SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

QUALITY IMPROVEMENT MANUAL

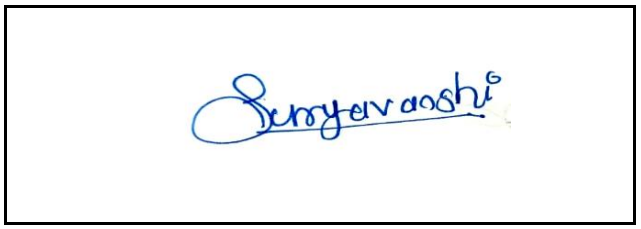
SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

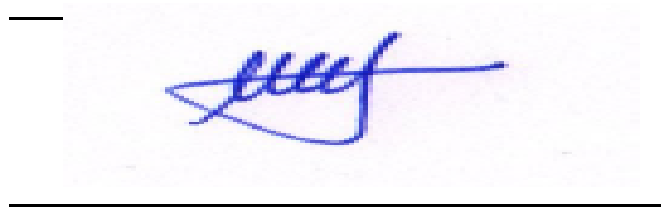
Annual Documents adequacy & Change Requirements Review

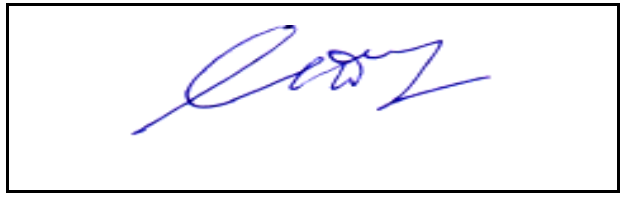
Sr.No	SOP /Doc No	Documents Name	Issue. No	Rev.No	Review Date	Change	Rev No	Revision Date	Reason for Change	Amendment
1	SDH/QIM/01	Content	1	0	20-Nov-22	No Any change review completed	0	20-Nov-23	No Any change review completed	No Any Amendment History
2		QPS- Organization Chart	1	1	20-Nov-22		1	20-Nov-23		
3		Roles and Responsibility	1	1	20-Nov-22		1	20-Nov-23		
		Standard Operating Procedure			20-Nov-22			20-Nov-23		
4		QI Committee	1	0	20-Nov-22		0	20-Nov-23		
5		QI Program	1	0	20-Nov-22		0	20-Nov-23		
6		Accreditation Co-ordinator	1	0	20-Nov-22		0	20-Nov-23		
7		Internal Quality Audits	1	0	20-Nov-22		0	20-Nov-23		
8		Nursing care Audit	1	0	20-Nov-22		0	20-Nov-23		
9		Key Performance Indicators Definitions	1	1	20-Nov-22		1	20-Nov-23		
10		Clinical Audits	1	1	20-Nov-22		1	20-Nov-23		
		Records								
		Annexure								

		Original Date	Effective Date	Next date of revision		Issue NO		
		01-Nov-21	**20 November 2023**	**20 November 2024**		1		

Reviewed & Prepared By	Recommended By	Approved By
Mrs.Shraddha suryavanshi	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director







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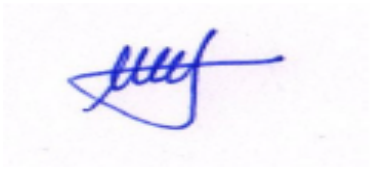
Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director

