1. POLICY:

To provide a framework for quality assurance and quality improvement, while focusing on patient safety and quality of care. These include a strong culture of safety that has been inculcated, a decrease in the incidence of adverse events, and constant monitoring of quality within the system.

Our hospitals quality systems policy is defined as below:

"INODAYA Hospital – Kakinada continuously strives towards setting up of quality systems and procedures that would result in the best clinical outcomes and highest patient satisfaction levels through improvising our clinical practices in the most ethical and transparent manner"

1. PURPOSE:

To ensure that the hospital follows all the standards and guidelines in accordance to NABH an autonomous body set by the QCI.

2. DEFINITION:

Quality Assurance:

Quality Assurance refers to administrative and procedural activities implemented in a quality system so that requirements and goals of service are full filled. It is the systematic measurement, comparison with a standard, monitoring of processes and an associated feedback loop that confers error prevention.

ABBREVIATIONS:

QCI: Quality Council of India

HOD: Head of Department
NABH: National accreditation board for hospitals and health care providers
ICU: Intensive Care Unit
QACC: Quality Assurance Core Committee
CQO: Chief Quality Officer
IPHS standards: Indian Public health Standards
SOP: Standard Operating Procedures
IPD: Inpatient Department
ICN: Infection Control Nurse
MRD: Medical Record Department
HR: Human resource
CT scan: Computerized tomography
OT: Operation Theatre

3. SCOPE:

The scope covers all Hospital employees and patients receiving services from the hospital.

4. RESPONSIBILITY:

CQO - Administrator, Medical Director, Clinicians, Quality Team and Quality Assurance Core Committee, Nursing team & allied healthcare support team

5. DISTRIBUTION: Policy is accessible to all staff members of the hospital through the Quality Systems Intranet Portal

6. PROCESS DETAILS:

8.1 DESCRIPTION OF THE PROCESS

1. The hospital follows a structured quality assurance and continuous monitoring programme, developed by Quality Assurance Core Committee of the hospital, on the basis of NABH standards
2. **Quality Assurance Committee** – Refer the document **'Hospital Committees'**
3. In line with our goal of providing quality services in our hospital, we had developed and set our mission, vision, quality policy, and service standards.
4. **Our Vision:**
   To provide quality services with best medical equipment and clinical expertise.

5. **Our Mission:**
   To provide our patients with quality, care through innovation, technology and compassionate care.

6. **Objectives:**
   Top management has established the following macro level objectives, which are measurable and consistent with Quality Policy to provide efficient, effective timely care with a human touch to our patients.

   1. To provide effective Quality Systems through right feedback mechanism for continuous improvement.
   2. To create congenial work environment and provide training on Quality concepts / systems to all concerned.
   3. To provide facilities for proper disposal of wastage as per the statutory requirements.

7. **Service standards:**
   7.1 Standards of service and adequate degree of patient care can be provided to the extent proper and workable ratio between doctor to patient, nurse to

patient and beds to patients are maintained, as also the extent of availability of resources and facilities. Consistent with this every possible effort will be made by this hospital to provide standard services.

7.2 To provide access to hospital and professional medical care to all patients who visit the hospital.

7.3 To prescribe a workable minimum waiting time for outpatients, before they are attended to by a qualified doctor and / or specialists and continuously strive to improve upon it.

7.4 To ensure that all equipment in the hospital are maintained efficiently in proper working order.

7.5 To ensure availability of beds and operation theatres facilities as freely as possible.

7.6 To ensure treatment of emergency cases with utmost promptitude and attention.

7.7 The patients' and families' rights are in consonance to accreditation standards.

7.8 All patients and visitors to the hospital will receive courteous and prompt attention from the staff and officials of the hospital in the use of its various services.

7.9 Reliability and promptness of diagnostic investigation results is ensured and whenever possible such reports will be made available.

7.10 Operation theatre is maintained on a regular basis to ensure that they are serviceable all the time and every effort will be made to keep the hospital and its surroundings, clean, infection-free and hygienic.

7.11 A regular system of obtaining feedback from the users is in place through exit interviews and periodic surveys. The inputs from these are continuously used for improving the service standards.

7.12 The hospital has necessary equipment's required for provision of service mentioned in 'scope of services and system to ensure proper maintenance and working of various equipment.

7.13 If any equipment is out of order, information regarding the same shall be displayed suitable indicating the alternate arrangements, if any, as also the likely date of re-commissioning the equipment after repairs and replacement.

7.14 When things go wrong or fail, appropriate action is taken on those responsible for such failures and action taken to rectify the deficiencies. Complainants will also be informed of the action taken, if requested.

7.15 In case of likely persistence of the deficiency, the reasons for the delay in rectifying the deficiency and the time taken for rectifying the same will be displayed prominently for the information of the public.

