SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

PSQ

Chapter Book

SAIDEEP
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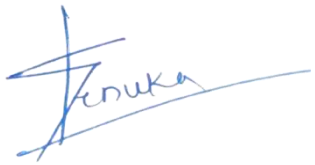
Annual Documents adequacy & Change Requirements Review

Sr. No	SOP /Doc No	Documents Name	Issue No	Rev. No	Review Date	Change Rev No	Change Rev No	Revision Date	Reason for Change	Amendment
1	SDH/PSQ/1.A	The Patient Safety programmed is developed, implemented by a multi- disciplinary safety committee.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
2	SDH/PSQ/2.A	The Quality improvement programmed is developed, implemented and by a multi-disciplinary committee.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
3	SDH/PSQ/2.B	The Quality improvement programmed is comprehensive and covers all the major elements related to quality assurance.	1	2	1-JAN-25	Amended as per 6th edition	2	1-JAN-26	No Any change review completed	No Any Amendment History
4	SDH/PSQ/2.E	There is a designated individual for coordinating and implementing the quality improvement programmed.	1	2	1-JAN-25	Amended as per 6th edition	2	1-JAN-26	No Any change review completed	No Any Amendment History
5	SDH/PSQ/2.F	The quality improvement programmed identifies opportunities for improvement based	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History

		on the review at pre defined intervals.								
6	SDH/PSQ/2.H	Audits are conducted at regular intervals as a means of continues monitoring.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
7	SDH/PSQ/2.I	There is an established process in the organization to monitor and improvement in the quality of nursing care.	1	2	1-JAN-25	Amended as per 6th edition	2	1-JAN-26	No Any change review completed	No Any Amendment History
8	SDH/PSQ/7.A	The organization implements an incident management system.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
9	SDH/PSQ/7.B	The organization has a mechanism to identify sentinel events.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History

Original Date	**Effective Date**	**Next date of revision**	**Issue NO**
01 Nov 21	**01 JANUARY 2026**	**01 JANUARY 2027**	**1**

Reviewed & Prepared By	**Recommended By**	**Approved By**
Mrs. Renuka Sonawane	**Dr. H. Kalgaonkar**	**Dr. S. S. Deepak**
Quality Coordinator	**Quality Head**	**Chairman & Managing Director**
		

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7	SDH/PSQ/2.H	There is an established process in the organization to monitor and improvement in the quality of nursing care.	1	1	1-JAN-23	No Any change review completed	1	1-JAN-24	No Any change review completed	No Any Amendment History
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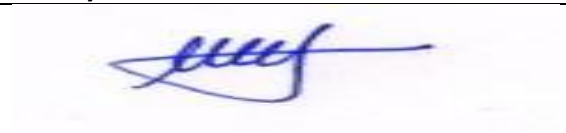
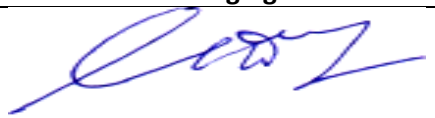
Original Date	**Effective Date**	**Next date of revision**	**Issue NO**
01 Nov 21	**01 JANUARY 2024**	**01 JANUARY 2025**	**1**

Reviewed & Prepared By	**Recommended By**	**Approved By**
Mrs. Shraddha Suryavanshi	**Dr. H. Kalgaonkar**	**Dr. S. S. Deepak**
Quality Coordinator	**Quality Head**	**Chairman & Managing Director**
		

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/PSQ/
		Issue No	02
		Rev No.	01
		Date	01JAN 2026
		Pages	1

Sr.No	Policy Name	Reference No
1	The patient-safety programme is developed, implemented and maintained by a multi-disciplinary safety committee.	PSQ 1.A
2	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.	PSQ 2.A
3	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance.	PSQ 2.B
4	There is a designated individual for coordinating and implementing the quality improvement programme.	PSQ 2.E
5	The quality improvement programme identifies opportunities for improvement based on the review at pre-defined intervals.	PSQ 2.F
6	Audits are conducted at regular intervals as a means of continuous monitoring.	PSQ 2.H
7	There is an established process in the organisation to monitor and improve the quality of nursing care	PSQ 2.I
8	The organisation implements an incident management system.	PSQ 7.A
9	The organisation has a mechanism to identify sentinel events.	PSQ 7.B

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – PSQ 1.A

The patient-safety program is developed, implemented and maintained by a multi-disciplinary safety committee.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

1.0 POLICY

All Patient Care Services Staff shall use every reasonable precaution to provide a safe environment to the patients.

