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		
11		Patients Safety Program	1	1	20-Nov-22		1	20-Nov-23		

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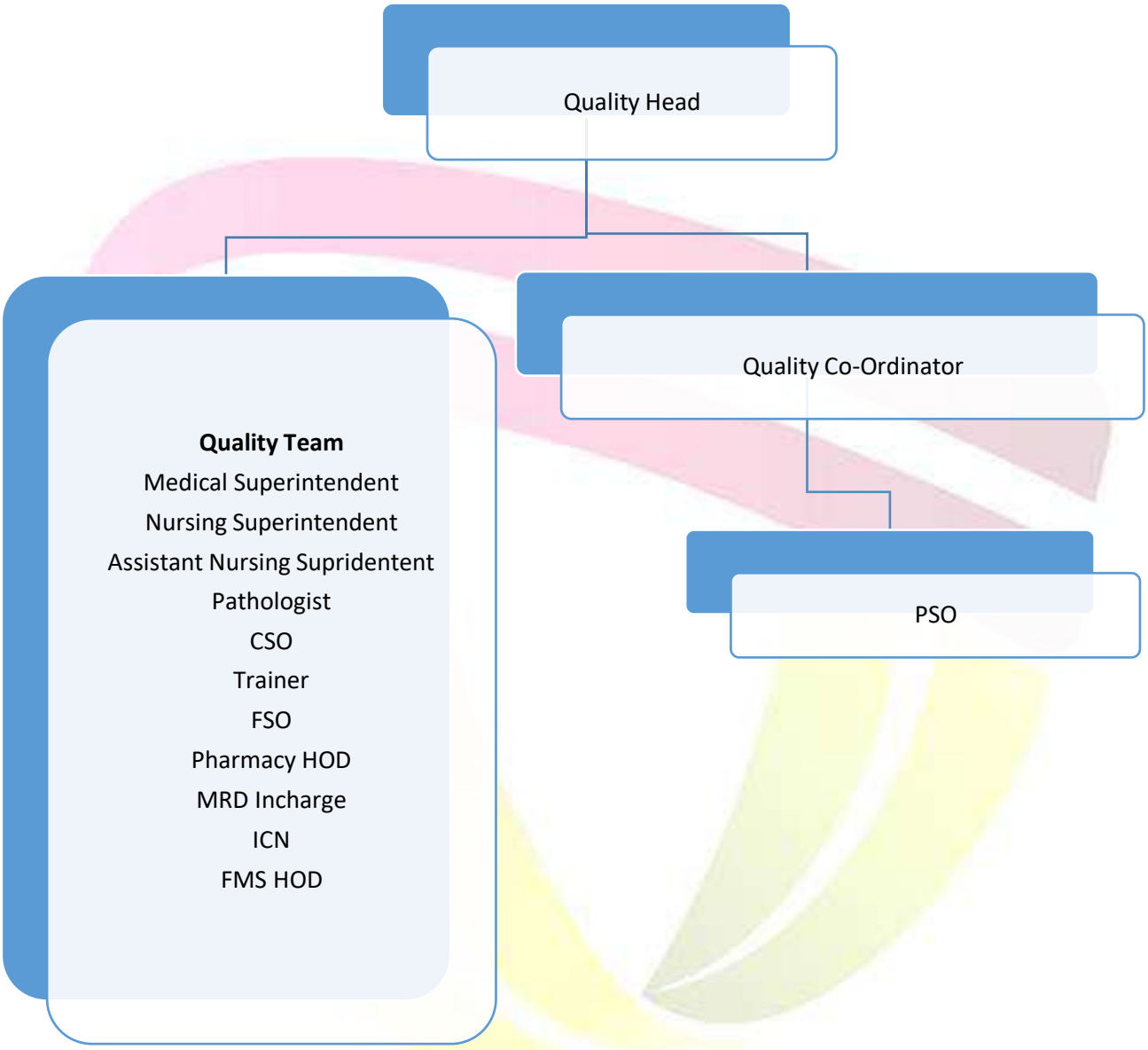
	SAIDEEP HOSPITAL QUALITY MANUAL	Doc No	SDH/LAB/01
		Issue No	01
		Rev No.	01
		Date	15/10/2021
		Page	1
	Amendment Sheet		

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

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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 HOSPITAL	Doc No	SDH/QIM/4.6
		Issue No	01
		Rev No.	01
	QUALITY IMPROVEMENT MANUAL	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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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

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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

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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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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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Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak 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

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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

PROCEDURE:

Introduction "Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery"

The authors of the Cochrane Review on audit and feedback offer a narrower definition. For them clinical audit is: "The provision of any summary of clinical performance over a specified period of time. The summary may include data on processes of care (e.g. number of diagnostic tests ordered), clinical endpoints (e.g. blood pressure readings), and clinical practice recommendations (proportion of patients managed in line with a recommendation)."