7.16 Special directions are given to the non-medical staff to deal with the patients and public courteously. Any breach in this regard when brought to the notice of the hospital authorities shall be dealt with appropriately.

7.17 Hospital encourages the patients and the public to inform the authorities when things go wrong. Suggestion / feedback boxes are provided across the hospital

7.18 Hospital follows all policies, processes, programs, committee meetings; regulatory guidelines, which have been prepared to meet the standards of accreditation as, set by NABH.

8. Structure for Quality Assurance:

Hospital has developed a structure for carrying out processes related to Quality Assurance in the hospital. This is as follows:

8.1 **Documentation system:** Hospital has developed its documentation on policies, procedures, programs, guidelines etc. These have been developed by committee personnel and staff of the hospital, reviewed by heads of the departments and have been approved by Hospital Administrator.

8.2 **Quality Assurance Committee/Department:** Quality assurance related activities is planned, undertaken, and controlled by Quality Assurance Committee/department which is a multidisciplinary committee having representation from various clinical, non-clinical, and administrative departments. Details of committee, its scope of work, frequency of meeting and mode of operations are detailed in Quality Assurance Committee's file.

8.3 **Accreditation Coordinator:** The hospital has designated an Accreditation coordinator, who has overall responsibility of coordinating the work of NABH accreditation. His / her responsibility will include:

a) To issue various documents to departments from time to time

b) To keep a record of all the documentation of the hospital, in relation to accreditation

c) To delegate the activities in departments and ensure its timely completion

d) To regularly receive feedbacks from departments regarding status of their work related to accreditation preparation

e) To plan and execute regular assessment of the hospital in accordance with accreditation standards

f) To coordinate all such activities required for quality assurance and continuous monitoring of the hospital

8.4 **Departmental coordination:** Each department of the hospital has been appointed with one in charge / coordinator. The responsibility of these coordinators will be

1. To receive and retain all the documents and official correspondence related to accreditation from time to time

2. To inform and orient the staff of their department on policies and procedures developed for their department

3. To ensure the completion of all the work assigned to their department for NABH accreditation preparation

4. To organize regular training programs for staff of their department

8.5 **Departmental Quality coordinators:** Each department has identified a pioneer for developing and improving the quality of service provided by the department. These pioneers continuously strive for improving the quality standards of the department and train the staff on best practices.

9 The Program:

a. The program is comprehensive and covers quality assurance of input, process and outcome. This has been developed by quality assurance committee and

implemented by various committees, accreditation coordinator and other personnel.

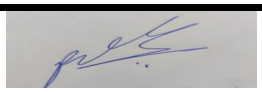
b. Quality assurance and continuous monitoring program is developed for following areas

- **i.** Applicable hospital wide (Table 1)
- **ii.** Applicable for laboratory (Table 2)
- **iii.** Applicable for radiology (Table 3)
- **iv.** Applicable for intensive care areas (Table 4)
- **v.** Applicable for surgical services (Table 5)
- **vi.** Applicable for infection control (Table 6)

c. Procedure for implementing the program is as follows

- **i.** The program which is applicable hospital wide and which is applicable for infection control is explicitly tabulated. Quality Assurance committee and Hospital Infection committee shall implement, monitor and improve the program.
- **ii.** The indicators report gives the figures for all indicators, which is reviewed and subsequent actions is taken based on adherence to standard value, by Hospital administration and QAC.
- **iii.** The program applicable for laboratory, radiology, intensive care area and surgical services shall be implemented through departmental in charge under the vigilance of QAC. Compliance to the key characteristics shall be identified from acceptance norms / criteria. The record shall be endorsed in the register as 'C / PC / NC' (C for Compliance, PC for partial compliance and NC for non-compliance). The record shall be entered at frequency defined in the table.

8.2 ACTIVITY AND RESPONSIBILITY (TABULAR FORMAT)

Prepared by: 	**Verified by:** 	**Approved by:** 
Dr.D.N.S.Prakash	**Mrs.G..Lakshmi Lavanya**	**Dr.G.Rammohan**
Medical Director	Chief Executive Officer	Managing Director

i. Quality assurance programme applicable hospital wide (Table 1)

PURPOSE	METHODOLOGY	RESPONSIBILITY	REMARKS
Setting goals and objectives	Setting of mission, vision, objectives, and service standards through committee discussion and approval of HA	QAC	Refer S. No. 4 to 8 of this document
Infrastructure	Identifying infrastructural requirement including • Physical facility • Manpower • Equipments This is determined on the basis of workload and change in scope of service	HA	Reference is taken from IS standards and IPHS standards.
Policies, procedures and other documentation requirement	This documentation is done to develop systems and processes that are necessary to provide uniform service of desired level of quality and communicate it to relevant personnel.	Various committees, accreditation coordinator and Medical Director	Refer document: (Apex control of documents)
Compliance monitoring	Compliance is monitored and non-conformity is tracked for taking corrective and preventive actions. This is done through compliance monitoring	All the staff of the hospital and Quality Assurance Committee	

