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| **Quality Improvement Manual** |
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| **Date of implementation :**  |   |
|   |
| **Approved By :**  |  ***Superintendent in Chief / Chief Medical Superintendent*** |
|   | Name : |
|   | Signature :  |
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|   |
| **Reviewed By:**  | ***District Hospital Quality Assurance Team (Incharge / Member)*** |
|   | Name : |
|   | Signature :  |
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|   |
| **Issued By:**  | ***SiC / CMS / Quality Manager*** |
|   | Name : |
|   | Signature :  |
| **Responsibility of Updating :**  | ***Head Of Department***  |
|   | Name : |
|   | Signature :  |
|   |
| **Last Date of Updating** |   |
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**Quality Improvement Manual**

# A Purpose:

* To provide an environment which assures safety for patients/clients, staff and the public, within a framework of continuously improving quality of care.
* To promote a quality culture and place quality at the core of service delivery.
* To encourage attainment of best practice.
* To promote a patient/client-centred organization and delivery of service

**B Scope**: Hospital Wide

# C Responsibility:

Chief Medical Superintendent and Quality Assurance Officer.

**TYPES OF COMMITTEES**

***QUALITY MANAGEMENT COMMITTEE***

**HOSPITAL Quality Management Committee** will be the Highest Executive Quality

Improvement Authority in the hospital. The committee will, in summary, reflect hospital endless Top Management Commitment to Continuous Quality Improvement. Chaired by Chief Medical Superintendent Quality Control Officer Department Heads, Hospital Quality Committee will be responsible for overall planning, directing, prioritizing, implementing and follow up of all CQI Initiatives and activities in the hospital. On the other hand, The Quality Committee will assure that, all necessary resources required for successful QM Plan Implementation are devoted at all functional levels.

**Scope**

Responsibilities, as pertinent to Quality Improvement include but not limited to the followings:

1. Develop (in coordination of Quality Management Department) / approve a Facility wide Quality Management Plan.
2. Integrate the overall Quality Management Plan and serve as a clearing house for improvement activities.
3. Oversee, coordinate, direct and prioritize Quality improvement activities. A high priority for the QMC will be the monitoring of the delivery of care whenever a new service is developed with particular emphasis on the transition and development period.
4. Assure the formation of cross-organizational work groups (Departmental Quality Improvement Teams (DQIT) to assess each function and identify the processes and activities within that function that are high volume, high risk and/or problem prone.
5. Receive reports monthly or quarterly from each department/service as appropriate and team reports on organizational Quality improvement activities.
6. Enforce the implementation of Plan, Do, Check, and Act methodology.
7. Review monitoring results that reflect the functions and activities provided by the staff in different disciplines (administrative, medical and non medical) within the facility.

1. In coordination with Quality Management Department, QMC will provide reports to the hospital CMS
2. Receive and evaluate Quality improvement team reports concerning specific activities for improving organizational Quality.
3. Oversee, coordinate and provide appropriate Quality Improvement information to the concerned departments and sections (both external &internal )
4. Review and revise the performance indicators and standards/thresholds periodically based on evidence/data collated over a period of time to as to continuously improve the quality of Services provided
5. Appointment of the position of quality assurance and improvement coordinator to oversee the obtaining and maintaining the quality standards and dealing with complaints
6. Initiate regular reviews by the independent specialist in the relevant fields of clinical practices used in the Hospital in providing the Healthcare Services
7. Ensure obtaining the NABH Accreditation and maintaining the same.

Problems that are referred to the QMC through any of the quality management activities, or identified by the QMC from a study of reports or communications, will be reviewed by the QMC. The committee will ensure that the responsible department, service or team is taking appropriate corrective action plans, prioritization and monitoring steps, and activities. Departmental Quality improvement teams will report on their activities for improving organizational Quality to QMD Such written and verbal reports are due at the time of presentation at QMC meeting.

**Presentation of reports of all Quality improvement activities will include**

1. The kinds of Quality Improvement activities that took place during the reporting period.
2. Departmental Performance Indicators as defined by accreditation standards 3. The problems, quality issues or opportunities to improve, if any, that were identified.
3. Evidence of ongoing organizational Quality efforts.
4. Method(s) of problem resolution or referral.
5. The monitoring required including the schedule, method and individual(s) responsible for monitoring.

