GSR INSTITUTE OF CRANIOMAXILLOFACIAL AND FACIAL PLASTIC SURGERY

CQI MANUAL

CQI-1

Purpose: GSR Institute of Facial Plastic Surgery is committed to continual quality improvement. This is achieved by:

1. The organization has quality improvement program which is implemented and documented as a continuous procedure covering all themajor areas of operations.
2. GSR INSTITUTE OF FACIAL PLASTIC SURGERY has designated individual for coordinating and implementing the quality improvement programme.
3. The quality improvement programme is comprehensive and covers all the major elements related to quality improvement and risk management.
4. The designated programme is communicated and coordinate damongst all the employees of the organization through proper training mechanism.
5. The quality improvement programme is reviewed at pre defined intervals and opportunities for improvement are identified.
6. Thequalityimprovementprogrammeisacontinuousprocessandupdateda tleastoncein ayear.

COMPREHENSIVE QUALITY IMPROVEMENT PROGRAM

The quality program is handled by eight defined committees of the hospital namely

1. Management review committee
2. Hospital safety committee,
3. Infection control committee,
4. MRD committee,
5. Drug review committee,
6. Purchase and inventory committee,
7. OT committee,
8. BMW committee.

Each month all committee decide to meet at a predefined date which is allocated on the previous month for the forth coming month.

1. **Management review committee** aims to focus on various aspect of day to day hospital work with the help of numerous feedback form and check list as defined and implemented. In the meeting of each month figures of the previous month are presented which also encompasses presentation of various managerial indicators like bed occupancy rate, in patient satisfaction index, out patient satisfaction index etc.

Alarming figures are discussed upon and necessary plan of action is thought of by the consent of all members in order to take care of the alarming figures.
The HR management is also a part of management review committee which includes discussion on various indicators like employment satisfaction index, employment attrition rate, employees' rights and responsibility index.
The requirement of staff is decided to be fulfilled by appropriate discussion among members.

Staff grievances and appraisal dues if any are under the perusal of this committee.
The committee also decides on the training program which is to be held each month.
The training record of the previous month is reviewed and staff feedback is critically evaluated on the same.
The committee also decides for designing yearly clinical audit.
The requirement of staff uniform and ID cards is also discussed and communicated to the purchase committee.

2. **The hospital safety committee** discusses about the security related events of the previous month and the status of the necessary actions taken for the same.

The day to day maintenance work by way of documented complaint register, also check registers of proper working of oxygen plant,

generators, maintenance of all equipment,
infrastructure maintenance, maintenance of the hard ware used for automation like computers, UPS, CPU, maintenance of medical equipment, etc are carried out through this committee.

3. **Infection control committee** meets every month to discuss about various infection rates namely, SSI Surgical Site Infection, CAUTI Catheter Associated Urinary Tract Infection, CLABSI Central Line Associated Blood Stream Infection. The culture reports from critical areas like OT, HDU, dental operatory, casualty etc are also discussed and action if deemed necessary are taken.

Various adverse drug reactions, blood transfusion reaction, which have occurred in the preceding month, are also talked about. Infection control Committee also closely observes any reported needle stick injury and the action is taken for the same.

4. The **MRD** (medical record keeping) committee meets each month discuss about errors which have occurred in the previous month by way of indicators like percentage missing records, percentage patient in which initial assessment done beyond 30 mins. Records not having discharge summary, as per the policy laid down for destruction of records, any such records is identified and there by documented and destructed using appropriate method.

5**. Drug review committee** meets each month to discuss on problems and issues pertaining to daily medication usage on patients at every step namely dispensing verification and administration .Indicators like % medication error are calculated and discussed for measures which could be taken to minimize those errors. The monthly use of narcotic drug if any are also strictly verified and followed.

6. The **purchase and inventory committee** meets each month to discuss

about the necessary procurement of necessary equipment (medical and non-medical), infrastructure changes, and materials of daily use. Required quotation is presented.

7. **OT committee** meets each month to discuss various indicators of previous month like patient utilization rate, equipment down time or any other issues pertaining to smooth functioning of theatres.

8. **Bio Medical Waste committee** meets each month and analyzes any flaw pertaining to smooth dispatch of medical and non-medical waste by respective agencies. Any flaws picked up are thus communicated to respective agencies for necessary change reqd.

All committees have their minutes written down and documented. The management review committee also overlooks the smooth functioning of other committee.