It involves measuring current patient care and outcomes against explicit audit criteria (also termed standards)

There is an expectation from the outset that practice will be improved.

Clinical audit should:

- Be a multi-disciplinary, multi-professional activity.
- Follow general accepted rules and standards which are based on international, national or local legal regulations, or on guidelines developed by international, national or local medical and clinical professional societies.
- Be a systematic and continuing activity, whereby the recommendations given in audit reports are implemented.
- NOT be research, quality system audit, accreditation or regulatory activity.

The general objectives of clinical audit should be to:

- Improve the quality of patient care.
- Promote the effective use of resources.
- Enhance the provision and organization of clinical services.
- Further professional education and training.

Clinical audit should :

- Address the practical clinical work by different professionals.
- Assess the local practice against the defined good practice, taking into consideration the local facilities and resources when the ultimate good practice cannot be reached by one step.
- Have professional initiation and foster an environment which enhances professional relationships and the multidisciplinary approach required to optimise patient care.
- All parties, those being audited and those carrying out the audit, should respect the confidentiality of patient data, the interviews and discussions with staff, audit reports and other performance data.

Using the method:

Clinical audit can be described as a cycle or a spiral (see figure 1). Within the cycle there are stages that follow a systematic process of establishing best practice, measuring care against criteria, taking action to improve care, and monitoring to sustain improvement. The spiral suggests that as the process continues, each cycle aspires to a higher level of quality.

Clinical audit requires the use of a broad range of methods from a number of disciplines, for example, organizational development, statistics, and information management. Clinical audit can be undertaken by individual healthcare staff, or groups of professionals in single or multidisciplinary teams. At the opposite end of the scale, a clinical audit project may involve all services in a region or even in the country. Effective systems for managing the audit project and implementing change are important whether a large number of people or only a few are involved in the audit project. At the start of an audit project, spending time on creating the right environment may be more important than spending time on the method itself.