**The QMC agenda and minutes will include the following**:

1. Call to order and approval of minutes.
2. Committee reports (e.g. Transfusion, Pharmacy & Therapeutics).
3. Risk Management reports.
4. Review of previously identified opportunities for improvement, quality issues, analysis, actions and follow-up.
5. Reports from the Departmental Quality Improvement Teams.
6. Scope of Services reports.
7. Multidisciplinary team reports on improving organizational Quality.
8. Departments’ Quality Improvement reports that integrates disciplines/departments along the continuum of care.
9. Accreditation Efforts & reports submitted to Accreditation bodies (e g. NABH).
10. Safety reports.
11. Resource Management reports.
12. Special Care Unit reports.
13. Patient Satisfaction Survey Report.
14. Ambulatory Care Services report.
15. Cardiac Arrest report.
16. Credentialing & Privileging report
17. Medical Audit reports
18. Conclusions and recommendations regarding actions or follow up.
19. New business.

The QMC will assist in planning for improving organizational Quality or evaluating new services.

The following steps will be established:

**Organize teams:** (multidisciplinary groups/committees, focus groups, task forces) The members of which will be empowered to implement decisions over the key elements in the process(es) of delivering services for which improvement efforts are to be made.

**Identify the customers):** Patients, Relatives, Doctors, Nurses, Clinics, Departments, and Operating room staff any other individual or group of individuals who will be the recipients of products and/or services.

**Identify the products and/or services of importance to the customers:** The patient's and family/significant other's perception of the quality of health care rendered and staff's opinion will be considered. Examples of areas for improvement may include: A warm meal, a parking space, an improved perceived quality of life, a short wait for pain medication, a nice atmosphere in the waiting area, and privacy in discussions with providers. Additional areas for improvement may include faster test results, improved communication between nurses and doctors, or any other variable or relationships subjective or objective that may be important to the customers). **Identify the process(es) that affect important products and/or services:** This can be any of the tasks and activities which affect the customers), e.g., delivering pain medication, transporting food, ordering tests, cleaning rooms, calling and paging procedures, planning discharge procedures or examining sentinel events.

**Delineate scope of care/service:** Each department will delineate the scope of care/services in hospital through the Plan for Patient Services.

# D SCOPE OF SERVICES at Hospital;

# 1. Services Available

The services provided at Hospital are displayed and the staff are trained and oriented to this information **a. Multi- Specialty services**

* General medicine
* General surgery and minimal access surgery
* ENT
* Anaesthesia
* Cardiology

* Pediatrics
* Obstetrics & Gynecology
* Orthopedics and Orthopaedic surgery
* Ophthalmology
* Dentistry and Dental Surgery
* Radiology / Interventional Radiology
* Laboratory Medicine
* Dermatology
* Cardiac Unit
* Psychiatric

***b. 24 hr services***

* Emergency Care Facility
* Delivery Facility
* Ambulance

# c. 24 hr on call services

* Blood Bank
* Laboratory
* Imaging
* Pharmacy

# 2*.* Services not Available at Hospital  Burns Care

* Neurology and Neurosurgery
* Intensive Care Facilities
* Cardiac Surgeries
* Paediatric Surgery
* Gastrointestinal Surgery ,etc

# E. QUALITY POLICY

Hospital is committed to provide high quality, affordable and accessible , preventive , curative , promotive and comprehensive health care services to the community and assure the best outcome.

# F. SAFETY POLICY

We at Hospital will ensure that all the best practices are adopted for the provision of the highest quality of healthcare, to guard the overall safety of patients and their attendants, employees, facilities & the environment.

* The Safety of All Patients Is the Primary Responsibility of all the Hospital staff members.
* The Safety of Facility, Assets & the Environment is Important to ensure the provision of quality services.
* Highest Levels of Comfort should be Maintained by Ensuring Occupational Safety so that the Effective & Efficient Healthcare Practices are Followed.

# G.QUALITY PLAN

All services and Departments utilize the established Quality Plan throughout the facility to improve targeted areas of concern.

The quality improvement plan has been prepared by a multidisciplinary committee of the hospital under the chairmanship of the hospital .The Committee invited inputs from the staff members and has established the quality plan in collaboration with staff representatives , hence its has support and acceptance from the staff members at various level.

QMS documents are established, implemented and maintained to meet the quality objectives of National standard requirements. Documented QMS comprises of the Quality Policy, Quality Objectives, Quality Manual, Procedure Manual, Instruction Manual, References- Technical manual & Operator manual and Formats. Records are maintained to demonstrate that the Medical service conforms to specify patients requirement. QMS meets all the relevant requirements of the Quality standards. The documentation has been done depending upon the complexity of processes and also on the competence of personnel performing the tasks.

Quality Manual is the apex document that broadly describes the QMS of Hospital Quality Manual makes a reference to the standard operating procedures adopted in the hospital.

Formats have been standardized for effective control of operations. Some of these formats, become records to demonstrate the status on compliance of the QMS and service provision that are designated as quality records. These are controlled as control of quality records procedures.