CQI-2

INDICATOR MONITORING SYSTEM

PURPOSE:

This system is for the purpose of identifying, calculating and monitoring those indicators that indicates the quality and safety levels of the hospital. The selection of indicators has been done in a manner so that all parameters relevant to quality and safety factors in the hospital are comprehensively covered.

SCOPE:

This document specifies following

1. Parameters established for quality andsafety
2. Indicators established for eachparameters
3. Methodology related to indicatorcalculation
4. Roles andresponsibilities

POLICY:

Quality and safety of the hospital shall be continually improved through structured system of calculating indicators, monitoring the indicator values with respect to the set standards, identifying trends and taking appropriate action based on the Indicator results. This system shall be considered as one of the most important system for achieving the Quality Policy and Objective of theHospital.

The parameters and indicators as described in this document shall be used for this purpose. **Quality Manager** shall take the responsibility and coordinate to get the data and Indicators calculated as per described frequency.

GSR HOSPITAL– CQI MANUAL

Standardized formats described in this document shall be used for collection of data and preparation of reports.

ABBREVIATION:

IV: Intravenous

OT: Operation Theater

ICN: Infection Control Nurse

OPD: Out Patient Department

IPD: In Patient Department

MRD: Medical Record Department

HR: Human Resource

HOD: Head of the Department

PEP: Pre ExposureProphylaxis

BB: BloodBank

PNDT: Pre Natal DiagnosticTechniques

LAB: Laboratory

CCU: Critical Care Unit

PAC: Pre Anesthetic Check Up

Important activities in Indicator Monitoring System:

1. Continual Quality ImprovementCycle
2. Parameters for Quality &Safety
3. Selection ofIndicators
4. Deselection ofIndicators
5. Standardvalue/Trend:
6. Quality & Safety Indicatorreport
7. Patient feedback and satisfaction analysis report

8. Medical Record Documentation Qualityreport
9. OT Utilizationrates
10. OPD Utilization rates
11. Validation ofreports
12. Mechanism to take action/decision on the basis of Indicatorreports.
13. Formats

1. **Parameters for Quality & Safety:** The parameter of Quality & Safety covers all parameters which affects or is related to the Quality of services and safety of patient, staff and visitors. Following parameters is defined for theHospital:

   a. Patient satisfaction
   b. Employeesatisfaction
   c. Managerial Quality
   d. Hospital widesafety
   e. Infection ControlQuality
   f. Medical Quality
   g. Departmental Quality

All activities under quality & safety programme and Indicator Monitoring System is directed towards strengthening and improving the above mentioned parameters. Various indicators as described in further section of this document is used for identifying the Quality level of each of these parameters.

2 **Selection of Indicators:** The indicator is selected for each of the above mentioned parameters. Selection of indicator depends upon the need for monitoring that indicator, which is determined by the Quality AssuranceCommittee.

The data required for monitoring and the formulae for calculating the indicator

value shall be worked up by Quality Assurance Manager and approved by Quality Assurance Committee. The formulae shall be filled in appropriate excel sheet for the purpose of automating the calculation of indicator value. Selection of indicator is a continuous activity and any indicator can be added or deleted on the basis of necessity.

3. **Deselection of Indicators:** An indicator can be deselected after approval of Committee and on followingbasis:

a. The indicator has achieved the standard value continuously for three months, and no need is felt for escalating the standardvalue.

b. The trend of Indicator values has shown a continual improvement and has achieved stability for a continuous period of threemonths.

c. If an indicator is felt to be unnecessary in meeting theobjective

4. **Standard value/Trend:** Standard values shall be fixed for each indicator to standardize the quality assurance programme. Standard values are set on the basis of internal benchmarking and perception of the Committee. Effort shall be directed to achieve/exceed this standard value. Trend shall be established for all Indicator values and effort shall be made to achieve the improvement intrends.

