# Quality Improvement through Different Tools in Trust Hospital

By

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PGDHM (Batch-First)

2008-2010




INTER NATIONAL INSTITUTE OF MANAGEMENT RESEARCH DELHI

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**FINAL INTERNSHIP AND DISSERTATION**

**IN**

**SANTOKBA DULLABHJI MEMORIAL HOSPITAL**

**CUM MEDICAL RESERCH INSTITUTE**

**JAIPUR**

**Feb., 1 – May 1, 2010**

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**Post Graduate Diploma in Health and Hospital Management**

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**SANTOKBA DURLABHJI MEMORIAL HOSPITAL CUM MEDICAL RESERCH INSTITUTE**

**JAIPUR**

**CERTIFICATE**

**This is to certify that Dr. Kajod Mal Meena has been working internship and Dissertation training in SDMH cum Medical Research Institute Jaipur.**

**He has under gone 3 months Internship and Dissertation from Feb., 1 2010 to May 1, 2010**

**During the period he visited various departments of hospital.**

**He has successfully competed his dissertation project on quality improvement through different tools in Trustee Hospital.**

**Importance of Biomedical Waste Management (BMWM) practices in quality Assurance Programme.**

**Rate of training programme in Hospital for contineuous quality improvement (CQI)**

**Role of standard formats & forms for facilitating processes under quality Assurance programmes.**

**For the successful completion for his post graduate Diploma in Hospital Management.**

**"I wish his success in all future endeavor"**

**Date :**

**May, 2010**

**Medical Superintendent.**

**SDMH Cum Medical Research Institute**

**Jaipur.**

**ACKNOWLEDGEMENT**

**This report in the result of three moths of practical training for my post graduation in hospital and health management, during this time course I have been guided and supported by many people, It in a pleasant aspect that I now have the opportunity to express my gratitude for all of them.**

**I am extremely indebted to my mentor Ms Minakshi Gautam Assitant Professor IIHMR New Delhi & Dr Avinash Mishra Medical Superitendent and Dr. M.P. lakhi Advisory Secretary. SDMH Cum Medical Research Institute, Jaipur for sharing his knowledge & precious time which inspired me to do my best during my dissertation/internship. It has been privilege to work under his dynamic supervision in hospital.**

**I express my gratitutde and regards to NABH consultant Dr. (Mrs.) Parul Diggiwal, Dr. Chandan Mohanti and SDMH's NABH cell members of the organization for supporting me with respect to my assignments.**

**I would also like to thank many other people working in this organization that provided a friendly and a warm atmosphere for my ideas to grow.**

**I would like to express my respect full regards to my mentor Mrs. Minakshi Gautam, Dr. P. Taneja & Professor I. Battacharya for showing their interest & sharing valuable views from their busy schedule.**

**In the end I would like to thank Rear Admiral Dr. V.K. Singh, DIRECTOR, & Brig.Dr. K.J. Singh Dean (Academic and Student Affair) and the entire family of 11 HMR New-Delhi from where I am pursuing my post graduation for their constant support throughout my dissertation and internship.**

**A Dissertation Proposal for**

**Post Graduate Diploma in Health and Hospital Management**

**by**

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## International Institute of Health Management Research

## New Delhi

**Date**

MAY,2010

**A Dissertation Proposal for**

# Post Graduate Diploma in Health and Hospital Management

"Quality Improvement through Different tools in trust hospital Santokba Durlabh ji Memorial Hospital Cum Medical Research Institute, jaipur (Rajasthan)."

*Importance of BMW practices in quality assurance programmed.

* Role of training programmed in hospital for continuous Improvement.

*Role of standard forms and formats for standard data capturing.

ABBREVIATIONS:

| | | |
|---|---|---|
| AVG | - | Average |
| BDS | - | Bachelor of dental surgery |
| BMW | - | Bio medical waste |
| CQI | - | Continuous quality improvement |
| DF | - | Degree of freedom |
| HK | - | House keeping |
| ICN | - | Infection control nurse |
| I M E P | - | Infection management and environment Plan |
| K A P | - | Knowledge, attitude and practices |
| N A B H | - | National Accreditation Board for Hospital & Health Care Health Providers |
| K A P | - | Knowledge, attitude and practices |
| O P D | - | Out patient department |
| P | - | Probability |
| Q | - | Quality |
| SDMH | - | Santokba Durlabh ji Memorial Hospital |
| TQM | - | Total Quality Management |
| TNA | - | Training Needs Assessment |

| Sl. No. | Calendar of activities | WK 1 | WK 2 | WK 3 | WK 4 | WK 5 | WK 6 | WK 7 | WK 8 | WK 9 | WK 10 | WK 11 | WK 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Discussion with the top management | | | | | | | | | | | | |
| 2 | Sensitization of workshop | | | | | | | | | | | | |
| 3 | Formation of waste Management committee | | | | | | | | | | | | |
| 4 | Data collection in term of man power equipment relevant statistics | | | | | | | | | | | | |
| 5 | Preparation of medical SOP's with the help of process owners. | | | | | | | | | | | | |
| 6 | Display of general guidelines instruction of waste management | | | | | | | | | | | | |
| 7 | Resource allocation discussion & preparation of communications schedule for HCW. | | | | | | | | | | | | |
| 8 | Reviews of progress by regular monitoring and rounds with the hospital | | | | | | | | | | | | |
| 9 | Preparation of training do mule both off site and on site | | | | | | | | | | | | |
| 10 | Preparation of questionnaire of BMW in Hindi and English Langue | | | | | | | | | | | | |
| 11 | Destruction of questionnaire among health care Workers | | | | | | | | | | | | |
| 12 | Collection and analysis of questionnaire | | | | | | | | | | | | |
| 13 | Discussion of analysis report with the employees in training sessions. | | | | | | | | | | | | |
| 14 | Discussion of BMW policy with all the employees of hospital | | | | | | | | | | | | |
| 15 | In terms of the hospitals were given special training due to these poor performance. | | | | | | | | | | | | |
| 16 | Planning of onsite training in all facility to the hospital house keeping staff by HODs | | | | | | | | | | | | |

FIG.

PERT CHART: INTERN SHIP / DISSERTATION TRAINING ACTIVITIES FROM FEB. 1,TO MAY I,2010

sdmh
the hospital that cares

SECTION 1

# Introduction



# SANTOKBA DURLABHJI MEMORIAL HOSPITAL

## Bhawani Singh Road, Jaipur



**ABOUT SDMH**

- As you arrive at Santokba Durlabhji Memorial Hospital, you become part of a long tradition of distinguished health care. Since about four decades, our mission has been excellence. We expertise in the diagnosis and treatment of disease and to train tomorrow's great doctors, nurses and other paramedical staff. Above all, we aim to provide the best quality health care and services to all of our patients.
- We are committed to excellence and know that good care involves more than good medicine. That's why our concern for you extends to every aspect of your stay. We want your experience at Santokba Durlabhji Memorial Hospital to be as pleasant and as comfortable as possible.
- Use the information provided here to learn more about the services and resources that are available to our patients and visitors. We thank you for choosing Santokba Durlabhji Memorial Hospital for your health care
- Santokba Durlabhji Memorial hospital is a trust managed, autonomous, fee for services, not for profit multidisciplinary, private hospital which was conceptualized by the venerable family patriarch, the Late Padamshri Khailshankar Durlabhji . He had the passion and compassion to deliver affordable health care to the people of Rajasthan which would be second to none in the country.

- Located in the heart of pink city, it is a self contained campus with staff residences, a bank, a post office, medical stores, dairy booth, inpatient attendant complex (Dharmshala) and other living facilities.
- November 29, 1971 is a red-letter day in the health care history of Rajasthan. It was on this day that the first ever hospital in the private sector of the state was inaugurated by the then Prime Minister of India, Smt. Indira Gandhi.
- It was a very modest beginning with a bed strength of only eighty beds and six specialties. However, Shri Khailshankar Durlabhji, a great visionary as he was, made ample provision for the all round development, growth and expansion of the hospital in the years to come. The bed strength has increased to 375 and many wards, Operation theaters, ICUs, laboratories, utility services, specialties and super specialties have been added.

**OWNERSHIP**

The hospital is owned by the Santokba Durlabh ji Memorial TRUST and is established to provide tertiary level health services to each and every person, irrespective of their religion, cast, sex in come status etc, The aim to ensure that nobody is denied health care in the society .User charges is displayed and collected in few areas of the hospital patient and their relatives are informed about the estimated costs of the treatment.

1958 *SANTOKBA DURLABHJI TRUST CREATED

1963*Santokba Durlabhji Diagnostic Clinic established

1969*NURSING HOME STARTED IN A RENTED BUILDING WITH OBSTETRICS AND GYNAECOLOGY, GENERAL SURGERY AND GENERAL MEDICINE

1971*SDMH INAUGURATED

1973*Eye Department founded

*Blood Transfusion services started

*ENT Department set up

1981* Cardiothoracic Unit for open heart surgery set up

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1996*Day Care Centre, AVEDNA ASHRAM STARTED

2000*ISO 9002 CERTI FICATION OBTAINED

2005*Medical CCU started, Laminar Flow Theatre started

2006*HEMLATA DURLABHJI CONFERENCE HALL COMMISSIONED

2008*NABL OBTAINED.

**MISSION**




This hospital cares. SDMH is committed to providing quality health care at the most affordable rates to all sections of society, irrespective of cast, creed or colour. Towards making this possible, we pledge to dedicate all our efforts and all our energies.

**VISION**




- ✓ To surpass current professional quality standards.
- ✓ To come up to the highest expectations of those we serve.

- ✓ To ensure a congenial and invigorating work environment that spurs all employees to reach their full potential.

**VALUES** 

In pursuit of our mission and attainment of our vision, we will be guided by the following values:

- ✓ Empathy
- ✓ Integrity
- ✓ Efficiency
- ✓ Trust
- ✓ Progressiveness

**SDMH ETHOS**

- ✓ Be punctual. Set an example to others
- ✓ Be courteous. It doesn't cost anything
- ✓ Be helpful. This only generates goodwill.
- ✓ Be humble. It never hurts anybody.
- ✓ The patient is our God- let us never forget that.
- ✓ Avoid unnecessary tests and expensive medicines- as much as possible
- ✓ The patient is already under stress- make his stay with us as pleasant as possible- but short.
    - What if you were the patient?

- How would you wish to be treated?
- Treat your patient thus.
- In all your behavior, in all your speech, in your thinking and in your attitude, set norms and standards worthy of emulation.
- Every day, in every way, Make SDMH a better place to be- a happier one too!




***SDMH FACILITIES***

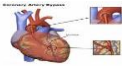
398 Beds - Super Deluxe, Deluxe and Private rooms, General Wards

***P**rivate room -24, Deluxe rooms -12, Semi-deluxe rooms -6 ,ICU Beds 61,*

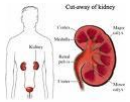
***General Ward beds -290, Emergency beds -5, consultant chambers -42,***

***Operation theatres – 8 etc.***

**DEPARTMENTS**

- ANAESTHESIOLOGY 
- CARDIOLOGY 
- CARDIOTHORACIC SURGERY 
- DENTISTRY 
- DERMATOLOGY 
- ENT 

- GASTROENTEROLOGY 
- GASTRO SURGERY 
- GYNAECOLOGY and OBSTETRICS.(With LDR room facility) 

- GENERAL SURGERY 
- GENERAL MEDICINE 
- NEPHROLOGY 
- NEUROLOGY 
- NEURO SURGERY 
- OPHTHALMOLOGY 
- ORTHOPAEDICS 
- PSYCHIATRY 
- PAEDIATRICS 
- PAEDIATRIC SURGERY 
- UROLOGY 

**INTENSIVE CARE UNITS (ICUs)**



-Medical, Surgical, Cardiac and Neuro ICUs

**SUPPORT SERVICES**

- RADIOLOGY AND IMAGING DEPARTMENT 
- LABORATORY 
- BLOOD BANK 
- PHYSIOTHERAPY DEPARTMENT 
- Dr P.K SETHI REHABLITATION AND JAIPUR LIMB TRAINING CENTRE 
- 
- AVEDNA AASHRAM (For Terminally ill cancer patients) 

**OTHER SERVICES**

- Cafeteria and 1598 eating joint.
- Drug Store
- Dharamshala(IPA Block)- Boarding and Lodging facilities for outstation patients and attendants

**24Hrs. AVAILABLE SERVICES**

- Emergency
- Blood Bank
- Ambulance

**RIGHTS OF THE PATIENTS**



**Right to Access to care**

- SDMH welcomes all patients. No patient shall be denied admission due to race, color, religion, ancestry, financial class or national origin.

