assessed by the hospitals at the Revised Estimates stage and surrendered for better utilization in other priority areas.

MCD stated (November 2006) that it would ensure full and optimal utilization of allocated funds/budget. No replies were received in respect of the savings from the other three hospitals.

1.6.2 Non-adjustment of advances

Rules[*] stipulate that moneys drawn on abstract contingent (AC) bills for payment of advances to suppliers of stores should be adjusted within a period of one month from the date of drawl by submission of detailed bill. Scrutiny of records of the hospitals for the years 2001-06 revealed that advances of Rs.16.41 crore (LNH-Rs.9.82 crore, DDUH-Rs.6.17 crore and HRH-Rs.42 lakh) drawn on AC bills during the years 1996-97 to 2005-06 mainly for opening of letters of credit (LOC) for procurement of equipment from foreign

[*] Rule 118 of Receipts and Payments Rules

suppliers had not been adjusted as of June 2006 due to non-submission of adjustment accounts by the banks. During the years 2004-06, LNH and DDUH had received refunds amounting to Rs.88.45 lakh after adjustment of the advances. Hence, inordinate delay in adjustment of these advances drawn on AC bills involved the possibility of deferring the refund of government funds lying for prolonged periods with the banks.

Government stated (October/November 2006) that Rs.6.32 crore and Rs.0.32 crore had been adjusted in LNH and DDUH respectively and efforts were being made to settle the remaining advance in LNH. MCD stated (November 2006) that efforts would be made to get the advances adjusted in respect of HRH. Such delays ranging upto nine years in adjustments of advances drawn for opening LOC indicate lack of effective control and monitoring, and deficient financial management.

1.6.3 Avoidable expenditure on payment of electricity charges

Expenditure on electricity is an important component of hospital expenditure. The electricity tariff provides that domestic rates may be charged for electricity consumed by hospitals.

Scrutiny of the records for the period from July 2002 to May 2005 of LNH and DDUH revealed that the hospitals paid energy charges and demand charges amounting to Rs.23.19 crore at non-domestic rates resulting in excess payment of Rs.6.23 crore as shown in the table below:

Table 1.2: Excess payment of electricity charges

(Rs. in Crore)

Hospitals	Electricity charges paid			Electricity charges payable			Excess payment
	Energy charges	Demand Charges	Total	Energy charges	Demand Charges	Total	
LNH	12.17	2.18	14.35	11.00	0.15	11.15	3.20
DDUH	6.12	2.72	8.84	5.63	0.18	5.81	3.03
Total	**18.29**	**4.90**	**23.19**	**16.63**	**0.33**	**16.96**	**6.23**

Government stated (October 2006) that payment of electricity charges were being made at domestic rates since May 2005. The Government, however, did not explain the circumstances that led to excess payment of Rs. 6.23 crore by the two hospitals on account of payment of electricity charges. Payment of electricity charges at rates higher than required indicates ineffective internal controls relating to payments and monitoring of hospital expenditure.

Recommendation

The hospitals should ensure optimal utilization of allocated funds, exercise effective control over payments of various charges and effect timely adjustment of advances for better management of their financial resources.

1.7 Manpower resources

The quality and efficiency of medical care that the hospitals are expected to provide largely depend on the adequacy of the manpower resources, both medical and para-medical, available to them. The performance audit revealed shortfalls in medical and para-medical staff as brought out in the succeeding paragraphs.

1.7.1 Shortages of medical and para-medical staff

The sanctioned strength of medical and para-medical staff for the Government hospitals is determined by the Planning Department of the Government of Delhi and by the respective municipal corporation/council for the hospitals under their administrative control. The men-in-position vis-à-vis the sanctioned strength in respect of the four hospitals as on 31 March 2006 was as given in the table below:

Table 1.3: Staff Position in the two hospitals of Government of Delhi

Cadre	Sanctioned strength	Men-in-position	Shortfall	% age of shortfall	Sanctioned strength	Men-in-position	Shortfall	% age of shortfall
	LNH				DDUH			
Medical Staff	473	354	119	25	429	429	Nil	Nil
Para Medical Staff	534	335	199	37	209	167	42	20

Table 1.4: Staff Position in the two municipal hospitals

Cadre	Sanctioned strength	Men-in-position	Shortfall	% age of shortfall	Sanctioned strength	Men-in-position	Shortfall	% age of shortfall
	HRH				CPH			
Medical Staff	386	336	50	13	57	44	13	23
Para Medical Staff	294	228	66	22	57	53	4	7

Shortage of staff ranged from 7 to 37 *per cent*.

LNH was the worst affected hospital with deficiency of 25 *per cent* in medical and 37 *per cent* in para medical staff. Two municipal hospitals also had significant deficiencies in medical staff to the extent of 13 to 23 *per cent* of sanctioned strength.

Further, Audit scrutiny revealed that there was also an increase in the patient load in these hospitals during last five years (2001-06) as shown below

Table 1.5: Percentage increase/decrease in number of patients

Hospitals	Increase (+)/Decrease(-) in the number of patients (%)	
	Indoor	Outdoor
LNH	16	8
DDUH	25	14
HRH	11	10
CPH	(-)2.5	24

No exercise had been done in the five years to review the adequacy of the sanctioned strength in the hospitals despite increase in patient load. Shortages of manpower adversely affected the hospitals' ability to render efficient medical and diagnostic services to people as discussed in paragraphs 1.8 & 1.9. Test check in one hospital (HRH) also revealed the following:

1.7.1.1 Department of Neurosurgery could not be established in HRH due to non-filling up of two sanctioned post of neurosurgeons. Consequently, 147 head injury cases reported to the hospital during 2003-05 had to be referred to other hospitals/trauma centres.