KEY MANAGERIAL INDICATORS

S.NO	NAME OF THE INDICATORS
1	% Employee who are aware of the rights and responsibilities
2	% OT utilization rate
3	% of inpatient satisfaction index.
4	% Employee satisfaction index
5	% Employee attrition rate
6	% Patients reporting discharge time<180 min

7	% Out patient satisfaction index
8	% Employee absenteeism rate
9	% of security related incidents including thefts
10	% Sentinel events analyzed in a defined period
11	% Missing records
12	% Equipment downtime
13	% Inpatients initial assessment completed within 30 min
14	% Incidences of falls

KEY CLINICAL INDICATORS

S.NO	**NAME OF THE INDICATORS**
1	% Rescheduling of O.T
2	% Medical records not having discharge summary
3	% of emergency patient's assessment completed within 30 min
4	% Bed occupancy rate
5	% Length of stay
6	% Care plan documented
7	% Surgical site infection rate
8	% Medication errors
9	% Medical records having initial assessment completed within 30 min of admission
10	% Incidences of bed sores after admission
11	% Adverse anesthesia events
12	% Incidence of adverse drug reactions
13	% Incidences of needle stick injuries
14	% Anesthesia related mortality
15	% Medical records not having initial assessment & plan of care

5. **Quality & Safety Indicator report:** This is a comprehensive hospital wide indicator report on all the parameters described above. Quality and safety Indicator report shall be generated on monthlybasis.

a. Indicators calculated in Quality and Safety IndicatorReport

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
1.	Percentage of inpatient cases Wherein initial assessment is completed within 30mins	number of inpatient cases wherein initial assessment is completed in 30 minutes/ Total number of inpatients reporting in thehospital X 100	Register for IPD initial Assessment	Staff Nurse	QR/Month-year/01.00
2.	Percentage of emergency patients wherein initial assessment is completed within 30min	number of emergency patients wherein initial assessment is completed in 30 minutes/ Total number of emergency patients reporting in the hospital X 100	Register for emergency initial Assessment	Staff Nurse	QR/Month-year/02.00
3.	Percentage of Cases wherein the care plan is documented & counter-signed by clinician	No of cases wherein care plan is documented and countersigned by the clinician/ Total number of admissions X 100	IPD files	Medical record department	QR/Month-year/03.00
4.	Percentage of re-scheduling of OT	Number of procedures rescheduled during the	Register kept for data	Anesthetist	QR/Month-year/4.00

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
	procedures	month / Total number of procedures performed during the month X 100	collection in OT.		
5.	Percentage of medicationerrors	Number of reported medication errors / Total number of inpatients on medication X 100	Incident reporting form	Sister In Charge	QR/Month-year/5.00
6.	Incidences of adverse drug reactions	Number of reported adverse drug reactions / Total number of medications administered to in Patients * 100	Incident reporting form	Sister In Charge	QR/Month-year/6.00
7.	Percentage of adverse anesthesia events	Number of patients reporting adverse Anesthesia events following administration of anesthesia / Total number of inpatients undergoing anesthesia for various proceduresX 100	Register kept For data Collection and Incident reporting form	Anesthetist and OT sister in charge	QR/Month-year/7.00
8.	Anaesthesia related mortality rate.	No. of death due to Anaesthesia / Total No.patient undergone administration of Anaesthesia x100	Register kept in OT for data collection and Incident reportingform	Anesthetist and OT sister in charge	QR/Month-year/8.00

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
9.	Percentage of medical recordsnot having discharge summary	Number of case sheets of discharged patients Not having documented dischargesummary /Total number of patients discharged X 100	Medical Records	Medical record In charge	QR/Month-year/9.00
10.	Percentage of medical records not having initial assessment & plan of care	Number of case sheets not having documented initial assessment and plan of care/ Total number of patients admitted through OPD and emergency X 100	Medical Records	Medical record In charge	QR/Month-year/10.00
11.	Percentage of medical records having incomplete / or improper consent.	Number of case sheets of OPD patients + in patients having improper, incomplete informed consent/ Total number of patients undergoing procedures in OPD and inpatients requiring Informed consent X 100	Medical Record	Medical record In charge	QR/Month-year/11.00
12.	Percentage of missing records	Total number of medical records(files) reported missing during themonth / Total number ofmedical records(files) made during the month X 100	Register	Medical record In charge	QR/Month-year/12.00
13.	Surgical site	Number of in patients	Registers with	ICN	QR/Month-

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
	Infection rate	reporting positive culture at the surgical site after surgery/ Total number of in patients undergoing surgicalprocedures (Post op 48 hrs) / X 100	ICN		year/13.00
14.	Incidences of falls	Number of inpatients in whom falls were reported / Total number of inpatients in the department X 100	Incident reporting forms	Sister In Charge	QR/Month-year/14.00
15.	Incidences of bed sores after admission	Number of high risk inpatients reporting of bed sores after admission/ Total number of high risk patients admitted X100	Registers in wards and ICU and Incident reporting form	Sister In Charge	QR/Month-year/15.00
16.	Bed Occupancy rate	[No. of inpatient days in a given month ÷ No. available bed days inthat month] x 100	Medical record department	Quality Manager	QR/Month-year/16.00
17.	OT utilization rate	OT utilization rate: (Total working hours of surgeries performed in OT+ Total hours taken for cleaning of OT) / Total working hoursof OT in a month X 100	OT register	Anesthetist and OT sister in charge	QR/Month-year/17.00