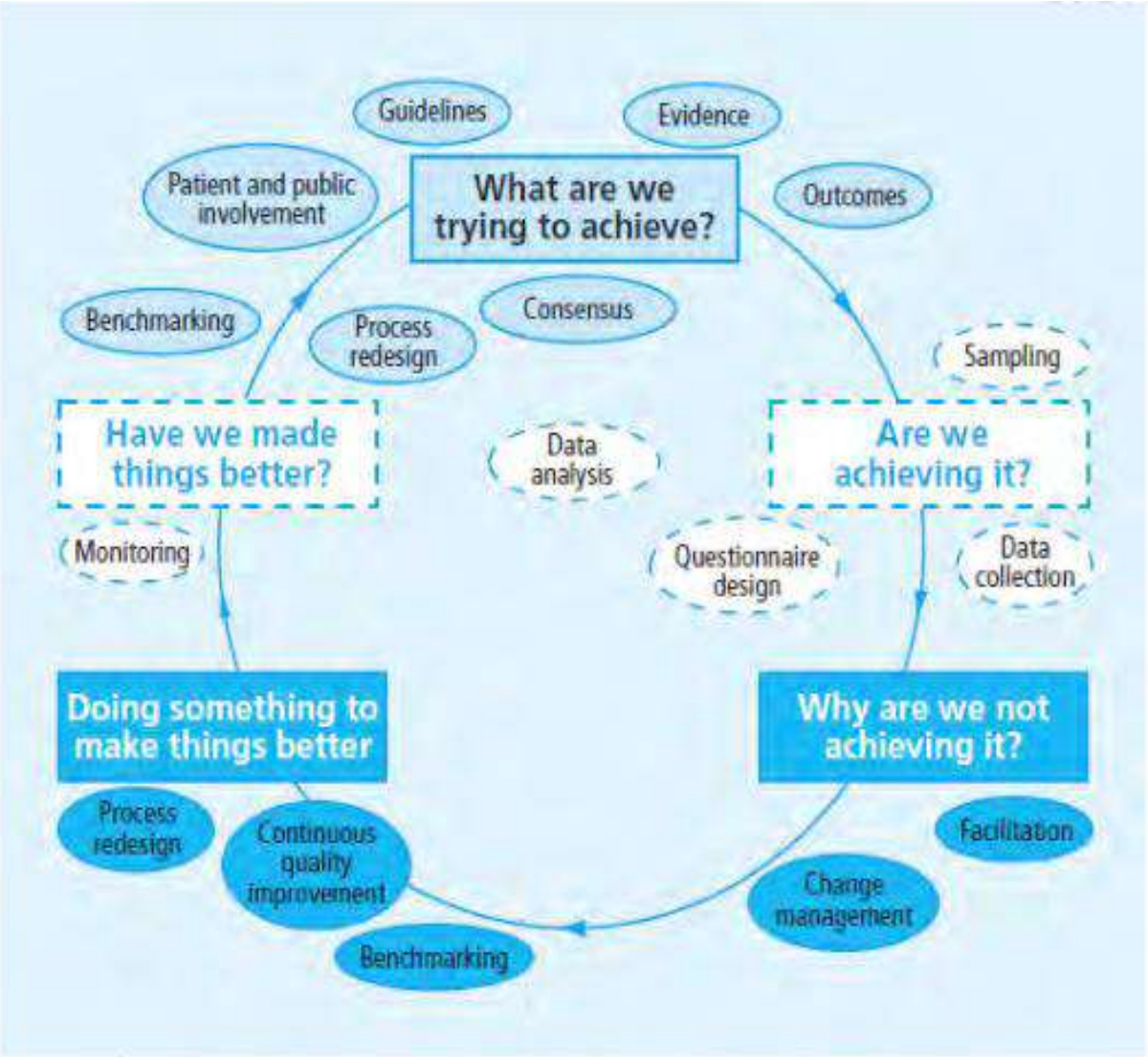


Fig. 1: The clinical audit cycle (adopted from NICE guidelines)

Stages:

The main stages of the clinical audit process are:

1. Selecting a topic.
2. Agreeing standards of best practice (audit criteria).
3. Collecting data.
4. Analysing data against standards.
5. Feeding back results.
6. Discussing possible changes.
7. Implementing agreed changes.
8. Allowing time for changes to embed before re-auditing.
9. Collecting a second set of data.
10. Analysing the re-audit data.
11. Feeding back the re-audit results.
12. Discussing whether practice has improved.

This process is summarised in the diagram below (figure 2).

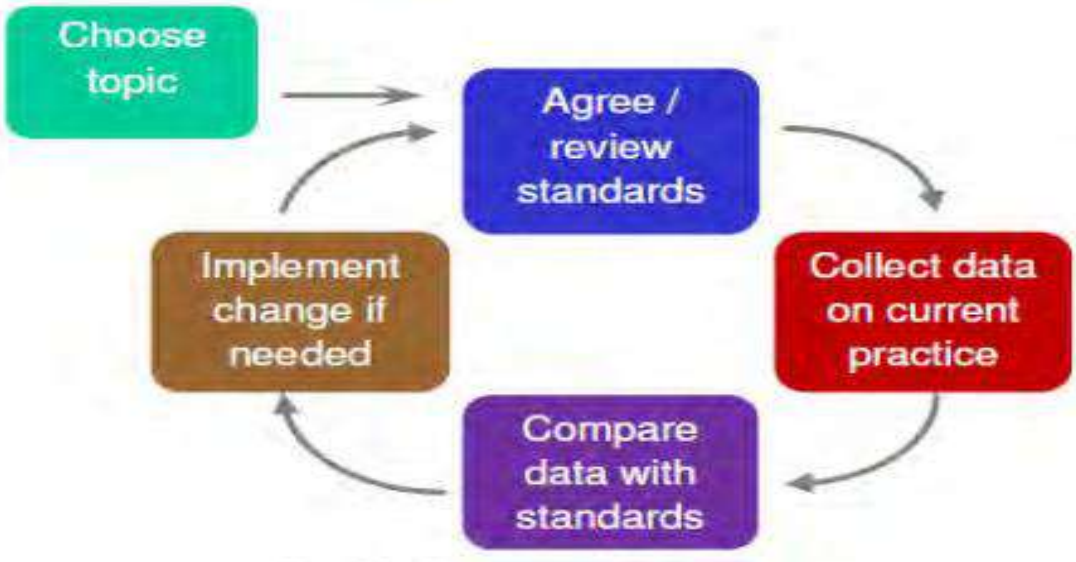


Fig. 2: The clinical audit process

What Clinical Audit Is Not? :