1.7.1.2 Against one sanctioned post of a specialist, no specialist was appointed since 2004-05 in department of burns and plastic surgery. As a result, the OPD was not being run since 2004-05, though the department treated 3,341 patients during the preceding years 2001-03.

1.7.1.3 The department of psychiatry has one sanctioned post of a specialist. The only available specialist left for a foreign assignment in June 2004 and since then the department was being managed by two medical officers of which only one had a diploma in psychiatry. No OPD was being run since 2004, whereas, 25,417 patients were treated during the preceding year 2001-03.

The Government and the MCD stated (October/November 2006) that the matter of shortage of staff was under consideration of the Government.

1.7.2 Shortage of nurses

The Indian Nursing Council has prescribed norms for nurses in hospitals. The position of sanctioned posts vis-à-vis the norms and the actual strength of the nurses in four hospitals as of March 2006 was as under:

Table 1.6: Staff position of Nurses

Name of hospital	Required as per norms	Sanctioned posts	Actual	Shortage vis-a-vis norms (%)	Shortage vis-a-vis sanctioned posts (%)
LNH	1434	1120	737	49	34
DDUH	478	427	381	20	11
HRH	528	428	363	31	15
CPH	79	69	55	30	20
Total	2519	2044	1536	39	25

There was an overall shortage of 39 *per cent* in nursing staff with respect to norms and 25 *per cent* with reference to the sanctioned posts. In individual hospitals, the shortages ranged from 20 to 49 *per cent* as compared to the norms and from 11 to 34 *per cent* when compared to the sanctioned posts. Such

shortages in the strength of nursing staff are likely to adversely affect the capacity of the hospitals to treat patients and provide quality patient care.

The Government and the MCD stated (October/November 2006) that the matter of shortage of staff was under consideration of the competent authority.

Recommendation

The hospital and departmental authorities should undertake an overall manpower review to assess the actual requirement of manpower hospital-wise and take effective steps to fill in the critical vacancies so that the ability of the hospitals to offer the full range of intended health care services is not hindered.

1.8 Patient care

1.8.1 Out-Patient Department

1.8.1.1 Patients awaiting surgery

The position of patients awaiting surgery in the different departments of LNH DDUH, HRH and CPH was as under:

Table 1.7: Patients awaiting surgery

Name of the department	Total number of patients awaiting surgery	Date on which the surgery likely to be conducted	Reasons for awaiting surgery
LNH			
Orthopedic	42	2-3 months	Less operation time
Neurology	5	2-4 months	Non availability of OT
DDUH			
Orthopedic	60	3-4 weeks	Lack of operation time
Burns & Plastics	42	2 months	OT days are less
ENT	65	2-3 months	OT days are less
HRH			
ENT	30	15 days -2 months	Shortage of staff
CPH			
Orthopedic	10	3-4 weeks	Shortage of support staff, less OT days, increase in number of patients
Surgery	60	1 - 2 ½ months	

Note: Figures of LNH and DDUH are as on 31 March 2006 and HRH and CPH are as on 4 August 2006.

The waiting time for patients awaiting surgery in the four hospitals ranged from 15 to 120 days. The waiting time for Orthopedic surgery in LNH was much higher as compared to CPH and DDUH and the neurosurgery department

of LNH did not have any OT despite availability of a neurosurgeon. As such, neurosurgeries in LNH were conducted in the emergency OT as and when it was available. The waiting period in DDUH, HRH and CPH was due to shortage of staff or of OTs. Hence, inadequacy of medical staff and basic medical equipment and facilities seriously impacted the capability of the hospitals to perform timely surgical procedures on patients.

Government stated (October/November 2006) that construction of new building was under progress in LNH and separate OTs would be provided once it was complete. It further stated that OT days and time would be increased in DDUH to reduce waiting time of patients. MCD confirmed (November 2006) the audit findings and attributed the delays in HRH to shortage of staff.

1.8.1.2 Delay in investigations

There was waiting period of 6 to 59 days for radiological and cardiological tests due to shortage of staff.

Timely and expeditious diagnosis is a pre-requisite to early curative treatment. Audit scrutiny in HRH and CPH revealed that there was a backlog of patients, who had been prescribed various radiological and cardiological tests and investigations ranging from six days to nearly two months as depicted below:

Table 1.8: Patients awaiting investigations

Sl. No.	Particular of test	Total number of patients awaiting test (OPD)	Date by which backlog likely to be cleared	Backlog
1	**Echocardiography**	137 (HRH) (as of 2 April 2006) 18 (CPH) (as of 15 June 2006)	31 May 2006 21 June 2006	59 days 6 days
2	**TMT**	28 (HRH) (as of 2 April 2006)	2 May 2006	30 days
3	**Ultrasound**	782 (HRH) (as of 11 May 2006) 51 (CPH) (as on 14 June 2006)	31 May 2006 23 June 2006	21 days 10 days
4	**Intravenous polygraphy**	22 (HRH) (as of 11 May 2006)	24 May 2006	14 days
5	**Barium Study**	8 (HRH) (as of 11 May 2006)	22 May 2006	13 days

The waiting time for cardiological tests and ultrasound was much higher in HRH as compared to CPH. Audit scrutiny also revealed that against sanctioned posts of five specialists, seven medical officers and two junior residents in Radiology department of HRH, there were only two specialists and three medical officers. Similarly in the Cardiology department, there were four senior residents, against the sanctioned strength of five senior residents, that declined to one in April 2006.