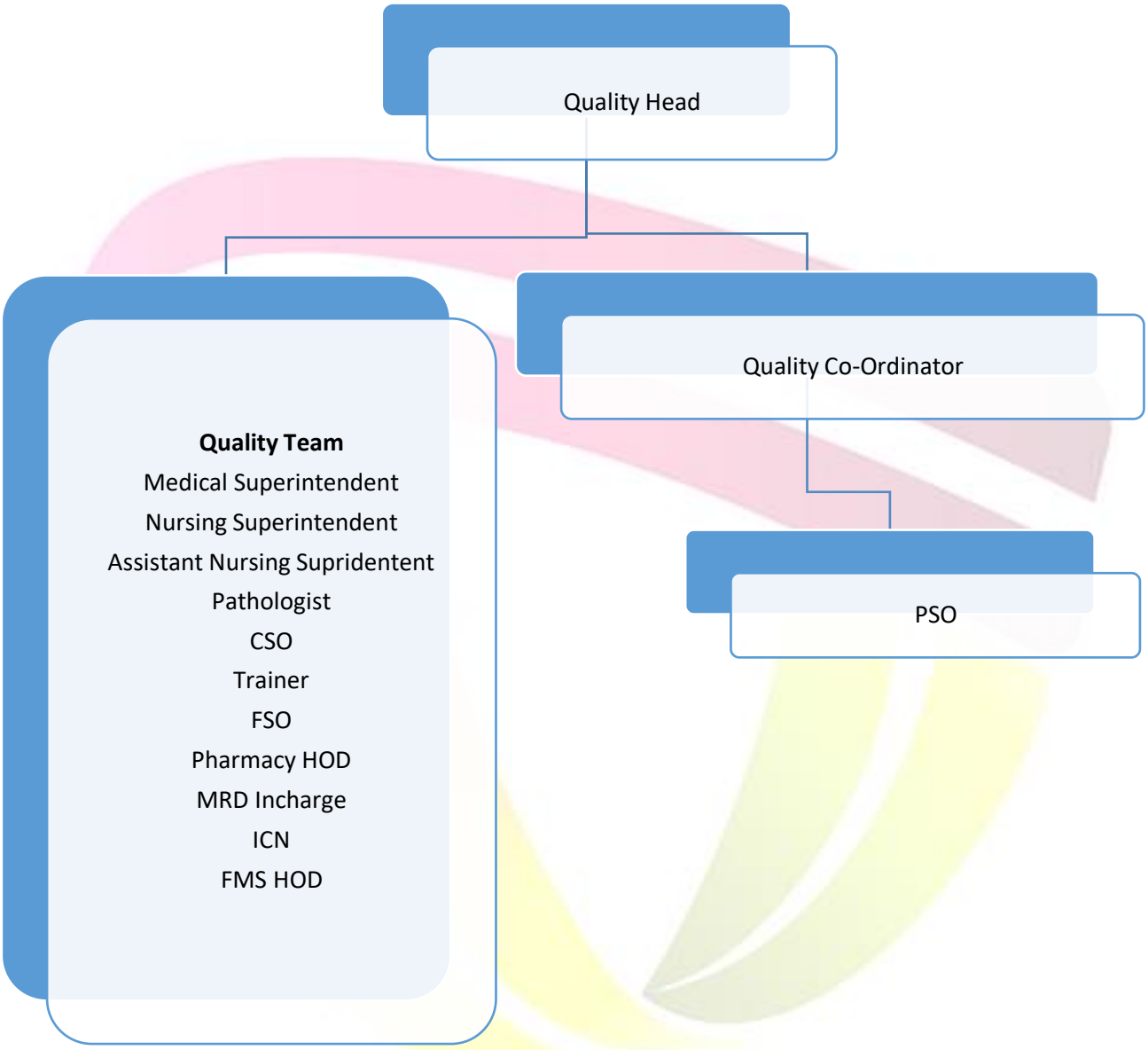


	SAIDEEP HOSPITAL QUALITY MANUAL	Doc No	SDH/LAB/01
		Issue No	01
		Rev No.	01
		Date	15/10/2021
		Page	1
	Amendment Sheet		

Sr. No	Page No	Clause No	Date of Amendment	Amendment Made	Reasons	Signature of Approval Authority
01.						

