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AMENDMENT SHEET

Sl. no	Section no & page no	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

DOCUMENT HISTORY		
Original Issue **02**	**Original Issue Date** **20 May 2019**	**Reason for Amendment**
Reviewed on: 01 May 2022 **Reviewed by:** Dr. DINESH KUMAR M K DEPUTY MEDICAL SUPERINTENDENT		**Policy Review & Update**

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PREPARED BY	REVIEWED BY	APPROVED BY
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CONTROL OF THE MANUAL

1. The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable.

2. The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

3. HOD – Human Resources and Development department is responsible for issuing the amended copies to the copyholders, the copyholder should `acknowledge the same and he /she should return the obsolete copies to the HOD.

4. The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

5. The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH. The authority over control of this manual is as follows:

Preparation	Approval	Issue to
Quality Department	Deputy Medical Superintendent	Operations Department

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy', and the photocopies of the master copy for the distribution are considered as 'Controlled Copy'.

Distribution List of the Manual:

Sl. No.	Designation
1.	Quality Department
2.	Operations Departments
3.	Patient Care Departments

CONTENTS

1.0 PURPOSE:

1.1 To guide and ensure the continuous improvement of quality services provided by MMC Hospital.

1.2 To fix key indicators for the processes, to organize measurement process to assess the performance index on such key indicators.

1.3 Scheduling of periodical measurement of performance index of key indicators explained above.

1.4 To identify appropriate tools for continual improvement.

2.0 SCOPE:

2.1 Hospital Wide – All Inpatient care areas

2.2 Applicable to all employees of the hospital

3.0 RESPONSIBILTY:

3.1 Consultants / Doctors

3.2 All hospital staff

3.3 Core / Quality Assurance Committee

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board for Hospitals and Healthcare providers

4.2 CQI : Continuous Quality Improvement

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5.0 DEFINITION:

5.1 **Quality Indicators :** Quality indicators are the means to judge the real performance of certain clinical as well as managerial parameters selected for monitoring and evaluation.

5.2 **Non Conformance :** Defined as any event or circumstance not consistent with the standard routine operations or not having compliance to defined processes of the hospital in staff functions on support activities to internal/external customers or on care processes to patients.

5.3 **Sentinel Events :** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof to a patient, visitor, or an employee. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof", includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

5.4 **Near Miss :** Any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.

5.5 **Hazardous conditions :** Refer to any set of circumstances (exclusive of disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

5.6 Lapse in compliance to statutory safety norms resulting in near miss harms the patients / staff / visitors or to infrastructure.

5.7 **Quality improvements :** It is an ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to the patients.

5.8 **Risk management :** Clinical and administrative activities to identify evaluate and reduce the risk of injury.

6.0 REFERENCE:

6.1 **NABH** : Pre Accreditation Entry Level Standards for Hospitals, Fifth Edition, April 2020.

6.2 **CQI.1** : There is a structured quality improvement, patient safety and continuous monitoring programme in the organization.

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6.3 **CQI.2 :** The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.

7.0 POLICY:

7.1 Organization has designated a person as Assistant Manager Quality to meet the quality standards.

7.2 Quality improvement and patient safety programme shall be implemented by Quality & Safety Team.

7.3 The Hospital management makes available adequate resources required for quality improvement and patient safety program.

7.4 The quality improvement & safety programme is reviewed every **3** months and opportunities for improvement are identified.

7.5 MMC Hospital has identified key performance indicators to monitor the clinical and managerial areas.

7.6 All the key indicators shall be monitored every month and reviewed in discussion with the Quality & Safety committee members.

7.7 **Quality Policy:**

7.7.1 To assure quality healthcare to patients through reliable healthcare services, available medicines and maintainable equipment's.

7.7.2 Ensure efficiency of operations and effectiveness of treatment through our competent human resources.

7.7.3 To review this policy for continuing, adequacy and effectiveness.

7.7.4 To achieve this through the quality objectives and target set for various departments.

7.8 **Quality Objectives:**

7.8.1 The Quality Objectives are defined in line with the stated Quality Policy, including those needed to meet the requirements of product / service, are established at relevant functions and levels within the Hospital, suitable to be measured.

