Internship Training at Sarvodaya Multispeciality

And Cancer Hospital, Hisar

Haryana

By

KUMARI MOUSHMI

PGDHM 2012-2014

International Institute of Health Management Research
New Delhi

Internship Training

At

Sarvodaya Multispeciality and Cancer Hospital, Hisar

Haryana

Project Title

Establishing Quality Management System in Sarvodaya Multispeciality And Cancer Hospital

By

KUMARI MOUSHMI

Under the guidance of

Mrs. Kirti Udayai

Post Graduate Diploma in Hospital and Health Management

2012-2014

International Institute of Health Management Research
New Delhi

ACKNOWLEDGEMENT

I have no adequate words to express my loyalty to God for showering his blessings over me and guiding me in my path and career.

Heartfelt thanks to **Sarvodaya Multispeciality and Cancer Hospital** in enabling me to facilitate accreditation process in compliance to National accreditation Board for Hospitals & Healthcare Providers at their hospital. I feel privileged to be associated with this organization of repute and being a part of the quality movement initiative taken up by its authorities.

I would like to express my gratitude to **Dr. I.K Khokhar (CEO-Quality Health Care Initiative)**, who has given opportunity to work with **Sarvodaya Multispeciality and Cancer Hospital, Hisar, Haryana.**

I am profoundly grateful to **Dr. Umesh Kalra, Managing Director and Dr. (Mrs.) Sarita Kalra, Medical Superintendent,** who have been supportive right from the beginning. I am sure, that with their leadership, the objective of achieving quality standards of the level of accreditation norms will not be a distant dream.

I would like to express my gratitude to **Mrs. Kirti Udayai**, **Assistant Dean, IIHMR** for her support and encouragement, kind and true guidance on my dissertation project whenever required and when spirits were down. She helped me by supervising my project, structuring, evaluating my report, carrying out my investigation and suggestion on the improvements.

My sincere thanks to all the HODs, In-charges and staff of the hospital, who took out time from their busy schedule, to interact with me and provide me with the information required for this study. Needless to say, this activity could not have been completed successfully without their selfless contribution.

Lastly, we would like to express our gratitude to all who directly or indirectly contributed to the successful completion of this study.

Kumari Moushmi
IIHMR, New Delhi, Batch "E"

TO WHOM SO EVER MAY CONCERN

This is to certify that **Ms Kumari Moushmi** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone dissertation at **Sarvodaya Multispeciality and Cancer Hospital Hisar, Haryana** From 28th Jan. to 28th April.

The Candidate has successfully carried out the study designated to him during dissertation and his approach to the study has been sincere, scientific and analytical.

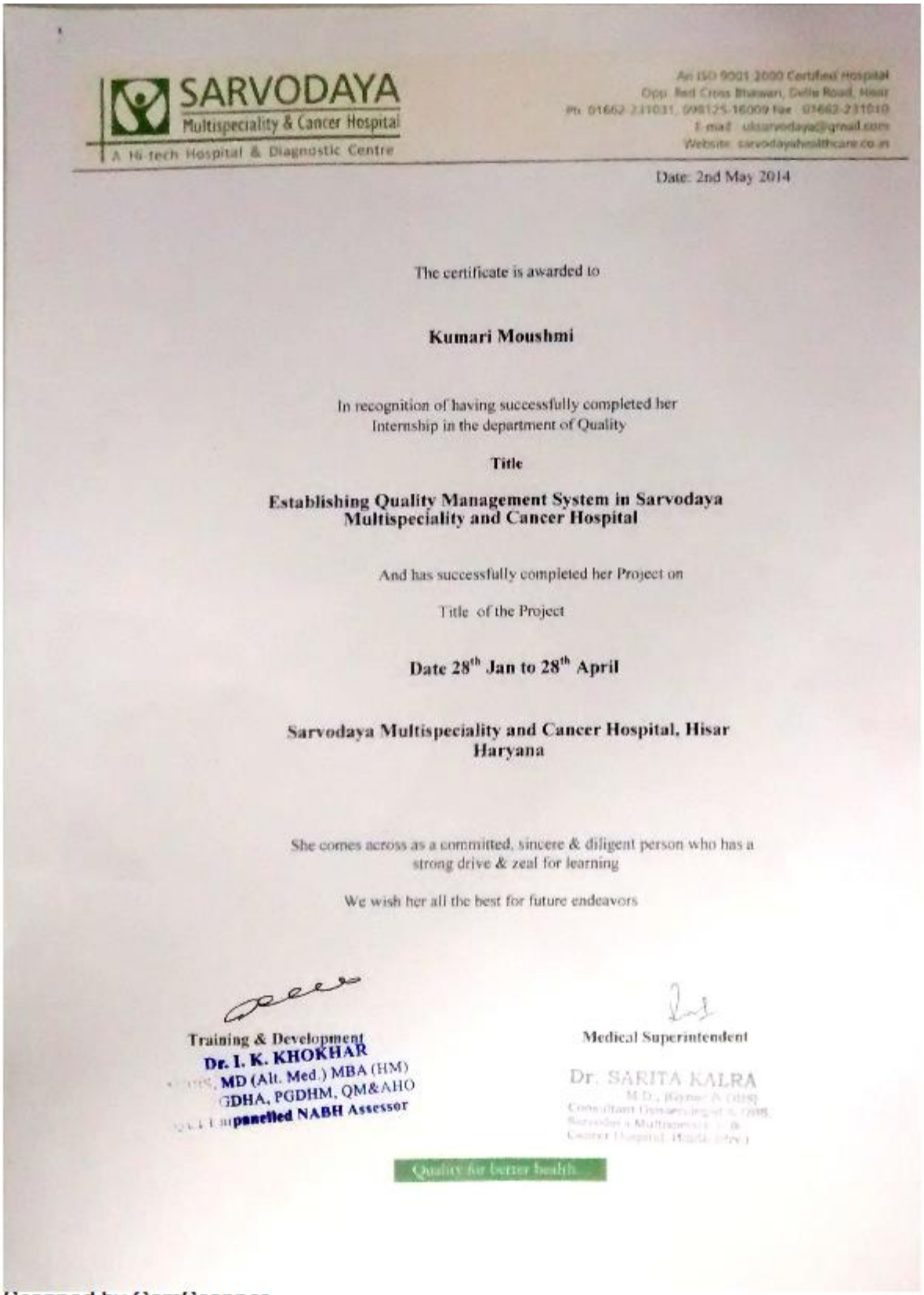
The dissertation is in fulfilment of the course requirements.

I wish him success in his future endeavours.

Mrs. Kirti Udayai

Assistant Dean

IIHMR, New Delhi.



SARVODAYA
Multispeciality & Cancer Hospital
A Hi-tech Hospital & Diagnostic Centre

An ISO 9001:2000 Certified Hospital
Opp. Red Cross Bhawan, Delhi Road, Hisar
Ph. 01662-231031, 098125-16009 Fax : 01662-231010
E-mail : ulssarvodaya@gmail.com
Website : sarvodayahealthcare.co.in

Date: 2nd May 2014

The certificate is awarded to

Kumari Moushmi

In recognition of having successfully completed her
Internship in the department of Quality

Title

Establishing Quality Management System in Sarvodaya Multispeciality and Cancer Hospital

And has successfully completed her Project on

Title of the Project

Date 28th Jan to 28th April

Sarvodaya Multispeciality and Cancer Hospital, Hisar Haryana

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish her all the best for future endeavors

Training & Development
Dr. I. K. KHOKHAR
MD (Alt. Med.) MBA (HM)
GDHA, PGDHM, QM&AHO
Empanelled NABH Assessor

Medical Superintendent
Dr. SARITA KALRA

Quality for better health

Certificate of Approval

The following dissertation titled "**Establishing Quality Management System in Sarvodaya Multispeciality and Cancer Hospital, Hisar Haryana**" is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a pre-requisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Ravindra Aggarwal	5/5/2014
Dr A. K. KHOKHAR	5.5.14
Keshe Udaya	Keshe Udaya

Certificate from Dissertation Advisory Committee

This is to certify that **Ms. Kumari Moushmi**, a participant of the **Post Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled, **Establishing Quality Management System in Sarvodaya Multispeciality and Cancer Hospital, Hisar, Haryana"** in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Mrs. Kirti Udayai

Assistant Dean

IIHMR, New Delhi

Date: 05/05/2014

Dr. I.K.Khokhar

CEO-Quality Health Care Initiative

NABH Assessor

Date: 05/05/2014

INTERNATION INSTITUTE OF HEALTH MANAGEMENT RESEARCH,
NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Establishing Quality Management System in Sarvodaya Multispeciality and Cancer Hospital, Hisar, Haryana".**

and submitted by (Name) …**Ms. Kumari Moushmi**……..

Enrollment No. …**PG/12/039**…… under the supervision of

……**Mrs. Kirti Udayai**…….. for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the

period from ……**28th January**…….. to ……**28th April 2014**…….. embodies

my original work and has not formed the basis for the award of any degree, diploma associate ship,

fellowship, titles in this or any other Institute or other similar institution of higher learning.

Moushmi
Signature 07/05/2014

NAME OF THE STUDENT	:	**Kumari Moushmi**
DISSERTATION ORGANIZATION	:	Sarvodaya Multi Specialty Hospital, Hisar
AREA OF DISSERTATION	:	Establishing Quality Management System in Sarvodaya Multi-Specialty Hospital, Hisar
ATTENDANCE	:	100%
OBJECTIVES ACHIEVED	:	Legal Compliances Motivation of Staff, Formation of a Team, Training, Quality Indicators Data Collection Infection Control Team Rounds.
DELIVERABLES	:	Implementation of Total Quality Management System
STRENGTHS	:	Commitment of Top Management, Good Infrastructure
SUGGESTIONS FOR IMPROVEMENT:		Process is at the moment at very slow speed, it should pick up.

Signature of the Officer-in-Charge/ Organization Mentor (Dissertation)

Date: 3/5/14

Place: Delhi

Dr. I. K. KHOKHAR
MBBS, MD (Alt. Med.) MBA (HM)
MHA, PGDHA, PGDHM, QM&AHO
QCI Empanelled NABH Assessor

INTERNSHIP REPORT

ORGANIZATION PROFILE

SARVODAYA HOSPITAL is a 120 bedded Super specialty hospital with ultramodern equipment and all the super specialties. The hospital is managed by eminent doctors of repute having immense experience in the prestigious medical institutions of India. The hospital has the empanelment of various Governmental bodies, TPA's and a good number of important corporate. The hospital is also in the process of undergoing **NABH Accreditation**.