2.0 PURPOSE

This Safety Management Plan serves to describe the policies and processes in place to minimize safety risks to patients and staff through a comprehensive hazard surveillance program and analysis of aggregate information.

3.0 DEFINITION:

Safety Programme- A Programme focused on patient, staff and visitors safety.

Adverse Event- An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care.
Adverse events may be preventable or non-preventable.

No Harm- This is used synonymously with Near Miss. However, some authors draw a distinction between these two phrases.
A Near Miss is defined when an error is realized just in the nick of the time and abortive action is instituted to cut short its translation. In the NO Harm scenario the error is not recognized and the deed is done but fortunately for the health care professional, the expected adverse event does not occur. The distinction between the two is important and is best exemplified by reaction to administered drugs in allergic patients. A prophylactic injection of Cephalosporin may be stopped in time because its suddenly transpires that the patient is known to be allergic to penicillin (Near Miss).
If this vital piece of information is overload and the Cephalosporin is administered, the patient may fortunately not develop an anaphylactic reaction (No Harm Event)

Sentinel Event- A relatively infrequent, unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.
Major and enduring loss of function refers to sensory, motor, physiological or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.

4.0 ABBREVIATION:

HOD – Head of the Department
ID- Identity
BME- Bio Medical Engineer
WHO- World health organization

5.0 SCOPE:

The Safety Management Plan defines the mechanisms for controlling hazards, promoting and implementing safety measures for the patients, staff in particular and the hospital in general.

6.0 RESPONSIBILITY:

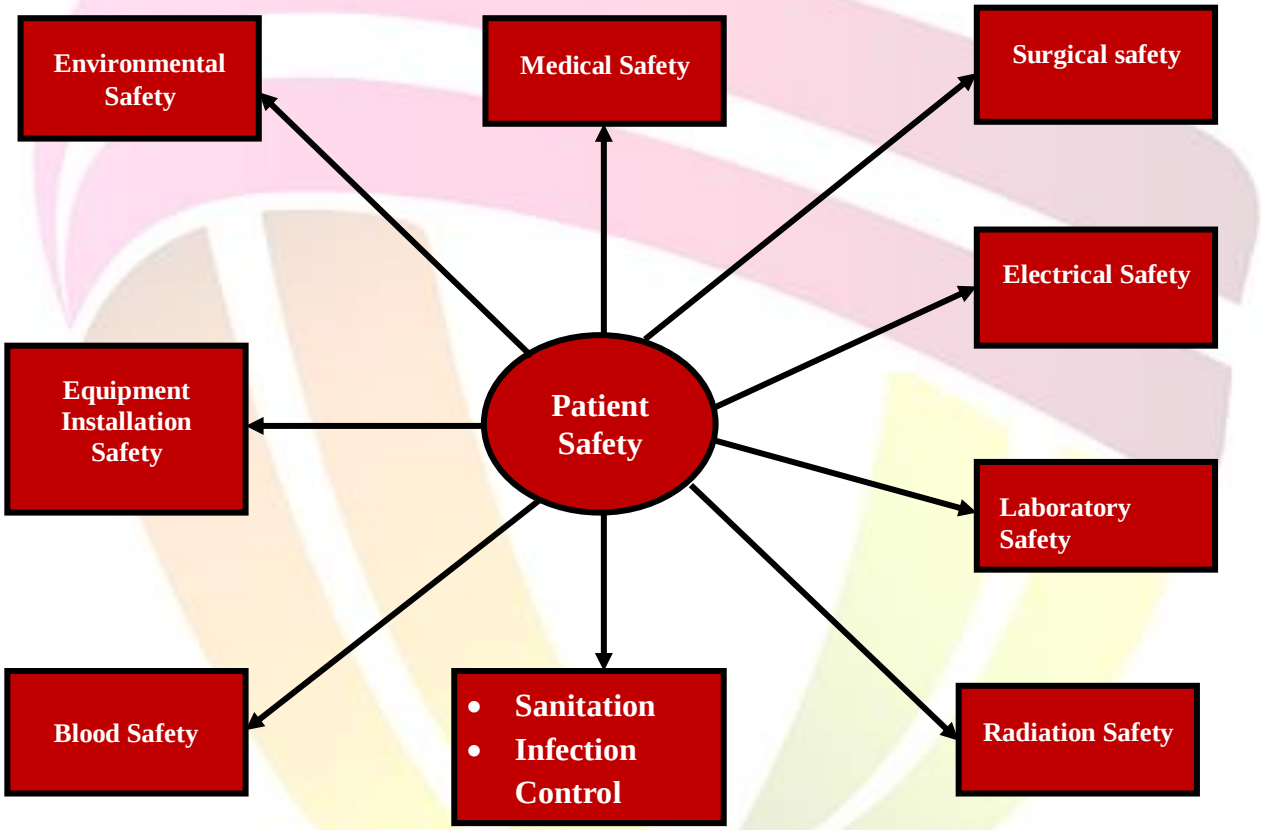
Hospital Management and Safety Committee