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
18.	Equipment downtime	No of days equipment non functional during the month / No of working days in the month X 100	Register inOT	OT In charge,	QR/Month-year/18.00
19.	Out patient satisfaction index	Total number of patients satisfied by OPD services/ Total number of patients visiting OPD X 100	Feedback forms	Hospital Administrator	QR/Month-year/19.00
20.	Inpatient satisfaction index	Total number of patients satisfied by hospital services/ Total number of patients admitted in the hospital X 100	Feedback forms	Hospital Administrator	QR/Month-year/20.00
21.	Percentage of Patients reporting waiting time < 20 mins in OPD	Patients reporting waiting time < 30 mins (insert your hosp bench mark) / total no of pts in OPD X 100	Sample survey in OPD and diagnostics	Hospital Administrator	QR/Month-year/21.00

22.	Percentage of Patients reporting discharge time < 180 mins	Patients reporting discharge time <180 mins/totalnoofpts discharged X 100	Registers in Wards	Sister In Charge	QR/Month-year/22.00
23.	Employee satisfaction index	Total no of Satisfied employees based on employee feedback Performa /Total number of employees in the hosp X 100	Employee feedback forms	HR Manager	QR/Month-year/23.00
24.	Employee attrition rate	Total number of employees resigned or	HRD department	HR Manager	QR/Month-year/24.00

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
		left the service of the hosp for any reason / Total number of employees on the rolls of the hospital X 100			
25.	Employee absenteeism rate	Total number of employees absent without leave in the hospital / Total numberof employees on the rollsof the hospital X 100	H R Department	HR Manager	QR/Month-year/25.00
26.	Percentage of employees who are aware of the employee rights, responsibilities, and welfare schemes.	Number of employees aware of their rights, responsibilities and welfare schemes/ Total number of employees in the hospital X100	Feedback form / Survey record	HR Manager	QR/Month-year/26.00
27.	Percentage of sentinel events analyzed ina define period	No of sentinel events analyzed / No of sentinel events reported X 100	Incident reporting form	Quality Manager	QR/Month-year/27.00
28.	Number of security related incidents including thefts.	Number of security related incidents including thefts. Trend to be monitored	Registers kept with Security Head	Hospital administrator	QR/Month-year/28.00
29.	Incidence of needle stick injuries	[No. of injuries / parenteral exposures in a given month ÷ No. of inpatient days in month] x 100	Needle Stick Injury Forms	ICN	QR/Month-year/29.00

S. No.	Indicator	Formula / method	Source of data	Responsibility for generating data	Quality report number
30.	Average length of stay	No. of inpatient days in a given month ÷ No. discharges and deaths in that month (in days)	MRD department	Quality Manager	QR/Month-year/30.00

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 **datacollection** worksheet of the **QualityIndicators** file from respective **sources before 5th of every subsequent month**	Quality Manager
2.	Enter the data in 'data collection' worksheet	Concerned staff
3.	The worksheet of 'Indicators' will show the indicator value	Concerned staff
4.	Take the print of indicators and file it. Name the file as **'Quality Indicators'**	Quality Manager
5.	This has to become a system and should be done Quarterly	Quality Assurance Committee
6.	This report should be discussed in quality assurance committee, and actions should be taken for those indicator which is showing unacceptable values	Quality Assurance Committee

6. **Patient feedback and satisfaction analysis report:** Patient feedback is collected on regular basis and analyzed every month to identify the patient satisfaction level with various services provided by the hospital. This report is generated every month and reviewed in QA committeequarterly.

a. **Indicators in patient feedback and analysisreport**

Following aspects / indicators are monitored through this system

- Satisfaction level with front deskservices
- Satisfaction level with Medicalstaff
- Satisfaction level withConsultants
- Satisfaction level with supportservices
- Satisfaction level withBilling
- Satisfaction level with dischargeprocess

Analysis: Overall satisfaction of individual aspect shall be calculated by taking the average of sub-question of each aspect. Level of satisfaction shall be grouped in 3 categories