# H. OBJECTIVES

1. To focus on Quality of patient care.
2. To improve the performance of all professionals & protect patients
3. To monitor, measure, assess and improve performance and to enhance patient satisfaction.
4. To guard, measure and improve patient safety.
5. To inculcate an excellent hygienic treatment process
6. To involve all employees to participate in improving Quality
7. To search for pattern of non-compliance with goals, objectives & standards through:
	* Problem identification
	* Problem assessment
	* Finding the root cause
	* Solution Generation
	* Plan for the solution implementation
	* Implementation of corrective action
	* Monitoring **I. SCOPE:**
8. Patient satisfaction
9. Improved Clinical Outcome
10. Reduction in Morbidity and Mortality
11. Improved service quality of the hospital through increased efficiency & effectiveness.
12. Optimum Utilization of resources
13. Job Satisfaction along with growth of the employee & organisation.
14. To facilitate and oversee the implementation of the chosen strategies for overall Quality

Assurance and Quality Improvement (QA/QI) initiative in the organization in line with the quality policy of the company

* + To develop Annual plan for QA/QI in line with quality Assurance and Improvement plan as per the Quality policy of the hospital to develop Continuous Quality Improvement
	+ To oversee improvement of the quality via external accreditation, including provision of guidance advice and necessary support for taking care of new processes and changes in the system required for any such accreditation/ certification

# J. CONTINUOUS QUALITY IMPROVEMENT (CQI)

Quality improvement is about ensuring that our focus is on improving, not just maintaining our services at Hospital. Quality improvement involves a focus on the safety, effectiveness, efficiency, acceptability, accessibility and appropriateness of services for consumers (who might be patients, relatives/parents, or the hospital and other health care professionals).

# 1. Purpose of continuous quality improvement is to-

1. Monitor patient and staff satisfaction
2. Monitor of quality indicators
3. Monitor of Adverse Drug reactions and medication errors
4. Monitor patient safety indicators
5. Monitor of medical audit results
6. Monitor Utilization of Facilities
7. Monitor Patient Satisfaction Rate
8. Monitor Employee Satisfaction Rate
9. Ensuring fire safety mock drill twice in a year.
10. Ensuring facility safety round twice a year in patient care areas and once a year in non- patient care areas

# 2. Goals of Continuous quality Improvement -

1. To utilize an interdisciplinary hospital-wide team approach to Quality improvement activities
2. To maintain a Quality improvement team to be responsible for each key function and will evaluate the need for Quality improvement activities for the function on an ongoing basis by reviewing policies and procedures relating to that function and make necessary revisions as well as to establish priorities for measuring Quality to initiate Quality improvement measures in a prioritized manner.
3. To improve patient care guidelines relating to operative and other procedures, in a collaborative effort.
4. To utilize a standard format for documenting and reporting all Quality measures hospital-wide
5. To collect data on staff views regarding Quality improvement activities
6. To establish priorities for Quality improvement activities
7. To develop a formal tool for prioritizing Quality improvement activities

1. To strive to raise the benchmark in all aspect of service delivery and meet the quality standard expected for the same.
2. To ensure optimum utilization of resources in terms of human resource , infrastructural resource and financial resource.

# K. AUTHORITY AND ACCOUNTABILITY

# 1. Chief Medical Superintendent (CMS)

* The CMS is responsible for providing support for the proper functioning of hospital-wide Quality improvement activities.
* The CMS provides support, direction, and/or assists with the resolution of problems or opportunities to improve care or services as needed.
* The CMS provides the corporate office with pertinent information regarding Quality improvement activities.

 **2- JOB DISCRIPTION OF QUALITY CONTROL OFFICER**

 Quality Assurance Officer has the overall authority, responsibility and commitment to communicate, implement, control and supervise the compliance of this management system with standards.

The roles and responsibility of the Quality Assurance Officer include:

* Developing quality Improvement Plan of the hospital.
* Participating Effectively in Implementing & Follow up of QM Plan activities.
* Orchestrating Quality Improvement Initiatives & Activities Hospital wide.
* Will be charged with assisting the hospital departments in their activities to improve the quality of care delivered, and to improve organizational quality.
* Developing methodologies along key organizational functions including, but not limited to, Quality control, patient complaint/ satisfaction, health care standardized approaches such as outcomes of resuscitation, blood use, restraints, medication use, pressure injuries, risk management, cost management, pain management, and infection control.
* Orchestrating all hospital Accreditation activities. Revise system standards as needed to maintain accreditation.