- Financial audit
- Internal audit
- Organizational audit
- Counting things/ Investigations
- Routine monitoring of clinical outcomes
- Peer review including Mortality & Morbidity (M&M)
- Staff, patient, service user, carer surveys

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		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

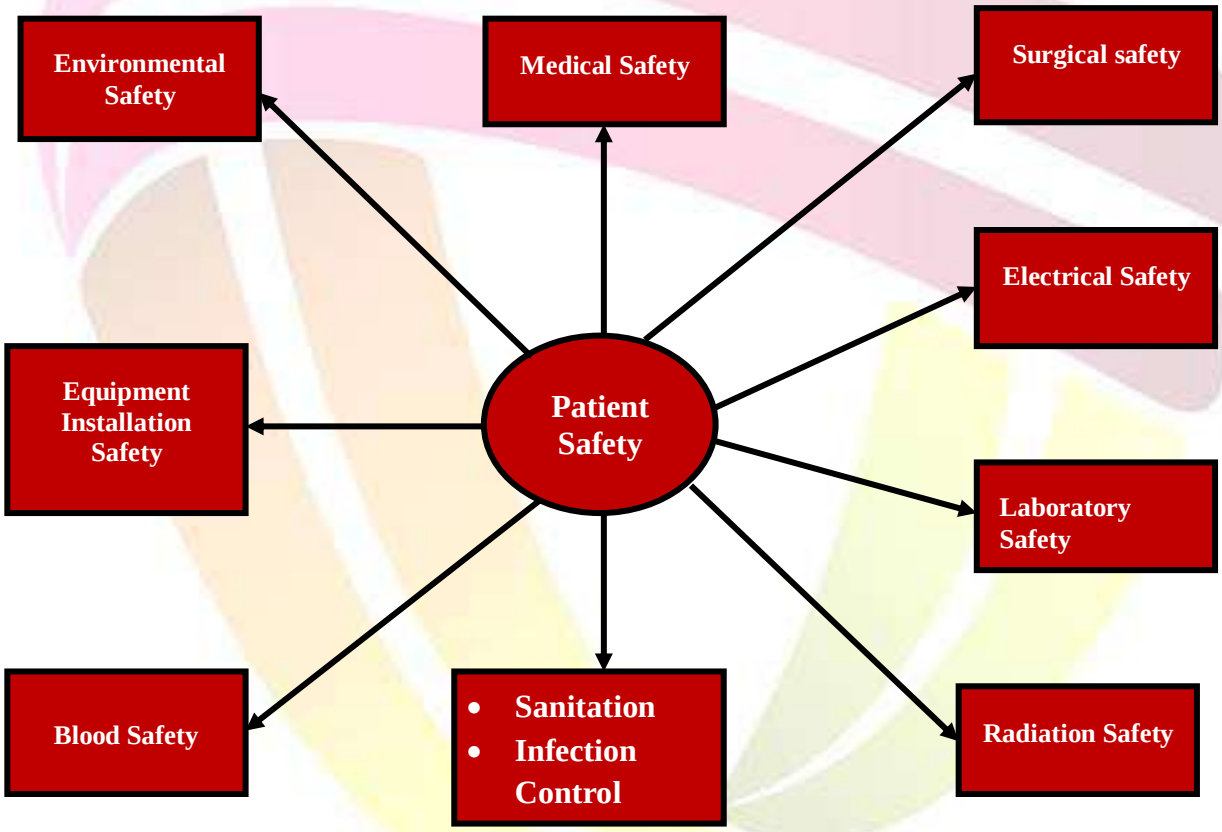
7.0 DISTRIBUTION:

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 Chief Medical Administrator		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. Identify patient safety risks:-

Find out which patients are most likely to try to commit suicide.

6. Prevent mistakes in surgery:-

Make sure that the correct surgery is done on the correct patient and at the correct place

Patients Safety Plan										

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

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SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	**SAIDEEP HOSPITAL** **QUALITY IMPROVEMENT MANUAL**	Doc No	SDH/QIM/4.8
		Issue No	01
		Rev No.	01
		Date	1 Nov 21
		Pages	9
	Patients Safety Programm		

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										
IPSG 6 (Reduce risk of fall)												
26	Staff Awareness											
27	Measure of prevention of fall during transfer											

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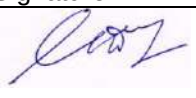
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

28	Fall safety devices in place										

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.

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