The hospital was established in October, 2004 with a view to provide curative and preventive medical care through caring environment. Located at a pleasant ambience in the heart of Noida the hospital has grown into an excellent knowledge centre with comprehensive and seamless approach to clinical services besides providing tertiary care. Hospital has a faculty of highly experienced and specialized doctors who are leaders in their respective fields. Backed by a staff that is well trained, caring and with an excellent work culture the institute offers a highly professional and yet patient friendly environment. The infra structure / equipments also get upgraded on a regular basis along with the strong training outputs for the staff.

One of the most comprehensive healthcare providers in North India. Our priority is high quality, cost effective patient care founded on excellent practice. We have multi specialty hospital that is fully equipped to handle each and every conceivable medical problem. We strive as a team to provide services and care which improves the quality of life of our patients. The hospital has state-of-the-art Equipment, the most qualified and experienced doctors and an efficient and trained Paramedical staff ensures that you receive services that are at par with the best in the country.

SARVODAYA Hospital's Emergency Department is open 24 hours a day and is geared to retrieve and care for all clinical cases. SARVODAYA Hospital's Emergency Department is staffed by qualified and experienced

We have a creative team of nurses who enjoy the challenges of Emergency care. All of our Emergency Department staff work as members of a multi-disciplinary team in a progressive and rewarding environment. New staffs are provided with a comprehensive orientation and are warmly welcome.

The Emergency Department is amongst the most modern and well-equipped facilities of its type in North India. SARVODAYA Hospital has 24 hours trauma care, one of the best in the

region. The hospital is fully equipped with MRI, CT Scan, X-Ray, USG, Blood Bank backed up by Orthopedics, Neuro-Surgery, Surgery, Anesthesia, Plastic Surgery and Physician virtually all kind of emergencies and being treated. Emergency dialysis facilities are also available

OBJECTIVES AND SCOPE

To provide promotive, preventive and curative health care services of the highest standard through the chosen super specialties.

- To engage credential professionals in all disciplines and services.
- To provide state of the Art health care with compassion and dignity to all.
- To provide reliable and updated diagnostic services.
- To introduce new technologies in clinical services without delay.
- To extend health consciousness in the community.
- To ensure safety of patients, attendant's employees and all the stake holders.
- Continuously enhance customer satisfaction.
- To promote staff development and increase employee satisfaction.
- To practice environmental management system.

MANAGEMENT

Ownership:

The Hospital is owned by **Dr. Umesh Kalra** (Proprietorship)

Our Vision:

Sarvodaya Hospital is to be the Regional Centre for Excellence and Expertise in caring for the unique needs of our patients and Communities

OUR AIM IS TO BE A WORLD CLASS HEALTH CARE ORGANIZATION

Our Mission:

Our mission is to deliver world class and Integrated Health Care to the Community with compassion and at a very low cost.

Ethical Management:

- To render practice with full dignity of profession and man.
- Affordable medical excellence.
- Satisfaction of patients their relatives and attendants.
- Protection of environment, safety of patients and staff.
- Provision of Biomedical waste disposal.
- To comply with all appropriate statutory and regulatory requirements.

Human Touch:

Is the foremost that eventually brings forth the dictum "satisfied patients are Brand Ambassadors".

This policy is maintained through management of the processes and system across the organization and strives at continual improvement.

TASK PERFORMED AT THE ORGANIZATION

The hospital provides the following services:

1. Anesthesia

- Neuro- Anesthesia
- Critical care
- Anesthesia to High risk patients

2. Internal medicine

- General medicine
- Health checkups
- General medical care in relation to surgical
- Patients

3. Surgery	- General surgery
	- Laparoscopic surgery
	- Onco-Surgery
4. Oncology	- Chemotherapy
	-Radiotherapy
	-Onco-surgery
5. Cardiology	- Non interventional cardiology
6. Orthopedics	- Trauma
	- Joint replacement
	- Management of poly trauma
7. Intensive Care Unit	- Management of poisoning
	-Medico legal cases
	- Management of burns
	- Management of medical surgical and
	-Respiratory Emergencies
8. Gynecology & Obs	- All diseases relating to female reproductive organs
	- High Risk Deliveries

	- D & C's
	- M T P's
	- C-section
	- Hysterectomies
9. Neuro-Surgery	-Craniotomy, Laminectomy etc
10. Dental	- Oral hygiene and tooth problems
	-Maxillofacial Surgery
	-Dental Implants
	-Orthodontics
11. Physiotherapy	- Pediatrics physiotherapy
	-Neuro-Physiotherapy
	- Respiratory physiotherapy
	- Physiotherapy for Arthroplasty cases
	- Physiotherapy for all trauma cases
12. Laboratory services	- Biochemistry.
	- Hematology
	-Pathology.
13. Pharmacy	- Dispensing medicines as per prescriptions
	- Maintaining cold chain for necessary drugs and vaccine

14. Pediatrics & Neonatalogy-

- Emergency Services
- In-Patient Services (NICU & Paediatric Ward)
- Specialized care in Child Birth and new born Bronchial Asthma, Diarrhoea and Vomiting with dehydration, allergic reactions, fits.
- General Services
- Neonatology
- Gastroenterology
- Nephrology
- Paediatric Haematology & Oncology
- Paediatric Endocrinology & Hormonal Disorders
- Paediatric , Psychiatric & Counselling
- Paediatric Pulmonary Lung Diseases including Bronchoscope
- Adolescent Medicine
- Development Medicine
- Vaccination of Children and Adolescent.

The Hospital provides the following OPD services

(Daily from 9am. to 2 pm and 5pm.to 7 pm.)

1. General medicine
2. General surgery
3. Oncology.
4. Onco-Surgery
5. Pediatrics
6. Radio diagnosis
7. Orthopedics
8. Gynecology and obstetrics
9. Physiotherapy
10. Dental
11. Neuro-surgery

Casualty – casualty is a part of critical care management. A casualty medical officer is available round the clock. As soon as a patient comes to casualty the CMO attends to the patient immediately and institutes first aid. The appropriate consultant/consultants on call are informed immediately. The consultants usually come and see the patients in the casualty itself.

All the services provided in the hospital are prominently displayed at prominent places.

The entire staff is very well oriented to the above services.

There are separate In-charges for Admissions, O P D's and Casualty

All the above staff reports to Medical Superintendent.

Casualty, Imaging, Laboratory and Pharmacy services are available round the clock.

Facilities: - Sarvodaya Hospital has the most modern diagnostic and self-support services which include.

- Emergency-24 Hrs.
- Out Patient Dept. (OPD)
- Intensive care unit. (ICU)
- Maternity Support.
- Advanced Nursery.
- Laparoscopic Surgery
- LINAC
- 1.5 Tesla MRI
- NCV,EMG
- ECG & EEG
- ECHO.
- TMT/PFT.
- Elaborate Radio Diagnostics.
- Ultrasound.
- Mammography
- Digital X-Ray.
- CT Scan.

- 4D color Doppler.
- 3 Operation Theatres (2 major and 1 minor).
- C-Arm.
- OPG
- Fully Computerized Lab.
- Physiotherapy.
- Central Gas Pipeline.
- Chemist Shop-24 Hours.
- Ambulance- 24 Hours.
- Canteen-24 Hours.

ICU SERVICES

SARVODAYA Hospital's Intensive Care Unit (ICU) is a state of the art, 10 bed combined Intensive Care.

Backed by 24 hour on site Medical cover, our ICU is fed internally from the operating theatres, wards and the Emergency Department. There is an extensive nurse bank and the Unit is renowned for valuing and rewarding these highly qualified staff. 10 bedded ICU, Nurse Patient Ratio 1:1

OT- 2 fully equipped operation theatres with laminar air flow, central oxygen, central suction, triple zoning to prevent infection.

LAB SERVICES

- Histopathology
- Clinical Biochemistry
- Hematology
- Blood Bank- 24 hours service available

KEY LEARNINGS

- To Co-ordinate all NABH Activities in the Hospital.
- Making a Manual of every department of the hospital, as per NABH Standards.
- Making SOPs of every department of the hospital as per NABH Standards.
- Making Committees, Forms and Formats of the hospital.
- Data collection of Quality Indicators.

DISSERTATION REPORT

TABLE OF CONTENTS

Contents: **Page no:**

INTRODUCTION

QUALITY -- IMPORTANCE & SIGNIFICANCE:-

QUALITY:

First it was "to produce and flourish" later it shifted to "to produce quality and flourish" and now the situation is "manage quality and flourish"

The term quality has several meanings in everyday life. The concept refers to the condition of goods or services, as well as to the value of an object. In general the meaning of the term "quality" depends on who uses a product or who receives a service.

The common feature of all interpretations is that a comparison is made between objectives and the extent to which these objectives are attained.

Similarly in health care scenario, a giant health care provider like this organization targets quality as compared against the "the smiles and satisfaction" on the face of the patient, relatives and the staff on the whole of the organization. To achieve this, the hospital draws a comparison of its set standards with the benchmarked standards, universally accepted and thus identifies the gaps in the delivery of the desired levels of care to the patients.

Quality is a continuous process. In the delivery of the quality services the hospital is already guided by the ISO standards of quality care, in addition the hospital is endeavoring to achieve the NABH standards, which is a further development on the ISO standards.

IMPORTANT DEFINITIONS

1. Quality assurance:

Quality assurance is that set of activities that are carried out to monitor and improve performance so that the care provided is as effective and as safe as possible. Objective of quality assurance is to improve patient care and perform efficiently and effectively.

2. Benchmarking:

Benchmarking is the continuous search for an adaptation of significantly better practices that leads to superior performance by investigating the performance and practices of other organizations (benchmark partners).

This is a process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization that produce the same service or product (external benchmarking); or with reference to a similar to function or process in another industry (functional benchmarking).

3. Quality Audit:

Quality audit means a systematic, independent examination of quality system. Quality audits are typically performed at defined intervals and ensures that the institution has clearly – defined quality monitoring procedures linked to effective actions. The processes involve assessing the Standard Operating Procedures (SOP's) for compliance to the regulations, and also assessing the actual process and results against what is stated in the SOP.