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7.8.2 To maintain high standards of service at all levels.

7.8.3 Monitoring of set standards in all areas of hospital through quality improvement & safety programme.

8.0 PROCEDURE:

8.1 Approach to Designing, Measuring, Assessing And Improving Quality:

8.1.1 **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, planning and providing systematic organization-wide improvements.

8.1.2 **Designing:** Processes, functions or services are designed effectively based on: Mission and vision of MMC Hospital. Needs and expectations of patients, staff, and others. Baseline quality expectations are utilized to guide measurement and assessment activities.

8.1.3 **Measurement:** Data is collected for a comprehensive set of Quality measures. 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:

8.1.3.1 Patient assessment

8.1.3.2 Laboratory safety & quality

8.1.3.3 Diagnostic Radiology safety & quality

8.1.3.4 Processes related to medication use

8.1.3.5 Processes related to anesthesia

8.1.3.6 Processes related to the use of blood and blood components

8.1.3.7 Processes related to medical records content, availability and use

8.1.3.8 Risk management activities

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8.1.3.9 Needs, expectations, and satisfaction of patients

8.1.3.10 Processes related to patient and staff safety.

8.1.3.11 Surveillance of hospital acquired infection.

8.1.3.12 Utilization of facility.

8.1.4 **Assessment:**

8.1.4.1 The assessment process involves the relevant departments to draw conclusions about the need for more intensive measurement.

8.1.4.2 A systematic process is used to assess collected data in order to determine whether it is possible to make improvement of existing processes, actions taken to improve the Quality Improvement processes, and whether changes in the processes resulted in improvement.

8.1.4.3 Collected data is assessed at least **Half Yearly** and findings are documented and are forwarded through the proper channels.

8.1.4.4 The reference used may include the following: Internal comparisons in Quality of processes and outcomes are made over time. Quality comparison of data is made about processes with up-to- date information. Quality comparison of data is made about processes and outcomes with other hospitals utilizing reference databases when possible.

8.1.4.5 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. Intense assessment is performed on the following:

8.1.4.5.1 Major discrepancies between preoperative and postoperative diagnoses in pathology reports.

8.1.4.5.2 Confirmed major transfusion reactions.

8.1.4.5.3 Significant adverse drug reactions.

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8.1.4.5.4 Adverse events or patterns of adverse events during anesthesia use.

8.1.4.5.5 Unexpected patient death.

8.1.4.5.6 Wrong site / side / patient surgery

8.1.4.6 When findings of the assessment process are relevant to an individual's Quality, the pertinent information will be provided to the Medical Superintendent for determining their use in peer review and/or periodic evaluations of a licensed independent practitioner's competence at reappointment.

8.1.5 **Internal Communications:**

8.1.5.1 The top management has defined and implemented an effective and efficient process for communicating the Quality Policy, Objectives, Quality management requirements and accomplishments.

8.1.5.2 This helps the hospital to improve the performance and directly involves its people in the achievement of the Quality Objectives.

8.1.5.3 The Management actively encourages feedback and communication from people in the hospital as a means of involving them through the following modes:

8.1.5.3.1 Monthly meets;

8.1.5.3.2 Management Review Meetings;

8.1.5.3.3 Team briefings and other meetings.

8.1.6 **Documentation:**

8.1.6.1 **Quality Manual:** This is an outline of hospital policies together with the Mission, Vision and Values of **MMC HOSPITAL** Quality Policy and Patient Safety priorities. Quality Manual also contains the structure and functions of the continuous quality improvement programme.

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8.2 **Assistant Manager Quality** at **MMC HOSPITAL** has the overall authority, responsibility and commitment to communicate, implement, control and supervise the compliance of various departments with the accreditation standards. The roles and responsibility of the NABH Coordinator include:

8.2.1 Establishing and maintaining the Quality Improvement and Patient Safety Program.

8.2.2 Document control.

8.2.3 Documentation of all Committee Meetings, Agenda and Minutes.

8.2.4 To ensure that Quality Manual and other Quality documents are current.

8.2.5 Schedule and conduct Internal Audits.

8.2.6 Schedule and conduct of Management Review meeting.

8.2.7 Ensuring corrective and preventive action arising from the above

8.3 **Document Control:**

8.3.1 Documents such as regulations, standards, policies, SOPs, manuals and other normative documents as well as drawings, software form part of the Hospital Quality Management System.

