SRI LAKSHMI MEDICAL CENTRE AND HOSPITAL

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AMENDMENT SHEET

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

CONTROL OF THE MANUAL

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.

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.

Quality Manager 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 Quality Manager.

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

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
Quality Manager	Chairman, Sri Lakshmi Medical Centre & Hospital.	Accreditation coordinator

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:

S.No.	Designation
1	Chairman
2	Quality Manager
3	Accreditation Coordinator

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1.0 PURPOSE:

1.1 To guide and ensure the continuous improvement of quality services provided by Sri Lakshmi Medical Centre & 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

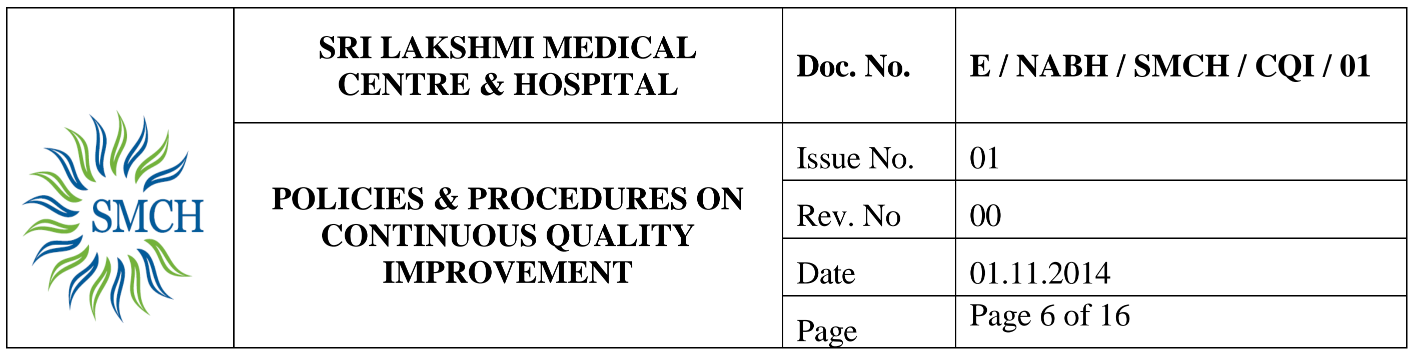
4.2 CQI : Continuous Quality Improvement

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 **Sentinel Events:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof to a patient, visitor, or an employee.

5.3 **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.



5.4 **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, First Edition, April 2014.

7.0 POLICY:

7.1 Organization has designated a person as NABH coordinator 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 Sri Lakshmi Medical Centre & Hospital has identified key performance indicators to monitor the clinical and managerial areas.

7.5 **Quality Policy:**

7.5.1 We hereby assure quality healthcare to patients through reliable healthcare services, available medicines and maintainable equipments.

7.5.2 We shall ensure efficiency of operations and effectiveness of treatment through our competent human resources.

7.5.3 We shall review this policy for continuing suitability, adequacy and effectiveness.

7.5.4 We shall achieve this through the quality objectives and targets set for various departments.

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.

8.1.2 **Designing:** Processes, functions or services are designed effectively based on: Mission and vision of Sri Lakshmi Medical Centre & Hospital needs and expectations of patients, staff, and others.

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

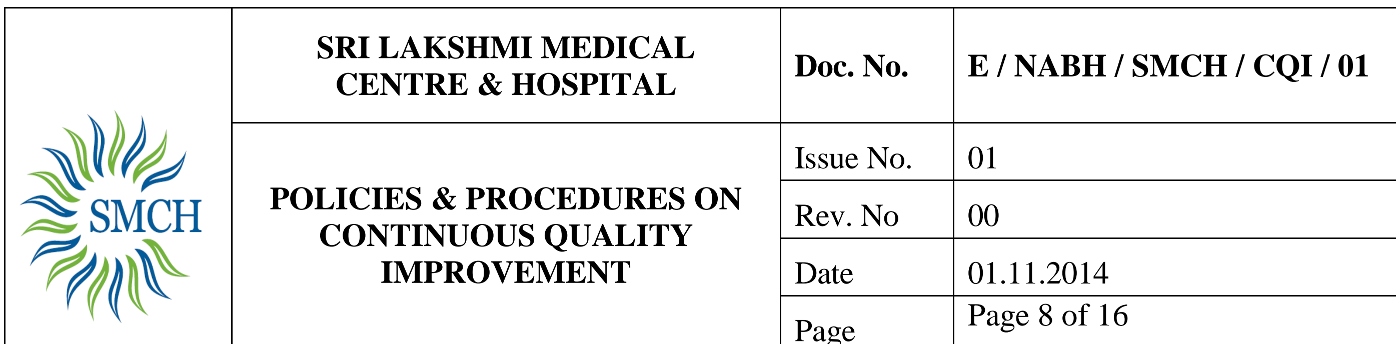
8.1.4 **Assessment:**

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 annually and findings are documented and are forwarded through the proper channels.