4. Accreditation

The term "accreditation" (applied to organization rather than to specialty clinical training) reflects the origins of systematic assessment of hospital against explicit standards. Accreditation is a process by which an impartial body will review the operations of an organization, to ensure that the organization is functioning in a manner that is consistent with quality standards set in par with National/International Standards. An accreditation process consists of a review of policies and procedures (the "desktop review") and onsite visit to the applicants' organization to determine that it is, in fact, operating according to its stated policies.

The three essential ingredients common to all control system are-

i) Defined targets

ii) Performance Measurement Tools and

iii) Charge Mechanisms

Examples of quality-related elements are as follows:-

- Safety of environment.
- Patient Satisfaction & feed-back mechanisms
- Clinical Training
- Performance Assessment
- Budgets & Cost Control Mechanisms.
- Medical Audit

All accreditation system has explicit standards for organizations against which the participating hospital assess itself before a structured visit by external "surveyors". These "surveyors" submit a written report back to the participating hospital with recommendations for the development prior to a follow–up survey. Accreditation may be awarded for a fixed term or may be withheld by an independent assessment board, if the hospital does not meet a defined threshold of standards.

One common characteristic of accreditation systems around the world is that in principle, they are independent of purchases providers and government and participation is voluntary.

All accreditation system has a published set of standards and criteria for assessment of the environment in which clinical care is delivered. Globally there is trend towards standards that are constructed around the "pathway" which a patient might perceive through a range of services including primary and secondary care. There is also increasing emphasis on clinical, managerial performance and on health indicators benchmarking. In the developing countries like India, where literacy ratio is so low, one cannot accept the common man to even raise a voice against poor quality of health care services.

Therefore, it becomes inevitable for healthcare institutions to take initiative to guarantee quality health care to all and this is possible only when some statues or some monitoring body is formulated which shall set standards conducive to our country requirements, which is binding on healthcare providers.

Importance:-

a) Important approach for improving the quality of health care structures, high quality of care and patient safety.
b) It strengthens the fundamental leadership and steering role of national health authorities.
c) It is in a structured form cost – cutting tool as through it optimal resources is utilized.
d) It is used as a tool for international categorization and recognition of hospitals.

5. Quality Council of India (QCI)

Quality Council of India is set as an Autonomous body by the Government of India (Ministry of Commerce & Industry, Department of Industrial Policy & Promotion being the nodal Ministry) to establish and operate National Accreditation Structure for conformity assessment bodies.QCI is also assigned the task of monitoring and administering the National Board for Quality promotion and effective functioning of the National Information and Enquiry Services. Indian industry is represented on QCI by three premier associations ASSOCHAM, CII and FICCI.

Secretary	Mr.Gridhar J Gyani
Executive Officer (Administration & Accounts)	Mr.Yogesh kr.Srivastva

The main objectives of QCI are:-

a) To establish National Accreditation Boards, suitable for the country and in accordance with relevant international standards and guidelines for:-

   i. Bodies certifying Quality management Systems, Environment management systems, Products and Carrying out third party inspection.
   ii. Registration of Quality Management Personnel and Training Organizations.
   iii. Testing and calibration Laboratories.

b) To raise quality consciousness in the country through National Board for Quality promotion including conducting seminars, study tours and using other forms for promotion, by promoting business excellence through quality award schemes, competitions etc.

c) To ensure effective functioning of a National Information and Enquiry Services on Standards and Quality.

d) To promote, co-ordinate, guide and implement a national quality initiative for building confidence in Indian Industry.

e) To enter into arrangements with similar foreign agencies and develop procedures for exchange and transfer of technologies, study tours, training in specialized areas of quality technology, conducting of joint projects, providing technical assistance in the establishment of quality consciousness and for other matter consistent with the aims and objectives of the society.

f) To encourage industrial/applied research and development in the field of quality and dissemination of its result in relevant publications including professional and trade journals.

g) To facilitate up gradation of testing and calibration facilities of laboratories. And to encourage the development of a National Laboratory Accreditation system for global recognition and for acceptability of measurement and test results.

1. NABL

National Accreditation Board for Testing and Calibrations Laboratories (NABL) is an autonomous body under the aegis of department of Sciences and Technology, Government of India and is registered under the Societies Act.

NABL has been established with the objective to provide Government, Industry in general with a scheme for third-party, assessment of the quality and technical competence of testing and calibration labs. Government of India has authorized NABL as the sole accreditation body for testing and calibration laboratories. NABL has an established Accreditation System in accordance with ISO/IED 17011:2004, which is followed internationally.

NATIONAL ACCREDITATION BOARDS FOR HOSPITAL & HEALTHCARE PROVIDERS (NABH)

National Accreditation Boards for Hospital & Healthcare Provides (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations. The board is structured to cater to much desired needs of the consumers and to set benchmarks for progress of healthcare industry.

The standards provide framework for quality assurance and quality improvement for hospitals. The standards focus on patient safety and quality of care. The standards call for continuous monitoring of sentinel events and comprehensive corrective action plan leading to building of quality culture at all levels and across all the functions.

Sources of NABH Standards are as follows:-

The sources of the Standards are developed by committee of expert Technical members. Multiple information sources are:

- Scientific literature

- JCI Standards (Joint Commission)
- UK healthcare Quality Standards
- Thailand Standards
- Apollo Draft Standards
- AHA Drafts Standards (Academy of Hospital Administrators)
- JCI Survey compliance data (Joint Commission International)
- Research Findings
- Individual inputs form field expert
- ISO 9001:2000

Benefits of NABH standards are :-

Benefits for patient:

- Accreditation results in high quality of care & patient safety
- The patient gets services by credential medical staff
- Rights of the patient are respected and protected
- Patient satisfaction is regularly evaluated

Benefits for the hospital:

- Accreditation to the hospital are satisfied due to continuous learning
- Good working environment
- Leadership and ownership of clinical processes
- It improves overall professional development of Clinicians and Para Medical staff
- Provides leadership for quality improvement within medical and nursing

Benefits to the community:

- Quality revolution
- Disaster preparedness
  - Epidemics
  - Physicals
- Accesses to comparative database

Benefits to paying and regulatory bodies:

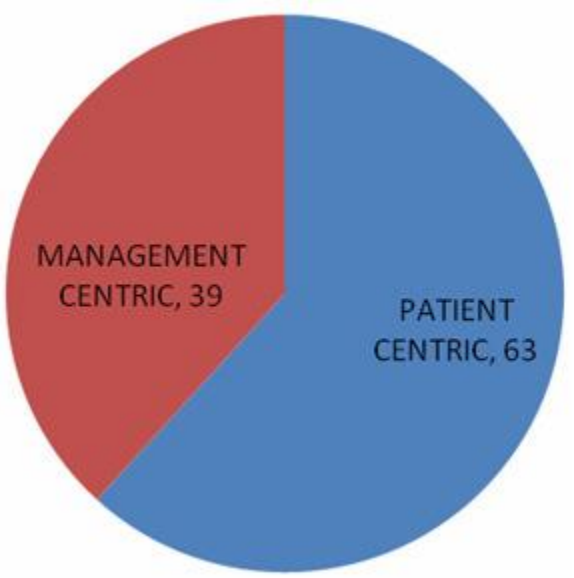
- Accreditation provides an objective system of empanelment by insurance and third parties.
- Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

NABH is a consultant of QCI, set up to establish and operate accreditation programme for healthcare organizations, the board is structured to cater to much desired needs of the consumers and to benchmarks for progress of health industry. The boards while being

supported by all stakeholders including industry, consumers, Governments, have full functional autonomy in its operations.

The **10 chapters** in the standard reflect two major aspects of healthcare delivery i.e. **Patient Centered Standards (chapter 1-5)** and **Organization Centered Standards (chapter 6-10).**

Outline of NABH Standards:



Patient Centered Standards

- 1. Access, Assessment and Continuity of Care (AAC).
- 2. Care of Patients (COP).
- 3. Management of Medication (MOM).
- 4. Patient Rights and Education (PRE).
- 5. Hospital Infection Control (HIC).

Organization Centered Standards

- 6. Continuous Quality Improvement (CQI).
- 7. Responsibilities of Management (ROM).

- 8. Facility Management and Safety (FMS).
- 9. Human Resource Management (HRM).
- 10. Information Management System (IMS).

NABH COMPRISES OF 10 CHAPTERS, 102 STANDARDS AND 636 OBJECTIVE ELEMENTS:

Chapter 1). Access, Assessment and Continuity of care (AAC)

Intent of the chapter:

Patients are well informed of the services that an organization can and cannot provide. This will facilitate in appropriately matching patients with the organizations resources. Only those patients who can be cared for by the organization are admitted to the organization .Emergency patients receive life- stabilizing treatment and are then either admitted (if resources are available) or transformed appropriately to an organization that has the resources to take of such patients. Out -patients who do not match the organization's resources are similarly referred to the organizations that have matching resources.

Patients that match the organizations resources are admitted using a defined process. Patients cared for by the organization undergo an established initial assessment and periodic and regular reassessments.

Assessments include planning for utilization of laboratory and imaging services. The laboratory and imaging services are provided by competent staff in safe environment for both patients and staff.

These assessments result in formulation of definite plan of care.

Patient care is multidisciplinary in nature and encourages continuity of care through well-defined transfer and discharge protocols. These protocols include transfer and adequate information with the patient.

Summary of Standards

ACC.1.	The organization defines and displays the services that it can provide.
ACC.2.	The organization has a well defined registration and admission process.
ACC.3.	There is an appropriate mechanism for transfer (in and out) or referral of patients.
ACC.4.	Patients cared for by the organization undergo an established initial assessment.
ACC.5.	Patients cared for by the organization undergo a regular reassessment.
ACC.6.	Laboratory services are provided as per the scope of services of the organization.
ACC.7.	There is an established laboratory-quality assurance programme.
ACC.8.	There is an established laboratory safety programme.
ACC.9.	Imaging services are provided as per the scope of services of the organization.
ACC.10.	There is an established quality-assurance programme for imaging services.
ACC.11.	There is an established radiation-safety programme.
ACC.12.	Patient care is continuous and multidisciplinary in nature.
ACC.13.	The organization has documented discharge process.
ACC.14.	Organization defines the content of the discharge summary.