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S. S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepal Chairman & Managing Director	



Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepal Chairman & Managing Director	

JOB DESCRIPTION

DESIGNATION: Quality Co-Ordinator	**REPORTING TO**: Chief Admin& HR Manager
DEPARTMENT: Administration	**RESPONSIBLE FOR:** Responsible for Quality audits, Quality improvement plans, quality indicators & quality meetings as per NABH norms.
QUALIFICATION: Graduate with Certification course in NABH quality improvement.	**TO BE REVIEWED**: 1st April every year
SKILLS SET REQUIRED: Leadership, good communication, supervision.	

RESPONSIBILITIES AND ACCOUNTABILITIES:

- To conduct medical, documentation and process audits periodically to ensure adherence to the various processes and protocols.
- To ensure that the quality indicators are collected and mapped correctly.
- To present the analysis of the data compiled.
- To ensure that the quality improvement plans are implemented.
- Conduct quality meetings.
- To focus on areas where the quality indicators show low performance Meetings & Reports.
- NABL/NABH Audit
- To assist the reporting head in different activities, as and when directed from time to time.
- To give soft skill training to staff

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S. S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

JOB DESCRIPTION	
DESIGNATION: Safety officer	**REPORTING TO**: Administrative Officer
DEPARTMENT: Safety	**RESPONSIBLE FOR**:, Directing the planning and development of the safety program and the issuance of directives and recommendations concerning accident prevention.
QUALIFICATION: HSC & Diploma (Fire & Safety)	**TO BE REVIEWED**: 1st April every year
SKILLS SET REQUIRED: Should be fluent in Hindi, English, Marathi, good communication and basics of computer.	

RESPONSIBILITIES AND ACCOUNTABILITIES:

- Develop and implement a comprehensive safety program which provides for the following;
- Regular and periodic facility and equipment inspections.
- Investigation of employee job-related accidents.
- Educational and training programs for supervisors and employees. Programs to promote increased safety awareness and accident prevention throughout the campus
- Reports to the General Manager Operations on a weekly basis the status of the safety program.
- Accumulate, maintain, and analyse accident records.
- Communicating and coordinating with the other interfacing teams such as Infection Control Committee, Radiation Safety Committee and Laboratory Safety team

PURPOSE AND SCOPE

The purpose of this document is to specify the role and functioning of the Quality Improvement Committee

RESPONSIBILITIES

Managing Director

The overall responsibility of implementing the policy rests with the MD of the hospital.

PROCEDURE

The detailed Terms of Reference of the Quality Improvement Committee describing composition, responsibilities and functioning is a part of the Hospital Policy Manual.

The Accreditation Coordinator of the hospital as the Member Secretary / Convenor of the QI Committee is responsible for conducting the committee activities and maintaining its records. The hospital QPS Team supports him in this process.

RECORDS

- Minutes of Meetings / Proceedings

PURPOSE AND SCOPE

The purpose of this document is to describe the Quality Improvement Program of the Hospital and its components

RESPONSIBILITIES

Accreditation Coordinator / QPS Team

The overall responsibility of developing and implementing the QI program lies with the Accreditation Coordinator supported by the QPS team of the hospital

PROCEDURE

Processes for improvement shall be accomplished using the various quality improvement models to address problems as they are identified. Review of all plans shall be no less than annually and may be revised throughout the year as necessary.

The objectives of the Quality Improvement Program are to assure the following:

- Clinical and administrative staffs monitor and evaluate the quality of patient care and clinical performance, including proactive risk assessment of selected high-risk processes and report information to the Quality Management Committee for action.
- Identified problems shall be tracked to assure improvement or resolution through redesign of the process.
- Information from Departments/Services related to tested and implemented process findings of discrete performance improvement activities shall be used to detect trends, opportunities to improve, or potential problems.
- The objectives, scope, organization, and effectiveness of the redesigned processes shall be evaluated annually and revised as necessary to ensure effectiveness is maintained over time.