8.1.4.4 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.



8.1.4.5 **Internal Communications:**

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

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

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

8.1.4.8.1 Monthly Meetings;

8.1.5 **Documentation:**

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

8.2 **Chairman/Quality Manager/NABH Coordinator** at **SRI LAKSHMI MEDICAL CENTRE & 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 Schedule and conduct Internal Audits.

8.2.4 Schedule and conduct of Management Review meeting.

8.2.5 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 NABH Coordinator 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.

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 NABH Coordinator takes all necessary corrective action when any deviation is detected in Quality Management System.

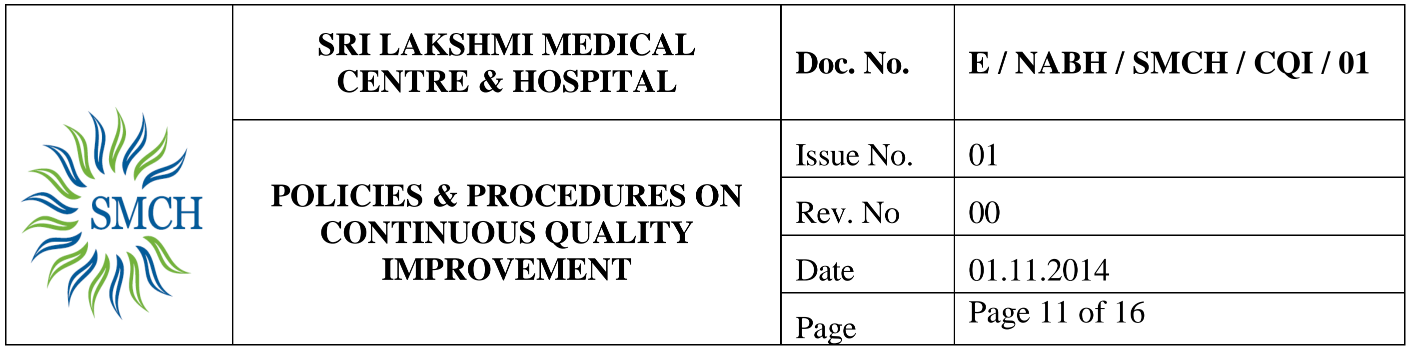
8.6 **Root Cause Analysis:** Deviations are detected by:

8.6.1 Patient complaints/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).

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 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.

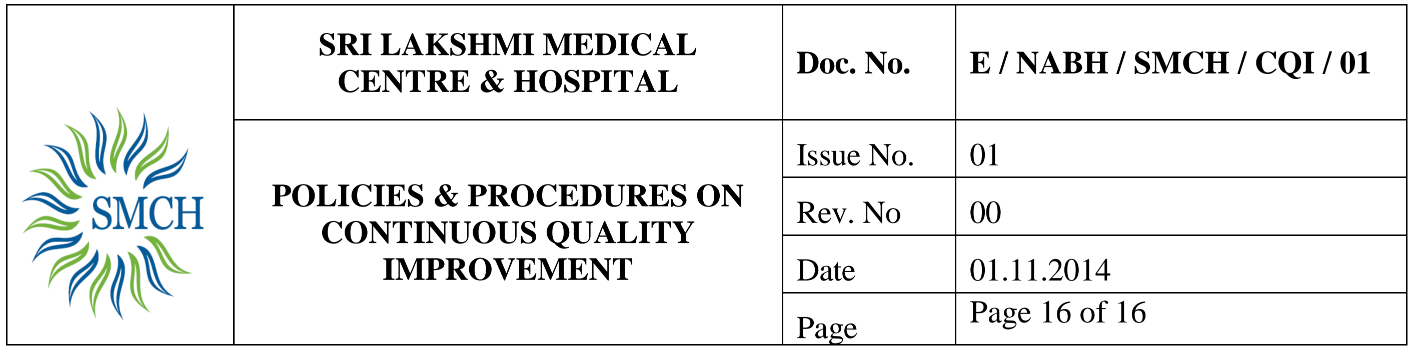
8.11 Key Indicators Followed in Sri Lakshmi Medical Centre & Hospital