* Maintain continuous knowledge and understanding of the NABH function, standards,
* Educate and support staff in all departments to meet new regulatory requirements on ongoing basis.
* Mock surveys coordination.
* Annual Evaluation of Quality Improvement Program
* Leading & coordinating Medical Record Review activities
* Compile, review and reformulate standards and processes across the institutions.
* Identify and share across the system best practice models and care processes (those, which achieve optimal patient outcomes, Enhance patient/family and staff satisfaction, are cost effective and resource appropriate.
* Communicate with and obtain input/ approval as needed from the Quality Committee.
* Guiding all Departmental Quality Improvement Teams (DQIT) to Foster multidisciplinary preparation for case Management,
* Utilize variance data to identify areas for continuous quality improvement processes at each department.
* Develop training/orientation program for key members to facilitate system expansion and standardization.
* Establish system- wide variance database for benchmarking, system improvement opportunities.
* Examine Patient Care Model.
* Information management Support/ Database studies.
* Support & Reporting of Outcomes to Quality Management Committee.
* Liaison to Risk Management

# 3.Head of Departments

The HODs of the respective departments shall review all documents issued to personnel in the laboratory in the laboratory as a part of management system annually and the shall approve it for the use.

The HOD’s are responsible for the following:

* Developing and implementing mechanisms designed to ensure the uniform quality of patient care processes within their department.
* Developing and implementing an effective and continuous program to measure, assess, and improve Quality.

* Continuously assessing and improving the Quality of care and services provided.
* Adopting an approach to Quality improvement that includes planning the process for improvement, setting priorities for improvement, assessing Quality systematically, implementing improvement activities based on assessment, and maintaining achieved improvements.
* Participating intra and interdepartmental activities to improve organizational Quality as appropriate.
* Communicating information relevant to cross-organizational Quality improvement activities to appropriate individuals.
* Allocating adequate resources for assessing and improving the organization’s governance, managerial, clinical, and support processes, by assigning personnel, as needed, to participate in Quality activities; providing adequate time for personnel to participate in Quality improvement activities, creating and maintaining information systems and appropriate data management processes to support collecting, managing, and analyzing data to facilitate ongoing improvement in Quality, and providing for training of staff in Quality improvement methods.

a. Analyze and assess the effectiveness of their contributions to improving Quality.

# L. APPROACH TO DESIGNING, MEASURING, ASSESSING AND IMPROVING QUALITY at Hospital :

# The Hospital has:

* Identified the processes needed for the QMS and their application throughout the hospital  Determine the sequence and interaction of these processes.
* Determine criteria and methods needed to ensure that both the operation and control of these processes are effective.
* Ensure the availability of resources and information necessary to support the operation and monitoring of these processes.
* Monitor, measures and analyses these processes and
* Implement the actions necessary to achieve planned results and continual improvement of these processes.

# M. PLANNING

Planning for the improvement of patient care and health outcomes includes a hospital-wide approach.

* The hospital maintains a plan that describes the hospital’s approach, processes, and mechanisms that comprise the hospital’s Quality improvement activities.

* The Team approach serves as a means of collaboration between departments and disciplines in planning and providing systematic organization-wide improvements.

# N. DESIGNING

Processes, functions or services are designed effectively based on:

* Mission and vision of Hospital
* Needs and expectations of patients, staff, and others.
* Baseline Quality expectations are utilized to guide measurement and assessment activities

# O. MEASUREMENT -

* Data is collected for a comprehensive set of Quality measures
* To Establish a baseline when a process is implemented or redesigned
* To Describe process Quality or stability
* To Describe the dimensions of Quality relevant to functions, processes, and outcomes
* To Identify areas for improvement
* To Determine whether changes in a process have met objectives
* Data is collected as a part of continuing measurement, in addition to data collected for priority issues.
* Data collection considers measures of processes and outcomes.
* Data collection includes at least the following processes or outcomes:
* Patient assessment
* Operative and other invasive and noninvasive procedures that place patients at risk
* Laboratory safety & quality
* Diagnostic Radiology safety & quality
* Processes related to medication use
* Processes related to anesthesia
* Processes related to the use of blood and blood components’
* Processes related to medical records content, availability and use

* Processes related to timely procurement of supplies
* Reporting as required by law
* Risk management activities
* Needs, expectations, and satisfaction of patients
* Staff expectations and satisfaction
* Processes related to patient and staff safety
* Process related to optimum utilization of resources.

# P. ASSESSMENT-

The assessment process involves the necessary departments to draw conclusions about the need for more intensive measurement. A systematic process is used to assess collected data in order to determine whether specifications for newly designed processes were met & the level of Quality and stability of important existing processes, priorities for possible improvement of existing processes, actions taken to improve the Quality Improvement processes, and whether changes in the processes resulted in improvement.