**Right to be treated with Respect and dignity**

- The patient has the right to considerate, respectful care at all times and under all circumstances, with recognition of his personal dignity and worth

**Right to Privacy and confidentiality**

- Patients have the right to talk in confidence with health care providers and have their health care information protected.

**Right to ensure Personal safety and security**

- The patient has the right to expect reasonable safety in so far as the hospital practices and environment are concerned.

**Right to Information**

- The patient has the right to obtain from the Senior Consultant / Consultant responsible for coordinating his / her care, complete and current information concerning his / her diagnosis (to the degree known), treatment and any known prognosis.
- The patient has the formal right of access to his / her medical records. The Senior Consultant / Consultant shall be notified when such requests are made.
- A patient may not be transferred to another facility unless he / she has received a complete explanation of the need for a transfer and the alternatives for a transfer, and unless the transfer is acceptable to the other facility.
- The patient has the right to request and receive an itemized and detailed explanation of his / her finalized bill for services rendered in the hospital.

**Right for Consent**

- The patient has the right to reasonably informed participation in decisions involving his / her healthcare. concise explanation of his / her condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient shall not be subjected to any procedure without his / her voluntary, competent, and informed consent, or that of his / her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

**Right to voice complain and grievance Redressal of Complaint**

- The patient has the right to file a complaint regarding services and is entitled to information regarding the hospital's mechanism for the initiation, review and resolution of such complaints.

**Right to refusal of treatment**

- The patient may refuse treatment. When refusal of treatment by the patient or his / her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

**Right to have a second opinion**

- Patient has a right to ask for a second opinion from any other consultant in whom he/she has confidence.

**Patient responsibilities** 

Patients have the responsibility for

- Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health
- Following the treatment plan recommended by those responsible for their care
- Their actions if they refuse treatment or do not follow the healthcare team's instructions
    - Rate list is available at reception and Patient relation/ welfare officer, for any further information on charges.

**Room Up gradation**- In case you want to upgrade a room type, the charges of higher room category with retrospect shall be charged, except the room rent.

- Refunds of Rs. 50,000/-would be made in cash. Refunds above Rs. 50,000/-would be made in the form of cheque and in the patients name only or as authorized by the patient.
- One visitor pass will be issued on payment basis.
- One permanent attendant pass will be issued to you as per the room/bed allocated at the time of admission. On transfer of the patient from that bed to another bed, kindly exchange your pass/passes from the IPD Reception.
- No permanent attendant pass will be issued for the patients in the ICU.
- Please **do not bring children below the age of twelve (12).** This is a precautionary measure as children are more prone to catch infection.
- For reasons of dietary restrictions and Infection Control please **do not bring any eatables to the hospital from outside.** All dietary requirements of the patient are taken care of by us. Attendants shall have their meals at the cafeteria or may order from the kitchen.
- The entire hospital premise is a "**No Smoking Zone". Consumption of Alcohol or any other type of intoxicating substance is strictly prohibited inside the hospital.**
- Please **avoid bringing costly items** to the hospital. There might be a chance of losing/misplacing these items. Patient & Patient attendants are responsible for their belongings.
- Please **do not make use of candles, dhoop, agarbattis, lighters, matchboxes** etc. as they are a potential hazard in a hospital and they can also trigger our sensitive Smoke Detector System.
- For reasons of infection control, Flowers are not allowed to any patient areas.

- In case of any complaint patient/attendant can contact ward-sister on duty/ floor manager/ Patient welfare officer/ patient relation officer (during 9:00 am to 5:00pm.)
- After 5:00pm please contact- sister supervisor on duty (contact no. 9929607032)




**HOSPITAL RULES FOR INPATIENTS**

The Management of Santokba Durlabhji Memorial Hospital wishes you a comfortable stay in the hospital and a speedy recovery. Kindly follow the hospital rules and help us in providing efficient services.

**SERVICES** of Medical, Nursing, Sanitary and Maintenance staffs are available round he-clock. In case of any difficulty contact the Nursing Station on your floor / Doctor on Duty.

**FOOD AND BEVERAGES -** Patients will be served therapeutic diet as perthe doctor's advice in their food rooms. Attendants should eat in the canteen.

**VISITING HOURS -**Should be strictly adhered to. All patients coming to the hospital have very low resistance levels to fight infection. Visitors are a source of infection. To avoid inconvenience to any patient, one visitor will be allowed at a time between 6.00 am to 8.00 am and 6.30 pm to 8.30 pm for patients in wards. The ICU timings for the attendants are 8.00 am to 9.00 am and 5.00 pm to 6 pm.

**ATTENDANTS -** Only one attendant is allowed with all categories of patients for the reason given above.

**SCHEDULE OF CHARGES -** Hospital charges are not negotiable.

**ADMISSION ADVANCE -** Must be paid at the time of admission to cover the expenses for surgery / treatment. Personal cheques are not accepted.

**SETTLEMENT OF BILLS -** Must be done on presentation of the bills. Pending payments as per the due slip should be cleared immediately. Please get receipt for all payments made.

**DISCHARGE-**Check out time is 12.00 noon. Patients discharged after 12 noon will be charged one day's room rent. Please clear your bills before 12 noon.

**PATIENTS' BELONGINGS -**The management will not be, in any way, responsible for any loss or damage to the patient's belongings or any other property from either the hospital room, locker or any other part of the hospital, including theft or pilferage.

**AIR CONDITIONING -** Please ensure that all the windows / doors are closed for effective air-cooling.

**TIPS / BAKSHISH -** Please do not offer any tips / bakshish to any of the hospital employee.

**YOUR FEEDBACK -** For evaluation of Hospital services, you are requested to fill up the Patient feedback Form available at the Nursing Counter. Your suggestions will help us serve you better.

**CHANGE OF ROOM -** The Management reserves the right to change the room allotted to any patient at any time, without assigning any reason thereof and without any previous notice, or to shift the patient to any other suitable accommodation.

| | |
|---|---|
| Billing | 256 |
| Ambulance | 400 |
| Code Blue | 200 |

# ORGANISATION CHART

↓

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| | | | |
|---|---|---|---|
| ↓ | ↓ | ↓ | ↓ |
| All HOD's | Medical Director | Chief Controlar Administrator | Sr. Consultants |
| ↓ | ↓ | ↓ | ↓ |
| Sr. Consultants | Advisor Secretary | Dy. Controlar Administrator | CMO/RMO |
| ↓ | ↓ | ↓ | ↓ |
| Medical Nursing Superintendent | Medical Superintendent | Asstt. Chief Controlar Administrator | Sr. Resident (SR) |
| ↓ | ↓ | ↓ | ↓ |
| Dy. Medical Nursing Superintendent | Additional Medical Superintendent | Sr. Accountant | Jr. Resident Doctors |
| ↓ | ↓ | ↓ | ↓ |
| Metron | Dy. Medical Superintendent | Jr. Accountant | DNB Doctors |
| ↓ | ↓ | ↓ | |
| Staff Nurse/Ward Nurse/Ward Incharge | *Asstt*. Medical Superintendent | Office Superintendent/UDC & LDC | |

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2008*NABL OBTAINEDSSS

## AIMS OBJECTIVES AND METHODOLOGY

Quality improvement through different tools in trustee hospital SDMH Cum Medical Research Institute Jaipur as per requirement of National Accreditation Board for Hospital & Health Care providers(NABH).

a. To identify the base line level of all quality indicators (structure/process and outcome)

b. To Assess the existing services delivery standards of the SDMH.

C. To Tran the key personnel in these processes.

d. To bench mark the indicators.

e. To review the outcome.

f. To facilitate the process of NABH accreditation activity going on with the SDMH.

## INTRODUCTION:

What is quality of care?

There are many different definitions for the term “quality” in the context of health care”……proper performance (according to standards) of inter vent ions that are known to be

safe ,that are affordable to the society in questions, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition " (Roemer and Montoya -

The Quality to technical care consists in the application medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risk. The degree of quality is therefore, the extent to with the care provided is expected to achieve the most favorable because of risks and benefits (Donabedian1980)

"Quality is doing the right thing, right the first time and doing is better the next time, with the resource constraints and to the satisfaction of the community." Ministry of health and population of Malawi 1997)

Dimensions of quality :

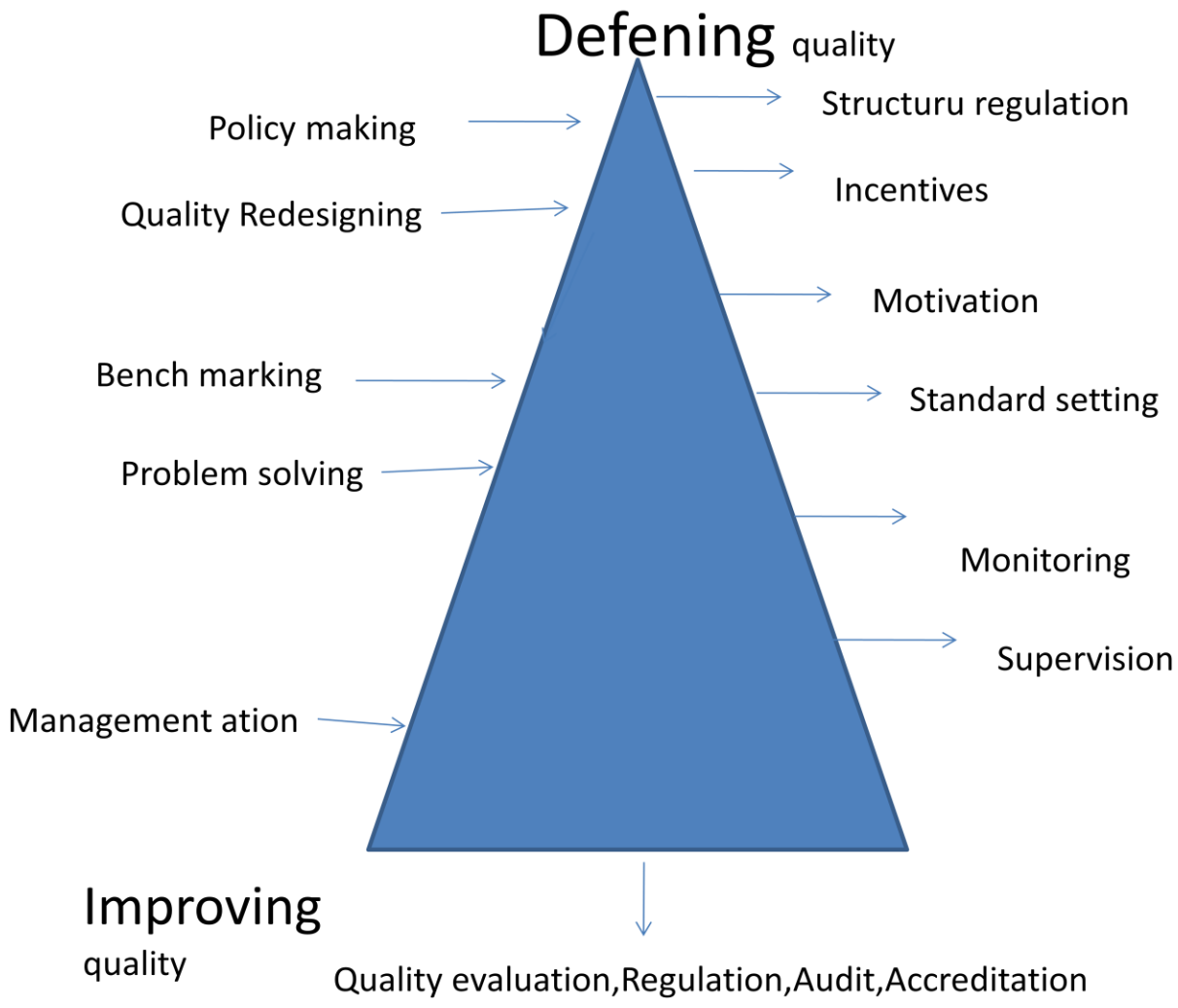
1. Technical performance.
2. Assess of services.
3. Effectiveness of care.
4. Efficiency of service delivery.
5. Inter personal relations.
6. Continuity of services.
7. Safety.
8. Physical infrastructure and comfort.
9. Choice

What is Quality Assurance in health care ?