Chapter 2). Care of Patients (COP)

Intent of the chapter:

The organization provides uniform care of patients in different settings. The different settings include care provided in outpatient units, various categories of wards, intensive care units, procedure rooms and operation theatre. When similar care is provided in these different settings, care delivery is uniform. Policies, procedures, applicable laws and regulation guide emergency and ambulance services, cardio-pulmonary resuscitation, use of blood and blood products, care of patients in the Intensive care and high dependency units.

Policies, procedures, applicable laws and regulations also guide care of vulnerable patients (elderly, physically and/or mentally challenged and children), high-risk obstetrical patients, pediatric patients, patients undergoing moderate sedation, administration of anesthesia, patients undergoing surgical procedures, patients under restrains, research activities and of life care.

Pain management, nutritional therapy and rehabilitative services are also addressed with a view to provide comprehensive health care.

The standards aim to guide and encourage patient safety as the overall principle for providing care to the patients.

Summary of Standards

COP.1.	Uniform care of patients is provided in all setting of the organization and is guided by the applicable laws, regulations and guidelines.
COP.2.	Emergency services are guided by documented policies, procedures and applicable laws and regulations.
COP.3.	The ambulance services are commensurate with the scope of the services provided by the organization.
COP.4.	Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.
COP.5.	Documented policies and procedures guide nursing care.
COP.6.	Documented procedures guide the performance of various procedures.
COP.7.	Documented policies and procedures define rational use of blood and blood products.
COP.8.	Documented policies and procedures guide the care of patients in the Intensive care and high dependency units.
COP.9.	Documented policies and procedures guide the care of vulnerable patients (elderly, physically and/or mentally-challenged and children).
COP.10.	Documented policies and procedures guide obstetric care.
COP.11.	Documented policies and procedures guide pediatric services.
COP.12.	Documented policies and procedures guide the care of patients undergoing moderate sedation.
COP.13.	Documented policies and procedures guide the administration of anesthesia.
COP .14.	Documented policies and procedures guide the care of patients undergoing surgical procedures.

COP.15.	Documented policies and procedures guide the care of patients under restraints.
COP.16.	Documented policies and procedures guide appropriate pain management.
COP.17.	Documented policies and procedures guide appropriate rehabilitative services.
COP.18.	Documented policies and procedures guide all research activities.
COP.19.	Documented policies and procedures guide nutritional therapy.
COP.20.	Documented policies and procedures guide the end of life care.

Chapter 3). Management of Medication (MOM)

Intent of the chapter:

The organization has a safe and organized medication process. The process includes policies and procedures that guide the availability, safe storage, prescription, dispensing and administration of medications.

The standards encourage integration of pharmacy into everyday functioning of hospitals and patient care. The pharmacy should guide and audit medication process. The pharmacy should have oversight of all medication stocked out of the pharmacy. The pharmacy should ensure correct storage (as regards to temperature, look-alike, sound-alike etc), expiry dates and maintenance of documentation.

The availability of emergency medication (crash carts) is stressed upon. The organization should have a mechanism to ensure that the crash carts are standardized throughout the organization, readily available and replenished in a timely manner. There should be a monitoring mechanism to ensure that the required medications are always stocked and well within expiry dates.

Every high risk medication order should be verified by an appropriate person so as to ensure accuracy of the dose, frequency and route of administration. The “appropriate person” could be another doctor, trained nurse or preferably, a clinical pharmacist. Such a person would also look for drug-drug interactions, renal or hepatic dosing etc. There should be a mechanism by which this person could verify the order with prescribed in case of doubts or clarifications and then make changes to the order after such clarifications. The verification should occur before the medication is administered but preferably, prior to dispensing of the

medication. There should be a protocol by way of which, in case of continued conflict, the person can provide higher authority to ensure patient safety.

The process also includes monitoring of patients after administration and procedures for reporting and analyzing medication errors.

Safe use of high risk medication like narcotics, chemotherapeutic agents, radioactive isotopes, investigational drugs and concentrated electrolytes are guided by policies and procedures.

Patients and family members are educated about the safe medication and food-drug interactions.

Medications also include blood, implants, devices and medical gases.

Summary of standards:-

MOM.1.	Documented policies and procedures guide the organization of pharmacy services and usage of medication.
MOM.2.	There is a hospital formulary.
MOM.3.	Documented policies and procedures exist for storage of medication
MOM.4.	Documented policies and procedures guide the safe and rational prescription of medications.
MOM.5.	Documented policies and procedures guide the safe dispensing of medications.
MOM.6.	There are documented policies procedures for medication management.
MOM.7.	Patients are monitored after medication administration.
MOM.8.	Near misses, medication errors and adverse drug events are reported and analyzed.
MOM.9.	Documented procedures guide the use of narcotic drugs and psychotropic substances.

MOM.10.	Documented policies and procedures guide the usage of chemotherapeutic agents.
MOM.11.	Documented policies and procedures govern usage of radio-active drugs.
MOM.12.	Documented policies and procedures guide the use of implantable prosthesis and medical devices.
MOM.13.	Documented policies and procedures guide the use of medical supplies and consumables.

Chapter 4). Patient Rights and Education (PRE)

Indent of the chapter:

The organization defines the patient and family rights and responsibilities. The staff is aware of these and is trained to protect patient rights. Patients are informed of their rights and educated about their responsibilities at the time of admission. They are informed about the disease, the possible outcomes and are involved in decision making. The costs are explained in a clear manner to patient and/or family. The patients are educated about the mechanisms available for addressing grievances.

A documented process for obtaining patient and/or families consent exists for informed decision making about their care.

Patient and families have a right to information and education about their healthcare needs in a language and manner that is understood by them.

Summary of Standards

PRE.1.	The organization protects patient and family rights and informs them about their responsibilities during care.
PRE.2.	Patient and family rights support individual beliefs, values and involve the patient and family in decision-making processes.
PRE.3.	A patient and/or family members are educated to make informed decisions and are involved in the care-planning and delivery process.

PRE.4.	A documented procedure for obtaining patient and/or family's consent exists for informed decision making about their care.
PRE.5.	Patient and families have a right to information and education about their health care needs.
PRE.6.	Patient and families have a right to information on expected costs.
PRE.7.	Organization has a complaint redressal procedure.

Chapter 5).Hospital Infection Control (HIC)

Intent of chapter:

The standards guide the provision of an effective infection control program in the organization. The program is documented and aims at reducing /eliminating infection risks to patients, visitors and providers of care.

The organization measures and takes action to prevent or reduce the risk of Hospital Associated Infection (HIA) in patients and employees.

The organization provides proper facilities and adequate resources to support the Infection Control Program.

The program includes an action plan to control outbreaks of infection, disinfection/sterilization activities, Bio-Medical Waste (BMW) management, training of staff and employee health.

Summary of standards

HIC.1.	The organization has a well-designed, comprehensive and coordinated Infection Prevention and Control (HIC) programme aimed at reducing /eliminating risks to patients, visitors and providers of care.
HIC.2.	The organization implements the policies and procedures laid down in the Infection Control Manual.
HIC.3.	The organization performs surveillance activities to capture and monitor infection

	prevention and control data.
HIC.4.	The organization takes actions to prevent and control Healthcare Associated Infection (HAI) in patients.
HIC.5.	The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).
HIC.6.	The organization identifies and takes appropriate action to control outbreaks of infections.
HIC.7.	There are documented policies and procedures for sterilization activities in the organization.
HIC.8.	Bio-Medical Waste (BMW) is handled in an appropriate and safe manner.
HIC.9.	The infection control programme is supported by the management and includes training of staff and employee health.

Chapter 6). Continual Quality Improvement (CQI)

Intent of the chapter:

The standards encourage an environment of continuous quality improvement. The quality program should be documented and involve all areas of the organization and all staff members. The organization should collect data on structures, processes and outcomes especially in areas of high-risk situations. The collected data should be collated, analyzed and used for further improvements. The improvements should be integrated into the organizations quality plan. Infection control and patient-safety plans should also be integrated into the organizations quality plan.

The organization should define its sentinel events and intensively investigate when such events occur.

The quality programme should be supported by the management.

Summary of standards

CQI.1.	There is a structured quality improvement and continuous monitoring programme in the organization.
CQI.2.	There is a structured patient-safety programme in the organization.
CQI.3.	The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.
CQI.4.	The organization identifies key indicators to monitor the managerial structures, processes and outcomes, which are used as tools for continual improvement.
CQI.5.	The quality improvement programme is supported by the management.
CQI.6.	There is an established system for clinical audit.
CQI.7.	Incidents, complaints and feedback are collected and analyzed to ensure continual quality improvement.
CQI.6.	Sentinel events are intensively analyzed.

Chapter 7). Responsibilities of the Management (ROM)

Intent of the chapter:

The standards encourage the governance of the organization in a professional and ethical manner. The responsibilities of the management are defined. The organization complies with all applicable regulations. The organization is led by a suitably qualified and experienced individual. The responsibilities of the leaders at all levels are defined. The services provided by each department are documented.

Leaders ensure that patient-safety and risk-management issues are an integral part of patient care and hospital management.

Summary of Standards

ROM.1.	The responsibilities of those responsible for governance are defined.
ROM.2.	The organization complies with the laid-down and applicable legislations and regulations.

ROM.3.	The services provided by each department are documented.
ROM.4.	The organization is managed by the leaders in an ethical manner.
ROM.5.	The organization displays professionalism in management of affairs.
ROM.6.	Management ensures that patient-safety aspects and risk- management issues are an integral part of the patient care and hospital management.

Chapter 8). Facility Management and Safety (FMS)

Intent of the chapter:

The standards guide the provision of a safe and secure environment for patients, their families, staff and visitors. The organization shall take steps to ensure this.

To ensure this, the organization conducts regular facility inspection rounds and takes the appropriate action to ensure safety.

The organization provides for safe water, electricity, medical, gases and vacuum systems.

The organization has a program for clinical and support services equipment management.

The organization plans for emergencies within the facilities and the community.

The organization is a no-smoking area and manages hazardous materials in a safe manner.

Summary of standards:

FMS.1.	The organization has a system in place to provide a safe and secure environment.
FMS.2.	The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.
FMS.3.	The organization has a program for engineering support services.