7.0 DISTRIBUTION:

Hospital Wide

8.0 PROCEDURE:
PATIENT SAFETY

All Patient Care Services Staff shall use every reasonable precaution to provide a safe environment to the patients.



Responsibility: Safety officer, all health care providers and patients.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

Process:

The precautions listed herein should not be considered to be all inclusive, as safe practice requires sound judgment in individual situations and constant awareness of the environment.

1) General Precautions

a) All patients shall be oriented to the clinical area(s). Orientation shall include the following:

- **i)** Room number and unit layout.
- **ii)** Call bells and how to request assistance.
- **iii)** Bed operation.
- **iv)** Visiting hours, as applicable.
- **v)** Patients wear foot coverings when out of bed. Non-skid shoes or slippers shall be encouraged.
- **vi)** All staff shall wear photo I.D. badges when on duty.
- **vii)** The patient care area and waiting hall shall be clean, well-lighted, and free from clutter.
- **viii)** The floor shall be clean and dry. Appropriate signage is in place when floor is wet.
- **ix)** Patient beds and treatment tables shall be kept at the lowest possible height except when elevated for delivery of care and when the staff member is continuously at the bedside (e.g., intensive care units).
- **x)** Supplies, machines, and equipment shall be stored in designated areas. Equipments not in use shall be promptly returned.
- **xi)** Patient care equipment shall be inspected and labeled by the Biomedical Department prior to initial use and according to Preventive Maintenance Schedules.

b) Broken or malfunctioning equipment

- **i)** The equipment shall be removed from clinical area
- **ii)** The breakdown shall be reported immediately to the BME Department.
- **iii)** All spills shall be cleaned immediately according to applicable guidelines for the type of spill.
- **iv)** Each staff member shall continuously assess for unsafe conditions and takes appropriate corrective action.

v) "Near misses", accidents, and occurrences (patients, visitors, and staff) shall be immediately reported to Quality department in an incident reporting form.

2) Identification Bands:

a) They shall be used when the patients are admitted in the hospital
b) The identification band shall be placed on the wrist of inpatients.
c) If the patient's medical condition prohibits the application of the identification band to the patient's wrist or ankle, the identification band shall be attached to a visible part of the patient's body using tape appropriate to the patient's condition/allergies.
d) If the Identification Band is removed by a staff member, then a new band shall be made, identification re-confirmed, and the band placed on the patient.
e) Before a patient is transferred, the transferring nurse shall verify the identification band is in place.