PURPOSE	METHODOLOGY	RESPONSIBILITY	REMARKS
	registers kept in various departments		
Walk through monitoring	Walk through monitoring or physical monitoring is done by designated member of QAC, Hospital infection control committee, hospital safety committee, Accreditation coordinator, Residents, registrars, Medical Director	QAC, Hospital infection control committee, hospital safety committee, Accreditation coordinator, Residents, registrars, Medical Director	Following aspects are specially looked for • Infection control • Hospital safety • Record maintenance • Policy compliance
Indicator monitoring	A list of indicators has been developed to monitor the key features necessary for quality assurance. These are developed for structure, process, clinical and managerial activities. A monthly report is generated with all these indicators which is reviewed for necessary action by Quality Assurance committee	QAC	Table No.11
Training and	Necessary instructions to the	QAC and hospital	Training files

PURPOSE	METHODOLOGY	RESPONSIBILITY	REMARKS
orientation	staff for quality assurance are communicated through their departmental incharges. Quality Assurance is also included as one of the training needs, on which training is organized at regular intervals	administration	
Continuous process	The contents of this program is reviewed every year by Quality Assurance Committee for adequacy.	QAC	Following aspects is reviewed every year • Objective and service standards • Adequacy of documentation • Monitoring systems • Various Indicators and their standards • Structure for implementation of quality assurance program • Any other system required for quality

PURPOSE	METHODOLOGY	RESPONSIBILITY	REMARKS
			improvement

i. Applicable to Laboratory (Table 2)

S. No.	Key characteristics	Acceptance norms / criteria	Responsibility and conformance verification.	Frequency
1.	Surveillance of test results	Weekly surveillance of a sample of test results	HOD / Laboratory In-charge	Weekly
2.	Check of calibration and maintenance of equipments according to standard.	As per the manufacturer's instruction. (at every reconstitution)	Technician	Weekly
3	Compliance monitoring	Compliance as per standards, SOP and policies	Laboratory staff	Continuous
4	Timely intimation of critical results	As soon as the result is generated	Technician	Daily
Biochemistry				
1.	Daily washing of equipments with Disinfectant and distilled water.	Clean glassware	Technician	Weekly

S. No.	Key characteristics	Acceptance norms / criteria	Responsibility and conformance verification.	Frequency
2.	Calibration of analytes (Biochemistry Kit)	As per the manufacturer's instruction.	Technician	As per manufacture instructions
Haematology				
1.	Maintenance of equipment	As per the instruction in operation manual.	Technician	Daily
2.	Calibration of equipment's	As per the manufacturer's instruction.	Service Engineer of the company.	Yearly
Pathology				
1.	Tests to be done on fresh specimens received in containers with lids.	Proper covering of sample with lid	Technician	Daily
Microbiology				
1.	Preparation of media under strict aseptic precautions	Sterility	Technician	Weekly

Prepared by:	Verified by:	Approved by:
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Medical Director	Chief Executive Officer	Managing Director

S. No.	Key characteristics	Acceptance norms / criteria	Responsibility and conformance verification.	Frequency
2.	Checking of gas cylinder for any leakage	Offensive smell		Daily

ii. Applicable for radiology (Table 3)

S. No.	Key Characteristics	Acceptance Norms / Criteria	Responsibility And Conformance Verification	Frequency
1.	Surveillance of test results	Weekly surveillance of a sample of test results	HOD / Laboratory In-charge	Weekly
2.	Check of calibration and maintenance of equipments according to standard.	As per the manufacturer's instruction. (at every reconstitution)	Technician	Weekly
3.	Compliance monitoring	Compliance as per standards, SOP and	Radiology staff	Continuous

S. No.	Key Characteristics	Acceptance Norms / Criteria	Responsibility And Conformance Verification	Frequency
		policies		
4.	Timely intimation of critical results	Within ½ hour	Technician	Daily
5.	Waiting time for investigation.	• X ray : 30 min or less (90% cases) • Ultrasound : 40 min after preparation (90% cases) • CT Scan : 30 min after preparation (90% cases)	Technician / Radiologist	Weekly
6.	Report delivery time	90% x-ray and ultrasound reports delivery on time as per policy CT/Mammogram reports by 10:30 AM next day	Technician / radiologist	Weekly
7.	Uptime of equipment	95 % - 98 %	Supervisor/ Technician / Radiologist	Monthly

iii. Applicable to Intensive care department (Table 4)