Since diagnostic services help doctors in making early and accurate diagnosis of disease and charting out the treatment plan, such delays could adversely impact patient care.

MCD attributed (November 2006) the backlog to shortage of staff and stated that the matter had been taken up with the concerned authorities.

1.8.2 In-Patient Department

The average bed occupancy in the different hospitals during 2001-06 was as given in the table below:

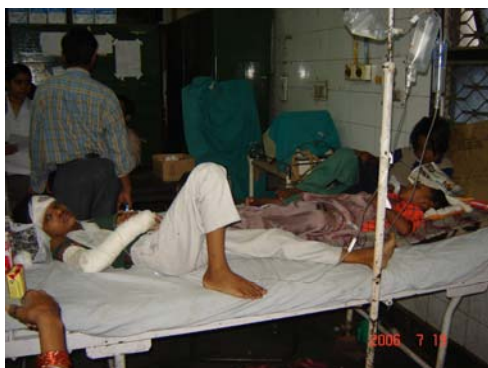
Table 1.9: Average bed occupancy

Hospital	Average bed occupancy in percentage				
	2001	2002	2003	2004	2005
LNH	125	124	126	125	123
DDUH	119	124	123	120	123
HRH	NA*	NA	NA	74	71
CPH	NA	NA	NA	NA	NA

* NA-Not available due to non-maintenance of records.

The sanctioned vis-à-vis actual bed strength for indoor patients and average bed occupancy in the four hospitals during period from 2001-02 to 2005-06 is detailed in *Annexure -I*

Figure -1: Internal bed occupancy in Lok Nayak Hospital and Deen Dayal Upadhyay Hospital



There was overcrowding at DDUH and LNH while beds remained vacant in HRH.

Of the four hospitals test checked, LNH and HRH had shortage of beds of only seven *per cent* and nine *per cent* respectively with reference to the number of beds sanctioned and there were no shortages in the other two hospitals. But due to increase in patient load without corresponding increase in the bed strength, the average bed occupancy was at times more than one patient per bed in LNH and DDUH. In these two hospitals (DDUH and LNH) the average bed occupancy rate ranged from 119 to 126 *per cent* during 2001-05 indicating over-crowding in wards of indoor patients. Sharing of beds by the seriously ill patients could cause both stress and discomfort to the patients as well as expose them to the risks of infection.

The two municipal hospitals did not even maintain any records as to bed occupancy. HRH started maintaining such records from the calendar year 2004

depicting 26 to 29 *per cent* beds remaining unoccupied during the two calendar years of 2004 and 2005. CPH, however, did not maintain any record of bed occupancy.

The Government accepted (October 2006) the facts and figures reported by audit in respect of LNH. MCD attributed (November 2006) the low bed occupancy in HRH to shortage of specialists and non-admission of patients in Eye, ENT, Burns & Plastic wards located in heritage building during this period as it was under renovation.

Recommendation

The hospital need to pool their resources so as to minimize the waiting time of patients for both investigations as well as surgeries. The department may also consider creating an on-line network connecting all public hospitals in Delhi whereby patients in an overcrowded hospital may be offered an option to shift to other government or municipal hospitals in the city where beds may be available.

1.9 Casualty and emergency services

The Emergency department is required to render a comprehensive range of services from elementary first aid and general out patients' services to sophisticated management of surgical and medical emergencies and full-scale trauma care. All the four hospitals were operating round the clock (three shifts) casualty and emergency services. Audit examination disclosed that the casualty and emergency services in the hospitals were hampered due to inadequacy of beds, shortage of medical staff, essential drugs and necessary equipment and facilities.

The number of patients received in casualty, admitted in the emergency wards and surgeries performed during the period 2001-06 in the four hospitals are given in *Annexure*- II

Audit analysis revealed the following:

1.9.1 The emergency wards in LNH and DDUH had a bed capacity of 40 and 37 which would mean availability of 14,600 and 13,505 bed days respectively during a year. Against this, annual admissions during the years 2001-02 to 2005-06 ranged from 35,735 to 50,474 in LNH and from 26,927 to 39,411 patients in DDUH, i.e. an average bed occupancy of 282 *per cent* and 236 *per cent* respectively. Thus at times, two to three patients had to be accommodated on a single bed.

1.9.2 In LNH and DDUH, the time of arrival of patient in casualty was not recorded in any register/admission card of the patient. It was only in medico legal cases that the time when the doctor examined the patient was recorded. Consequently, the time gap between arrival of a patient and his receiving medical aid could not be ascertained.

1.9.3 Further, in DDUH, 12 items of essential medicines indented by the casualty and emergency departments were not supplied by the store for a period ranging from three months to 18 months. Of these 12 items, eight medicines/injections were awaited in casualty/emergency as of May 2006, thus, affecting the patient care services adversely in respect of patients suffering from hypertension, infections, abdominal pains, hypothermia and gangrene. In DDUH, a spinal stretcher board and board for cardiac massage indented by the casualty department in June 2005 had not been procured as of May 2006.