SL NO	INDICATOR	NUMERATOR	DENOMENATOR	STANDARDIZATION FACTOR	Definition
1	Time for Initial Assessment of Indoor patients	Sum of time taken	Total number of patients	100	The time shall begin from the time that the patient has arrived at the bed of the ward till the time that the initial assessment has been conducted by a doctor. In case of emergency, time shall begin from the time patient has come to the door of emergency till the time initial assessment completed by the doctor
2	Time for Initial Assessment of Emergency patients	Sum of time taken	Total number of patients	100	

3	Percentage of re-scheduling of surgery	Number of cases re-scheduled	Total number of surgeries performed	100	Re-scheduling of patients includes cancellation and postponement (beyond 4 hours) of the surgery.
4	Percentage of medication errors	Number of medication errors reported	Number of patients under medication	100	A medication error is any preventable event that may cause or lead to inappropriate medication usage or harm to a patient. Eg: errors in prescribing, transcribing, dispensing, administering and monitoring of medications; wrong drug, wrong dose, or wrong strength errors; wrong patient errors
5	Percentage of medication chart with error prone abbreviations	Number of medication chart with error prone abbreviations	number of medication chart reviewed	100	Medication chart with illegible handwriting and unaccepted error prone abbreviations
6	Percentage of modification of anesthesia plan	Number of cases where anesthesia plan is modified	Total number of patients given anaesthesia	100	Anesthesia plan is the outcome of preanesthesia assessment. Any changes done after this shall be considered as modification of anesthesia plan.
7	Percentage of Adverse Anesthesia Events	Number of patients who developed adverse anesthesia events	Number of patients who underwent anesthesia	100	Adverse drug event is any untoward medical occurance that may present during treatment with anesthetic product but which does not necessarily have causal relationship with this treatment

8	Percentage of blood and blood products transfusion reactions	Number of transfusion reactions occurred	Number of blood and blood products transfusions done	100	a systemic response of the body to the administration of blood in compatible with that of the recipient. The causes include red cell incompatibility.
9	Percentage of missing records	Number of records	Total number of medical records generated per month	100	A medical record is considered as missing, when it could not be found out from the MRD after 72nd hour of record request
10	Urinary Tract Infection Rate due to urinary catheter	Number of Urinary Catheter associated UTIs	Number of patients who were inserted with Urinary Catheter	1000	As per latest CDC guidelines
11	Ventilator associated pneumonia Rate	Number of ventilator associated pneumonias	Number of patients on a ventilator	1000	As per latest CDC guidelines
12	Surgical Site Infection Rate	Number of surgical site infections	Number of surgeries performed	100	As per latest CDC guidelines
13	Incidence of falls	Number of falls	Number of Admissions	100	loss of upright position that results in landing on the floor, ground or an object or furniture or a sudden uncontrolled unintentional, non-purposeful downward displacement of the body towards floor/ floor or hitting another object like a stair or chair.

14	Percentage of employees provided pre-exposure prophylaxis	Number of employees provided with Pre-exposure prophylaxis	Total No of Employees in the hospital	100	Pre exposure prophylaxis is any medical or public health procedure used before exposure to the disease causing agent, its purpose is to prevent, rather than treat or cure a disease.
15	Number of needle stick injuries	Number of needle stick injuries reported	Number of IP days	100	NSI is a penetrating stab wound from a needle that may result in exposure to blood or other body fluids. NSI are wounds caused by needles that accidently puncture.
16	Percentage of admissions with adverse drug reactions	Number of ADR	Number of patients under medication	100	
17	Percentage of unplanned Ventillation followed by anesthesia	Number of patients requiring unplanned Ventillation followed by anesthesia	Number of patients who underwent anesthesia	100	Every anesthesia plan shall invariably mention if there is a possibility of the patient requiring Ventillation followed by anesthesia. Every case wherein patient requires Ventillation but this was not captured in the anesthesia plan shall be part of numerator
18	Incidence of bedsore after admission	Number of patients who requiring new/ worsening of pressure ulcer	Number of Admissions	100	
19	Waiting time for diagnostic procedures , X RAY:	Sum of TAT (patient in time for procedure - reporting time) X RAY	Number of patients reported for Multiple x rays taken	100	



19 a	Waiting time for diagnostic procedures ,lab investigations	Sum of TAT (patient in time for procedure - reporting time)	Number of patients reported	100	
20	Percentage of medical records not having discharge summary	Number of medical records not having discharge summary	Number of discharges and death	100	