The quality improvement program at Saideep Hospital is constituted by the following key components / activities;

Internal Audits / Assessments	- Identification of areas of concern through audits by NABH trained multi-disciplinary audit team (cross departmental) - Covers all departments, units and key processes - CAPA based on audit findings for improvement	3 rounds a year (2 rounds mandatory) 4-6 months interval
Key Performance / Quality Indicators Program – Clinical & Managerial Indicators	- Quantitative indicator based tracking of structure, process and outcomes of clinical and managerial process - Aimed at monitoring processes trends and identify opportunities for improvement - Selection of indicators based on NABH standards and own developed indicators	- Continuous tracking - Collated, trended and analyzed on monthly, quarterly and annual basis
Patient Complaints , Grievances and Feedback Management System	- Multi-modality patient grievances and complaints tracking system - IP and OP feedback surveys	- Continuous - Surveys collated on monthly basis
Clinical Audit System	- Retrospective / concurrent audit of clinical processes and system with a defined checklist - Encompass all aspects of clinical and nursing care	- 2-3 cycles of audits a year
Nursing Audit	- Nursing team lead audits of	- Concurrent

	patient care processes to improve quality of nursing care practices	
Out Sourced Services Management System	- Audits and monitoring process of outsources services based on parameters specified in the outsources agreements / Service Level Agreements	- As specified in out sourced agreements
Documents and Records Management	- Tracking system for all clinical and non-clinical documents and records used by the organization ensuring standardization	- Concurrent
External Audits – NABH	- External standards compliance audits by NABH Assessors - CAPA based on audit finding and long term systems improvement based on NABH standards and guidelines	- 18 months intervals
Quality Improvement Projects	- Specific goal oriented improvement projects using P-D-C-A methodology targeting specific identified areas of improvement - Lead by QPS Team	- 3-4 QI projects every year

RECORDS

- Minutes of Meetings / Proceedings

PURPOSE AND SCOPE

The purpose of this document is to describe key roles and responsibilities of the QI Coordinator / Accreditation coordinator

RESPONSIBILITIES

Managing Director

The overall responsibility of appointing and monitoring the activities of the QI Coordinator / Accreditation Coordinator lies with the Managing Director

PROCEDURE

Saideep Hospital has designated a staff members as the QI Coordinator / Accreditation Coordinator with sufficient authority and specified responsibilities

The key responsibilities of the QI Coordinator / Accreditation Coordinator as as given below

1. To over see the QI program of the hospital with support from QPS team members
2. To over see the documents and records management system
3. To support the QI Committee in its functioning
4. To regularly monitor and receive feedbacks from departments regarding status of their work related to accreditation preparation.
5. To plan and execute regular assessment of the Hospital in accordance with accreditation standards.
6. To coordinate all such activities required for quality assurance and continuous monitoring of the hospital.

The detailed scope of role of the QI Coordinator and his relationship with other stakeholders is specified in the Roles & Responsibility section of this manual

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

RECORDS

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Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

PURPOSE

To determine the conformity or nonconformity of the quality system elements with the specified requirements of NABH standards, hospital documentation and implementation requirements.

SCOPE

This procedure shall be applicable for the audit of all functions of the hospital

RESPONSIBILITIES

The Quality Improvement Coordinator shall be responsible for planning, coordinating and reporting the outcome of internal quality audits.

Trained quality auditors shall be responsible for auditing as per plan, report non-conformities and for the follow-up verification of corrective actions.

The Functional Heads shall be responsible for analyzing the non-conformities and deciding and implementing corrective actions in their functional areas.

The Quality Improvement Committee shall be responsible for reviewing the outcome of internal quality audits and to verify suitability and effectiveness of the quality system.

PROCEDURE

4.1 Audit Planning

The Quality Improvement Coordinator shall prepare an Annual Audit Plan function wise (Refer attached format).

Each function shall be audited at least three times in a year. The frequency shall also be dependent on any organizational changes, reported deficiencies and any such aspects.

He/she shall prepare a detailed Audit Schedule (Refer attached format) for each round of audits and shall intimate the auditees and auditors well in advance.

4.2 Auditors

Auditors shall have completed at least secondary education and should have demonstrated competence in clearly expressing concepts and ideas orally and in writing.