1. Collected data is assessed at least quarterly by the quality assurance committee and findings are documented and are forwarded through the proper channels.
2. A pre-determined level of Quality, or threshold, which would trigger a more in-depth review, is established for each Quality measure to assist in the assessment of the data collected. The reference used may include the following:
	1. Internal comparisons in Quality of processes and outcomes are made over time
	2. Quality comparison of data is made about processes with up-to- date information
	3. Quality comparison of data is made about processes and outcomes with other hospitals utilizing reference databases when possible
3. The assessment process includes the use of statistical process control techniques/tools as appropriate. Training for use of statistical process control is provided to the hospital leaders where needed; team members/staff are educated regarding statistical process control techniques on an ‘as needed’ basis.
4. When assessment of data indicates, a variation in Quality, more intensive measurement and analysis will be conducted and in addition, the department/service or team will reassess its Quality measurement activities and re-prioritize them as deemed necessary. Intensive assessment is initiated when statistical analysis shows the following:

* 1. Important single events, levels of Quality, and patterns or trends that vary significantly and undesirably from those expected
	2. Quality that varies significantly from other organizations
	3. Quality that varies significantly and undesirably from recognized standards
1. Intense assessment is performed on the following:
	1. Major discrepancies between preoperative and postoperative diagnoses in pathology reports
	2. Confirmed major transfusion reactions
	3. Significant adverse drug reactions
	4. Adverse events or patterns of adverse events during anesthesia use
	5. Unexpected patient death
	6. Wrong site/side/patient surgery
2. When findings of the assessment process are relevant to an individual’s Quality, the pertinent information will be provided to the Medical Director for determining their use in peer review and/or periodic evaluations of a licensed independent practitioner’s competence at reappointment
3. When a Quality measurement does not reach the predetermined acceptable level of Quality, or if it is reached, but evaluation indicates the Quality is not acceptable, the Quality improvement process should continue. If the level of Quality shows no improvement for the time frame established by the department/service team plan, an intensive evaluation is conducted with input from the Quality Steering Committee regarding the need for continued measurement or reprioritization.

# Q. INTERNAL COMMUNICATION -

The top management has defined and implemented an effective and efficient process for communicating the Quality Policy, Objectives, QMS requirements and accomplishments. This helps the hospital to improve the performance and directly involves its people in the achievement of the Quality Objectives. The Management actively encourages feedback and communication from people in the hospital as a means of involving them through the following modes.

* Weekly, fortnightly & monthly meets
* Management Review Meetings
* Team briefings and other meetings.
* Notice Board, Email

# R. KEY PROCESSES identified are -

1. Service Delivery
2. Resource Management
3. Management Responsibility
4. Continual Improvement

# 1) Service Delivery

Planning and development of processes required for the service delivery has been developed and documented in process map in accordance with the other requirements of QMS. While planning for any new service, hospital shall determine the following.

 i. Quality Objectives and requirements for the services

The need to establish processes, documents and provide resources specific to the service. Required verification, validation, monitoring, inspection and test activities, specific to the service and the criteria for service acceptance. Record needed to provide evidence that the service delivery process meet the requirement. ii. Patient/s – Related Process

Determination of requirements related to the Services Patients/their relatives’ stated and implied requirements (including if any additional requirements determined by the hospital, legal & regulatory requirements) are identified before delivery of the service, initiating action to provide necessary treatment to the patient which are as per the documented procedures. iii. Review of requirements related to the service

The type of treatment (OPD or indoor) is reviewed for its adequacy based on the information available for the concerned patient or accompanying relative along with the records of vital parameters and investigation results. Any changes required subsequently, its communication to the concerned patient/ relative and to the relevant department is done as per the documented procedures.

Records of type of treatment identified/ provided are maintained as per the documented procedures.

Where the patient is unable to provide enough details the statement of requirements as capture by the concerned doctors are taken as base for providing necessary service and same is conveyed to the patient and/ or the relatives before providing the treatment for acceptance.

During the course of the treatment of at the end of one set of treatment the consent of the patient/relative is taken for subsequent treatment, subject to the willingness of the patient and in case of their unwillingness they may be discharged or referred to other hospital as the case may be.

1. Patient Communication

The arrangements for communication on enquiries and service related information, approximate charges are carried out at the time of registration or at the time of admission of treatment by the concerned authorities.

Patient feedbacks including complaints are handled as per the various service procedures for the different type of treatments.