- **High** – Feedback as excellent and Good shall be taken as high level of satisfaction
- **Medium** – Feedback as average shall be taken as medium level of satisfaction
- **Low** – Feedback as poor shall be taken as low level of satisfaction

Standards to be achieved:

- % of feedback collection shall be more than 50% of total dischargedpatients
- % of high level satisfaction in any of the aspects shall be 70% orabove
- % of low level of satisfaction in any of the aspects shall be 19% orless

b. Procedure of patient feedback collection and satisfactionanalysis

S. No.	Procedural Steps
1.	Patient feedback shall be collected in standardized patient feedback form
2.	At the time of discharge handover the patient feedback form to the patient
3.	Courteously request the patient to provide his / her feedback
4.	If patient do not wish don't force him / her for feedback
5.	Help the patient in providing feedback if required
6.	The filled feedback forms shall be collected for complete month
7.	Enter the data from feedback forms in to excel sheet (for calculation)
8.	The calculations are then entered in standardized patient feedback report
9.	The report shall be sent to Quality Assurance Committee and to corporate qualityteam
10.	One copy of the report shall be maintained in patient feedback analysis file
11.	At the end of 3 months trend of patient feedback shall be drawn in graphical format

7. **Medical Record Documentation Quality Indicator Report:** This indicator report identifiesthequalityofmedicalrecorddocumentationandisidentifiedfromth

8. borough screening of medical records. The documentation aspects to be screened and measured has been defined and is as given below

a. Procedure of Generating Medical Record Quality IndicatorReport

S. No.	Procedural Steps
1.	Screening of at least 50% of discharge files received in MRD on daily basis
2.	Entries are made in excel sheet template on the basis of screening
3.	Calculation is done for specific entries at the end of month
4.	These calculations are then entered in Standardized format of Medical Record Documentation Quality Indicator
5.	The report is then reviewed by MRD in charge
6.	The report is sent to QAC chairperson for discussion in committee for necessary corrective and preventive actions
7.	A copy of the report is sent to Corporate Quality Team for review and validation

9. **OT utilization rates:** Detailed utilization rates are calculated on monthly basis for Operation Theatres, to assess the level of managerial quality andefficiency.

a. Mechanism to calculate OTutilization:

S. No.	Procedural Steps	Responsibility
1.	On daily basis details of surgeries, type of surgery, OT number, In time, Out time, Total OT hours, and turnaround time shall be entered in the excelsheet	OT coordinator
2.	This excel sheet shall be send to Quality Manager at the end of the month	OT coordinator
3.	From the data available in this excel sheet Quality Manager shall generate a report for each OT	Quality Manager
4.	Reports shall be submitted to Quality Assurance committee chairperson for discussion and action in committeemeeting	Quality Manager

10. **OPD utilization rates:** Detailed utilization rates are calculated on monthly basis for OPD, to assess the level of managerial quality andefficiency.

a. Mechanism to calculate OPDutilization:

S. No.	Procedural Steps
1.	Details of specialty wise no. of OPD patients, average consultation time, number of consultation chambers, functional hours per day and functional days in the month shall be entered in excel sheet on monthly basis
2.	Automated cells with formulae filled in it, will calculate % utilization of each specialty OPD chambers
3.	Total OPD utilization percentage will also get calculated
4.	The report is sent to chairperson QAC, unit quality coordinator and corporate quality coordinator

11. **Procedure of validation of Indicator reports:** To ensure that data and indicators being seeding hospital for action and decisions are genuine and valid, a procedure of validation has been put in place. Validation of all indicator reports shall be done either offsite or onsite as described in the procedure below

S. No.	Procedural Steps
1.	Receive completed indicator reports along with main data sheet from unit
2.	Validation can be done offsite and / or onsite
3.	For offsite validation, check all entries against each indicator value and mark those which shows an obscure or irrelevant values
4.	Mark all those indicators for which value has not been calculated
5.	Check the data sheet thoroughly and identify those data values which shows obscure or irrelevant values
6.	Mark all those data values for which values has not been entered
7.	For indicators showing obscure values, check the formulae filled in cells
8.	On the basis of these checks complete the offsite validation report as per the format
9.	If required onsite validation can be decided
10.	For onsite validation, cross check a randomly selected data from the registers / records maintained in the department

12. **Mechanism to take action / decision on the basis of indicator report:** These indicator reports are meant for quality assurance and continual improvement. Action shall be decidedandtakenonthoseindicatorvalueswhicharebelowstandardlimitorshowsa downward trend. All indicators shall show a progressive improvement and this shall be depicted in trend graphs. Responsibilities and target shall be specified while taking action and all action shall be recorded in committee meeting minutes.