3) Side Rails

a) Patients shall be placed in a bed that has functional side rails.
b) The following patients shall have side rails raised when unattended by staff:
   i) Vulnerable patients
   ii) Those given pre-op or pre-procedural medication.
   iii) Patients on stretchers (unless equipped with safety belts) .

4) Seizure Precautions:

a) Basic Precautions - In-patients with a history of seizure disorder shall be observed for.
   i) Oral airway patency.
   ii) Side rails shall be always up and bed shall be in low position.
b) High Risk Precautions - Patients admitted for active seizure disorder or who experience seizures shall be observed while in hospital/clinic. Suction equipment shall be readily available for all such patients.

5) Ambulation

a) Staff shall accompany all patients:
   i) For initial ambulation after surgery,
   ii) After procedures requiring sedation,
   iii) After prolonged bed rest, and
   iv) In other situations as deemed necessary and as ordered by the physician.

6) Transportation

a) Wheels of stretchers, wheelchairs, and beds shall be locked when a patient is lifted from or assisted onto them.

b) Side rails shall be raised on stretchers, where no side rails exist, safety belts shall be fastened for patients in wheel chairs.

7) Patient's Role in Promoting Safe Health Care:

Patients shall be encouraged to become an active, involved, and informed member of their health care team. Listed below are ways that the patients may be encouraged to promote their own safety.

i) Patients shall be instructed to ask if they have questions about their health or safety.

ii) If the patient is scheduled for a surgery, the patient shall be asked to verify prior to the procedure, the site/side of the body that will be operated on.

iii) If the patient's identity is not checked before medications are given, blood/blood products are administered; blood samples are obtained or prior to an invasive procedure, the patient shall be asked to remind the staff.

iv) Patients shall be instructed to adhere to the hospital's 'No Smoking Policy'.

v) Patients shall be instructed to follow the 'Patients Responsibilities'.

Hospital National Patient Safety Goals:

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

1. Identify patients correctly:-

Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.

2. Improve staff communication:-

Get important test results to the right staff person on time.

3. Use medicines safely:-

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up. Take extra care with patients who take medicines to thin their blood. Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

4. Prevent infection:-

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the
World Health Organization. Set goals for improving hand cleaning. Use the goals to improve
hand cleaning. Use proven guidelines to prevent infections that are difficult to treat.

Use proven guidelines to prevent infection of the blood from central lines. Use proven guidelines to prevent infection after surgery. Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

5. Prevent mistakes in surgery:-

Make sure that the correct surgery is done on the correct patient and at the correct place
on the patient's body. Mark the correct place on the patient's body where the surgery is to be done. Pause before the surgery to make sure that a mistake is not being made

Patients Safety Plan											
IPSG 1 (Identify Patient Correctly)											
1	ID Band Used										
2	UHID Mentioned										
3	Patient Name										
IPSG 2 (Improve effective communication)											
4	Patient education form										
5	Informed about hospital facilities										
6	Patient condition informed										
7	Critical Test value Register Entry										
8	Verbal order signature										
9	Handover written in clear and legible hand writing										
10	Handover Signed and Date by Medical officer										
11	Hand over Signed and Date by Nursing										
IPSG 3 (Improve safety of high alert medication)											
12	High Risk Medication lighted with red colour pen										
13	Counter Sign by In charge										
14	Kept in designated place										
15	Close monitoring done										
16	LASA Drug storage										
IPSG 4 (Ensure correct site procedure and patient)											
17	Consent form filled										
18	Patient Identification done										
19	Site marking done										
20	Time out										
IPSG 5 (Hand Hygiene)											
21	Hand Hygiene after 5 moments	BY Doctor									
22		By Nursing staff									
23		By GDA									
24		By Housekeeping staff									
25		By Lab technician									

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

Patient Safety Solution as per WHO:-

They come under the headings of:

1. Look-alike, sound-alike medication names
2. Patient identification
3. Communication during patient hand-overs
4. Performance of correct procedure at correct body site
5. Control of concentrated electrolyte solutions
6. Assuring medication accuracy at transitions in care
7. Avoiding catheter and tubing misconnections
8. Single use of injection devices and
9. Improved hand hygiene to prevent health care-associated infection

The Patient Safety Solutions, a core programme of the WHO World Alliance for Patient Safety, brings attention to patient safety and best practices that can reduce risks to patients. It ensures that interventions and actions that have solved patient safety problems in one part of the world are made widely available in a form that is accessible and understandable to all.

9.0 REFERENCES:

Hospital Committees, WHO Patient safety guidelines, Safety Manual, Patient safety Programme.

10.0 RECORDS AND FORMATS:

Minutes of meetings, Record of Quality Indicator with their Analysis, Internal audit reports, Facility rounds report.

- Lab Safety Programme refer lab safety Manual
- Radiology Safety Programme Refer Radiology Dep. Manual.

Reference – PSQ 1.A

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

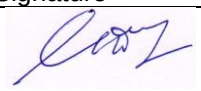
CHAPTER NAME-PSQ 2.A

The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME-PSQ 2.B

The quality improvement programme is comprehensive and covers all the major elements related to quality assurance.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

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	- 2-3 cycles of audits a year

	and system with a defined checklist - Encompass all aspects of clinical and nursing care	
Nursing Audit	- Nursing team lead audits of patient care processes to improve quality of nursing care practices	- Concurrent
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 PDCA methodology targeting specific identified areas of improvement - Lead by QPS Team	- 3-4 QI projects every year

RECORDS

- Minutes of Meetings / Proceedings

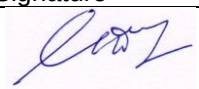
Reference – PSQ 2.A ,2. B

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 Jan 2026	No changes

CHAPTER NAME-PSQ 2.E

There is a designated individual for coordinating and implementing the quality improvement programme**.**

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

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

RECORDS
REFEREANCE -PSQ 2E

CHAPTER NAME-PSQ 2.F

The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals**.**

CHAPTER NAME – PSQ 2.H

Audits are conducted at regular intervals as a means of continuous monitoring

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak 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

2.1 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.

2.2 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.

2.3 Carrying Out the Audit

Assigned auditors shall carry out 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

Record	Record	Format	Responsibility	Indexing	Minimum Retention Period
1	Annual Audit Plan	Manual	Quality Improvement Coordinator	NA	Till Obsolete
2	Audit Schedule	Manual	Quality Improvement Coordinator	Schedule-wise	1 Year
3	Nonconformance Report	Manual	Quality Improvement Coordinator	Alphabetical Order	1 year after closing
4	Audit Summary	Manual	Quality Improvement Coordinator	Order of Audits	3 Years

Reference - PSQ 2 F

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

CHAPTER NAME – PSQ 2.I

There is an established process in the organisation to monitor and improve the quality of nursing care.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak 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

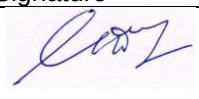
- Nursing Audit Checklists
- Nursing Audit Reports

CHAPTER NAME – PSQ 7.A

The organisation implements an incident management system.

CHAPTER NAME – PSQ 7.B

The organisation has a mechanism to identify sentinel events

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

INTRODUCTION

Incident reporting is a key tool of quality improvement and risk management and it is essential to learn from experience. The process enables any person to report an incident which has given, or may give rise to, actual or possible personal injury, or resulted in or could have resulted in a loss to the hospital, either financial or by way of reputation. This would include incidents such as staff injuries through manual handling, theft of hospital assets, improper patient care, e.g. misdiagnosis, equipment malfunction/failure, patient accidents, etc.

The hospital has a duty to communicate effectively with patients and/or their relatives as part of the process should errors or problem with their treatment arise.