FMS.4.	The organization has a programme for bio-medical equipment management.
FMS.5.	The organization has a programme for medical gases, vacuum and compressed air.
FMS.6.	The organization has plans for fir and non-fire emergencies within the facilities.
FMS.7.	The organization plans for handling-community emergencies, epidemics and other disasters.
FMS.8.	The organization has a plan for the management of hazardous materials.

Chapter 9). Human Resource Management(HRM)

Intent of the chapter:

The most important resource of a hospital and health care system is the human resource. Human resources are an asset for effective and efficient functioning of a hospital. Without an equally effective human resource management system, all other inputs like technology, infrastructure and finances come to naught. Human resource management is concerned with the "people" dimension in management.

The goal of human resource management is to acquire, provide, retain and maintain competent people in right numbers to meet the needs of the patients and community served by the organization. This is based on the organization's mission, objectives, goals and scope of services.

Effective Human Resource Management involves the following processes and activities:-

(a) Acquisition of Human Resources, which involves human resource planning, recruiting and socialization of the new employees.
(b) Training and development relates to the performance in the present and future anticipated jobs. The employees are provided with opportunities to advance personally as well as professionally.
(c) Motivation relates to job design, performance appraisal and discipline.
(d) Maintenance relates to safety and health of the employees.

The term "staff/employees" refers to all salaried personnel working in the organization. The term "staff" refers to all personnel working in the organization including employees, "fee for service" medical professionals, part-time workers, contractual personnel and volunteers.

Summary of the Standards:

HRM.1.	The organization has a documented system of human resource planning.
HRM.2.	The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.
HRM.3.	There is an ongoing programme for professional training and development of staff.
HRM.4.	Staffs are adequately trained on various safety-related aspects.
HRM.5.	An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.
HRM.6.	The organization has documented disciplinary grievance handling policies and procedure.
HRM.7.	The organization addresses the health needs of the employees.
HRM.8.	There is a documented personal record for each staff member.
HRM.9.	There is a process for credentialing and privileging of medical professionals permitted to provide patient care without supervision.
HRM.10.	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.

Chapter 10). Information Management System (IMS)

Intent of the chapter:

Information is an important resource for effective and efficient delivery of health care. Provision of health care and its continued improvement is dependent to a large extent on the information generated, stored and utilized appropriately by the organizations. One of the major intent of this chapter is to ensure data and information meet the organization's needs and support the delivery of quality care and service.

Provision of patient care is a complex activity that is highly dependent on communication of information. This communication is to and from the community, patients and their families, and other health professionals. Failures in communication are one of the most common root cusses of patient safety incidents. The goal of information management in a hospital is to ensure that the right information is made available to the right person. This is provided in an authenticated, secure and accurate manner at the right time and place. This helps achieve the

ultimate organizational goal of a satisfied and improved provider and recipient of any health care setting.

An effective Information management system is based on the information needs of the organization. The system ids able to capture, transmit, store, analyse, utilize and retrieve information as and when required for improving clinical outcomes as well as individual and overall organizational performance.

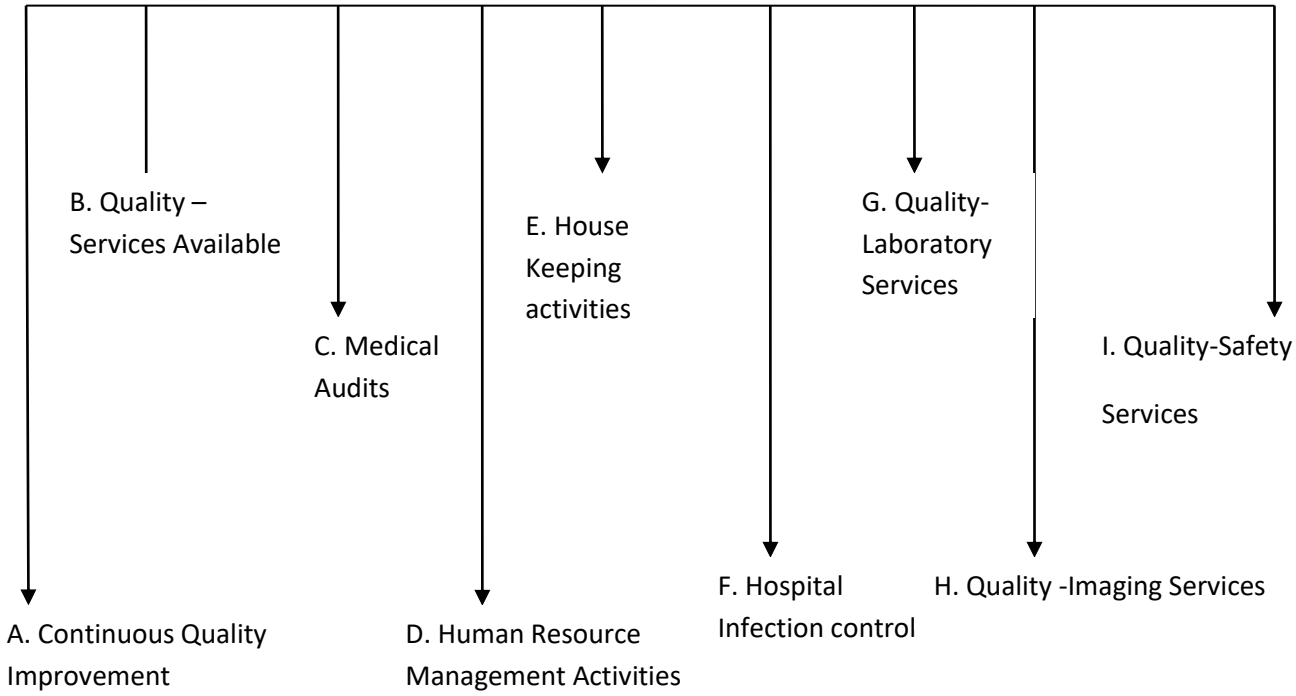
Although a digital-based information system improves efficiency, the basic principles of a good information management system apply equally to a manual/paper-based system. These standards are designed to be equally compatible with non-computerized system and future technologies.

Summary of Standards

IMS.1.	Documented policies and procedures exist to meet the information needs of the care provider's management of the organization as well as other agencies that require data and information from the organization.
IMS.2.	The organization has processes in place for effective management of data.
IMS.3.	The organization has complete and accurate medical record for every patient.
IMS.4.	The medical records reflect continuity of care.
IMS.5.	Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.
IMS.6.	Documented policies and procedures exist for retention time of records, data and information.
IMS.7.	The organization regularly carries out medical records.

QUALITY MANAGEMENT SYSTEM PROGRAMME AT

SARVODAYA MULTISPECIALITY AND CANCER HOSPITAL, HISAR, HARYANA



CONTINIOUS QUALITY IMPROVEMENT

There is a structured Quality Management and Continuous Monitoring Programme in the organization.

A Multi-disciplinary committee is formed to cater to the quality aspects in the organization. The committee comprises of the following members:-

1. Director Academic Services.
2. Deputy Medical Superintendent.
3. Quality Coordinator.
4. GM-Administration.
5. Consultant and Head Laboratory Services.
6. Consultant Imaging Services.
7. Nursing Supervisor.
8. Executives – Administration.

SARVODAYA HOSPITAL, HISAR initiated Quality Management System by adopting standard certification ensuring the existence of the Internal Quality System and Quality Indicator System.

The management of SARVODAYA HOSPITAL has taken up the initiative to standardize the patient care and its management system and initiate an activity of continual quality improvement.
With this thought, the hospital has chosen NABH Accreditation norms as a reference to improve and standardize the health care delivery in the hospital.

Quality Health Care Initiative is an organization providing consultancy to all spheres of hospital planning and management. Quality and accreditation division of the organization is well known to provide consultancy services to hospitals, willing to implement quality management and accreditation systems.

QHCI has been appointed by SARVODAYA HOSPITAL as consultants to provide the consultancy services in planning and facilitating the hospital in achieving NABH accreditation.

SARVODAYA HOSPITAL, HISAR appointed each individual for each quality system standard. Organization appointed NABH co-coordinator for NABH accreditation.

Quality Management System in SARVODAYA HOSPITAL, HISAR covers all major elements related to quality management and risk management. Quality Management covers Laboratory, Imaging Services and each and every department. Risk management covers control of Radioactive material, infection control in general and in all High Dependency Unit and general safety covers other cases such as fire, electric and mechanical operations.

All Quality Management System including risk management system is initiated through various awareness program .Each and every activity is supported by several relevant training programs, which are initiated by the concerned In–charges.

Performance of every quality system is reviewed in management review meeting as per the requirement of the relevant quality system standard further this is reviewed in various general meeting organized by the management. Performance Appraisal is another initiative taken by the management, which also evaluate performance of individual and side by side the project and others. Top Management believes the Quality Management System is a continual process up-dated at least once in a year or more as required.

The Organization Identifies Key Indicators to monitor the Clinical and managerial structures, processes and outcomes.

COMPOSITION AND ROLE OF VARIOUS COMMITTEES

1) CPR COMMITTEE:-

Frequency of meeting: Once in 3 Months

Chairperson: **Medical Superintendent**

Members:

Consultant Anesthesia	-	Coordinator
Consultant Medicine	-	Member
Consultant Pediatric	-	Member
Consultant Surgery	-	Member
In-charge / ICU	-	Member
Matron	-	Member

Purpose:

- Proper implementation of code Blue.
- Training of CPR to Doctors.
- Training of CPR to staff nurses and other staff.
- Training of CPR to Technical staff & Ambulance Drivers.

2) HOSPITAL INFECTION CONTROL COMMITTEE:-

Frequency: Once in a month

Chairperson: Medical Superintendent

Members:

Microbiologist	-	Member
Consultant surgery	-	Member
Consultant Medicine	-	Member

Consultant Pediatric	-	Member
Consultant Gynae & Obs	-	Member
Administrator	-	Member
Matron	-	Member
Quality Manager	-	Member
Infection control Nurse	-	Coordinator
In-charge House Keeping	-	Member
In-Charge CSSD	-	Member

Purpose:

An infection control committee provides a forum for multidisciplinary input and co-operation and information sharing to recommend and monitor all infection control activities in the hospital.