Figure - 2: Casualty and Emergency in Deen Dayal Updhyay Hospital and Lok Nayak Hospital

1.9.4 Against the sanction of 100 beds in emergency ward in HRH only 49 were available. Test check of records for the year 2005 revealed that the bed occupancy ranged up to 122 *per cent* in emergency ward.

1.9.5 In CPH, there was no sanctioned post of medical and para medical staff against a requirement of six medical and 21 para medical staff to run the emergency services. Similarly against a requirement of 22 staff nurses, 11 posts were sanctioned of which eight were actually filled up. At present, emergency services at CPH were being managed by one medical officer/senior resident, one junior resident and two para medical staff. While confirming the facts in August 2006, the hospital stated that emergency services were being managed with the existing staff and the shortage of staff had affected the patient care.

Government stated (October/November 2006) that necessary directions had been issued to the departments concerned for further improvement in the system and for putting the time of arrival of patient in the emergency register. It added that casualty in DDUH was likely to be shifted to the trauma block which would automatically expand it. The reply furnished by the Government lacked content as the trauma block it referred to had not been handed over to DDUH as of September 2006 since its construction in August 2004. MCD confirmed (November 2006) that the shortfall in actual beds in HRH was due to utilization of space for other services like CT scan center, physiotherapy and labour room. However, there was no indication as to how the shortfall in beds for emergency services was to be made up.

It was evident that casualty and emergency services were not receiving the necessary attention and priority in terms of infrastructure and supplies and consequently, they were not adequately equipped to provide emergent medical assistance to the patients.

Recommendations

- *The casualty and emergency departments need to be strengthened on a priority basis commensurate with the increasing number of patients received. Availability of essential equipment, drugs and medicines should be ensured.*

- *In order to ensure as well as monitor timely treatment, the time of arrival of a patient in emergency and the time when emergent medical aid is given should be recorded and periodically reviewed by the medical superintendent.*

1.10 Procurement of equipment and medicines

An efficient system of procurement would involve timely assessment of requirements and effecting of purchases in an economic and efficient manner.

Audit scrutiny of procurement in the four hospitals revealed non-adherence to stipulated procedures, adhocism in assessment of requirements, delay in both placing of orders as well as in commissioning of equipment even after their receipt which not only resulted in wastage of financial resources but also deprived the patients of timely medical care as discussed in the succeeding paragraphs.

1.10.1 Violation of purchase procedure

Extra expenditure of Rs.31.67 lakh ignoring the lowest tenders.

During 2003-04, DDUH purchased equipment and medicines valuing Rs.8.17 crore by inviting only financial bids in contravention of the purchase procedure. Neither the technical specifications were prescribed nor were technical bids invited. Subsequently, 73 supply orders were awarded ignoring the lowest tenderers (up to L-7) without any clear justification on record. Non-acceptance of the lowest tenderers resulted in an extra expenditure of Rs.31.67 lakh.

Government stated (November 2006) that tenders were floated in single bid system during 2003-04 that was changed subsequently to three bid systems. Audit scrutiny however revealed that the three bids system was being regularly followed prior to 2003-04 and also in subsequent years. Hence, the purchases lacked financial probity and need to investigated.

1.10.2 Delay in purchase of equipment

Audit scrutiny of procurement cases in three hospitals (LNH, DDUH and HRH) disclosed that 72 *per cent* of the procurements made during 2001-06 were delayed as shown in the table below:

Table 1.10: Delay in procurement

Hospital	Total No Purchase orders issued	Cases where procurement/supply was delayed	Percentage of delayed cases	Period of delay (in months)
LNH	43	16	37.21	14 to 44
DDUH	19	19	100	5 to 48
HRH	44	41	93.18	4 to 47
Total	**106**	**76**	**71.69**	

No procurement case was finalised in time by DDUH and the position in HRH was equally grave. Purchases of 76 equipment in the three hospitals valued at Rs. 8.20 crore were delayed on account of delay in completing prescribed procedures and obtaining approvals of the competent authority which could have been avoided by better monitoring and administrative control and timely pursuance. Government stated (October 2006) that directions had been issued to improve the system. MCD confirmed (November 2006) the audit findings.

1.10.3 Impact of delay in procurement of medical equipment

Delay in procuring important medical epuipment hampers rendering of prompt and quilty medical services to the people. Test check in HRH and DDUH disclosed the following :

1.10.3.1 One tread mill test machine and one echo cardiographic machine were declared Beyond Economical Repair (BER) in April 2000 and December 2002 respectively. Specifications for replacement of tread mill test machine was approved in October 2000 while that of the cardiographic machine was approved in February 2004. The supply order for the tread mill machine was, however, placed in March 2001 at a cost of USD 30,000 after 10 months from the date on which it was declared BER. Similarly, the supply order for the cardiographic machine was placed in August 2004 at a cost of Rs. 21 lakh i.e. 19 months after the machine was declared BER. Due to the delay, an average of 568 and 2,474 patients were deprived of requisite facilities of tread mill and cardiographic tests in the intervening period.

1.10.3.2 DDUH purchased a Computerized Tomography (CT) scanner at a cost of Rs.2.72 crore in August 2002. The equipment was received in hospital in April 2003 but installed and commissioned in April/May 2004 i.e. after 18 months as against stipulated period of two to three months due to dispute over the make of the picture tube of the scanner. In the intervening period, an average of 4,626 patients remained deprived of the diagnostic facility.