The hospital is in the process of developing a database for the purpose of recoding and analyzing incident data. This will allow trends and common types of incidents to be identified and action plans developed to address the most commonly occurring incidents.

The healthcare industry in the country in general is going through increases consumer activism and increased litigation under the CPA. Litigation can be both very damaging personally, financially and from a publicity standpoint, for the hospital and staff involved. Reporting incidents promptly can lead to the avoidance of litigation through good communication with the injured party, and/or out of court settlement (as appropriate). Where an incident is defensible, prompt and thorough investigation will allow the hospital to effectively defend its position.

PURPOSE AND SCOPE

The purpose of this policy is to guide the hospital staff in managing the risks through better system of reporting incidents and near misses; and analyzing them through classification and severity ratings.

The policy and accompanying procedures apply to hospital staff (permanent and temporary) including those working on contracts or service agreements with outsourced agencies.

RESPONSIBILITIES

Quality Coordinator

The QC is responsible for ensuring incident reporting and investigation processes are in place and acts as the co-coordinating officer for investigations into Sentinel Events and Grade III incidents. He/she shall be responsible for proving regular updates to the associate director and top management as per requirement from time to time.

Nursing Superintendent

The Nursing Superintendent is responsible for ensuring that investigations into incidents, including those involving doctors are undertaken in accordance with this policy and liaising with Chief Medical Administrator and Quality Coordinator to ensure that investigations are co-ordinate and comprehensive and action is taken to minimize the risk of recurrence.

Security Officer

The security officer is responsible ensuring incidents impacting on the protection of people, property and assets, maternity and pediatric units, drugs and hazardous materials are reported to the Medical Administrator, QC and Medical Superintendent.

Head of the Departments

Responsibility for ensuring that this Policy is notified to all staff rests with Head of the Departments, who are responsible for monitoring its compliance. They are also responsible for ensuring that any remedial action required is planned and implemented liaising with Associate director / QCO and other staff as necessary.

Person In-charge at the time of Incident

He / She shall be responsible for initiating the incident reporting procedure. This person should ensure that, where appropriate, remedial action is taken to ensure the safety of anyone involved and any evidence is preserved and co-ordinate the provision of any prompt appropriate information or apology to the patient and or relatives They should also ensure that the Ward In-charge /Nursing Superintendent / HOD is suitably informed of incidents.

DEFINITIONS

Near Miss:

It is more of an error. It is the most common type of error. The error can lead to an incident but has not happened so in a “near miss”, as it is intercepted

prior to the completion as an incident and thereby has not harmed the patient. This has to be reported.

Incident:

Incident if that has “caused harm to a patient or visitor”, the list of areas and incidents are in the incident reporting form which has to be checked for the entire day and filled every day that evening and signed by the corresponding ward supervisor and sent to the Quality control Office by the next day.

Adverse Event:

An adverse event is any adverse change in health or side effect that occurs in a patient while he is receiving the treatment or within a previously specified period of time after the treatment has been completed.

The incidents like

- Adverse Drug Reaction (ADR),
- Adverse transfusion reaction and
- Adverse anesthesia events are adverse events looked at present.

The root cause analysis shall be done by the Pharmacovigilance Committee and Transfusion Committee and submitted to the Management Committee Every month.

Sentinel Events:

These are rare events but can be more serious and need to be investigated immediately.

These are that involves both patient care and health care delivery system and process deficiencies hence the patient can be harmed.

POLICIES

5.1 All incidents relating to patient and personnel safety occurring in hospital shall be reported using appropriate forms to designated officers as per this policy and supporting procedures. This shall include near misses.

5.2 Various categories of incident reporting forms and guidance materials / posters on incident categorization and reporting shall be made available in all nursing stations / units to actively encourage compliance to incident reporting.

5.3 No punitive actions will be undertaken by the hospital administration on self reported incidents.

5.4 The designated officers for each category of incident shall undertake root cause analysis for each incident reported to them and suggest positive corrective and preventive actions.