Scope and function:

- To review and approve a yearly program of activity for surveillance and prevention of HAI (Hospital Acquire Infection).
- To review epidemiological surveillance data and identify areas for intervention.
- To assess, promote and improve practices at all levels of the health workers engaged in various health facilities.
- To ensure appropriate staff training in infection control and safety to review risks associated with new technologies, and monitor infections risks of new devices and products, prior to their approval for use.
- To review and provide inputs into investigations of infectious diseases epidemics.

3) MEDICAL AUDIT COMMITTEE:-

Chairperson: Medical-Superintendent

Members:

Consultant Gynae & Obs.	-	Member

Consultant Pediatrics - Member

Consultant Medicine - Member

Consultant Dental - Member

Surgeon - Member

TOPICS TO BE AUDITED BY MEDICAL AUDIT COMMITTEE:

The topic should be common i.e.

- Long and short stay cases
- Specific Diseases
- Specific Operations
- Vulnerable group
- Increased incidence of diseases
- Post operative infections / complications
- All deaths

4) DRUG & THERAPUETIC COMMITTEE:-

Frequency: Once in 3 Months

Chairperson: Medical Superintendent

Members:

Consultant Medicine - Member

Consultant Surgery - Member

Consultant Gynae & Obs - Member

Consultant Pediatrics - Member

Pharmacy in-charge - Member

Matron - Member

Scope & Activities:

- To suggest the brand names to be used.
- To enlist various companies whose drugs may be prescribed keeping in view the quality.
- The committee formulates policies regarding evaluation selection and therapeutic use of drugs and related devices.
- To guide the implementation of policies and procedures regarding pharmacy services and usage of medicines.
- To serve in an evaluative, educational and advisory capacity to the medical staff and organizational administration in all matters, pertaining to rational use of drugs and other medical and surgical consumables, prosthesis and implants.
- To develop a hospital drug formulary accepted for use in the organization and provide for its constant revision based on objective evaluation of their relative therapeutic merits, safety and cost.

5) QUALITY COMMITTEE:-

Frequency: Once in 6 months

Chairman: Medical Superintendent

Members:

Consultant surgery	-	Member
Consultant Medicine	-	Member
Consultant Pediatric	-	Member
Consultant Gynae & Obs	-	Member
Administrator	-	Member
Matron	-	Member
Quality Manager	-	Coordinator
Floor coordinator	-	Member

Infection control nurse	-	Member
Administrator	-	Member
Matron	-	Member

Purpose:

The circular establishes objectives, functions, responsibilities and authority of the quality assurances and improvement committee.

Scope and Objectives:

1. To develop, implement, evaluate or rectify the continuous quality improvement plan.
2. To establish measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of hospital services.
3. To develop quality indicators on a priority basis.
4. To access information periodically based on the quality indicators, take action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
5. To establish and support specific quality improvement initiatives.

6) SAFETY COMMITTEE:-

Frequency: Once in 3 months

Chairperson: Medical Superintendent

Members:

Safety Manager	-	Member
HOD Laboratory	-	Member
Radiologist	-	Member
HRD Manager	-	Member
Administrator	-	Member

Matron - Member

Maintenance in-charge - Member

Quality Manager/coordinator - Member

Security officer - Member

Purpose:

To ensure a progressive patient safety program to provide safe and effective care to the patient of hospital by creating an environment conducive to the following

1. An organization culture focused on safety and prevention of errors.
2. Staff that is aware and educated about safety, risks and error prevention.

7) VISHAKHA COMMITTEE (SEXUAL HARASSMENT COMMITTEE):-

Chairperson: M D

Members:

Med. Supt. - Member

Administrator - Member

H R Manager - Member

Purpose:

To look into the issues of sexual harassment at the work place as and when any case comes into notice and to provide safe work environment to all the employees of the hospital.

8) GRIEVANCE REDRESSAL COMMITTEE:-

Chairperson: M S

Members:

General Manager Admin. - Member

Nursing Superintendent - Member

Administrator - Member

H R Manager - Member

Purpose:

- To settle grievances of the employees in shortest possible time, at lowest possible level of authority.
- To provide for various stages of escalation so that the aggrieved employees grievances are resolved/ answered within a differed period.

INDICATORS USED FOR QUALITY ASSURANCE AND CONTINUOUS MONITORING

Following indicators are measured and monitored by Quality Assurance Committee as a part of quality assurance and continuous monitoring programme Indicators for clinical structure, process and outcome.

Sl. No.	Indicator	Formula / method	Source of data
1.	Time taken for Initial Assessment of the Inpatient	Time taken by the doctor for the initial assessment of the inpatientX100 / Time required to be taken by the doctor for the initial assessment of the inpatient	Initial Assessment Register
	Time taken for Initial Assessment of the Emergency Patient	Time taken by the doctor for the initial assessment of the in patient in emergency X100 / Time required to be taken by the **doctor** for the initial assessment of the in patient in emergency Time taken by the nurse for	Register kept in emergency for data collection for initial assessment

Sl. No.	Indicator	Formula / method	Source of data
		the initial assessment of the in patient in emergency X100 / Time required to be taken by the **nurse** for the initial assessment of the in patient in emergency	
2.	Percentage of Cases wherein the care plan is documented & counter-signed by clinician	No of cases wherein care plan is documented and countersigned by the clinicianX100/ Total number of admissions	IPD files
3.	Percentage of Cases wherein the screening for nutritional needs has been done	No of in patients wherein nutritional screening is done by dieticianX100/ Total number of in patients	IPD Files
4.	Percentage of Cases wherein the pre-defined initial nursing assessment is documented	number of cases wherein pre defined initial nursing assessment is documentedX100/ Total number of discharges & deaths	Register for IPD initial Assessment
5.	Number of reporting errors per 1000 investigations	no of samples reporting errors in lab or imaging servicesX1000/total no of investigations conducted in lab or imaging services	Register in Laboratory and Imaging Department

Sl. No.	Indicator	Formula / method	Source of data
6.	Percentage of re-dos	No of re-dos performed in lab or radiologyX100 / total number of investigations or procedures conducted in the lab or radiology	Register kept for data collection in Lab and Imaging Department
7.	Percentage of reports co-relating with clinical diagnosis	No of cases co relating with clinical diagnosisX100/ Total number of cases prescribed radiological procedures or laboratory investigations	Register kept for data collection in Lab and Imaging Department / Requisition slip
8.	Percentage of adherence to safety precautions by employees working in diagnostic department.	Number of health care providers regularly adhering to universal precautions in lab or adhering to safety precautions in radiology departmentX100 / Total number of health care providers working in lab or radiology department	Register kept for data collection in Lab and Imaging Department
9.	Incidence of medication error	Total no. of medication errorX100/no. of patient days	IPD File
10.	% of admission with adverse drug reactions	Number of adverse drug reactionsX100 / Total number of medications discharges & deaths	Register at respective ward / Incident Reporting form
11.	Percentage of medication charts	Number of case sheets with error prone	Medical records

Sl. No.	Indicator	Formula / method	Source of data
	with error prone abbreviations	abbreviationsX100/Total number of case sheets reviewed	
12.	Percentage of patients receiving high risk medication developing adverse drug event	No. of patients receiving high risk medication developing adverse drug eventX100/no. of pts receiving high risk medication	Register at respective ward / Incident Reporting form
13.	Percentage of modifications of anesthesia plan	Number of in patients where anaesthesia plan was modified after PACX100/Total number of inpatients posted for surgery after Pre anesthetic check up	Register kept for data collection in Cardiac OT
14.	Percentage of unplanned ventilation following anaesthesia	Number of patients put on unplanned ventilation following anaesthesiaX100/ Total number of inpatients undergoing anaesthesia for various procedures	Register kept for data collection and Incident reporting form
15.	Percentage of adverse anaesthesia events	Number of patients reporting adverse anaesthesia events following administration of anaesthesiaX100 / Total number of inpatients undergoing anaesthesia for	Register kept for data collection and Incident reporting form

Sl. No.	Indicator	Formula / method	Source of data
		various procedures	
16.	Anaesthesia related mortality rate.	No. of death due to Anaesthesia / Total No. of patient undergone administration of Anaesthesia	Register kept in OT for data collection and Incident reporting form
17.	% of unplanned return to OT	No. of unplanned return to OTX100/No. of patients operated	Register kept for data collection OT
18.	Percentage of re-scheduling of procedures	Number of procedures rescheduled during the monthX100 / Total number of procedures performed during the month	Register kept for data collection in Cardiac OT
19.	Percentage of cases where the organisation' s procedure to prevent adverse events like wrong site,	No. of cases where procedure was not followedX100/No. of surgeries performed	Register kept for data collection in Cardiac OT

Sl. No.	Indicator	Formula / method	Source of data
	wrong patient and wrong surgery have been adhered to		
20.	Percentage of cases who received appropriate prophylactic antibiotic within defined time frame.	No. of patients who did receive appropriate prophylactic antibiotic X 100 / No. of surgeries performed.	IPD File
21.	Percentage of transfusion reactions	Number of transfusion(whole blood and components) reactionsX100 / Total number of transfusions of whole blood and blood components	Register kept in Blood bank and respective ward for data collection
22.	Percentage of wastage of blood and blood products.	No. of blood and blood products wasted X 100 / No. of blood and blood products issues from the blood bank.	Register kept in Blood bank for data collection
23.	Percentage of blood component usage.	No. of components used X 100 / No. of blood and blood products used.	Register kept in Blood Bank for data collection
24.	Turnaround time for	Total time when blood is	Register kept in Blood

Sl. No.	Indicator	Formula / method	Source of data
	issue of blood and blood components	ordered till received	Bank for data collection
25.	Urinary Tract infection rate	No. of urinary catheters associated UTIs in a month X 1000 / No. of urinary catheter days in a month.	ICN Registers
26.	Pneumonia rate	No. of "ventilator associated pneumonias" in a month	ICN Registers
27.	Blood stream infection rate	No. of central line associated blood stream infections in a month X 1000 / No. of central line days in that month.	ICN Registers
28.	Surgical site infection rate	No. of surgical site infection in a month X 100 / No. of surgeries performed in the giver month.	ICN Registers
29.	Mortality rate	No. of deaths X 100 / No. of discharges and deaths	MRD Register
30.	Return to ICU within	No. of returns to ICU within	ICU Admission &