Quality assurance(QA) is a planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources.

THE CORE ACTIVITIES OF QUALITY ASSURANCE:

The quality assurance triangle



Characteristics of a “good” standard

1. Realistic: Standards can be followed or achieved with existing resources.

1).To find out the knowledge, attitude and practices (KAP) of BMW management among the employees of SDMH Jaipur using a self designed questionnaire.

2).Comparison amongst the employee categories regarding KAP of BMW management by classifying them in to doctors, nurses, lab and sanitary workers.

3).Identifying the weak points and creating awareness on weak points and areas identified.

PERT CHART Activities done during the project.Chart-2

ATERIAL AND METHODS

STUDY DESIGN:- Cross Sectional Study (Qualitative).

STUDY SETTING:- The present study was carried out in the SDMH

2. Reliable: Following the standards for a specific intervention results in the same outcome

(all Factors being equal).

3. Valid: The standards are based on scientific evident or other acceptable experience.

4 Clear: The standards are under stood in the same way by everyone concerned and are not subject to distortion or misinterpretation.

5. Measurable: per romance according to the standards may be assessed and qualified.

MEASURING QUALITY:

-MEASURING QUALITY – STANDARDS BASED APPROACH TO QUALITY-EVALUATION

1.Observation of service delivery-expert observers, peers , supervisors.Mystery

2.MYSTERY CLIENT METHOD .

3. AUDIT OF INDIVIDUAL PATIENT RECORDS.

4. REVIEW OF DATA FROM AUTOMATED INFORMATION SYSTEM.

5. Testing (written test, simulation with standardized patients, computer based testing)

6. Health worker interview. 7. Patient exist interview.

<u>Standards- based approach to quality evaluation-</u>

1. Structure standards e.g. Building

2. Process standards e.g. patient education, equipment management

3. Outcome standards e.g. patient mortality, mother mortality, hospital infection

Indicator monitoring system of quality evaluation

Characteristic “good” indicator-

1 .Valid,  2.Reliable ,3.Measureable, 4.Objective,

5. Can be adjusted for risk or severity.

6. Able to be abstracted from available data sources system.

7. Relates to key organizational or patient structures, or outcomes.

Combined  standards and indicator evaluation systems-

External evaluation of quality. The various approaches to quality evaluation and Improvement in the health sector: Licensure, accreditation, Certification( including  credential review process),

And indicator measurement.

Improving  quality :

1. Quality management method and tool to close the Gap between current and expected level of quality and Redesign heath care process.
2. Licensure, accreditation ,and certification
3. Organizing for quality  structure-
    1. Physical sense of an office or department.
    2. Level of organization 1. Oversight.

2. Co-ordination and support & conducting

4.Support functions

a. Capacity building . b. Communication of Q.A efforts c. Reward of quality work

# Section - 4

## PROJECT – 1

1. Importance of BMW practices in quality assurance programmed,*Knowledge, Attitude and practices regarding BMW management in SDMH cum Research Institute Jaipur,


**ABSTRACT**

Hospital waste creates hazards in from of transmission of diseases, environmental pollution etc. Proper disposal of hospital waste there for e has become very important. Manpower forms critical limiting factor in the efficiency of system of proper hospital waste management Understanding employee's awareness about biomedical waste awareness about biomedical waste management is essential for developing a strategy for its proper disposal. Present study was carried out at SDMH Jaipur using a self designed questionnaire. Total 98 employees participated in the study when the knowledge regarding general assessed the average score was Highest amongst laboratories technician and nurses (7).follow by doctors(6.4) and least amongst sanitary staff (3.6).However when the practical knowledge was assessed the average score was maximum amongst nursing staff(8.17)following doctors(8.3)and least in sanitary staff(7.2).The attitude of doctors about biomedical waste management was more positive with a score of (4.2) then the paramedical employees and the low score of nursing staff(4.8)followed by sanitary staff(4.2) is a matter of serious concern. To improve, firstly the hospital management should be more involved in waste management system and secondly importance of this subject should be emphasized on everyone concerned .This would be by creating awareness about but bio medical waste management amongst public patients and hospital staff.


**INTRODUCTION** ***:-***

All activities of living thing of earth produce waste in some from or the other normally aerobic process in the environment degrades such products. These waste s both bio degradable and non-bio degradable hardly had any impact on the environment until the invention of plastics by modern man, The process of natural degradation could not

keep pace with the increased in waste generated by the over increasing population of mankind and its necessities. The air, the water and the Land are today being coming disposal sinks for the waste. The last decade witnessed assign for an increase of public concern regarding medical waste disposal. This was fuelled by reports of beach washing of medical waste on the Coasts of Florida and Gulf and the "Recycling" of disposable articles in developing countries. The reports and figures available from developed countries indicate that approximately 1-5Kg of waste is generated per bed per day, with substantial Intra country and Inter specialties differences. The data available from developing on a lower side with 1-2 Kg per day per bed . In India, It is estimated to be 2.0Kg per bed per day. The concern regarding the medical waste is mainly due to the presence of pathogenic organism and organic substances in hospital solid wastes in significantly high concentrations. The substantial number of organisms of human origin in solid waste suggests the presence of virulent strains of viruses and pathogenic bacteria in undetected numbers. Therefore improper handling of solid waste in the hospital may increase the airborne pathogenic bacteria which could average effect the hospital environment and community at large. Improper hospital waste management has serious in put on our environment apart from risk of water, air& soil pollution, It has considerable impact on human health due to aesthetic effects. It is the man behind machine\technology that have been organized by numbers of institutions to develop methodology for B M W management and its understanding. However, ground realities are far from ideal and need a lot of effort and commitment at the top level for effective implementation. The current scenario in the country reveals partial to no segregation at the time of generation which at times is done by the contractors, or the rag pickers.

The definite apathy of intellectuals towards the operational aspects of the BMW management system can be attributed to the tubular vision of the professionals that is mainly focused on the curative aspects of the patient care services with lack of understanding towards the role of support services in the overall concept of comprehensive health care delivery.

## REVIEW OF LITERATURE

Government of India reacted towards the global concern and notified the biomedical waste management rules 1998(Ministry of Environment & Forests) Notification, New-Delhi 20$^{th}$ JULY 1998). These Rules have been framed in exercise of the powers conversed by sections 6-8 and 25 of environment protection act 1986. This is applicable to every hospital and Nursing home, veterinary institution, animal houses or slaughter houses, which generate biomedical waste with in a time frame. This law has exempted

clinics; dispense service and la boratories providing treatment or diagnostic facility to less than 1000patients per month. The objectives and rationale of BMW management are mainly to reduce waste generation efficient collection, handling and disposal in such a way that it control infection and provides softy to employees working in the system and ensure cost effectiveness by avoiding penalties and fines imposed by regulatory authorities. According by waste is required to be treated and disposed of in accordance with schedules prescribed. The basic elements are to recognize the waste identify where waste where waste is generated and determine the cause of generation, plan disposal of the waste in a scientific manner so as to render it environmentally nonhazardous auss and eliminate or minimize the source of infection. When the concern is so much about the medical waste there is a need for such a ruling the care worker sought to understand what actually bio medical is Waste and the waste connected with the hospital. Hospital waste refers to all waste, biological or non biological that is discarded, and is not intended for farther use in a hospital according to a WHO report around 85% of the hospital wastes are Actually nonhazardous, 10% are infective (hence, hazardous), and the remaining5% are noninfectious but hazardous (chemical, pharmaceutical and radioactive).

Biomedical waste differ from hospital waste in the sense that it is "any solid, fluid or liquid waste, including its container any inter mediate product, These products could be generated during the diagnostic treatment or Immunization of human beings or animals, In research pertaining there to, or in the production or testing of biological and the animal waste from slaughter houses or any other like establishments.

**JUSTFICATION**:

1) . SDHM Jaipur is preparing itself for NABH accreditation but

I found that in spite of committees and documents in place, the BMW management was not up to the mark and not being practiced fully. The management also wanted something to be done in this regards.

**2).Hospital waste create informs of transmission of diseases, environmental pollution etc. proper dispos al of hospital waste there for is very important.**

3).Manpower forms a critical limiting factor in the efficiency of system of proper hospital waste management and there for understanding employee's awareness about BMW is essential.

All this Inspired me to conduct a study related to knowledge attitude and practices (KAP) of BMW management among employees of hospital. so that first necessary and adequate

knowledge could be imported which leads to building up of a positive attitude and which then can be transformed in to safe practices.

## OBJECTIVES

1) To find out the knowledge, attitude and practices (KAP) of BMW management among the empoylees of SDHMS jaipur using a self designed questionnaire.
2) Comparison amongst the employee categories regarding KAP of BMW management by classifying them in to doctors, nurses, lab and sanitary workers.
3) Identifying the weak points and creating awareness on weak points and are identified.

## MATERIAL AND MEHTHODS

STUDY DESIGN:- CROSS SECTIONAL Study (Qualitative).

Study setting :- The Present study was carried out in the SDMH located in Jaipur (Rajasthan). The hospital has been functioning since 1971.The hospital has waste disposal policy as per Government recommendations.

It has a hospital infection control committee under chairmanship of Medical Superintendent or Chief Administrator Controller or Medical Director or Advisor secretary Trust hospital.

A lot of direct and indirect efforts have been exercised to sensitize the work force to current issues in BMW previously.

STUDY PERIOD:-

The study was carried out from Feb 1, 2010 to May 1, 2010.

Study population included hospital employees directly related to patient core this included a total of 98 employees follows.

- 70 Doctors Including HOD, Sr.Consultants, Sr.Residents, Residents, Tutors and DNB Students etc.
- 08 Paramedical staffs(Including Nursing staff and Technician)
- 20 Sanitary staffs.

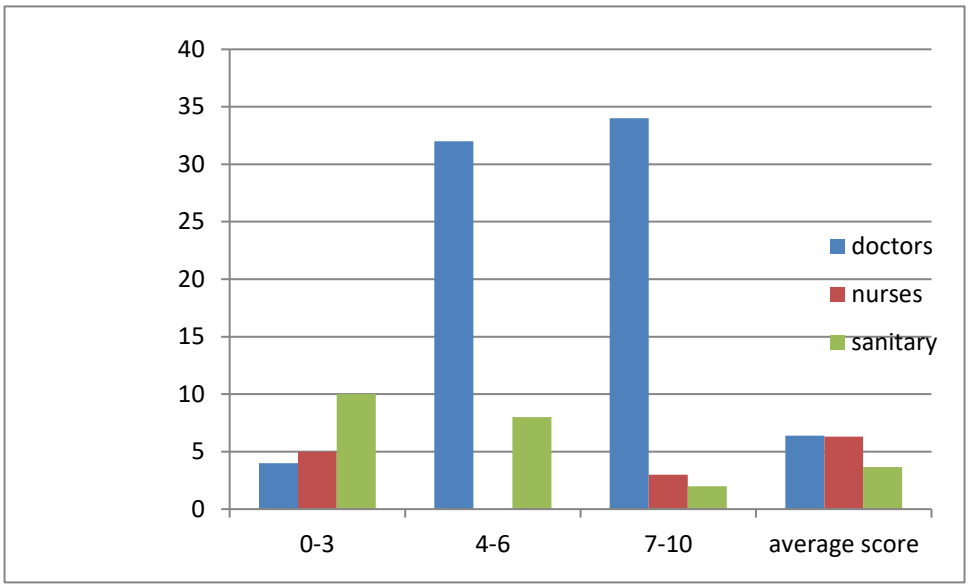
**INSTRUMENT FOR DATA COLLECTION:**

A self designed (Pre-Structured) Questionnaire was used.