5.5 The QCO shall prepare trend analysis for all incidents reports on a quarterly basis.

5.6 The reported incidents and trend analysis shall be a standing agenda for all Hospital Management Committee meetings.

PROCEDURE (S)

The following procedures have been established for implementation of this policy.

- Procedure for Categorization and Flow of Reporting for Incidents
- Procedure for Sentinel Event Reporting & Analysis
- Procedure for Adverse Drug Event Reporting & Analysis

MONITORING

The Quality Management Office will review and assess classification of incidents; analysis and follow up actions undertaken. An analysis will be undertaken of the distribution, location, type, and population involved in incidents to identify any trends, system, or procedural failure.

Quarterly reports are to be provided to the Quality controller based on the analysis of incidents and the trends. Reviews of incidents and trends should form a standing agenda item for review meetings of the Hospital Quality & patients safety Committee.

REFERENCES – PSQ 7.a.b

APPENDICES

Appendix 1: Procedure for Adverse Drug Event Reporting & Analysis
Appendix 2: Procedure for Categorization and Flow of Reporting for Incidents
Appendix 3: Procedure for Sentinel Event Reporting & Analysis

Appendix 1: Procedure for Adverse Drug Event Reporting & Analysis

1. Notification:

Suspected adverse drug reactions are reported immediately to the registered nurse in charge of the patient to physician and the drug reaction form filled and sent to pharmacology department.

2. Monitoring

The Qualified nurse in charge of the patient observes closely for the adverse reaction. The patient's vital signs are frequently monitored and nurses are to be ready with all emergency measures.

3. Documentation

All suspected adverse drug reactions are properly documented in the patient's record including time of reaction, patient's response to drug therapy including signs and symptoms and measures instituted, the name of physician and time notified and the patient general condition.

Appendix 3: Procedure for Sentinel/Incident Event Reporting & Analysis

1. The sentinel/incident event reporting Performa will be available at the nursing station. The reporting shall be done by the ward staff. In the case of events involving doctors, the reporting shall be done by the immediate senior doctor.