8.3.2 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 documents are maintained in paper or electronic media as appropriately required.

8.3.3 Documents are identified and established as two levels namely:

8.3.3.1 Quality Manual;

8.3.3.2 Hospital Policies & Procedures;

8.3.4 The Heads of the Departments of the respective departments shall review all documents issued to personnel as a part of management system annually and they shall approve it for the use. The Head of Quality issues the finalized document.

8.3.5 The Head of Quality ensures that:

8.3.5.1 Authorized editions of appropriate documents are available at all locations where operations essential to the effective functioning of the Hospital are performed.

8.3.5.2 Documents are periodically reviewed and revised where necessary to ensure suitability and compliance with applicable requirements.

8.3.5.3 Invalid or obsolete documents are promptly removed from all prints of issue or use, or otherwise assured against unintended use.

8.3.5.4 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.

8.3.6 **Document Changes:**

8.3.6.1 Revision of management systems documents is carried out when necessary by the original author and updated at least once in two years.

8.3.6.2 When alternate persons are designated for review, they shall first familiarize themselves with pertinent background information upon which to base their review and approval.

8.3.6.3 Document control system does not follow for the **amendments by hand unless** there is an extreme circumstance.

8.3.6.4 These amendments shall be marked, initialed and dated only by the Head of the Department.

8.3.6.5 The amendment shall be brought to the notice of the NABH coordinator and the same shall be reissued

8.4 **Preventive Actions:**

8.4.1 The Assistant Manager Quality shall be perpetually vigilant and identify potential sources of non-compliance and areas that need improvement.

8.4.2 These may include trend analysis of specific markers such as turnaround time, risk analysis, etc.

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8.4.3 Where preventive action is required, a plan is prepared and implemented.

8.4.4 All preventive actions must have control mechanisms and monitor for efficacy in reducing any occurrence of non-compliance or producing opportunities for improvement.

8.5 **Corrective Action:**

8.5.1 The Assistant Manager Quality takes all necessary corrective action when any deviation is detected in Quality Management System.

8.6 **Root Cause Analysis:** Deviations are detected by:

8.6.1 Patient complains / feedbacks.

8.6.2 Non-compliance receipt of items / sample.

8.6.3 Non-compliance at Internal / external Quality Audit. Management Reviews.

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

8.7 **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.

8.8 **Monitoring of Corrective Actions:** The NABH Coordinator shall monitor the outcome parameters to ensure that corrective actions taken have been effective in eliminating the problem.

8.9 **Procedures for Internal Quality Audit:**

8.9.1 Internal audit shall be conducted by the internal audit team members once in six months.

8.9.2 Internal audit team members shall be trained on Pre Accreditation Entry Level NABH standards either internally (a trained person who in turn trains the other members of the team) or externally (training conducted by Quality Council of India).

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8.9.3 Audit starts with the opening meeting. All departmental heads shall be informed about the purpose of audit, audit timings and duration of audit etc.

8.9.4 Check list based on standards will be used by the auditor. All minor correction shall be suggested then and there by the auditor to the departmental staff.

8.9.5 Audit gets over with the closing meeting, over all observations shall be summarized by the chief auditor. Audit observations shall be handed over to the chairman of the quality assurance committee in a standardized format.

8.9.6 All the audit reports shall be discussed with the core committee members and the observations noticed will be presented to the Chairman for improvements.

8.9.7 The Audit reports shall be forwarded to the concerned Departmental Heads. Corrective and preventive actions will be done by the department staff based on the audit observations. Reports of the corrective and preventive actions will be submitted to the Quality department by the concerned Head of the department.

8.10 **Procedure for collection of data, interpretation and analysis of Quality Indicators:**

8.10.1 **Collection of Data:** Reports of all key indicators as decided by the management will be submitted to the quality coordinator at the end of every month by the Head of each department. All the data will be collected in the standardized format.

8.10.2 **Analysis of Data:** All the data will be assessed in the form of Structure, process and the outcome.