1.10.4 Acceptance of medicines/vaccines of reduced shelf life

Medicines valuing Rs.1.04 crore accepted with reduced shelf life.

One of the terms and conditions laid down by the Directorate of Health Services, Government of Delhi, for purchase of medicines is that the supplier should ensure that not more than 1/6th of shelf life had passed from the date of manufacturing at the time of supply. NDMC follows the guidelines prescribed by the Government of Delhi. In MCD, 1/4th and 1/6th of shelf life should not have passed in case of medicines, and vaccines and sera respectively. Audit scrutiny revealed that during the period 2004-06 and 2001-06, LNH and HRH accepted 35 and 74 supplies respectively of various medicines/vaccines valuing Rs.1.04 crore with reduced shelf life as these were supplied beyond the permissible time period.

Government stated (October 2006) that necessary instructions had been issued to concerned departments for further improvement. MCD stated (November 2006) that the prescribed shelf life of the medicines, vaccines and sera would be ensured after installation of its hospital management and information system.

Recommendation

The system of procurement of equipment and medicines need to be streamlined to ensure timely availability of requisitioned equipment and other medical stores so that the full benefits in terms of enhanced patient care are derived from the investments made.

1.11 Maintenance and utilization of equipment

Proper maintenance and upkeep of equipment is critical for patient care. The functional status of machinery and equipment in the hospitals as of June 2006 was as under:

Table 1.11: Functional status of machinery and equipment

Name of hospital	Total number of equipment	Non-functional	
		Under repair/not in use	Under condemnation
LNH	913	57	86
DDUH	225	25	11
HRH	379	13	49
CPH	125	32	26
Total	1642	127	172

Thus, 7.7 *per cent* of the equipment were not functional in various departments as of June 2006 for want of repairs. Further Audit scrutiny revealed the following:

15 items of equipment costing Rs 33.34 lakh were lying non-functional for want of repair for periods upto more than two years.

Thirty-five machines reported non-functional in HRH during March 2001 and January 2006 were repaired after an average delay of seven months. The delay was attributable to administrative delay in obtaining the estimates from the firms and sanction of the competent authority. Thirteen equipment costing Rs.19.22 lakh in HRH which included a cardiac monitor and defibrillator, incubators and diathermy machine, and two equipment in CPH costing Rs. 14.12 lakh were awaiting repairs for periods ranging from five months to twenty six months. No effective action was taken by the hospital management to expedite the repairs and bring the machines into use. Charak Palika Hospital stated (September 2006) that four equipment were repaired and sixteen were under process of condemnation. Thus, lack of effective pursuance and administrative laxity on the part of the hospital managements resulted in a large number of equipment lying in a state of disrepair for prolonged periods.

Recommendation

Time frames should be prescribed for repair of critical equipment to minimize idle time of the machines

1.12 Ambulance services

LNH, DDUH, HRH and CPH have a fleet of nine, five, three and two ambulances respectively. A test check of the utilization of the ambulances during the year 2005-06 revealed that more than 50 *per cent* usage of

ambulances in the four hospitals (in terms of distance traveled) was for purposes other than patient care as indicated below:

Table 1.12: Utilization of ambulances (In kms)

Hospital	Shifting patients to other hospitals	Shifting of Patients to their residences	Used by doctors for emergencies	Used by doctors for other purposes	Used for misc. purposes	Total use
LNH	11174	6931	2350	6901	61063 (69%)	88419
DDUH	26140	170	NIL	1240	3066(10%)	30616
HRH	7017	409	195	625	9975 (55%)	18221
CPH	4998	Nil	84	12	5342(51%)	10436
Total	49329	7510	2629	8778	79446	147692
% utilisation	33.40	5.08	1.78	5.94	53.79	

Thus, all hospitals except DDUH had been using ambulances largely for other/miscellaneous purposes rather than patient care. It was also noticed that the ambulances in LNH and CPH were not equipped with essential equipment for basic life support such as oxygen cylinders, suction pump, blood pressure instrument, stethoscope, first aid bag, pain relievers, etc.

Government stated (October 2006) that a Central Accident Trauma Service (CAT) had been introduced which met most of the ambulance service requirement. The reply is not tenable as the CAT service is primarily for accidents and trauma cases while ambulances are required for patient care.

Recommendation

The ambulances should have all essential equipment for emergency patient care in hours of need and should ordinarily not be diverted for non-medical purposes.

1.13 Availability of essential drugs and medicines

The Directorate of Health Services, Government of Delhi, prescribed in 2002 a list of 359 essential drugs and medicines for its hospitals. There should not normally be a position of 'no stock' in respect of these medicines. Audit scrutiny of the records of the hospitals revealed as under:

1.13.1 Non-availability of essential life saving drugs and medicines for serious diseases including terminally ill patients

Essential medicines were not available for one month to 5 years in LNH, HRH and CPH .

LNH, HRH and CPH could not make available 93, 67 and 69 essential drugs and medicines respectively required for treatment of cases of cancer, diabetes, hypertension, typhoid, tuberculosis, blood clotting, Parkinson's disease and epilepsy patients for periods ranging from one month to five years during 2001-06. Due to non-availability of essential drugs/medicines, patients were compelled to purchase the same from outside. Audit analysis also revealed

delays of four days to 15 months in HRH in initiating procurement procedures after consumption of stock.