1. Design and Development

The hospital is not directly involved in design and development of devices, equipment or drugs. Clinical use of established treatment modalities is adopted designed individually for each patient. As each patient is unique the outcomes are documented and monitored individually and modifications carried out in the treatment plan. Deviations from expected outcome are documented in the patient record and discussed by the concerned department. The frequency of such a review depends upon critically of the disease vi. Quality Objectives and requirements for the services

The need to establish processes documents and provide resources specific to the service. Required verification, validation, monitoring, inspection and test activities, specific to the service and the criteria for service acceptance. Record needed to provide evidence that the service delivery process meet the requirement.

 vii. Patient(s) – Related Process

Patients/their relatives’ stated and implied requirements (including if any additional requirements determined by the hospital, legal & regulatory requirements) are identified before delivery of the service, initiating action to provide necessary treatment to the patient, which are as per the documented procedures.

x**.** ControlofServiceDelivery

1. All Medicare service operations are taken care as per the documented procedures manual.
2. Relevant information for norms and acceptable criteria are provided through internal/ external standards.
3. Suitable infrastructure facilities are provided to ensure the conformity of service/ process requirements.

1. The necessary instruction manual & protocols are available.

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| **Red tags** |

 - (immediate) are used to label those who cannot survive without immediate treatment but who have a chance of survival.

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| **Yellow tags** |

* (observation) for those who require observation (and possible later re-triage). Their condition is stable for the moment and, they are not in immediate danger of death. These victims will still need hospital care and would be treated immediately under normal circumstances.

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| **Green tags** |

* (wait) are reserved for the "walking wounded" who will need medical care at some point, after more critical injuries have been treated.

 **White tags** – (dismiss) are given to those with minor injuries for whom a doctor’s care is not required.

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| **Black tags** |

 - (expectant) are used for the deceased and for those whose injuries are so extensive that they will not be able to survive given the care that is available.  |

xii Patient’s Property **-**

Service Delivery procedures address the requirement of any items brought in by the patient or the relative to ensure.

* 1. Verification on receipt
	2. Immediately handing over the patient’s personal belongings to his/her relative. Incase of absence patient’s relatives, the ward nurse will ensure proper storage of patient’s personal belongings.
	3. Recording of any nonconformity observed such as loss, damaged, unsuitable for use etc.
	4. Reporting of non conformities to customers
	5. Trace ability of these items to respective patient by excising control by the attending nurses
	6. At the time of admission for specific type of treatment, the valuables of the patient are taken from the patient & handed over to the relative prior to the commitment of the treatment

* 1. Preservation of items required for service delivery & patient handling**-**

The requirements of preservation is primarily identified for the medicine and other disposable which are meant for administering to the patients are kept duly identified in proper packaging and storage condition through out the period of treatment of the patients to protect them safely and necessary controls are exercised on them so that they are fit for use. After use proper method of disposals are followed for unusable and disposables.

Proper care is taken for the handling of patients at different stages, locations appropriate for the type of patients, their age, type of illness and conditional requirement of the patients from time to time.

Adequate arrangement is made for samples of body fluids, and X-rays etc.

Procedures are defined for handling patient in ICCU& OT and areas of sensitivity. Procedures are defined for handling dead body and mortuary.

* 1. Control of Monitoring Devices

This requirement of control of measuring and monitoring instrument require for providing different treatments to the patients are detailed in procedure of the respective function where calibration activity is carried out to ensure that these instrument are reliable for providing necessary service. Example anesthesia, radiology, Laboratory etc. The list of equipments and calibration process, calibration records are detailed in the instruction manuals, wherever applicable.

# Members:

1. Director – Hospital
2. Chief Medical Superintendent
3. Medical Superintendent
4. Dr.
5. Dr.
6. Sr.Nursing Incharge

# Objective:

* To evaluate the clinical care given to the patient by the care providers of the hospital by assessing the patients file (following random sampling of patients medical record).
* To take up and investigate any patient’s grievance in relation to the clinical care given to the patient in the hospital.
* To suggest remedial measures to the concerned clinician in case any discrepancy in clinical practices is noted and ensure their immediate implementation.

# Frequency of Meeting: Monthly

# 2. Resource Management.

# i. Provision of Resource

Resources required are identified and provided as defined in the organization chart given in the Quality Manual and documented procedure to ensure that

 Implementation, maintenance and continual improvement of QMS  To enhance patient satisfaction.

The exercise for identification of additional resource requirements for management, performance of work and verification activities, including internal audits is done in the hospital’s core management committee meetings. This committee also functions as the Management review committee.

The request application for manpower is used by user department & initiated to the personal department. In case of capital request, the concerned department initiates an application along with capital request form. The approval on the respective form is taken from the relevant authorities .After approval, these resources are provided at appropriate times.