8.10.3 **Structure:** Structure includes the facilities provided to the staff. Formula used for calculation. Training or awareness of the set formulas / quality improvement programme.

8.10.4 **Process:** Strict adherence of developed procedures in the daily work routine. In case of deviations same will be documented in the quality indicator reporting form with proper reasoning.

8.10.5 **Out Come:** Based on the reports received trend analysis will be done and the same will be reported to the chairman/ Management.

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8.11 **Key Indicators Followed in MMC HOSPITAL:**

SL. No	Name of the indicator	Numerator	Denominator	Standardization factor
Clinical care Indicators:				
Monitoring Includes appropriate patient Assessment:				
1	Time for Initial Assessment of Indoor patients.	Time of initial assessment – time of admission.		
2	Time for Initial Assessment of Emergency patients.	Time of initial assessment – time of receiving the patient.		
3	Percentage of cases where in the predefined initial nursing assessment is completed & documented.	Number of patients where nursing assessment completed within 30 minutes.	Number of discharged case sheet	100
Monitoring includes safety and quality control programmes of the diagnostic services:				
4	Number of reporting errors / 1000	Number of reports with errors.	1000 reports	
5	Percentage of adherence to safety precautions by employees working in diagnostics .	Number of employees adhering to safety precautions .	Total number of employees in the departments.	100
6	Percentage of re-scheduling of procedures daily.	Number of cases re-scheduled daily.	Total number of cases posted for the day.	100
Monitoring includes adverse drug events:				
7	Percentage of medication errors	umber of medication errors reported	Number of patients under	100
8	Incidence of adverse drug reactions reported in a month.	Number of adverse drug reactions reported in a month.	Number of patients who got medication in a	100

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Monitoring includes use of anesthesia:				
9	Percentage of modification of anesthesia plan for the month.	Number of cases where anesthesia plan is modified for that month.	Total number of patients given anaesthesia for that month.	100
10	Percentage of Adverse Anesthesia Events for a given period of time.	Number of Adverse Anesthesia events for a given period of time.	Number of patients given anesthesia for a	100
11	Anesthesia related mortality rate for a given period of time.	Number of patients died because of anesthesia for a given period of time.	Number of patients given anesthesia for a given period of time.	100
Monitoring includes use of blood and blood products:				
12	Percentage of blood and blood products transfusion reactions.	Number of transfusion reactions occurred.	Number of blood and blood products	100
Monitoring includes availability and content of medical records:				
13	Percentage of Medical Records not having discharge summary	Number of medical records without Discharge Summary	Total number of discharges / LAMAs / deaths in that month	100
14	Percentage of Medical Records not having initial assessment for a given period of time	Number of admissions without initial	Number of Admissions made for a given period of time	100

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15	Percentage of missing records	Number of records that are missing	Total number of medical records generated per month	100
Monitoring includes infection control activities:				
16	Urinary Tract Infection Rate due to urinary catheter in a month	Number of Urinary Catheter associated UTIs in a month	Number of urinary catheter days	1000
17	Ventilator associated pneumonia Rate	Number of ventilator associated pneumonias in a month	Number of ventilator days	100
18	Surgical Site Infection Rate	Number of surgical site infections in a given month	Number of surgeries performed in that month	100
19	CLABSI (Central line associated blood stream infection)	Number of CLABSI	Number of central line days in that month	1000
<u>Managerial indicators</u> **Monitoring includes procurement of medication essential to meet patient needs:**				
20	Percentage of drugs procured by local purchase	Number of drugs procured locally during that period	Total quantity ordered in that period	100
21	Number of stock outs including emergency drugs	Number of stock outs occurred (including emergency drugs)		
Monitoring includes reporting of activities as required by laws and regulations:				
22	Number of Births informed to the authorized bodies.			
23	Number of deaths informed to authorized bodies.			
24	Number of Notifiable diseases informed to govt.			