**SCORE OF HOSPITAL EMPLOYEES WITH RESPECTS TO GENERAL INFORMATION OF BMW MANAGEMENT** :

| Score | Doctors | Nurses | Sanitary Staff |
|---|---|---|---|
| 0-3 | 4 | 5 | 10 |
| 4-6 | 32 | 0 | 8 |
| 7-10 | 34 | 3 | 2 |
| Average Score | 6.4 | 6.3 | 3.65 |

General Inform




Graph-1A

**SCORE OF HOSPITAL EMPLOYEES WITH RESPECTS TO GENERAL INFORMATION OF BMW MANAGEMENT** :

Chi-square value : 45.49; df:4; P<0.005

94% Doctors answered more than five questions correctly, 50% of sanitary staff answered correctly. However only 38% Nurses could answer more than five question correctly

knowledge regarding in general information was almost the same in Doctors and lab/OT staff while it was least in sanitary staff.

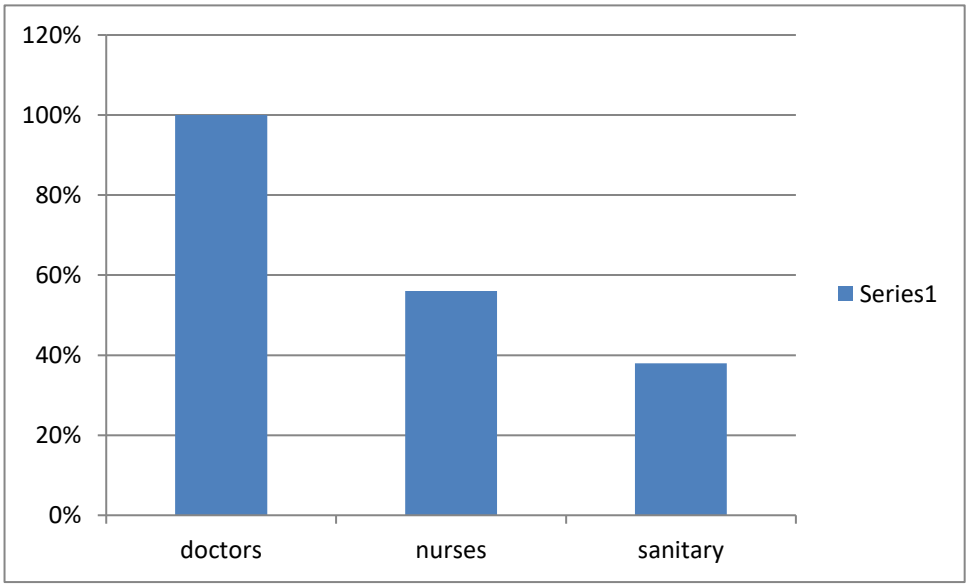
Going further in details of general information regarding the BMW management, the employees knowledge regarding the meaning and symbol of bio hazard is as follows:

## Doctors :

From above detail is clear that the nurses (27%) and sanitary workers only (2%) knew very little above the meaning and symbol of bio hazard. Which is not acceptable both for the sake of their own health as well as the patients and attendants .

**For the knowledge regarding the health hazards of BMW, the following were the findings :**

| Doctors | Nurses | Sanitary |
|---|---|---|
| 100% | 56% | 38% |




Graph-3A

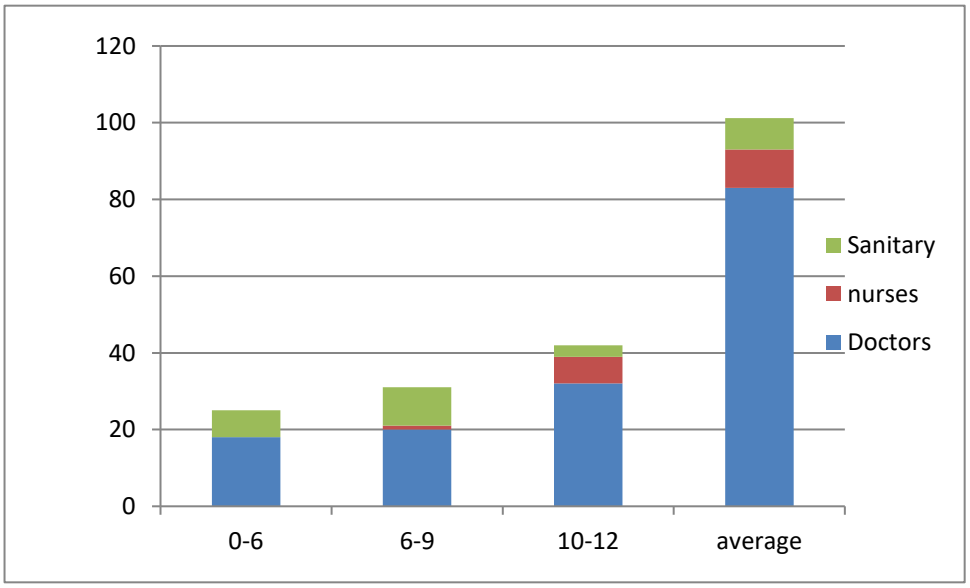
**For the knowledge regarding the health hazards of BMW, the following were the findings :**

Graph-3A Showing health hazard- For the knowledge regarding the health hazards of BMW, the following were the findings :

The knowledge regarding the health hazards of BMW of sanitary staff which is supposed to hand be the BMW is significantly low (only 38%) regarding the knowledge of percentage of hazardous waste of the total waste generated in the hospital the Doctors scored the highest with 40% followed by Nurses with 12.5% in sanitary staff it was only 80% .

**Score of hospital employees with respect to practical knowledge on BMW management**

| Score | Doctors | Nurses | Sanitary Staff |
|---|---|---|---|
| 0-6 | 18 | 0 | 7 |
| 7-9 | 20 | 1 | 10 |
| 10-12 | 32 | 7 | 3 |
| Average Score | 83 | 10 | 8.17 |




Graph-4A

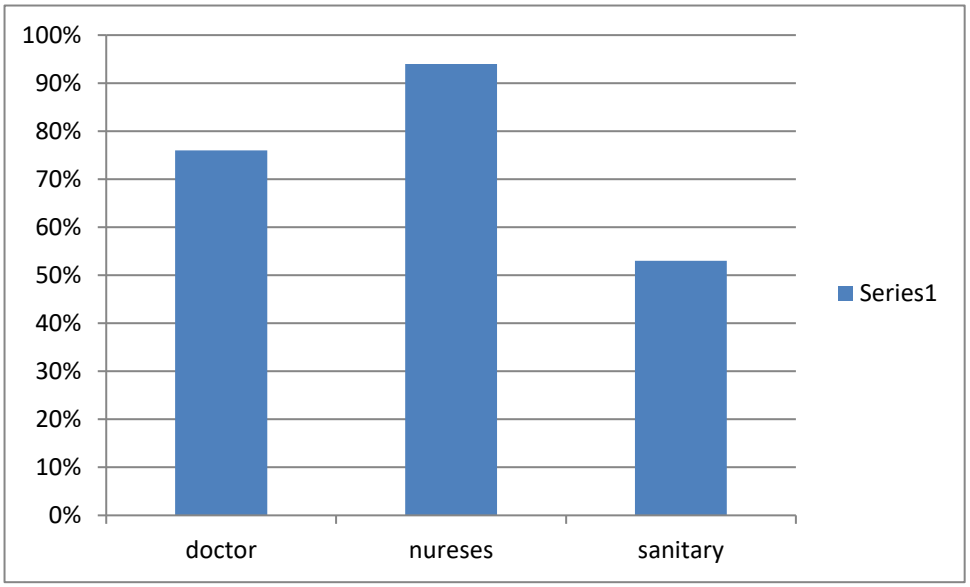
Score of hospital employees with respect to practical knowledge on BMW management

Chi-square value : 13.489; def:4; P<0.05

**Practical knowledge of BMW management in different categories-**

| Doctors | Nurses | Sanitary |
|---|---|---|
| 80% | 90% | 56% |
| | | |
| | | |

Practical knowledge of BMW management in different categories-



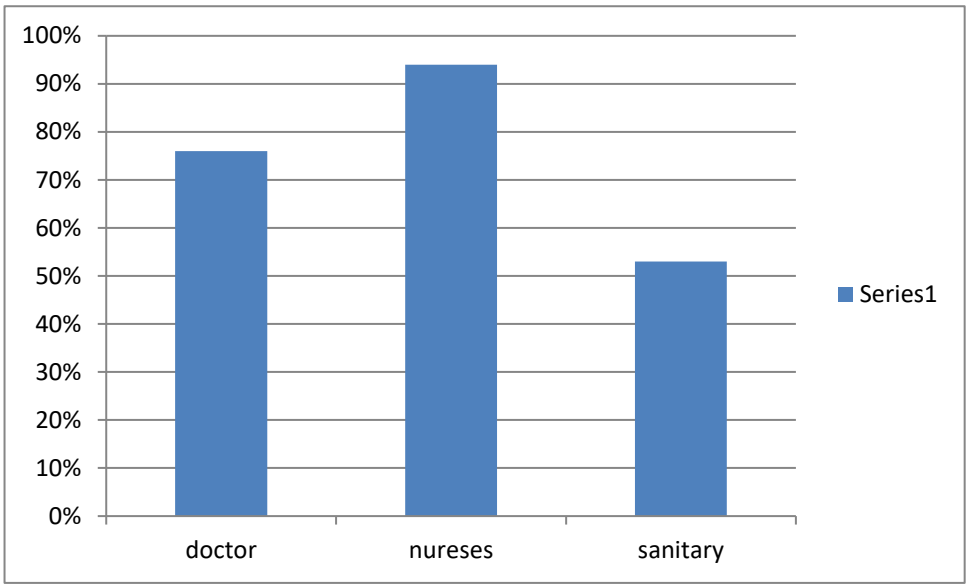

Graph-5A

After Statically analysis Using chi-square test, it was found that the different in the knowledge of employees with respect to practical knowledge on BMW management is statistically significant. ($P<0.05$)

When questions regarding segregation of waste were asked, 72% nurses were aware about it. However 58% sanitary staff knew the precise details with doctors scoring the least (57%).

**Segregation of waste :**

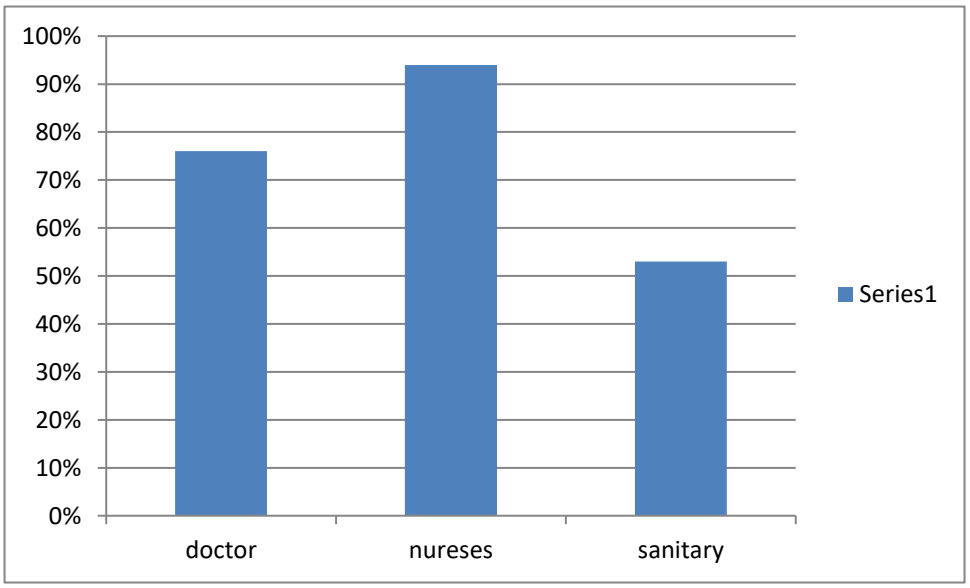
| Doctor | Nursas | Sanitary satff |
|---|---|---|
| 57% | 72% | 58% |
| | | |




Graph-6A

When questions regarding transportation of BMW were as cad, 94% of Nurses were aware about if followed by Doctors (76%), Sanitary staff (53%).