# ii. Human Resources a. General

Skill requirements for all the positions in the organization chart have been identified. The competence of personnel is judged at the time of appointment and later on through appraisal system. **b.Competence** Awareness and Training

Competence of the personnel is assessed on the basis of the education, experience, skill and training before they are assigned the responsibilities in the QMS.

Training needs of all the personnel are identified, established and reviewed to ensure competence for the responsibility to be assigned. The responsibility for these lies with the department heads while the Medical Superintendents (M&F wings) does the over all coordination.

Training needs of the new recruits and personnel transferred from other hospitals are identified and established as per the requirements. The responsibility of general training program is with the Administrative department, while specific job related training is the responsibility of the department head.

Department In-charge along with the Medical Superintendents (M&F wings) is responsible for ensuring the training on identified needs is provided to the employees. Medical Superintendents (M&F wings) evaluates the effectiveness of training conducted.

A consolidated database of training records of all the employees is maintained.

Records of personnel qualified for performing specific assigned tasks and activities also maintained by the Medical Superintendents (M&F wings) & the individual department In-charge.

# iii. Infrastructure

Infrastructure required by all personnel to achieve the conformity of the service requirements are identified and provided before the commencement of the work/ activity and are maintained and improved regularly as per the documented procedure.

# iv. Work Environment

Work environment needed by all personnel to achieve the conformity of the service requirements are identified and provided before the commencement of the work/activity and are maintained and improved regularly.

# v. Purchasing

# a. Purchasing Process

Purchase activity is carried out as per the documented procedure. Suppliers are evaluated by the Purchase committee at the time of selection and at regular intervals thereafter, based on their ability to meet the specific requirements including that of the QMS and any specific quality assurance requirements. In the process they may seek help of relevant departments. Appropriate controls are exercised on the supplier only by the Purchase Committee.

# b. Purchasing Information

Relevant clerks in the administrative wing and the pharmacy wing is responsible for ensuring that the purchase orders are reviewed and approved for adequacy of specified requirements.

Purchase orders provide complete details of the materials ordered. Where appropriate attachments are sent along with the Purchase Orders

# c. Verification of Purchased Product

On receipt, the material is inspected by store against the specifications as given in the Purchase Order. There is no requirement for any customer verification of the Purchase product. Anyhow in future if any such requirement is there, a suitable system shall be developed

# 3. Responsibility of Management at Hospital

1. Top Management of the hospital is totally committed to development and implementation of an effective and efficient QMS for continual improvement

1. Top management has established vision, mission, policy and strategic objectives consistent with the purpose of the hospital, which leads to the achievement of patient satisfaction.
2. Top Management provides its full support by participating in improvement projects, searching for new methods & Solution. Top management also ensures the availability of the resources that are necessary to support the Hospital’s strategic plan.
3. Patient needs and expectations are determined and converted into requirements and fulfilled as documented in process map & procedure for service delivery process and Management

Responsibility.

1. Obligations related to the statutory and regulatory requirements are taken care as appropriate.
2. Top management takes initiatives in communicating the Hospital’s values, vision, mission, policies and objectives and targets. Some examples are as follows:
	* The CMS has released the vision, values and policies to all the employees
	* The Medical Superintendents (M & F wing) communicates the Quality Policy and Objectives of the hospital to all the employees.
	* CMS presides over the management review meeting as per the agenda and reviews the progress of the implementation of the quality system periodically.
	* CMS./MS (M & F wing) addresses all the employees through inter officer Memo whenever new initiatives are taken towards improvement.
3. The top management of the hospital is highly committed towards process - oriented approach. Accordingly all the processes are documented and implemented. Internal audits and management review meetings are used as effective tools to ensure the implementation of the laid down processes and also verifying their continuing suitability, effectiveness and adequacy of the system.
4. The hospital is an integral part of the public health system .The top management identifies and respects the hospital’s social responsibility. Various programme, community outreach programmes are organized in lieu of the hospital’s social responsibility. Some examples such as Medical Check up Camps, Blood Donation Camps, Immunization Programme for various age groups , Free treatment for people below poverty level.

Various committees have been incorporated into the managements system of the hospital for effective implementation of the QMS.

**S.QUALITY MANAGEMENT SYSTEM (QMS)**

Quality Management System of hospital is established, documented, implemented and maintained for continual improvement in accordance with requirements of Quality Objectives.

The hospital has established, implemented and maintains a Quality Management System appropriate to the scope mentioned earlier. Hospital has documented its policies, process, program, procedure, and instructions and has communicated this to all relevant personnel and has ensured that these documents are understood and implemented.