Sl. No.	Indicator	Formula / method	Source of data
	48 hours.	48 hours X100 --- No. of discharges and deaths.	Discharge Register
31.	Return to the emergency dept. within 72 hrs with similar presenting complaints.	No. of returns to emergency within 72 hours with similar presenting complaints X 100 --- No. of patients who have come to emergency.	Emergency Admission & Discharge Register
32.	Re-intubation rate.	No. of re-intubation within 48 hours of extubation X 100 --- No. of intubation	ICU Admission & Discharge Register
33.	Percentage of research activities approved by ethics committee	No. of research activities approved by ethics committee X100 --- No. of research protocols submitted to ethics committee.	NOT APPLICABLE
34.	Percentage of patients withdrawing from study	No. of patients who have withdrawn from all on-going studies X 100 --- No. of patients enrolled in all on-going studies.	NOT APPLICABLE
35.	Percentage of protocols violations/deviations	No. of protocols violations / deviations reported X 100 --- No. of protocols violations	NOT APPLICABLE

Sl. No.	Indicator	Formula / method	Source of data
	reported.	that have occurred	
36.	Percentage of serious adverse events (which occur in Hospital) reported to the ethics committee within defined time frame.	No. of serious adverse events reported within the defined time frame X 100 --- No. of serious adverse events reported within and outside the defined time frame.	NOT APPLICABLE
37.	Percentage of consumables and drugs procured by local purchase.	No. of items purchased by local purchase X 100 --- No. of drugs listed in hospital formulary and hospital consumables list.	Pharmacy register
38.	Percentage of stock outs including the emergency drugs	No. of stock outs X100 --- No. of drugs listed in hospital formulary and hospital consumables list	Pharmacy register
39.	Percentage of consumables rejected before the preparation of goods receipt note	Total quantity rejected X 100 --- Total quantity received before GNR.	Registers at Pharmacy
40.	Percentage of variations from the	Total no. variations from the usual procurement process X	Register at Pharmacy

Sl. No.	Indicator	Formula / method	Source of data
	procurement process.	100 Total No. of items procured	
41.	Number of variations observed in mock drills	Number of variations observed in mock drills Trend of variations to be observed during each drill. Variations to be observed in all drills separately.	Mock drill forms
42.	Incidence of fall.	. No. of falls X 100 Total no. of patient days.	Incident reporting forms
43.	Incidences of bed sores after admission	Number of high risk inpatients reporting of bed sores after admission X 100 Total number of high risk patients admitted	Registers in wards and ICU and Incident reporting form
44.	Percentage of employees provided pre-exposure prophylaxis	No of employees provided PEP X 100 Total no of employees exposed to high risk situations	Register for data collection
45.	Bed Occupancy rate and average length of stay	No of beds occupied by in patients X 100 Total number of beds for inpatients in the hospital.	Medical record department

Sl. No.	Indicator	Formula / method	Source of data
		This will include beds earmarked for ambulatory patients also.	
46.	OT and ICU utilization rate	OT utilization rate: (Total working hours of surgeries performed in OT + Total hours taken for cleaning of OT) / Total working hours of OT in a month X 100 ICU utilization rate : Total number of bed days occupied in ICU /Total number of bed days available in ICU x 100	OT register
47.	Critical equipment down time.	Sum of down time for all critical equipment in hours.	Register at respective
48.	Nurse-patient ratio for ICUs and wards	No. of staff / No. of shifts --- No. of beds.	Register
49.	Out patient satisfaction index	Total number of patients satisfied by OPD services X 100 --- Total number of patients visiting OPD	Feedback forms
50.	In patient satisfaction index	Total number of patients satisfied by hospital services/ Total number of patients	Feedback forms

Sl. No.	Indicator	Formula / method	Source of data
		admitted in the hospital (including ambulatory services) X 100	
51.	Waiting time for the services including the diagnosis and out-patient consultation	Patients reporting waiting time < 30 mins (insert your hosp bench mark) / total no of pts in OPD	Sample survey in OPD and diagnostics
52.	Time taken for discharge.	Sum of time taken for discharge --- No. of patients discharged	Registers in Wards
53.	Employee satisfaction index.	Total no of Satisfied employees based on employee feedback Performa X 100 --- Total number of employees in the hosp	Employee feedback forms
54.	Employee attrition rate	Total number of employees resigned or left the service of the hosp for any reason X 100 --- Total number of employees on the rolls of the hospital	HRD department
55.	Employee absenteeism rate	Total number of employees absent without leave in the hospital X 100 ---	HR Department

Sl. No.	Indicator	Formula / method	Source of data
		Total number of employees on the rolls of the hospital	
56.	Percentage of employees who are aware of the employee rights, responsibilities, and welfare schemes.	Number of employees aware of their rights, responsibilities and welfare schemes X 100 / Total number of employees in the hospital	Feedback form / Survey record
57.	Number of sentinel events reported, collected and analysed within the defined time frame.	No of sentinel events analyzed X 100 / No of sentinel events reported	Register / Incident reporting form
58.	Percentage of near misses	Total number of reported near misses analyzed X 100 / Total number of near misses reported	Register / Incident reporting form
59.	Incidence of blood body fluid exposure.	No. blood body fluid exposures X 100 / No. of in- patient days	ICN Register
60.	Incidence of needle stick injury	No of employees reporting of incidents of needle stick injury X 100 / No of employees vulnerable to incidents of needle stick	Needle Stick Injury Forms

Sl. No.	Indicator	Formula / method	Source of data
		injury	
61.	Percentage of medical records not having discharge summary	No. of medical records not having discharge summary X 100 / No. of discharges and deaths.	Medical Records
62.	Percentage of medical records not having codification as per International Classification of Diseases	No. of medical records not having codification as per International Classification of Diseases X 100 / No. of discharges and deaths.	MRD Register
63.	No. of medical records having incomplete and / or improper consent.	No. of medical records having incomplete and / or improper consent X 100 / No. of discharges and deaths.	Medical Record
64.	Percentage of missing records.	Total number of medical records(files) reported missing during the month X 100 / Total number of medical records(files) made during the month	Register of MRD

REVIEW OF LITERATURE

Healthcare embraces a full range of services covering health promotion and protection, disease prevention, diagnosis, treatment, care and rehabilitation.

Groene O[1], Botje D, Suñol R, Lopez MA, Wagner C.

Faculty of Public Health and Policy, London School of Hygiene & Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, UK. oliver.groene@lshtm.ac.uk.

Health-care providers invest substantial resources to establish and implement hospital quality management systems. Nevertheless, few tools are available to assess implementation efforts and their effect on quality and safety outcomes.

This review aims to (i) identify instruments to assess the implementation of hospital quality management systems, (ii) describe their measurement properties and (iii) assess the effects of quality management on quality improvement and quality of care outcomes.

Dale M. Needham, Pulmonary and Critical Care, Johns Hopkins University, Baltimore, MD, USA. Email: dale.needham@jhmi.edu

The results of many quality improvement (QI) projects are gaining wide-spread attention. Policy-makers, hospital leaders and clinicians make important decisions based on the assumption that QI project results are accurate. However, compared with clinical research, QI projects are typically conducted with substantially fewer resources, potentially impacting data quality. Our objective was to provide a primer on basic data quality control methods appropriate for QI efforts.

Data quality control is essential to ensure the integrity of results from QI projects. Feasible methods are available and important to help ensure that stakeholder's decisions are based on accurate data.

A.M. Kanerva,T. Suominenand H. Leino-Kilpi

Studied patient rights in the context of short-stay surgery which was based on a definition according to which informed consent consists of five elements: consent, voluntariness, disclosure of information, understanding and competence. The results indicated some problems in the realization of informed consent. There were also certain problems with information. The respondents were least well informed about the drawbacks of anesthesia and about alternative forms of treatment.

Yusuf R M, Fauzi A R M, How S H, Akter S F U, A. Shah

Conducted a cross-sectional survey to know the awareness level of the hospitalized patients about their rights. They found that 90% of the patients were aware of their rights, and 85 % had enough information regarding their illness and modality of treatment. However, treatment options were discussed with 45 % of cases only, and 65% of patients were informed of their duration of treatment. Almost all patients (99%) said that their religious beliefs were respected by the staff and they had no problems in accessing those in times of need.

D. Shreedevi, A. Brazinov, E. Jansk, R. Jurkovi

Share the experience of promoting patients' rights in the Slovak Republic. To evaluate the public understanding of patients' rights issues, a questionnaire survey was deployed in both initial and final phases of the project with a time difference of one year. Initial survey showed that less than 60% of population was aware that the rights of patients are encoded in legislation, and more than 80% thought that these rights were not observed. The identical survey after one year revealed that public awareness on the issue increased in several areas.

OBJECTIVE

To Establish Quality Management System in Sarvodaya Multispeciality and Cancer Hospital in Legal Compliances, Motivation of staff, Formation of a Team, Training, Quality Indicators Data Collection and Infection Control Team Round.

METHODOLOGY

Study Design:- Qualitative Study.

Study Area:- Quality Department in Sarvodaya Multispeciality and Cancer Hospital, Hisar Haryana.

Study Population:- Over all Hospital.

Target Sample:- Every Departments of the Hospital.

Tools & Techniques: - Gap Analysis as per NABH Standards.

Champions Team Formation.

Manual of all Main departments of the Hospital as per NABH Standards.

SOPs of every department of the Hospital as per NABH Standards.

Training of NABH Standards.

Committees Formation.

Data Collection of Quality Indicator .

Self assessment tool kit.

Filling of the Infrastructure gap has been started.

Filling of the Application Form.

Applying for NABH Accreditation.

Data Analysis:- MS Excel.

Reference Period:- 28th January to 28th April, 2014.

Primary Data:- Gap Analysis as per NABH Standards, Champions Team Formation, Documentation, Committees Formation, Filling of the Infrastructure gap, Filling of the Application Form, Applying for NABH Accreditation, Self assessment tool kit & Quality Indicators, Direct Observation to the Quality Control Rounds.

Secondary Data:- Internet, Book of NABH 3rd Edition.