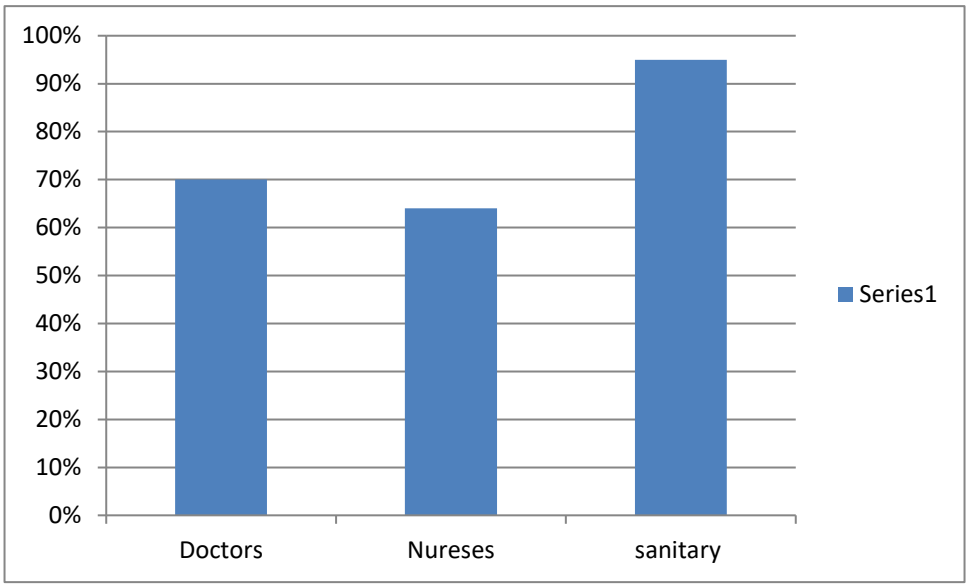
| Doctors | Nurses | Sanitary staff |
|---|---|---|
| 76% | 94% | 53% |




Graph-7A

The low awareness level of sanitary staff 53% regarding transportation of BMW is a serious concern since they are the people directly responsible and involved in if more over nurses also had low awareness who otherwise can suggest the house keeping staff to transport waste in a proper manner. When the attitude towards BMW management was assessed as 95% nurses compared to 70% doctors 64% sanitary staff had a positive attitude about various aspects of BMW management.

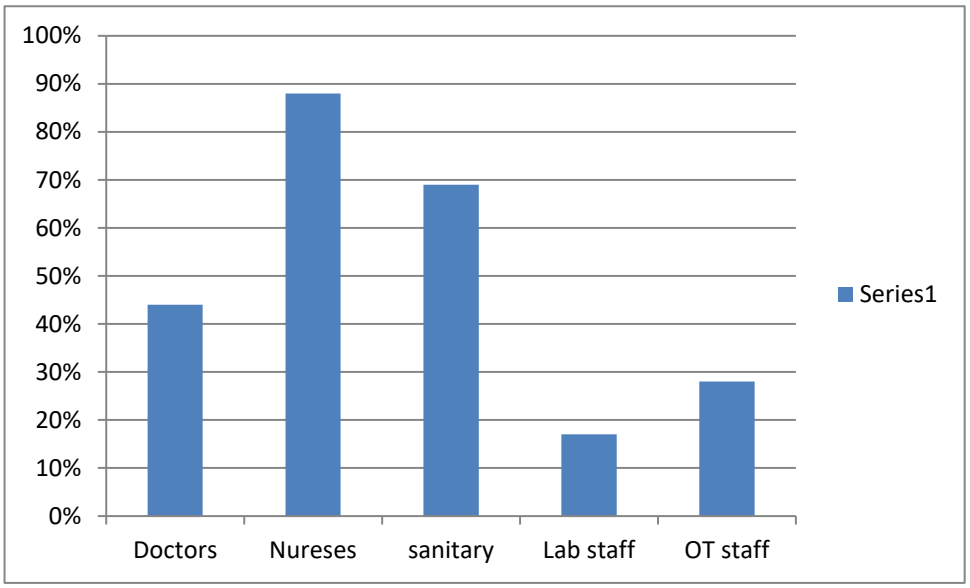
| Doctors | Nurses | Sanitary staff |
|---|---|---|
| 70% | 64% | 95% |




Graph 8A

Majority of Nurses (88%) and (44%) Doctors thought that it was not their responsibility as against 28% OT staff, 17% Laboratory staff and only 69% sanitary staff.

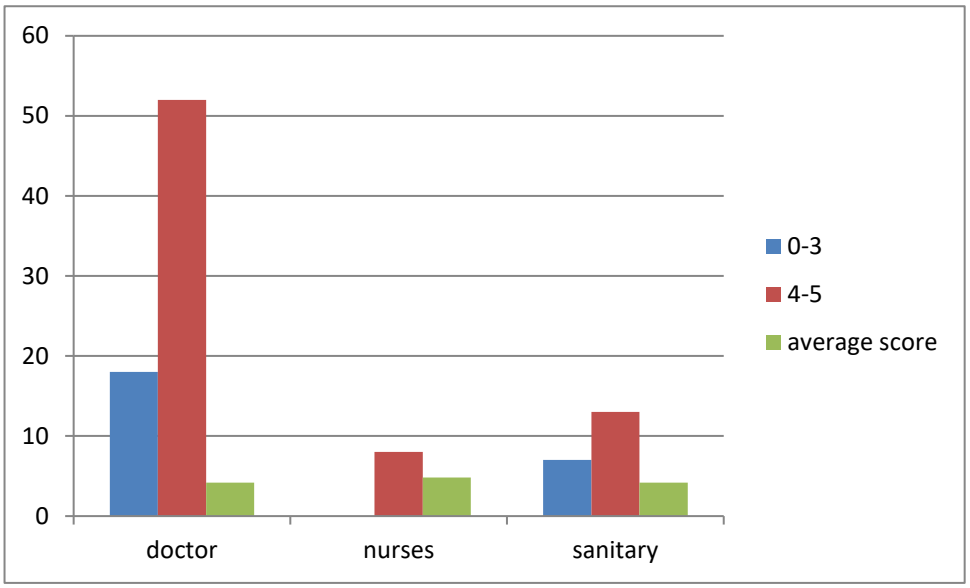
| Doctors | Nurses | Sanitary staff | Lab staff | OT staff |
|---|---|---|---|---|
| 44% | 88% | 69% | 17% | 28% |




Graph-9A

Scores of hospital employees with respect to attitude towards BMW management :

| Score | Doctors | Nurses | Sanitary Staff |
|---|---|---|---|
| 0-3 | 18 | 0 | 7 |
| 4-5 | 52 | 8 | 13 |
| Average Score | 4.2 | 4.8 | 4.2 |




Graph-10A

Chi-square value: 3.689, df 2, P<0.005

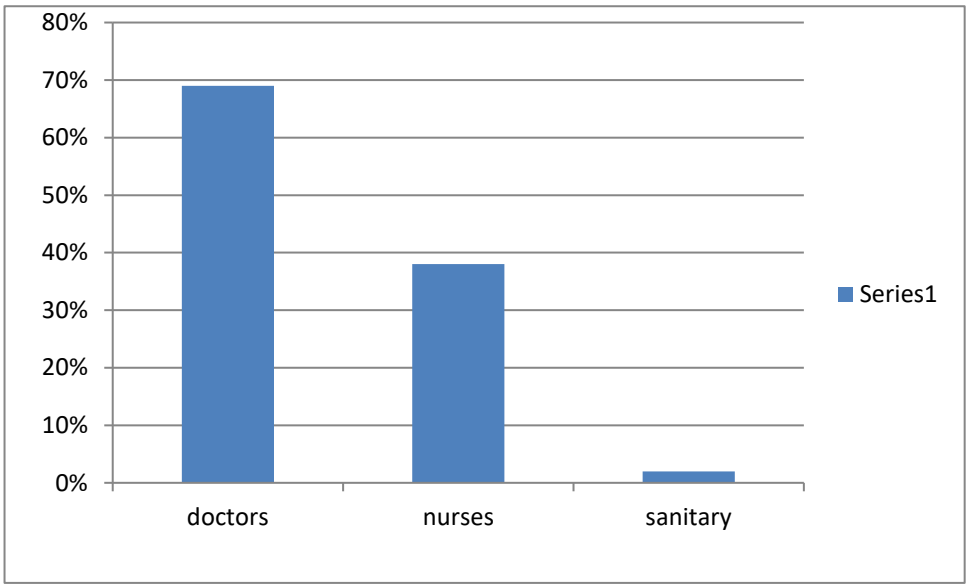
After statically analysis using chi-squire test, it was found that the different in the attitude of employees regarding BMW management is statistically significant (P<0.005).

General Information :

| | | | | |
|---|---|---|---|---|
| Average Score | 8 | | | |
| | 6 | | | |
| | 4 | | | |
| | 2 | | | |
| | 0 | | | |
| | | Doctor | Nurses | Sanitary |

| Doctors | Nurses | Sanitary Staff |
|---|---|---|
| 69% | 38% | 2% |

Bio hazard (Meaning & symbol)




Graph-11A

Place of work and type of work done by employee was noted the questionnaire Included three sets of questions:-

Set- 1: 10 questions regarding -

1) Meaning and symbol of biohazard

2) % of Infectious waste in hospital

3) Health hazards of BMW

4) Environmental effects of BMW

5) Rules and regulations about BMW management

6) Transmission of diseases through infected needles

7) Classification of BMW

Set-2: 12 questions regarding –

1) Steps in BMW management
2) Segregation of BMW
3) Collection of BMW
4) Transportation of BMW

5) Personal protective equipment
6) Storage of BMW
7) BMW management Committee
8) Disposal of BMW

Set-3: 5 Questions of regarding

1) The Hype and propaganda of BMW management
2) Responsibility
3) Effectiveness of committees
4) Confusion over color of Bins
5) Compliance with rules and regulations

STATISTICAL ANALYSIS:

Statistical analysis for analysis a scoring system was used where and 1 point was given for correct answer and 0 point was given for wrong answer. The statistically analysis was done using “Chi-square test”

RESULTS:

The study included following - *98 employees out of which 70(71.42%) were Doctors,

*98 employees out of which 8(o8.16%) were Nurses,

*98 employees out of which 20(20.40%) were Lab technicians & OT staffs and 20 (56.16%) were the Sanitary staff, when knowledge regarding general information of bio medical waste was assessed the average score was highest in doctors (6.4) followed by nurses (6.3) and least in sanitary staff (3.65).

SCORES OF HOSPITAL EMPLOYEES WITH RESPECT TO GENERAL INFORMATION ON BMW MANAGEMENT:

**SCORES OF HOSPITAL EMPLOYEES WITH RESPECT TO GENERAL INFORMATION ON BMW MANAGEMENT:**

| SCORES | DOCTORS | NURSESS | SANITARYSTAFF |
|---|---|---|---|
| 0 – 3 | 4 | 5 | 10 |
| 4 – 6 | 32 | 0 | 8 |
| 7 – 10 | 34 | 3 | 2 |
| AVERAGE SCORE | 6.4 | 6.3 | 3.65 |

Chi-square value 45.49; Df 4; P<0.005

After statistical analysis using Chi-square test, It was found that the difference in the knowledge of employees with respect to general information on BMW management is statistically significant.(P<0.005),

**FINDINGS:**

1) Doctors are found to have the highest knowledge with respect to general information on BMW management and sanitary staffs are found to have the lowest, Nurses & Sanitary staffs have very little information about the meaning and Symbol of bio hazards.
2) The knowledge regarding the health hazards of BMW of sanitary staff which is supposed to handle the BMW is significantly low but after the training given to them the knowledge among them rise.
3) Doctors have the best knowledge of practical aspects of BMW management and sanitary staffs the least. The letter is an ominous sign.
4) Nurses have the most positive attitude regarding BMW management and sanitary staff scored the least, the latter again is a serious concern.
5) All most 50% of the doctors were of view that BMW management is not their responsibility which is very strange.
6) All most everybody agreed with the hype and propaganda regarding BMW management is not their responsibility which is very strange.

-Least knowledge about segregation of waste.

-Only half of them knew about the meaning and symbol of biohazard.

-Only half of them knew about the percentage of infectious waste in hospital.

- Only half of them knew about the health hazards of BMW.

**NURSES :**

Best knowledge about segregation of the waste.