S. No.	Key Characteristics	Acceptance Norms / Criteria	Responsibility And Conformance Verification	Frequency
1	Infection control and sterility of ICU	• Carbonization • Weekly swab culture	ICU in charge / staff	Once in a week
2	Sterility of Ventilator	Sterilization after each utilization followed by culture.	ICU in charge /maintenance in-charge / staff	Once in a week
3	Monitoring and measurement of life saving equipment and other equipments	• Functional status check. • Calibration – Yearly/as and when required • AMC/Preventive Maintenance – Yearly/as and when required	ICU in charge / staff / Maintenance in-charge	Monthly

iv. Applicable to surgical services department (Table 5)

S. No.	Key Characteristics	Acceptance Norms / Criteria	Responsibility And Conformance Verification	Frequency
1.	Punctuality of O. T	• Start functioning at time	OT in charge	Once in a

S. No.	Key Characteristics	Acceptance Norms / Criteria	Responsibility And Conformance Verification	Frequency
	staff			week
2.	Complete pre-operative preparation before patient is shifted to O. T	• Part preparation • Nail polish removing. • Removal of all ornaments. • Consent for procedure • Change of clothes.	O.T. Staff Anesthesiologist	Daily Once in a week
3.	Anesthesia induced after 17.00 hrs.	Acceptable only during emergency	Anesthesiologist	Once in a week
4.	Cases continuing beyond 19.00 hrs.	Acceptable only when necessary	Anesthesiologist	Once in a week
5.	Infection Control and sterility of O. T	• Daily carbonization • Weekly air culture • Weekly fumigation • Hypochlorite treatment of infected linen / instruments for 3 – 4 hrs before autoclaving. • Restricted entry of visitors into O.T. complex	OT in-charge / O.T. Staff / Anesthesiologist	Once in a week

v. Applicable for infection control (Table 6)

S. No	Purpose	Methodology	Responsibility	Remarks
1.	Surveillance and collection of data related to hospital acquired infections	Infection control nurse shall do daily surveillance of the hospital and record the patients infections in the hospital	Infection control nurse	This data shall be presented to Hospital infection control committee for analysis
2.	Adherence to standard precautions	Non-adherence to standard precautions shall be recorded in compliance monitoring register by observing staff	All staff of the hospital	Hospital infection control committee shall keep a check on these registers and shall also do physical monitoring to identify non-conformity
3.	Urinary tract infections	Urine of all symptomatic catheterized patient shall be sent for culture	Treating physician	Infection control nurse and hospital Infection control committee shall be vigilant about this
4.	Respiratory tract infections	All patients on the ventilator having clinical feature suggestive of infection shall have their sputum or ET/tracheotomy secretions	Treating physician	Infection control nurse and hospital Infection control committee shall be

S. No	Purpose	Methodology	Responsibility	Remarks
		(obtained using a suction catheter) or ET/tracheotomy tip or protected specimen bruising (PSB) or mini broncho-alveolar lavage (BAL) for culture.		vigilant about this
5.	Intra-vascular device infections	For patients with symptoms suggestive of intra-vascular device infection and having central line the same shall be done by sending the tip for culture. For all peripheral lines clinical evidence of thrombophlebitis would suffice.	Treating physicians	Infection control nurse and hospital Infection control committee shall be vigilant about this
6.	Surgical site infections.	Pus / swab of such patients shall be sent for culture.	Treating physician	Infection control nurse and hospital Infection control committee shall be vigilant about this

Following documented procedures shall be followed in this regard

Procedure

S NO.	PROCEDURAL STEPS	RESPONSIBILITY
1.	To calculate the current month's indicators, obtain the monthly data in the **data collection** worksheet of the	Manager/Incharge-

	Quality Indicators file from respective sources before 5th of every subsequent month	Quality
2.	Enter the data in 'data collection' worksheet	Nurses, OT In-charge, MRD and other user departments
3.	The worksheet of 'Indicators' will show the indicator value	Manager/Incharge - Quality
4.	Take the print of indicators and file it. Name the file as 'Quality Indicators'	Manager/Incharge - Quality
5.	This has to become a system and should be done quaterly	Quality Assurance Core Committee / Manager - Quality
6.	This report should be discussed in quality assurance core committee, and actions should be taken for those indicator which is showing unacceptable values	Quality Assurance Core Committee / Manager - Quality

8. Quality Indicator details

- Quality indicators are captured as per NABH 5th edition i.e 70 quality indicators and extra 4 clinical and 4 managerial indicators in Quality metric dashboard.
- Non – compliance of the quality metric will be supported with corrective action & preventive action report compiled by the quality office.

- The Corrective action & preventive action will be submitted to the Medical Director's office for authorization and for filing purposes.
- The authorized CAPA report will be shared with all the stakeholders concerned with the quality metric and its related non-compliance

9. Internal audits are conducted as per scheduled plan once in six months with predefined checklist based on NABH 5th edition.
10. Mock Drill will be conducted as per schedule