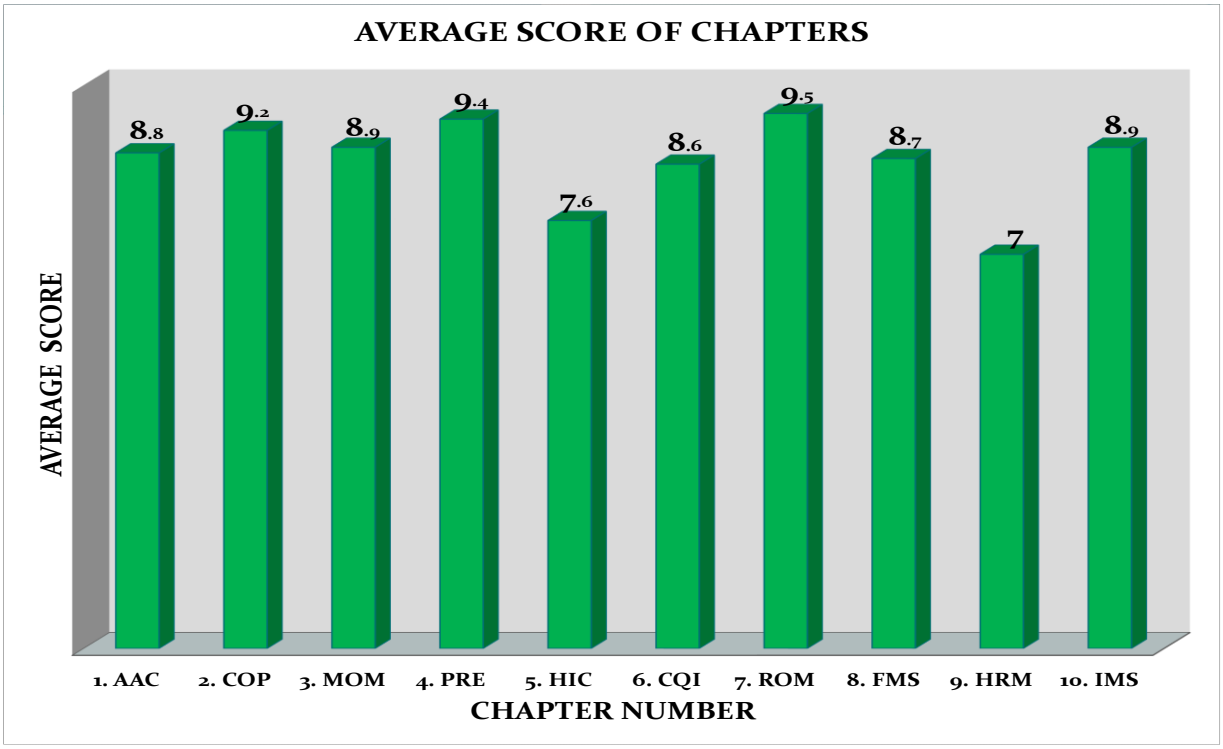
RESULTS AND DISCUSSION

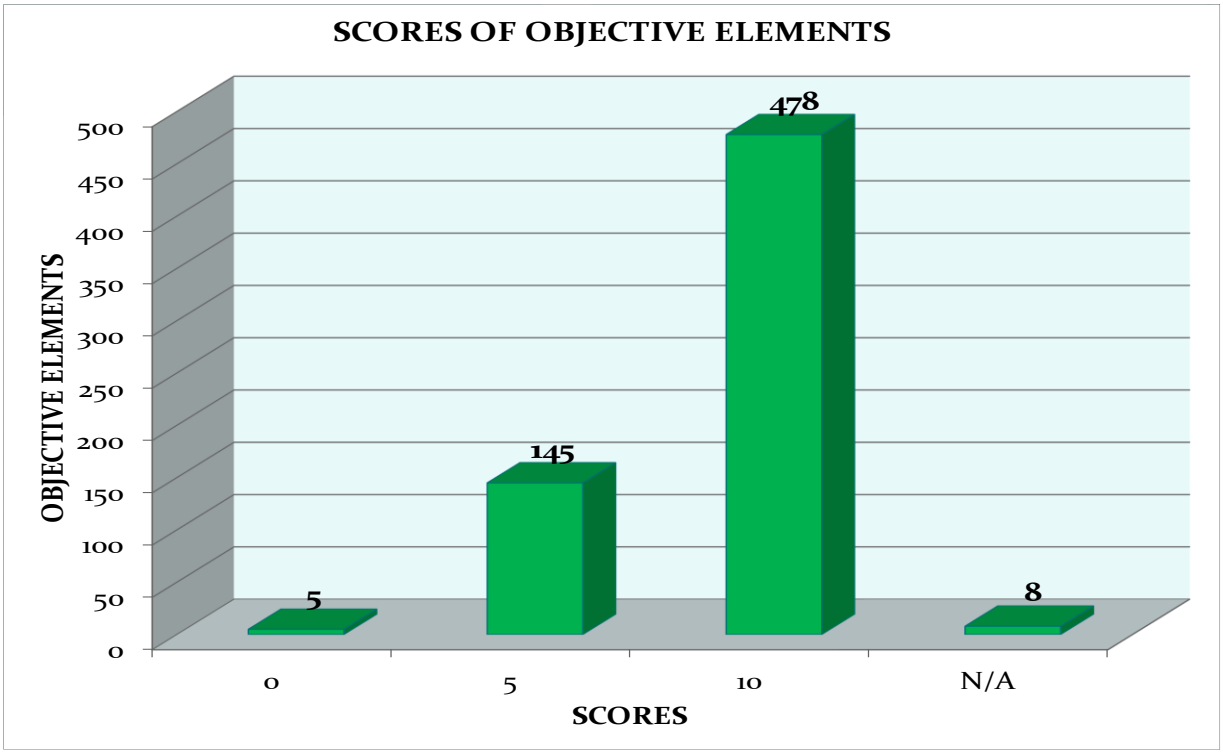
On the basis of detailed Self assessment tool kit on every standards and objective elements of NABH, following result can be derived.

- Total Average score of the **NABH** standards (**all chapters**) is coming out to be **8.6**
- Out of **636** Objective Elements as per **NABH** standards.
- **5** Elements have scored "**0".**
- 145 Elements have scored **"5".**
- **478** Elements have scored **"10".**
- **8** Elements are **N/A.**

(As per the self assessment tool kit of the hospital).

Sl. No.	Chapter	Average score
1	Access, Assessment and Continuity of Care (AAC)	8.8
2	Patients Rights and Education (PRE)	9.2
3	Care of Patients (COP)	8.9
4	Management of Medications (MOM)	9.4
5	Hospital Infection Control (HIC)	7.6
6	Continuous Quality Improvement (CQI)	8.6
7	Responsibilities of Management (ROM)	9.5
8	Facility Management & Safety (FMS)	8.7
9	Human Resource Management (HRM)	7
10	Information Management Systems (IMS)	8.9


AVERAGE SCORE OF CHAPTERS
AVERAGE SCORE
8.8
9.2
8.9
9.4
7.6
8.6
9.5
8.7
7
8.9
1. AAC
2. COP
3. MOM
4. PRE
5. HIC
6. CQI
7. ROM
8. FMS
9. HRM
10. IMS
CHAPTER NUMBER


SCORES OF OBJECTIVE ELEMENTS
OBJECTIVE ELEMENTS
500
450
400
350
300
250
200
150
100
50
0
5
145
478
8
0
5
10
N/A
SCORES

CONCLUSION

- **Sarvodaya Hospital** adopts best quality practices towards healthcare delivery to its patients, relatives, etc. Every department in the organization has its own Standards Operating Procedures as a guide towards quality practices.

- The department specific SOPs are designed and developed after adequate analysis and in depth discussion with all the department heads. These SOPs are available with the departments in black and white for the guidance of the staff whenever required.

- **Sarvodaya Hospital** cares for the safety of the patient and staff .HIC committee is constantly working towards reduction in infection rates, and developing infection control protocols to be followed by the staff at length.

- Special measures are being taken towards staff safety and occupational hazards. Bio-medical waste is disposed as per the Government rules and regulations. Radiology Department takes all the safety measures for patient, relative and for the staff. The concerned staff is immunized against high risk infections.

- The hospital is an ISO accredited hospital and is further aspiring towards NABH accreditation, as an effort towards "continued quality improvement" in the organization. The first gap assessment for NABH accreditation has already been completed, currently the hospital is preparing for the applying for NABH accreditation.

- In these three months I got an opportunity towards learning and understanding the quality management system as practiced in the organization.

BIBLIOGRAPHY

- Quality and Patient Safety Institute [Web site]. [cited 2009 Feb 19]. Cleveland (OH): Cleveland Clinic. Available from Internet: http://my.clevelandclinic.org/ about/quality/default.aspx.

- National Association for Healthcare Quality (NAHQ). Standards of practice for healthcare quality professionals [online]. 2007 [cited 2009 Mar 20]. Available from Internet: http://www.nahq.org/about/pdfs/codestandards.pdf.

- Data for safety: turning lessons learned into actionable knowledge [online]. 2008 [cited 2009 Mar 4]. Available from Internet: http://www.ashrm.org/ashrm/education/ development/monographs/Mono_ActionKnowledge.pdf.

- Different roles, same goal: risk and quality management partnering for patient safety [online]. 2007 [cited 2009 Mar 4]. Available from Internet: http://www.ashrm. org/ashram/education/development/monographs/ Monograph.07RiskQuality.pdf.

- Wagner C, Groenewegen PP, Bakker de DH, Wal van der G. Environmental and organizational determinants of quality management. Quality Management in Health Care. 2001;4:63–76.[PubMed].

- Sluijs EM, Wagner C. Progress in the implementation of Quality Management in Dutch health care 1995–2000. Int J Qual Health Care. 2003;15:223–234. doi: 10.1093/intqhc/mzg033.[PubMed] [Cross Ref].

- Heaton C. External peer review in Europe an overview from the ExPeRT Project. Int J Qual Health Care. 2000;12:177–182. doi: 10.1093/intqhc/12.3.177. [PubMed] [Cross Ref].

- Horváth A, Mogyorósy G, Sinka M, Szy I. Klinikai audit projekt a szaktárca minőségfejlesztési programjában (Clinical audit project in the quality improvement program of the ministry)Egészségügyi Menedzsment. 2003;5:36–40.

- Minőségügyi helyzetfelmérés az egészségügyben, 2002 év (Quality survey in health care, 2002)Boedapest: Ministry of Health, Social and Family Affairs; 2002. Ministry of Health, Social and Family Affairs.

ANNXURE