Most positive attitude.

Not even one fourth of them knew about the health hazards of BMW.

Only one fourth knew about the meaning find symbol of bio-medical hazards

More the 88% believe that BMW management is not their responsibility.

All most everybody agreed with the hype and propaganda regarding BMW management

**STAFF CATEGORY WISE FINDINGS:**

**DOCTORS:**

-Highest knowledge with respect to general information on BMW management.

-Good score showing positive attitude.

NURSES :

- Best knowledge about segregation of the waste.
- Most positive attitude.
- Not even one fourth of them knew about the health hazards of BMW.
- Only one fourth knew about the meaning find symbol of bio-medical hazards
- More the 88% believe that BMW management is not their responsibility.

**HOUSE KEEPING: (SANITARY STAFF)**

-Least general information about BMW before training but having a very high positive attitude, ready to learn and show good signs of improvement.

-only 2% amongst them knew about the meaning and symbol biohazards.

-Approximately only 1/3$^{rd}$ (38%) of them knew about the health hazards of BMW.

-Good practical knowledge.

-Almost 1/2 of them more of the view that BMW management is not their responsibility.

**DISCUSSION :**

The objective of BMW management is reduce waste generation, ensure its safe collection and disposal in a cost effective way to control infection, improve safety, prevent environmental pollution and illegal recycling ,a number of initiatives have been taken to help create awareness about BMW management in India ,The realities are however for from ideal.

The knowledge regarding the general information about BMW management was better in educated class like doctors followed by paramedical persons like nurses with average scores of 6.4, & 6.3 respectively nonmedical employees were having least knowledge about it i.e. about 3.65, This is expected because people with higher level of educations are known to have greater knowledge of environmental issues.

Health care workers are needed to understand the specific meaning of BMW infectious hazardous and nonhazardous waste .According to WHO report 85% of hospital waste is non hazardous waste. In present study when specific information in this regret was sought only 56% doctors, 100% nurses and 38% sanitary staff could tell the percentage of hazardous waste correctly.

The Government of India notified rules for BMW management in 1998 according to which every hospital should have a system for implementation of these policy guide lines. However almost all the employees were unaware of the policy?

When practical knowledge regarding BMW management was assessed it was found that nurses scored best with average score of 10 followed by doctors (8.3)

And sanitary staff (8.17) . This difference was statistically significant. This might be attributed to responsibility given to paramedical staff for implementation of rules by authorities and to the instruction manuals to which they need to adhere strictly. Segregation of BMW is considered one of the most important steps in BMW management. Medical and paramedical staff is responsible for this color coding of Bags is the method used for segregation of BMW, majority of staffs were about color coding to however precise practical knowledge for segregation of each category was found in 72% Nurses, 58% Sanitary staff and 57% doctors. Only 53% of sanitary staff knew how to collect the waste correctly width both surprising and worrying.

Majority of staff thought that the hype and propaganda regarding BMW was justifiable on account of various reasons like diseases transmitted transmissions, environmental problems and recycling etc. considering that paramedical staff was having good practical knowledge

about the issue it can be said that they were looking at the things and laid down procedures without understanding the reasons. If their knowledge can further be supplemented they will follow the procedures just not for the sake of following the commands but for practical, , scientific and moral reason also.

**RECOMMENDATION :**

1).Intensive training at regular time intervals about statutory public health guide lines for BMW management with a focus on mass education and motivation and change of mind set in all strata of medical practice. This may include: 1.workshops 2.seminars.

2).Awarding the departments who are found continuously in compliance with BMW management.

3). Needs for orientation programmed for new comers to understand the hospital function

4).Continuous logistic support .e.g. replacing the obsolete Bins timely. Proper color coded Bins with matching collection Bags, adequate availability and regular maintenance/replacement of niddles and syringes cutters.

5). User friendly approach (e .g .use of ampoule cutters nonelectric needle/syringe cutters which go handily with dressing trolley etc.

6). Close monitoring of the compliance with surprise and daily checks.

**PROBLEMS FACED**

1.Designing the Hindi ,English language questionnaire.

2.Dictating each and every question with their multiple choice to the sanitary staff who did not know even Rajasthan's language.

**CONCLUSION :**

Even after eleven years of making BMW management policy, Mandatory for every hospital the situation about knowledge and attitude, regarding the same were not found satisfactory in SDMH, the medical staff the high end of hierarchy seems to have proper theoretical knowledge and positive attitude, but less practical knowledge, where as paramedical and non medical staff has little theoretical knowledge and good practical knowledge, which seems to come out of compulsions as the attitude. These employees regarding BMW management is not so positive. To improve the situation the medical staff should be more involved in waste management system, and importance of this subject should be emphasized on everyone including public, patients and hospital staff. it will be apt to remember recommendations of WHO.

**"HUMAN ELEMENT IS MORE IMPORTANT THEN TECHNOLOGY"**

# PROJECT- 2

**ROLE OF TRAINIG PROGRAMME IN HOSPITAL FOR CONTINUOUS IMPROVEMENT**

Quality assurance programme can be successful in any setting whether it is a small health care or a larger one, for improving quality care services in SDMH.

**The main objective of this programme was to:**

1. Carry out base line study with respect to physical infrastructure and Identify Gaps in respect of building, manpower, equipment, and regulatory compliances, training modules.
2. To suggest alteration in structural changes of the hospital as per NABH requirement.
3. To prepare policy and procedure for various activities in line with NABH accreditation standards.
4. To train key personnel in understanding and complying with the accreditation standard.
   If we focus on last tip (4) it clearly indicate the necessity of these trainings in NABH programme and keeping this point on mind SDMH along with quality council of India, also included training part this programme. The main objective was to strengthen the processes and this was only possible if staff of SDMH participate on various training topic.

   To facilitate implementation of accreditation standards and help staff of respective areas to follow activity related to NABH it was very essential to train hospital staff on various process that was required for the success of quality assurance programme in SDMH . In any quality assurance programme continuous training of staff at all levels (managers at top, middle, lower as well as workers at floor level) is extremely important. This is also important for any professional organization and this is the reason why large successful organization tends to have a separate full fledged department of training .
   Considering this and also for NABH success in SDMH Jaipur was imperative that training of staff should go hand in hand while planning for other essential activity under NABH (Preparation of Sops, Committee meeting, infrastructural issue, equipment, manpower, etc.) because implementation activity of NABH can only be made possible if staff of SDMH Jaipur could be trained properly. As it is known “What the mind does not know, the eyes won’t see and the ands won’t do”

Preparation of training module under NABH .

1. NABH standards
2. Infection control
3. Bio-medical waste
4. Effective Communication
5. Fire Safety
6. Disaster management
7. Hospital safety and security
8. Radiology services
9. O T management
10. Medico legal issues in health care

A part from above training programme some practical demonstration was provided to support the staff of SDMH so that they could understand the process properly.

Table – 5 – Preparation of training programme and essential indicators :

| Sl.No. | Name of availability indicator check list | Yes/No |
|---|---|---|
| 1 | Basic life support/advance life support | |
| 2 | How to transfer patient from stretcher to Bed and from bed to stretcher | |
| 3 | How to use fire extinguishers | |
| 4 | Safe procedure to collect blood samples | |
| 5 | Safe procedure for injection | |
| 6 | Safe procedure to transport blood sample | |
| 7 | Safe procedure for keeping high risk medicines, use of medicines | |
| 8 | Process of handle blood spillage | |
| 9 | Process for recalling medicines | |
| 10 | Chemical spill handling | |
| 11 | Time out procedure in O.T. | |
| 12 | Practice on a avoiding wrong patient and wrong part surgery. | |
| 13 | Laboratory safety practices | |
| 14 | Radiation safety practices | |
| 15 | Segregation method of waste | |
| 16 | Hospital evacuation plan | |
| 17 | Hand washing methods | |
| 18 | Preparing drums for autoclave | |

| | | |
|---|---|---|
| 19 | Reporting/filling of adverse drugs/reaction forms | |
| 20 | Discipline | |
| 21 | Management of abusive/violent patient and patient party by securities | |
| 22 | Management of crash cart during emergency. | |
| 23 | Preparation of discharge summary. | |
| 24 | Management of lama cases. | |
| 25 | Preventive maintenance of equipment | |
| 26 | Process of restraints to patient | |
| 27 | Physician/Nurses responsibility during restraints | |
| 28 | Procedure to be observed pre and post application of restraint | |
| 29 | Mission and vision statement of the hospital | |
| 30 | OPD registration procedure | |
| 31 | Indoor admission procedure | |
| 32 | Triage decision | |
| 33 | Labeling and storage of donor blood | |
| 34 | Standard color code for Blood Group | |
| 35 | Hand washing methods | |
| 36 | Storage of pharmaceutical items. | |
| 37 | ICD coding for medical records | |
| 38 | Filling of records. | |

## Quality of structure:

## Construction space:

For training activities the hospital (depending upon its size) should have a library, Conference/Seminar rooms and separate training area for nurses, technician, and other categories of staff. This requirement for SDMH staff was fulfilled and they have been provided a central council/Conference hall, Auditorium Where all trainings both (Class room and demonstration related) training is provided.

**TOOLS :**

The central council committee of SDMH Jaipur is well equipped with all necessary material to support NABH programme. Conference is equipped with LCD PROJECTS, Training films, good sound systems, WIFI Internet and computers system with HIS and some time facility for live demonstration of surgical/other procedure through CCTV)

**QUALITY OF PROCESS:-**

1. A standard manual
2. Maintenance of previous training records and feedback forms
3. Well trained trainers can be external or internal initially training need analysis of staff was done and among the unit and departments, key person were Identified for providing continuous training to staff of SDMH. This are internal trainers, external trainers were invited for providing special training of various topics. Like ACLS, BCLS, Fire mock drill, disaster mock drills transportation method of patients managing ambulatory patients triage method of patients.

**QUALITY OF OUT COME:**

1. Increased satisfaction level of patient/staff.

2. Proper resource utilization because trainings of staff enable them to utilize their knowledge and efficiency, this results good will and minimum waste. Initially X-Ray wastage rate was nearly 6% on monthly consumption but after this training activity it came done to nearly three person.

3.Recommendation internship continues training at regular time intervals about hospital & health care improvement training are give regular awarded department who are found continuously and regularly attend the continuous improvement trainings by employees

4.Needs for orientation programs for new comers understand the hospital faction the man roll training programs in hospital for continuous.

5.Close mentoring of the compliance and delay check training programs

6.Trainers should be acknowledge were skill affection an effective personality and language local language communication is necessary for understand employees

CONCLUSION

NABH quality assessor and consultant are more need for improve health and hospital clinical training patient heath care services are improve by the continuous training provided to hospital works staff to continuous training roll is improve sternly patient health care services and hospital staff acknowledge and Attitude acknowledge improve frequently by continues training.

Hospital quality managers and quality consultants more need for improve patients heath care services and treatment. In SDMH the senior doctors are providing continuous training to every staff.

PROJECT-3

## 3 Role of standard forms and formats for standard data capturing.

PURPOSE:

.To develops standard forms and formats for facilitating patient care in terms of records management.

. To promote a quality culture and plate quality at the core of service delivery .

. To encourage attainment of best practice .

. For standard data capturing for facilitating medical audit under continuous quality improvement programme .

Objectives :

1. To focus on quality of patient case.
2. To improve the performance of all professionals of prate of patients.
3. To monitor, measure, assess and improve performance and to entrance patient satisfaction.
4. To guard, measure and improve patient safety.
5. To in culcate an excellent hygienic treatment process.
6. To involve all employees to participate in improving quality.
7. To search for pattern of non compliances with goals, objectives & standards through:
    1. Problem Identification.
    2. Problem assessment.
    3. Finding the root cause.
    4. Solution Generation.
    5. Plan for the solution implementation.
    6. Implementation of corrective action.
    7. Monitoring.

**Quality requirement :**

For providing comprehensive care both in terms of clinical and non clinical, data capturing in always given para mount importance. Formats and forms are developed oath for managerial and clinical process. As quality always revolves round structured, process and out come so. Information which in retrieved from these forms and formats play a vital role for fudging these out comes like whether care was up to the mark or not.

D.g. surgical site infection in a kind of formats which is required under NABH . This format is helpful in capturing infection rate and also provides information about surgery related infection.