Auditors shall be trained to the extent necessary to ensure competence in the skills required for carrying out audits and for managing audits.

4.3 Carrying Out The Audit

Assigned auditors shall carryout objective evaluation of the quality system during the audits.

The auditing shall include

- NABH Standards Compliance
- organizational structure of the function
- administrative and operational procedures
- personnel, equipment and material resources
- work areas, operations and processes
- degree of conformance of services being rendered
- documentation, reports, record-keeping

Personnel carrying out audits of quality system elements shall be independent of the specific activities or areas being audited.

5.4 Reporting And Follow-Up Of Audit Findings

Auditors shall report the audit findings (non conformances observed) and recommendations through a Nonconformance Report (Refer attached format) to the personnel responsible for the function being audited and to the Quality Improvement Coordinator.

The report shall cover

- specific examples of non conformity and possible reasons for such nonconformity, where evident,
- suggestion for corrective action in consultation and agreement with the auditee responsible,
- implementation and effectiveness of corrective actions suggested in the previous audits.

5.5 Concluding and Reporting For Management Review

The Quality Improvement Coordinator shall finalise and summarize the findings of the Internal Audit and convey the same to all concerned at the closing meeting. All auditors shall thereafter sign the Audit Summary.

RECORDS

Record Code	Record	Format	Responsibility	Indexing	File No	Minimum Retention Period
R-IQA-01	Annual Audit Plan	Manual	Quality Improvement Coordinator	NA	IQA/F01	Till Obsolete
R-IQA-02	Audit Schedule	Manual	Quality Improvement	Schedule-wise	IQA/F02	1 Year

			Coordinator			
R-IQA-03	Nonconformance Report	Manual	Quality Improvement Coordinator	Alphabetical Order	IQA/F03	1 year after closing
R-IQA-04	Audit Summary	Manual	Quality Improvement Coordinator	Order of Audits	IQA/F04	3 Years

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

PURPOSE AND SCOPE

The purpose of this document is to describe the process of Nursing Care Audits

RESPONSIBILITIES

Nursing Superintendent

The overall responsibility of the conduct of the Nursing Care Audit lies upon the office of the Nursing Superintendent

PROCEDURE

4.1 Audit Planning

The Nursing Care Audit is a concurrent process and regular audits are done. A monthly schedule is published and shared with the audit team and various nursing units. The audit schedule would consists of planned audits and surprise audits. In case of surprise audits the audit areas / nursing units will not be specified in the schedule

4.2 Auditors

Auditors are selected from among senior nursing staff.

Auditors shall be trained to the extent necessary to ensure competence in the skills required for carrying out audits and for managing audits.

4.3 Carrying Out The Audit

Assigned auditors shall carryout objective evaluation of the nursing care audits as per pre-existing audit tools / questionnaires.

The scope of the nursing care audit may be determined as specified below;

Vertical Audits – Complete audits of selected nursing care under a nursing units covering all aspects of nursing care

Horizontal / Thematic Audits – Focus audits on specified aspects of nursing care in a specified location or across locations – Medication management, infection control, specific high risk procedures like Central Line Insertions etc

Audit checklists for each team shall be developed by nursing team in consultation with QPS team

Personnel carrying out audits of a nursing unit or thematic area shall be independent of the specific activities or areas being audited.

5.4 Reporting Of Audit Findings

Auditors shall report the audit findings marked in the audit check lists to the Nursing Superintendent. The nursing team will collate the CA/PA required and follow up with the units where non-conformities was observed.

A summary report of nursing audits shall be submitted to the QI Committee on a monthly basis through the QPS team.

The report shall cover

- specific examples of non conformity and possible reasons for such nonconformity, where evident,
- quantitative analysis of trends evident from various thematic audits
- Suggestions for improvements.