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	bodies			
Monitoring includes risk management:				
25	Incidence of falls	Number of falls in a given month	Number of admissions in that month	100
26	Percentage of employees provided pre-exposure prophylaxis	Number of employees provided with Pre-exposure prophylaxis	Total number of employees in the hospital	100
Monitoring includes utilization of space, manpower and equipment:				
27	Bed occupancy rate	Total Number of beds occupied	Total Number Of Beds in the	100
Monitoring includes adverse events and near misses:				
28	Number of Sentinel events			
29	Number of needle stick injuries	Number of needle stick injuries reported		

8.12 **Analysis of data:**

8.12.1 All indicator data from departments shall be kept in a file department wise and at the end of the month shall be summaries for the assessment.

8.12.2 The outcomes of the Quality Care Indicators are analyzed every month and a comparative statement is made on the progress for each month.

8.12.3 The progress report is forwarded to the management.

8.12.4 In case of negative progress, if any, corrective action report shall be made by the Core Committee in discussion with the concerned Department Head and the same shall be submitted to the Management.

9.0 Responsibilities of management:

9.1 MMC hospital management shall allocate separate budget to meet the quality of hospital service.

9.2 All activities will be controlled by the top management and to execute or implement the necessary actions NABH Quality coordinator will be responsible.

9.3 **The defined process for checking the Inpatient medical records is as follows:**

9.3.1 Before the patients are discharged, the files are compiled, checked for completion by concerned nurse in-charge.

9.3.2 The discharged patient's records are dispatched to Medical Record department from the discharge counter.

9.3.3 The medical record department staff assembles the files, arranges in a specific sequence and rechecks for completeness.

9.3.4 Completed record files are then sent to a doctor who is appointed for a final check.

9.3.5 Later the medical record audit committee will review the sample records.

9.3.6 Such review will occur once in a month.

9.3.7 Sample size is taken in such a manner so as to be representative of all the medical records.

9.3.8 Sample is selected as randomly selected records from the all the specialties.

9.3.9 The review process is carried out as per the Medical Audit Check list.

9.3.10 The reports shall be discussed in Medical Record Review Committee or Quality committee meeting for necessary action.

9.4 **Following components are specially checked for:**

9.4.1 Completion of various components of the medical record.

9.4.2 Timeliness of entries. Legibility of authorship (name, sign, date).

9.4.3 Adequacy and fulfilling minimum requirements of assessment notes.

9.4.4 Medication order follow ups, verbal orders etc.

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9.5 **Internal audit (Refer Quality Improvement / System Manual):**

9.5.1 The parameters to be audited are defined by the organization.

9.5.2 A predefined check list has been formed.

9.5.3 Records are maintained by the quality committee team/ core committee team.

9.5.4 Internal audits are conducted to ensure the conformity of the quality management system and continual improvement of the effectiveness of the quality management system is ensured through improvement in process and revision of objectives both at the organizational and functional level.

9.5.5 Internal quality audits are planned for carrying it out at least two times a year to determine whether the quality management system conforms to planned arrangements and the quality management system requirements established by the hospital and whether the mentioned standards are implemented and maintained.

9.5.6 All audit reports are retained as quality records as per the record retentive program minimum for 2 years and are included as an essential input for Management Review.

9.5.7 All the audits are documented.

9.5.8 Separate audit sheets are prepared for nurses / technicians and doctors.

9.5.9 Non-conformities are closed by taking appropriate corrective and preventive actions.

9.5.10 Remedial measures are to be implemented.

9.6 **Analysis of safety audit shall be done through:**

9.6.1 Safety variances involving falls or injuries, material safety handling or damage / lost patient property shall be routed to Safety committee.

9.6.2 Equipment malfunctions reports shall be routed to Biomedical Dept.

9.6.3 Utility outages and pest control issues shall be routed to Hospital Support Services.

9.6.4 All housekeeping related issues shall be referred to Housekeeping.

9.6.5 All other issues shall be categorized departmental accountability wise and shall be referred to HODs concerned accordingly.

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9.7 **Reports (Quarterly):** Consolidated summary report on events with analysis and on concerns if any, shall be submitted to:

1) Managing Director
2) Administrator, for Management review and recommendations on Clinical related non-conformance and incidents;
3) Medication Usage Variances (Adverse Drug Reactions, Medication Errors, and Controlled Substance / Narcotic Discrepancy) shall be by Medical Superintendent involving P & T Committee;
4) Maintenance for management review and recommendations on safety deficiencies related Non-conformance/ Incidents.

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