MCD stated (November 2006) that alternative arrangements/substitutes were ensured in emergency cases. The reply is not tenable as action to replenish stocks should have been taken in time so as to ensure their availability at all times.

CPH stated (September 2006) that the hospital procures medicines required by its departments. Some of the medicines, though enlisted under the essential drugs by the Government of Delhi, are not relevant to the hospital and hence not stocked. The reply is not tenable as audit has pointed out only those medicines that were being purchased and used by the hospital.

Government stated (October 2006) that the system had been improved and all essential life saving drugs and medicines were now available.

A test check of records from January 2004 to June 2006 of the thalessaemia wards of CPH further revealed that life saving drugs Kelfar and Desfrol used to minimize the iron contents in thalessemia patients were not available for 14 to 156 days. Consequently, 4,075 indoor patients could not be administered these medicines. Accepting the facts,the hospital management attributed (July 2006) the non-availability of the drugs to procedural delays and delays in supply by the single firm manufacturing these drugs. It added that the medicines were purchased by the patients themselves from the Thalessaemia Society. Though it was a life saving drug, the hospital initiated the procurement process after a delay of two to four months of consumption of the stock which deprived the patients of the requisite facilities intended to be provided to them by the hospital.

1.13.2 Non-accountal of medicines and surgical consumable items

HRH did not maintain records for actual consumption of general medicines/ surgical consumable worth Rs. 5.40 crore.

A test check of the records of various wards/OTs in HRH for the years 2003-04 to 2005-06 revealed that records for actual consumption were not being maintained for general medicines/surgical consumables issued to them by the main stores. The value of the stores issued during this period was Rs.5.40 crore. In the absence of such records, the actual consumption/utilization of the medicines/surgical items issued from the main stores could not be verified in audit.

MCD attributed (November 2006) the non-maintenance of the records to shortage of staff nurses and stated that instructions had been issued to maintain stock register of all the items procured from the main store and consumed.

Recommendation

Stock registers must be maintained at the ward and OT levels for all medicines/drugs/consumables received from the main store to guard against pilferages and wastages.

1.14 Undue delay in augmentation of facilities

Given the ever increasing patient load and the general shortage of space and necessary medical facilities leading to over-crowding and delays in treatment, it was incumbent on the department/hospitals to augment the existing facilities in time.

Delay of 6 to 47 months resulted in cost escalation by Rs.3.43 crore.

Audit scrutiny revealed that the Government of Delhi sanctioned four works during 2000-03 for augmentation of facilities at LNH and DDUH at a total cost of Rs. 100.03 crore. There were, however, delays ranging from six months to nearly four years in completion of sanctioned works as indicated below:

Table 1.13: Execution of works as on May/June 2006

Sl. No.	Name of work	Work Cost (Rs. in Crore)	Stipulated date of start	Stipulated date of completion	Date of actual completion	Delay in months	Cost escalation (Rs. in crore)
1	General & Special Ward (LNH)	25.03	3.11.2000	2.11.03	Work in progress of General Ward (98% completed)	29	1.11
2.	C/o Casualty Block (LNH)	24.17	15.11.01	14.5.04	Work in progress (90% completed)	25	0.35
3	(a)C/o Orthopedic Block (b) Balance work (LNH)	14.41	21.7.2000 27.4.03	20.7.02 26.11.04	Contract rescinded Work in progress (80% completed)	47	0.15
4.	300 Bedded Super Specialty Wing (DDUH)	36.15	27.6.03	26.12.05	Work in progress (93%)	6	1.82
	TOTAL	100.03					3.43

The slippages were largely attributable to delay in demolishing the existing buildings, shifting of underground services, availability of site in piecemeal, rescission of original contract etc. Besides denying the much needed facilities to the patients, the delays resulted in cost escalation of Rs. 3.43 crore.

Audit further observed that civil construction works for 140 bedded Trauma-cum-Emergency Block at DDUH was completed in August 2004 at a cost of Rs. 7.78 crore. The building could, however, not be handed over/taken over as of August 2006 as the staff required to make the trauma block functional has

not been decided by the department. Consequently, orders for necessary medical equipment/gadgets had to be delayed till availability of adequate staff.

Government stated (November 2006) that possession of the building could not be taken due to pendency of some electrical and development works, fire safety clearance and No Objection Certificate from MCD.

Recommendation

Given the urgent need for augmentation of facilities, an inter-departmental mechanism should be established with PWD for monitoring the progress of works so as to ensure their expeditious completion. Procedures for taking over and bringing into operation of constructed buildings should be streamlined so as to obviate any delay.

1.15 Management of bio-medical wastes

The Union Ministry of Environment and Forests notified in July 1998 the Bio-Medical Waste (Management and Handling) Rules 1998 to regulate the generation, storage, transportation, treatment and disposal of bio-medical waste. Mention was made in the Report of the Comptroller and Auditor General of India for the year ended 31 March 2001 regarding various instances of non-compliance of the rules by the various hospitals including the four hospitals covered in the current performance audit exercise. The Government of Delhi had informed in October 2002 that bio-medical waste management was a continuous process that required constant attention and commitment by the in-charge of the hospital. It was also added that all the hospitals had been directed to take necessary steps/measures to ensure compliance with the Rules. Audit scrutiny however, revealed that the hospitals were still lacking in observance of rules as discussed below:

1.15.1 Deficiencies in management of bio-medical waste

Hospitals did not follow Bio-medical Waste Rules 1998.