The respective Department Head/ In Charge ensure that all the personnel working in the Hospital have understood the Quality Policy, Quality Assurance system and the objective for adopting the Quality Assurance System.

Hospital outlines its Quality Assurance System through three-tier documentation structure as below.

1. **Quality Manual**- An outline of Hospital and functioning of its management system.
2. **Quality System Procedures**- The system’s functioning is detailed in separate documents that are maintained by the quality assurance officer as controlled documents. The quality manual makes continuous references to system procedures in the relevant sections.
3. **Work instructions/Standard-operating procedure**: A higher degree with regard to activities and standards maintained are also maintained with the quality assurance officer as controlled documents.
* Establishing and maintaining a management system
* Document control
* Documentation of all management system activities
* To ensure that quality manual is up to date
* Schedule and conduct of internal audit
* Schedule and conduct of management review meeting
* Ensuring corrective and preventive action arising from the above

# T. DOCUMENT CONTROL

1. Documents such as regulations, standards, and other normative documents a well as drawings, software, and specifications, instructions and manuals form part of the Hospital Management System.A copy of each of these controlled documents shall be archived for future reference and the documents shall be retained in their respective department .The procedures and equipment details are retained in respective as long as he machine is being or until condemned .The documents are maintained in paper or electronic media as appropriately required.

Documents are identified and established as three levels namely:

* Quality manual
* SOP/ instruction manuals
* Records

Title and naming of documents as outlined in SOP The Quality Control Officer issues the finalized document.

The Quality Assurance Officer ensures that:

* Authorized editions of appropriate documents are available at all locations where operations essential to the effective functioning of the Hospital are performed.
* Documents are periodically reviewed and revised where necessary to ensure suitability and compliance with applicable requirements.
* Invalid or obsolete documents are promptly removed from all pints of issue or use, or otherwise assured against unintended use.
* Obsolete documents are retained for either legal and / or knowledge preservation purposes are suitably marked or destroyed or the record and the record of this maintained in a separate register.

Management system documents are uniquely identified.

* Date of issue
* Identification of revision status
* Page numbering with the total number of pages
* Identification of the end of the document
* Issuing authority

# 2. DOCUMENT CHANGES

Revision of management systems documents is carried out when necessary by the original author. When alternate persons are designated for review, they shall first familiarize themselves with pertinent background information upon which to base their review and approval.

Any alteration in the text is documented on the document or by way of maintenance of obsolete documents issued prior to review.

Document control system does not follow for the amendments by hand unless there is extenuating circumstances .These amendments shall be marked, initialed and dated only by the HOD, .The amendment shall be brought to the notices of the Chief Medical Superintendent and Quality Assurance Officer and the same shall be reissued in 7 working days of the change being in effect.

Hospital maintains documentation status currently in hard and soft versions. Hospital describing the changes in documents, its maintenance and its control in the computerized system establishes adequate procedures.

# U .PREVENTIVE ACTION

The Chief Medical Superintendent is perpetually vigilant and identify potential sources of non-compliance and areas that need improvement. These may include trend analysis of specific markers such as turnaround time, risk analysis and introducing proficiency testing for self-assessment.

Where preventive action is required, a plan is prepared and implemented. All preventive actions must have control mechanisms and monitor for efficacy in reducing any occurrence of non-compliance or producing opportunities for improvement.

# V. CORRECTIVE ACTION

The Chief Medical Superintendent takes all necessary corrective action when any deviation is detected in Quality Management System.

**i. Cause Analysis** Deviations are detected by:

* Patient complains/feedbacks
* Non-compliance receipt of items/sample
* Non-compliance at Internal/external Quality Audit
* Management Reviews

The CMS conducts and coordinates the detailed analysis of the nature and root cause of non-compliance along with the responsible persons from the respective sections.

# ii. Selection and Implementation of Corrective Actions

Potential corrective actions are identified and the one that is most likely to eliminate the problem is chosen for implementation. Corrective action is taken into consideration the magnitude and degree of impact of the problem. All changes from corrective action is documented and implemented.

# iii. Monitoring Of Corrective Actions

The CMS, shall monitor the outcome parameters to ensure that corrective actions taken have been effective in eliminating the problem.

# iv. Additional Audits

When the magnitude of non-compliance cases doubts on the departments’ overall compliance with documented procedure, additional audits are conducted.

# W. FLOW CHART-

Internal audit

Root Cause Analysis

Failure Mode and Effect Analysis

(

FMEA

)

Corrective Action / Preventive Action

Final decision by the

CMS

/MS (M&F

wing)

Process Reengineering, Protocol

Reconst

itution & Implementation