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

FORMS AND FORMATS APPLCABLE TO SDMH:

| Sl.No. | Forms/Formats |
|---|---|
| 1 | Incident reporting |
| 2 | Adverse drug reaction |
| 3 | General consent |
| 4 | Surgical consent |
| 5 | Anesthesia consent |
| 6 | Returnable/Non returnable gate pass |
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| 9 | Patient satisfaction questionnaire |
| 10 | Initial assessment form |
| 11 | Surgical site infection formats |
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| 13 | CPR check list |
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| 15 | Pain assessment score sheet |
| 16 | Various nursing check list |
| 17 | History card for equipments and calibration |
| 18 | Crash cart management check list. |

SDMH maintains documentation of forms and formats of patient and other SDMH describes the changes in forms and formats, its maintains and its control in the computerized system establishes adequate procedures.

Preventive actions :

The medical superintendents (M/S) is perpetually vigilant and identifies potential sources of non compliance and areas that need improvement. These may include trend analysis of specific markers such as turn round time, risk analysis and introducing proficiency testing for self assessment.

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

<u>CORRECTIVE ACTION :</u>

The medical superintendent (M/S) takes all necessary corrective action when any deviation in detected in quality management system.

1. Cause Analysis

   Deviations are detected by:
   1. Patients complains/feedback.
   2. Non compliance receipt of items/sample.
   3. Non compliance at internal/external Quality Audit
   4. Management Reviews

The medical superintendent (M/S) conducts and co-ordinates the detailed analysis of the nature and Root Courses of non compliance along with the responsible persons from the respective sections.

ii) Selection and implementation of corrective actions:

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

iii) Monitoring of corrective actions:

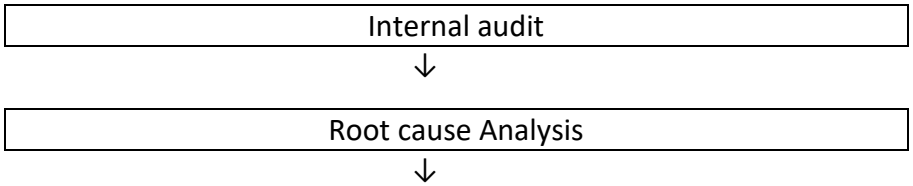
The medical superintendent M/S shall monitor the outcome parameters to assure that corrective actions taken have been effective in eliminating the problem.

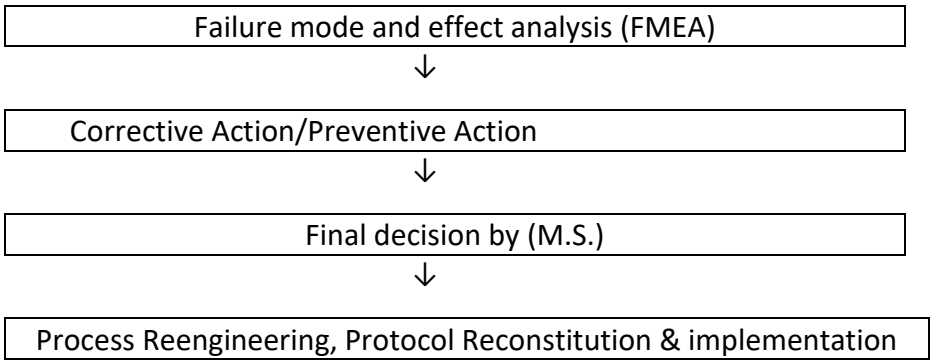
iv) Additional Audits:

When the magnitude of non compliance causes doubts on the departments over all compliance with documented procedure, additional audits are conducted.

v) Flow chart :

These forms and formats play a major role for CQI.






CONCLUSION :

For providing quality care services SDMH of Jaipur of Medical Treatment Cum Medical Research Institute in actively involved. NABH accreditation programme in SDMH Jaipur in the step toward this. It is very much evident that under NABH there are number of activity is required to be completed. When I joined the hospital as internship and dissertation trainee, our hospital was going through number of activities under HABH. After analyzing the status report of NABH activity I felt the urgent improvement of few areas, BMW is one of them during preparation of training schedule of Bio-Medical Waste I felt to initiate a common training programme. Thus the need for training was felt and a required schedule was prepared in which continuous training programme. Thus the need for training was felt and a required schedule was prepared in which continuous training programme was given importance and various trainers were selected and first training was given to them, and there after trainers gave training to rest of the staff.

Standardized form and format were advised by NABH committee in SDMH having those forms & formats that were needed under NABH thus with the help of NABH consultant and NABH co-coordinator required forms and formats were developed and are now being implemented.

As per CQI chapter of NABH, satisfaction survey is required to be conducted and to be monitored every 3 months. So satisfy the need of NABH, a proper questionnaire was developed and survey was conducted successfully conducting this we received number of valuable suggestion and ideas. These ideas were given consideration by the top management. Because of this survey results, Top management was able to improve satisfaction level of staff and patients.

These quality tools are definitely playing vital role in assuring quality and keeping the standards of SDMH at high level.

Table – 5 – Preparation of training programme and essential indicators :

| Sl.No. | Name of availability indicator check list | Yes/No |
|---|---|---|
| F1 | Basic life support/advance life support | |
| 2 | How to transfer patient from stretcher to Bed and from bed to stretcher | |
| 3 | How to use fire extinguishers | |
| 4 | Safe procedure to collect blood samples | |
| 5 | Safe procedure for injection | |
| 6 | Safe procedure to transport blood sample | |
| 7 | Safe procedure for keeping high risk medicines, use of medicines | |
| 8 | Process of handle blood spillage | |
| 9 | Process for recalling medicines | |
| 10 | Chemical spill handling | |
| 11 | Time out procedure in O.T. | |
| 12 | Practice on a avoiding wrong patient and wrong part surgery. | |
| 13 | Laboratory safety practices | |
| 14 | Radiation safety practices | |
| 15 | Segregation method of waste | |
| 16 | Hospital evacuation plan | |
| 17 | Hand washing methods | |
| 18 | Preparing drums for autoclave | |
| 19 | Reporting/filling of adverse drugs/reaction forms | |
| 20 | Discipline | |
| 21 | Management of abusive/violent patient and patient party by securities | |
| 22 | Management of crash cart during emergency. | |
| 23 | Preparation of discharge summary. | |
| 24 | Management of lama cases. | |
| 25 | Preventive maintenance of equipment | |
| 26 | Process of restraints to patient | |
| 27 | Physician/Nurses responsibility during restraints | |
| 28 | Procedure to be observed pre and post application of restraint | |
| 29 | Mission and vision statement of the hospital | |
| 30 | OPD registration procedure | |
| 31 | Indoor admission procedure | |
| 32 | Triage decision | |
| 33 | Labeling and storage of donor blood | |
| 34 | Standard color code for Blood Group | |

| | | |
|---|---|---|
| 35 | Hand washing methods | |
| 36 | Storage of pharmaceutical items. | |
| 37 | ICD coding for medical records | |
| 38 | Filling of records. | |

Quality of structure:

Construction space:

For training activities the hospital (depending upon its size) should have a library, Conference/Seminar rooms and separate training area for nurses, technician, and other categories of staff. This requirement for SDMH staff was fulfilled and they have been provided a central council/Conference hall, Auditorium Where all trainings both (Class room and demonstration related) training is provided.

TOOLS :

The central council committee of SDMH Jaipur is well equipped with all necessary material to support NABH programme. Conference is equipped with LCD PROJECTS, Training films, good sound systems, WIFI Internet and computers system with HIS and some time facility for live demonstration of surgical/other procedure through CCTV)

QUALITY OF PROCESS:-

4. A standard manual
5. Maintenance of previous training records and feedback forms
6. Well trained trainers can be external or internal initially training need analysis of staff was done and among the unit and departments, key person were Identified for providing continuous training to staff of SDMH. This are internal trainers, external trainers were invited for providing special training of various topics. Like ACLS, BCLS, Fire mock drill, disaster mock drills transportation method of patients managing ambulatory patients triage method of patients.

QUALITY OF OUT COME:

1. Increased satisfaction level of patient/staff.

2. Proper resource utilization because trainings of staff enable them to utilize their knowledge and efficiency, this results good will and minimum waste. Initially X-Ray wastage rate was nearly 6% on monthly consumption but after this training activity it came done to nearly three person.

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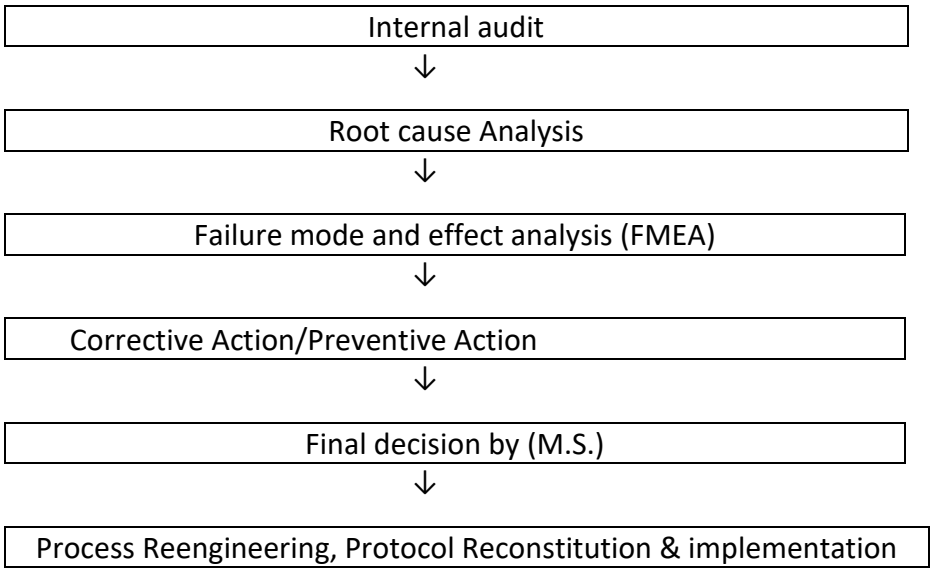
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# REFERENCES :


| Sl.No. | Book Name | Year | Page No. |
|---|---|---|---|
| 1 | SDMH Apex Manual | | |
| 2 | SDMH BMW policy | | |
| 3 | PMEP guide lines for BMW Management | | |
| 4 | NABH guide lines | | |
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| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | Preparation of BMW check list and distributing in all the department. | | | | | | | | | | | | |

# Prepared the draft of hospital signage system:

TRAINING IMPORTED O Prepared the draft of hospital signage system:

TRAINING IMPORTED OF FOLLOWING TOPICS

| S.N. | Training Name | yes | No | Duration of service | Remarks |
|---|---|---|---|---|---|
| 1 | Introduction to N A B H | | | | |
| 2 | On N A B H standards | | | | |
| 3 | Biomedical waste MGT | | | | |
| 4 | Housekeeping service | | | | |
| 5 | Fire management | | | | |
| 6 | Disaster management | | | | |
| 7 | Infection control | | | | |
| 8 | Effective communication | | | | |
| 9 | Nursing services | | | | |
| 10 | Hospital security | | | | |
| 11 | C P R | | | | |
| 12 | M L C in health care | | | | |
| 13 | Induction training | | | | |
| 14 | Continuous training | | | | |

*INVENTORY ANALYSIS A B C / V E D COMPLETED

*UtiliZation study of equipments ,men power is carried out.

* Time analysis completed.

# 1) Bio medical waste questionnaire

SHARING THRUOGHS REGARDING HOSPITAL WASTE MANAGEMENT:

Instructions :

(1) Feed free to tick any one response which you feel is the most appropriate

(2) B M W means biomedical waste.

* Please fill in the following before

* * You place of work (example ICU, OT, WARDS, LAB etc).

- Please fill in the blank@.....

-- Type of the work (please tick):

(1) Doctor

(b) Nursing

(c)Technician

(d) House keeping

(e) Others

LET 'S GET STARTED FIRI ENDS…….

Q.1) what is "Bio hazards"?

(a) Infectious waste

(b) Pathological waste

(c) All hospital waste

(d) Both a and b

Q.2) The symbol for ‘Bio hazard” is (tick one).