RECORDS

- Nursing Audit Checklists
- Nursing Audit Reports

SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	**SAIDEEP HOSPITAL**	Doc No	SDH/QIM/4.6
		Issue No	01
	QUALITY IMPROVEMENT MANUAL	Rev No.	01
		Date	1 Nov 21
		Pages	1
	Key Performance Indicator Definitions		

No	Indicator	Standard Reference	Formula	Source of Data	Responsibility	Verification Method and Frequency
1	Time taken for initial assessment of Indoor Patients	PSQ 3 a	As per NABH Standards 5th Edition	Case Sheet Audits	MR Audit Team	Sample Audit - Quarterly
2	No of reporting errors / 1000 investigations	PSQ 3 a	As per NABH Standards 5th Edition	Lab Records / Radiology Records	Clinical Laboratory / Radiology	Raw Data Audit - Quarterly
3	Percentage of adherence to safety precautions by staff working in diagnostics	PSQ 3 a	As per NABH Standards 5th Edition	Audit Forms	Quality Dept	Verified from source

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Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

4	Medication Errors Rate	PSQ 3 a	As per NABH Standards 5th Edition	Incident Report / Prescription Audit	Quality Team	Sample Audit - Quarterly
5	Percentage of of medication charts with errors prone abbreviations	PSQ 3 a	As per NABH Standards 5th Edition	Case sheet Audit	Case Sheet Audit Team	Sample Audit - Quarterly
6	Percentage of patients developing adverse drug reactions	PSQ 3 a	As per NABH Standards 5th Edition	Adverse drug reaction form	All patient Care Staff / QPS Team	Checking of raw data forms
7	Percentage of unplanned return to OT	PSQ 3 a	As per NABH Standards 5th Edition	OT Records	General OT OT Team / Cardiac OT Team	Checking of raw data forms
8	Percentage of re-scheduling of surgeries	PSQ 3 a	As per NABH Standards 5th Edition	OT Records	General OT OT Team / Cardiac OT	

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					Team	
8	Percentage of cases where the organization procedure to prevent adverse events like wrong site, wrong patient and wrong surgery have been adhered to	CQI 3e	Number cases rescheduled / No of patients operated * 100	OT Records	General OT OT Team / Cardiac OT Team	
9	Percentage of Transfusion Reactions	PSQ 3 a	As per NABH Standards 5th Edition	Transfusion Registers	Nursing Units / Wards	Audit of raw data
10	Standardized Mortality Ratio for ICU	PSQ 3 a	As per NABH Standards 5th Edition	ICU Case Sheets	MRD Team	Random Sample Audit of Raw Data Form - Quarterly
11	Return to ED with in 72 hours with similar presenting complaints	PSQ 3 a	As per NABH Standards 5th Edition	ED Records	ED Team	Checking of raw data forms

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

12	Incidence of hospital associated pressure ulcers after admission (Bed sore per 1000 patient days)	PSQ 3 a	As per NABH Standards 5th Edition	Incident Reports	Nursing Units / Wards	Checking of Raw Data forms
13	Catheter Associated Urinary Tract Infection Rate	PSQ 3 b	As per NABH Standards 5th Edition	Catheterization Registers & CAUTI Reports	Nursing Units / Wards	Checking of raw data forms
14	Ventilator Associated Pneumonia Rate	PSQ 3 b	As per NABH Standards 5th Edition	Ventilation Registers & VAP Reports	Nursing Units / Wards	Checking of raw data forms
15	Central Line Associated Bloodstream Infection Rate	PSQ 3 b	As per NABH Standards 5th Edition	Central Line Registers & VAP Reports	Nursing Units / Wards	Checking of raw data forms
16	Surgical Site Infection Rate	PSQ 3 b	As per NABH Standards 5th Edition	OT Registers & SSI Reports	Nursing Units / Wards	Checking of raw data forms

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar		Dr. S.S. Deepak	
Chief Medical Administrator		Chairman & Managing Director	