The Audit Report for the year ended 31 March 2001 had brought out the short-comings in segregation of bio-medical waste and in handling of bags and waste. However, inspections conducted by the Delhi Pollution Control Committee (DPCC) in LNH (August 2003 and December 2004) and in HRH (May 2006) revealed continuing deviations such as non-provision of isolated storage site, bio-liquid waste leaking from yellow bags lying outside the incinerator plant, lack of segregation of bio-waste in wards and non-labeling of bags containing bio-medical waste in both the hospitals.

Government stated (October 2006) that instructions had been issued for proper segregation of bio-medical waste to maintain hygiene and healthy environment

at the incinerator site. MCD stated (November 2006) that due to shortage of staff, a proposal has been initiated for outsourcing of collection/transportation of bio-medical waste. Management was thus yet to fully enforce the rules even though the non-compliance had been highlighted in audit nearly five years ago.

1.15.2 Under-utilisation of incinerators

Incinerators were underutilized in HRH hospital.

The Audit Report had also highlighted under-utilization of incinerators installed by the MCD in HRH. The MCD in its Action Taken Note stated in January 2003 that all the health centres of MCD would be attached to the incinerators installed at HRH for optimum capacity utilization. Audit scrutiny revealed that no action had been taken in HRH as of June 2006 to utilize the spare capacity of incinerators despite the lapse of more than three years and gross under-utilization of incinerators.

MCD stated (October 2006) that though an incinerator had been installed for disposal of all types of hospital waste, the DPCC had directed that only infectious waste is to be incinerated. Hence, the incinerator remained under-utilised. The reply is not tenable as continued under-utilization of incinerators clearly indicated that all the health centres of MCD were yet to be integrated with the spare capacity in HRH even for disposal of infectious waste.

Recommendation

The department/hospitals should make serious efforts to ensure compliance with the bio-medical waste rules through an oversight mechanism for management of storage, transportation, treatment and disposal of bio-medical waste in the hospitals.

1.16 Non-compliance to the provisions of Hospital Manual

The Hospital Manual issued by the Directorate General of Health Services, Ministry of Health & Family Welfare of the Government of India envisages constitution of a Hospital Infection Control Committee (HICC) by each hospital for the prevention and control of hospital associated infections. The primary function of the committee is to formulate policies regarding provision of equipment, isolation facilities and standardization of procedure for operation theatres, wards, kitchen, disinfection procedure, etc. in the hospital. It is to meet at least once every three months. The manual also envisages establishment of a mechanism for redressal of patient grievances including nomination of a Grievance Redressal Officer (GRO), placing of complaint boxes at strategic locations, registering and acknowledgement of complaints and follow up and monitoring of grievances by a committee headed by Medical Superintendent/Additional Medical Superintendent. Audit scrutiny of the

implementation and efficacy of these provisions in the hospitals revealed as follows:

1.16.1 Hospital infection control

1.16.1.1 LN hospital

The HICC headed by the medical superintendent was constituted in July 2004 which met only once in July 2004. The HICC has not formulated any policy for provision of equipment, isolation facilities, standardization of procedures for OTs, wards, kitchen, disinfection policy etc.

Infection control nurse is a very important part of the infection control team and functions as a liaison between the clinical departments and the microbiologist. Though an infection control team has been conducting surveillance activities, no infection control nurse was available in the hospital for collection of specimens from the high risk areas such as OTs, ICU, Nursery.

Government stated (October 2006) that the HICC had been re-constituted as most of the members had been transferred since the constitution of the committee in July 2004 and meetings were now being held every month.

1.16.1.2 DDU hospital

The HICC approved in January 2004 the practice of wet mopping inside the wards, OPD rooms, OPD corridors, OTs and casualty. However, the wet mops had not been purchased as of May 2006 and the old practice of sweeping with broom and dry mopping continued thereby exposing the indoor patients to the risk of dust and infection.

Further, suspected cases of pus, blood or urine were not reported by respective wards to the Department of Microbiology. As such, timely preventive/control action in such cases could not be taken.

Analysis of pus and urine samples (wards only) lifted for culture during 2003-05 revealed positive growth in 74 to 78 *per cent* of the pus samples and in 15 to 40 *per cent* of urine samples, which was considered to be high. The cases of positive growth were not reviewed by the committee till March 2006 to arrest the high rate of positive growth.

No records were available in the hospital regarding number of staff imparted training in infection control.

Government stated (November 2006) that the HICC had started reviewing cases of infection since April 2006 and a Hospital Infection Surveillance form had been designed that would help in solving the problem of tracing the source of infection. It further stated that in the absence of any guidelines from the Central Ministry more than one patient is admitted per bed irrespective of whether the patient is new born, pregnant female, child or adult. This causes overcrowding and leads to high rate of infection.

1.16.1.3 HR hospital

Though the bacteriological surveillance of environment in OTs, ICU and CCU were regularly conducted and monitored, the hospital did not monitor the bacteriological surveillance of environment of wards and OPDs as no samples were lifted by the hospital from these areas. MCD confirmed (November 2006) the audit findings.

1.16.1.4 CP hospital

No infection control committee had been set up in the hospital. Forty three out of 124 samples lifted during March 2001 to May 2006 from operation theaters (35 *per cent*) were found to be positive to the presence of various bacteria. No samples from other infection prone areas like ICU, surgical wards, etc. were lifted for culture test.