Q.3) Out of total hospital waste the percentage (%) hazardous waste in S D M H?

(a) 10 – 15 %

(b) 40 – 50 %

(c) 60 – 70%

(d) 80 – 90 %

Q.4 Health hazards of the B M W include:

(a) Psychological stress

(b) HIV /AIDS

(c) Hepatitis B and Hepatitis C

(d) Skin disease

(e) Cancer

(f)All of the above

Q.5 the B M W management and handling Rules1998 (M&H Rules) have been framed under:

(a) Environment protection act by ministry of environment and health

(b) Environment protection act by ministry of environment and Forest

(c) Environment protection act by ministry of Biomedical waste

(d) Environment protection act by ministry of environment and health and hospitals

Q.6 Failure of comply with the Rules of B M W management may lead to imprisonment and financial implications as under:

(a) 5 years 50,000

(b) 5years Rs100, 000

(c) 10 years Rs 50,000

(d) 10 years Rs100, 000

Q. 7 which of the following have a higher risk of transmission through infected needle?

(a) HIV /AIDS

(b) Hepatitis B

(c)Both have equal chance

(d)None of them gets transmitted through infected needles

Q.8 Energy hospital has to submit annual report about the categories and quantities of B M W handled during the previous year by?

(a) 31stJanuar y every year

(b) 31st Mach every year

(c) 30th April every year

(d) Any time of the year

Q.9) B M W does not include?

(a) Human tissue waste

(b) Expired medicines

(c) Sharps

(d) General waste

Q.10) the first step in the B M W management is?

(a) Segregation at the point of generation

(b) Storage

(c) Transport

(d) Waste treatment and disposal

Q.11) Human body parts are put in color bin?

(a) Yellow

(b) Black

(c) RED

(d) White

Q.12) Used cotton gauze, dressings are put in color bin?

(a) Yellow

(b)Red

(c)Black

(d)White

Q.13) Disposable syringes and catheters are put in color bin?

(a) Yellow

(b)Red

(c)Black

(d)White

Q.14) Discarded and out dated chemo drugs are put in color bin?

(a) Yellow

(b)Red

(c)Black

(d)White

Q.15) Always ensure that the waste bag s before being transported to the B M W curb point is?

(a) Full up to the brim and not tied

(b) Full up to the brim and tied

(c) Half full up to the brim and not tied

(d) Half full up to the brim and tied

(e)Three fourth full up to the brim and not tied

(f)Three fourth full up to the brim and tied

Q.16)A separate life is needed to transport the BMW to the curb point?

(a)Yes

(b)No

(c)Don’t know

Q.17) is it essential to wear personal protective equipment (PET) like gloves, mask and apron etc. while transporting BMW?

(a)Yes

(b)No

(c)Don’t know

Q.18) Infectious waste should not be stored more than the max. Limit of…….hours?

(a)12

(b) 24

(c) 48

(d72

Q.19) SDMH has a bio medical waste management committee?

(a)Yes

(b)No

(c)Don’t know

Q.20 should one cover all the cuts, abrasions and other areas of non intact skin while on duty in the hospital?

(a)Yes

(b)No

(c)Don’t know

Q.21) what is the right action for disposal of large quantity of waste paper?

(a)Burning

(b)Shredding

(c)Non of the above

Q.22)Do you agree with the propaganda about the BMW management being done now a days?

(a)Yes

(b)No

(c)Don’t know

Q.23)A single color Bin good enough to collect all the hospital waste as it would be less comelier some and confusing ?

(a)Yes

(b)No

(c)Don't know

Q.24) Committees like hospital infection control are good only on papers and they hardly severe any practical purpose?

(a)Yes

(b)No

(c)Don't know

Q.25)Hospital BMW management should not be every one's job as everyone has lot of other important job responsibilities in a hospital infect it should be entirely taken care of by the management staff?

(a)Yes

(b)No

(c)Don't know

Q.26) A hospital will run in any case whether we follow BMW management rules or not?

(a)Yes

(b)No

(c)Don't know

Q.27) A Separate lift is needed to transport the hospital waste because?

(a)It will reduce the waiting time for the worker who carries the waste

(b)The waste is infectious

(c)It is a necessary regulation in the hospital waste management rules and practically there is no need for a separate lift at all.

CHECK LIST FOR ADMINISTRATOR ROUNDS OR ALL DIAGNOSIS AND RADIOLOGY

CHECK LIST FOR ADMIN ROUND (OPD)

Name of administrator……. Month of……

| **S.NO.** | Activities | T**ime of visit** | **Room wise status** |
|---|---|---|---|
| A | Housekeeping and clinical activities | | Day…… |
| 1. | Weekly status | | $1^{st}$;$2^{nd}$;$3^{rd}$;$4^{th}$;$5^{th}$;$6^{th}$;$7^{th}$; |
| 2. | Minor OT supervision | | |
| 3. | Doctor availability for respective out patient service | | |
| 4. | Supervision of dispensary | | |
| 5. | Rooms toilet and corridor cleaning,dusting,wet&dry mopping etc. | | |
| 6. | BMW management | | |
| 7. | Sitting arrangement,drinking water arrangement | | |
| B | Administrative Activties | | |
| 1. | Duty Roster of RMO s-maintained | | |
| 2. | Duty Roster of Sweepers-maintained | | |
| 3. | Proper Uniform & Grooming of OT staff | | |
| | | | |

CHECK LIST FOR ADMIN ROUND (OPERATION)

Name of administrator……. Month of……

| **S.NO.** | Activities | T**ime of visit** | **Room wise status** |
|---|---|---|---|
| A | Housekeeping and clinical activities | | Day…… |
| 1. | Weekly status | | $1^{st}$;$2^{nd}$;$3^{rd}$;$4^{th}$;$5^{th}$;$6^{th}$;$7^{th}$; |
| 2. | All aseptic measures followed | | |
| 3. | Fumigation done weekly or required | | |
| 4. | All equipments are in working order | | |
| 5. | Rooms toilet and corridor cleaning,dusting,wet&dry mopping etc. | | |
| 6. | Position of mackintos | | |
| 7. | Handing over of duty of MOs&Nurses | | |
| 8. | Blood Requirement has been fulfilled in time | | |
| 9. | Segregation and disposal of waste, needle, hub cutter location(color coded bags should be kept in one place and capped, needle, syringes are not reused) | | |
| 10. | All medical equipments are working properly and checked | | |
| 11. | Night report register nurses and doctor report-maintained | | |
| 12. | Written consents are taken from patient | | |
| 13. | Hand washing procedure followed (availability of soaps, disinfectant ,water etc. | | |
| B. | Administrative activities | | |
| 1. | Duty Roster of RMOs-maintained | | |

| | | | |
|---|---|---|---|
| 2. | Duty Roster of Nurses-maintained | | |
| 3. | Duty Roster of sweeper-maintained | | |
| 4. | Inventory record of housekeeping material maintained | | |
| 5. | Proper Uniform & Grooming of OT staff | | |

CHECK LIST FOR ADMIN ROUND (PATHOLOGY AND LABORATORY)

Name of administrator……. Month of……

| **S.NO.** | Activities | T**ime of visit** | **Room wise status** |
|---|---|---|---|
| A | Housekeeping and clinical activities | | Day…… |
| 1. | Weekly status | | $1^{st}$;$2^{nd}$;$3^{rd}$;$4^{th}$;$5^{th}$;$6^{th}$;$7^{th}$; |
| 2. | Electrical facility light, fans etc. | | |
| 3. | Security staff visit | | |
| 4. | All equipments are in working order | | |
| 5. | Rooms toilet and corridor cleaning,dusting,wet&dry mopping etc. | | |
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| 5. | Proper Uniform & Grooming of OT staff | | |
| 6. | Sequence of medical reports in case sheet | | |

## Consent for surgery/procedures

Indoor No. ……  Date…….
Diagnosis ……..  Patient Name …….
Operative procedure/operation…….  Age ……..
OPD No. ……..  Gender M/F……..

I ……. (Patient name), given my full consent as an act of my own free will to under go the following surgery/procedures……..at…….(hospital name) under the supervision and guidance of Dr…….. (Doctors name) and his team of assistants, nurses and hospital staff as deemed necessary.

I have been explained in the language known & understood by me about the nature of the surgery/procedure being performed, its benefits and costs, risk associated with it, other alternatives and its prognosis.

I understand that anesthesia of either general/local/spinal/others will be used as deemed necessary and the risks associated with it.

I also consent for any additional procedures/treatment that might arise & needs to be done during the above mentioned surgery procedure.

I further consent and agree to the disposal by the hospital authority of any tissues or parts that may be removed in the course of my treatment at this hospital.

I further consent and agree to hospital for allowing specialist opinion or allowing other hospital's doctor to perform surgery procedure if need arises at the same time they can transfer to other hospital if need arises.

I hereby absolve ……..(Hospital name) and its surgical team & hospital staff of any liability for consequences arising because of the above mentioned surgery/procedures.

Consent of patient representative/surrogate :

This patient is unable to consent because …….. and hence I, ……. (Name/relationship with patient) therefore given my consent on behalf of the patient after discussion with the Doctor for the above mentioned surgery/procedure.

| | Name | Signature | Date | Time |
|---|---|---|---|---|
| Patient/Patient surrogate | | | | |
| Witness | | | | |
| Doctor | | | | |
| Interpreter | | | | |

Surgical site infection :

Date :……..
Name of Doctor:…….

Ward :……
Patient :

Name :……..
Age :……  Sex : ……
Date of admission:……
Operation:

Date of operation:……
Operation :…….
Wound Class :……..

Clean :……
Contaminated:……..
Dirty……

Duration of operation :…….

| | |
|---|---|
| Urgent: ……. | Yes |
| Non-urgent: ……. | Yes |
| Prosthesis: ……. | Yes |
| G.I. Surgery: ……. | Yes |

Other surgery (if any mention it):……

Antibiotics :

Starting Date :……

Duration : ……

Surgical site infection :

| | | |
|---|---|---|
| Infection site : ……. | Yes | No |
| Sample collection: ……. | Superficial | Deep |

Signature of Doctor

# Pain Assessment Score Sheet

Name of patient : Age :

Sex : M/F
I.P. No./Bed No.:
UHID:
Description:
……
……
……
……
……
……
……

Pain scale :

| | | | |
|---|---|---|---|
| Zero (0) | No pain | ( | ) |
| 1-3 | Mild Pain | ( | ) |
| 4-6 | Moderate Pain | ( | ) |
| 7-10 | Sever Pain | ( | ) |

Signature (of duty nurses)

Date :

Time :

Post-sedation recovery score sheet :

Name of the patient :……. Age :…….
Sex : ……
I.P. No./Bed No.:……
UHID :……..
Description :
……
……..

| Patient Sign | | Score |
|---|---|---|
| Consciousness | Awake, responds easily, A&OX3(or returned to base line) | 3 |
| | Respond readily, but easily falls asleep | 2 |
| | Arousable, but not readily | 1 |
| | No, Responding | 0 |
| Respiratory | Breath easily with adequate volume | 3 |
| | Slightly decreased rate and/or volume | 2 |
| | Labored or limited respiration | 1 |
| | Apnea or in adequate ventilation | 0 |
| Circulatory | B.P. and pulse within lease line limits | 2 |
| | B.P. and pulse approaching lease line limits | 1 |
| | Abnormally high or low B.P. and/or | |
| | Abnormally fast or slow pulse | 0 |
| Activity | Abb to more extremities voluntarily or on | |
| | Command (or returned to base line) | 2 |
| | Voluntory movement non purposeful | 1 |
| | Unable to lift head or head or more extremities | 0 |

Adult Score for discharge into or when released by a physician/dentist

Signature
Doctor (JR/SR/Consultant)

Signature duty Nurse
Date : …….
Time : ……

Pain Assessment Score sheet for Pediatric :

Name of patient :
Sex : M/F
In No./Bed No. :
UHID :
Description :
……
……

Pain scale :

| | | | |
|---|---|---|---|
| Zero (0) | No Pain | ( | ) |
| 1-4 | Mild Pain | ( | ) |
| 5-6 | Moderate Pain | ( | ) |
| 7-10 | Severe Pain | ( | ) |

Signature (duty nurse)

Date:

Time :