17	Hand Hygiene Compliance Rate	PSQ 3 b	As per NABH Standards 5th Edition	ICN Observation Audit	HIC Team	Sample audit - quarterly
18	Percentage of cases who received appropriate prophylactic antibiotics within specified time frame	PSQ 3 b	As per NABH Standards 5th Edition	OT Records	General OT OT Team / Cardiac OT Team	Checking of raw data forms
19	Percentage of re-scheduling of surgeries	PSQ 3 c	As per NABH Standards 5th Edition	OT Records	General OT OT Team / Cardiac OT Team	
20	TAT for issue of blood and blood components	PSQ 3 c	As per NABH Standards 5th Edition	BSU Record / Outsourced Blood Register	BSU	Checking of raw data sources

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Chief Medical Administrator		Chairman & Managing Director	

21	Nurse patient ratio for ICU and wards	PSQ 3 c	As per NABH Standards 5th Edition	Nursing Registers	NS Office	Checking of raw data sources
22	Waiting time for out-patient consultations	PSQ 4 c	As per NABH Standards 5th Edition	HIS	Hospital Admin	Sample audit
23	Waiting time for s diagnostics	PSQ 4 c	As per NABH Standards 5th Edition	HIS	Hospital Admin	Sample audit

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Chief Medical Administrator		Chairman & Managing Director	

24	Time taken for discharge	PSQ 4 c	As per NABH Standards 5th Edition	Case sheet Audit	MR Audit team	Sample audit - quarterly
25	Percentage of medical records having incomplete and improper consent	PSQ 4 c	As per NABH Standards 5th Edition	Case sheet Audit	MR Audit team	Sample audit - quarterly
26	Stock out of emergency medications	PSQ 4 c	As per NABH Standards 5th Edition	Incident reports	Quality Team	Audit of raw data
27	Number of variations observed in mock drills	PSQ 4 d	As per NABH Standards 5th Edition	Mock audit reports	Patient Safety Officer	Audit of raw data
28	Patient fall Rate (Fall per 1000 patient days)	PSQ 4 d	As per NABH Standards 5th Edition	Event Reports	All Staff	Audit of raw data

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29	Percentage of near misses	PSQ 4 d	As per NABH Standards 5th Edition	Event Reports	All Staff	Audit of raw data
30	Incidence of needle stick injuries	PSQ 4 d	As per NABH Standards 5th Edition	Event Reports	All Staff	Audit of raw data
31	Appropriate handovers during shift change (Doctors and nurses)	PSQ 3 d	As per NABH Standards 5th Edition	Nursing Records	Nursing	Sample audit of raw data
32	Compliance rate to Medication prescription in Capitals	PSQ 3 d	As per NABH Standards 5th Edition	Prescription Audit	Quality Team	Review of audit data

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

PURPOSE AND SCOPE

The purpose of this document is to describe the process of Clinical Audits

RESPONSIBILITIES

Nursing Superintendent

The overall responsibility of the conduct of the Nursing Care Audit lies upon the office of the Nursing Superintendent

PROCEDURE

4.1 Audit Planning

The Nursing Care Audit is a concurrent process and regular audits are done. A monthly schedule is published and shared with the audit team and various nursing units. The audit schedule would consists of planned audits and surprise audits. In case of surprise audits the audit areas / nursing units will not be specified in the schedule

4.2 Auditors

Auditors are selected from among senior nursing staff.

Auditors shall be trained to the extent necessary to ensure competence in the skills required for carrying out audits and for managing audits.

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5.4 Reporting Of Audit Findings

Auditors shall report the audit findings marked in the audit check lists to the Nursing Superintendent. The nursing team will collate the CA/PA required and follow up with the units where non-conformities was observed.

A summary report of nursing audits shall be submitted to the QI Committee on a monthly basis through the QPS team.

The report shall cover

- specific examples of non conformity and possible reasons for such nonconformity, where evident,
- quantitative analysis of trends evident from various thematic audits
- suggestions for improvements.

RECORDS

- Nursing Audit Checklists
- Nursing Audit Reports