CPH stated (September 2006) that infection control committee has since been constituted. However, samples were not being lifted as there was no culture facility available in the hospital.

Thus, no serious efforts have been made by the hospitals in implementing the measures stipulated in the manual for prevention and control of hospital-associated infections which could put the patients to unnecessary risk thereby complicating their treatment and recovery.

1.16.2. Redressal of patient grievances

1.16.2.1 LN hospital

The Grievance Committee in LNH was constituted in October 2005. However, no meeting of the committee had been held as of June 2006. There was only one complaint/suggestion box at the OPD entrance and no such box was placed at other strategic locations such as casualty and emergency, post-operative wards, pharmacy, etc. While the hospital stated in April 2006 that only one complaint had been received during the period 2002-06 along with some other verbal and minor complaints that were settled on the same day, the veracity of the claim could not be confirmed by Audit as no records were maintained. The

register maintained for recording opening of complaint boxes was furnished to Audit only for the period from 18 October 2005 to 31 March 2006.

Government stated (October 2006) that complaint boxes had been placed at strategic locations and instructions had been issued for further improvement.

1.16.2.2 DDU hospital

Though the hospital claimed in April 2006 that about five to ten complaints were received every month which were redressed by the Grievance Redressal Officer (GRO) within one month, audit scrutiny revealed that no record was maintained by the designated GRO for registering and taking follow up action on the complaints. The hospital could also not furnish the number of complaints received year-wise. It was further noticed that the proceedings of the committee meetings were not documented.

Recommendations

- *All hospital managements may undertake a review of the measures taken to prevent and control hospital associated infections and strengthen procedures for obviating the possibility of such infections through regular surveillance and requisite training and sensitizing of all medical and para medical personnel.*

- *Patient grievance redressal mechanism needs to be strengthened with proper maintenance of records depicting receipt of complaints and the action taken on them. Minutes of all the meetings should be prepared for follow up of the decisions taken. Facilities for online registration of complaints may also be considered.*

1.17 Acknowledgment

The draft performance audit report was communicated to the department in August 2006. An exit conference was held on 29 September 2006 that was attended by the Medical Superintendents of all the four hospitals. The views expressed at the exit conference as well as those communicated thereafter by the Government and the MCD in October/November 2006 have been taken into account and reflected in the performance audit report. However, the reply of Chairperson NDMC in respect of CPH was awaited as of November 2006.

ANNEXURE-I
(Referred to in Paragraph 1.8.2)

Indoor patients position in the two government hospitals

Sl. No.	Description	2001		2002		2003		2004		2005	
		DDUH	LNH	DDUH	LNH	DDUH	LNH	DDUH	LNH	DDUH	LNH
1.	**Number of sanctioned beds**	500	1597	500	1597	500	1597	500	1597	500	1597
2.	**Number of actual beds**	500	1432	500	1480	500	1481	500	1482	500	1482
3.	**Number of patients admitted**	50986	63312	50625	64424	52804	67960	58001	65554	63749	73564
4.	**Patient days(IPD)**	217175	653350	226300	669848	224475	681112	219000	676162	224475	665344
5.	**Average bed occupancy (%)**	119	125	124	124	123	126	120	125	123	123

Indoor patients position in the two municipal hospitals

Sl. No.	Description	2001		2002		2003		2004		2005	
		HRH	CPH	HRH	CPH	HRH	CPH	HRH	CPH	HRH	CPH
1.	**Number of sanctioned beds**	980	150	980	150	980	150	980	150	980	150
2.	**Number of actual beds**	NA	150	NA	150	NA	150	895	150	895	150
3.	**Number of patients admitted**	51060	11899	55094	11304	57122	11390	57269	10988	56671	11593
4.	**Patient days(IPD)**	202717	NA	208570	NA	240235	NA	242393	NA	231588	NA
5.	**Average bed occupancy (%)**	NA	NA	NA	NA	NA	NA	74	NA	71	NA

ANNEXURE-II-
(Referred to in Paragraph 1.9)

Details of patients received, admitted and operated

Year	Patients received in casualty		Patients admitted in emergency ward		Surgical operations done in emergency OT	
	LNH	**DDUH**	**LNH**	**DDUH**	**LNH**	**DDUH**
2001-02	135387	127970	36880	29955	17595	5719
2002-03	149000	140808	35735	26927	22729	5053
2003-04	145381	165922	40430	27957	22705	5113
2004-05	140103	164525	42764	35017	21486	6057
2005-06	157833	187575	50474	39411	17221	6340

Year	Patients received in casualty		Patients admitted in emergency ward		Surgical operations done in emergency OT	
	HRH	**CPH**	**HRH**	**CPH**	**HRH**	**CPH**
2001-02	73954	28541	17887	7306	3399	No major surgery performed.
2002-03	67325	30269	15096	10229	9006	
2003-04	64180	33947	20707	11425	12812	
2004-05	63464	34241	17229	13525	13385	
2005-06	65641	37155	19084	14030	12283	

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3 List of Essential Drugs for Hospital issued by the Govt. of NCT of Delhi.

4 Budget files for the years 2001-02 to 2005-06.

5 Purchase/repair files dealing with equipment, medicines and stock registers of medical stores and wards/OPDs.

6 Records relating to Medical Record Department (MRD), Emergency and casualty and Microbiology Department of the Hospitals.

7 Records of operation theatres, investigation labs.

8 Norms for nurses prescribed by Indian Nursing Council.