2. The Performa signed and completed shall be sent to the quality management office on the same day.

3. The QC shall inform the concerned unit chief and the HOD of the incident on the same day of the reporting.

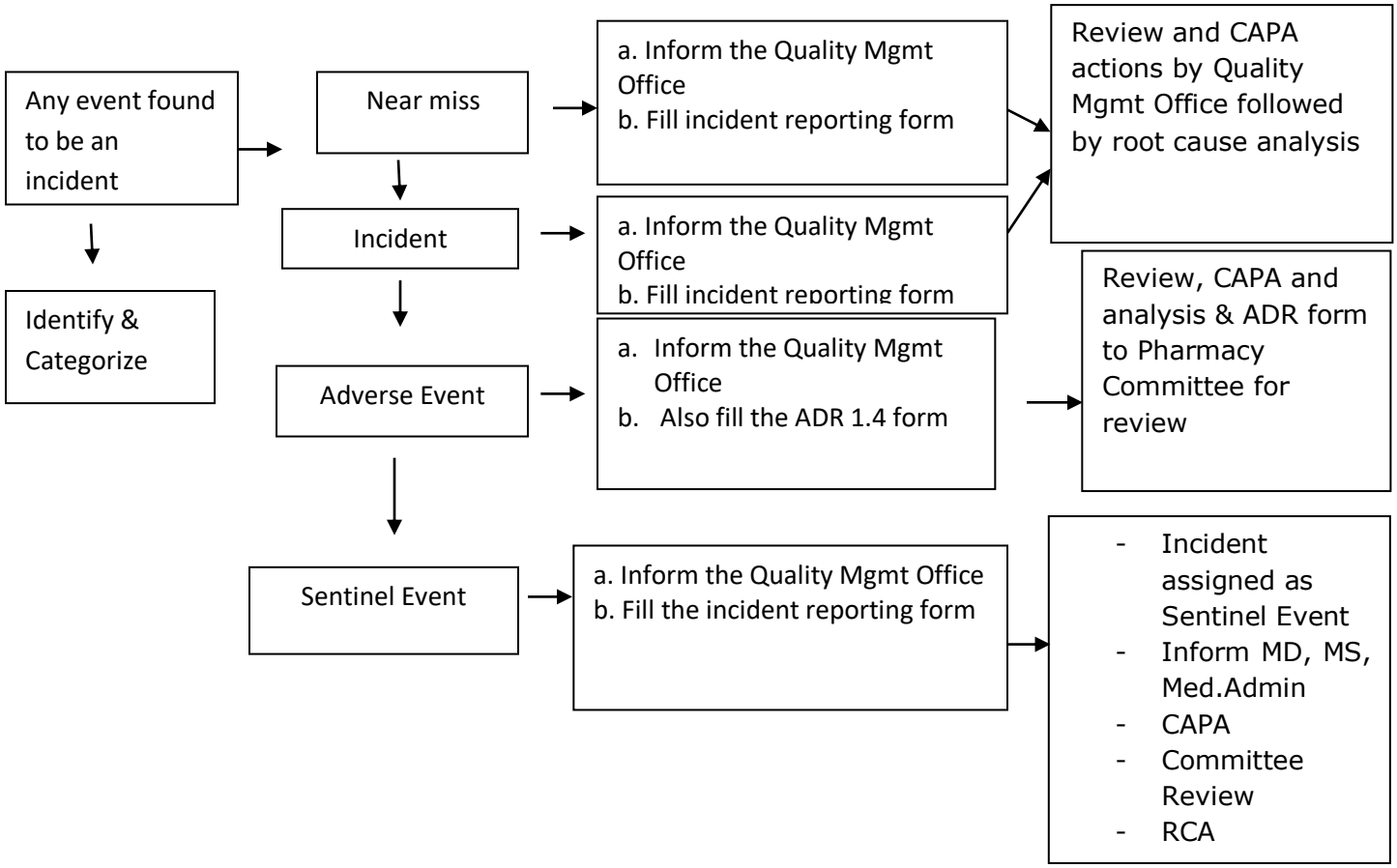
4. In case of any major illness to the patient, as a result of the event, the HOD discuss the treatment aspect and the costs involved with the Medical Superintendent

5. A committee shall be formed based on the nature of the incident. The employee shall be called for an enquiry by the committee, and the required action shall be taken depending upon on the severity of the incident.

6. The outcome of the meeting shall be decided by the committee on that day and the appropriate action shall be taken.

7. The minutes and the outcome of the meeting shall be sent to the hospital management committee within three days of the meeting.

Appendix 2 - Incident Reporting / Root Cause Analysis – FLOW CHART



Appendix 3: Procedure for Sentinel/Incident Event Reporting & Analysis

1. The incident / event reporting is done through Incident Report Format .The reporting shall be done by the ward staff. In the case of events involving doctors, the reporting shall be done by the immediate senior doctor.
2. The Quality Coordinator is altered by sms and forms review the incident. Any incident qualifying criteria for sentinel event as per NABH guidelines is designated as Sentinel Event in the system by QC
3. On marking an event as **sentinel event alerts** (Mobile sms) will be sent to Managing Director, Medical Directors, Medical Superintendent, Medical Administrator and Nursing Superintendent.
4. The QC shall inform the concerned HOD of the incident on the same day of the reporting.
5. In case of any major illness to the patient, as a result of the event, the HOD discuss the treatment aspect and the costs involved with the Medical Superintendent
6. A committee shall be formed based on the nature of the incident. The key stakeholders shall be called for an enquiry by the committee, and the required action shall be taken depending upon on the severity of the incident.
7. The outcome of the meeting shall be decided by the committee on that day and the appropriate action shall be taken. A copy of the proceedings is filed with the QM office and reviewed in the next quality committee meeting
8. The QC shall ensure a RCA and report of same will be appended in the incident report form.

REFERENCES – PSQ 7.a.b

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1Jan 2026	No Changes.