CQI-3

Role of the Management

Hospital Management at GSR Institute of Plastic Surgery makes sure that all the resources required for quality improvement programme are available and adequate. The Medical Director monitors all the purchase requirements required for the CQI.

Appropriate statistical and management tools are applied whenever required. The indicators are calculated by means of computer programs to avoid any calculation errors.

CQI-4

Clinical Audit

The purpose of the clinical audit is to verify the patient care in terms of all technical issues. The audits are performed using the checklist developed by the organization. To maintain a seamless facility for patient care services in the hospital and to facilitate proper and optimum utilization ofresources.

1. Medical staff participates in thissystem.
2. The parameters to be audited are defined by theorganisation.
3. Patient and staff anonymity ismaintained.
4. All audits aredocumented.
5. Remedial measures areimplemented

RESPONSIBILITY:

Manager Quality and Quality Assurance Committee

POLICY:

Patient care services of the hospital shall be assessing on regular basis by the Quality Manager and Quality Assurance Committee (Quarterly).

Quality assurance committee shall define the parameters to be audited for the patient care services.

The Quality Manager shall go on round of the hospital both clinical as well as supportive services of the hospital and find out the things are in proper manner or not.

Any issues arises shall be discuss in the committee'smeeting.

The committee shall meet on regular basis (refer committees document) and discuss the issues related to problem in the patient care services and make a unanimous decision to solve the problems.The committee shall also find way to improve the quality of patient care services in the hospital. The hospital follows the following parameter for auditing the patient care services.

Part - I

Identification data for inpatient to whom this case sheet pertains

1 RegistrationNo
2 Month ofadmission
3 Wardno
4 BedNo
5 Diagnosis on admission
6 Final diagnosis
7 No of days in hospital
8 "Disposal- Discharge/Expired/LAMA/Transferred)"

Part - II

Particulars of Clinician treating the case

1 Specialty
2 Status (Fulltime, part time,honorary)

Part - III

Relating to the records

1 Are the assessments of patients doneadequately?

2 Are the records duly named, signed, dated and timed by the concerneddoctors?

3 Are history, physical examination, diagnosis and treatment detailsavailable?

4 Are the laboratory and radiographic reports attached and entered in the record at appropriateplace?

5 Are the progress notes sufficient and relevant that the clinical course can befollowed?

6 Has the discharge summary preparedappropriately?

Relating to Diagnosis

7 Whether a provisional diagnosis was made and endorsed after theadmission?

8 Whether the provisional diagnosis tallies with the finaldiagnosis?

9 Whether laboratory findings support finaldiagnosis?

10 Whether radiological findings support finaldiagnosis?

11 Are laboratory investigations sufficient in relation to nature and gradient ofillness?

12 Was any laboratory investigation unnecessarily askedfor?

13 Was any radiological examinationsuperfluous?

14 Was any radiological examination indicated and yet not askedfor?

15 Whether the preoperative diagnosis tallies with the post-operativediagnosis?

16 Whether the autopsy findings tally with clinicaldiagnosis?

17 Whether the autopsy findings tally with pathologicaldiagnosis?

18 Whether the autopsy findings tally with radiologicaldiagnosis?

19 Was there any avoidable delay in arriving at thediagnosis?

Relating to treatment

20 Are the operation notesadequate?

21 Are the anesthesia notesadequate?

22 If the case required consultation by other specialists, was the same soughtfor?

23 Was the treatment given generally acceptable or open toquestion?

24 Whether the overall treatment given to the patient can be judged from the data endorsed in the medicalrecord?

25 Whether the clinician exceeded the privilege or limits of his or her training and competence?

26 Whether there was adequate indication forsurgery?

27 Whether any normal organ or tissueremoved?

28 Whether any part of the treatment given wassuperfluous?

29 Whether the patient refusal to undergo a prescribed treatment wasjustifiable?

Relating to End result

30 Was the final result in consonance with the nature of the case and expectedprognosis?

31 In case of death, whether it was expected, justifiable ornot?

32 Were the complications justifiable ornot?

Relating to Complications and Cross-infection

33 Whether there was any hospital cross infection which could have beenavoided?

34 Whether there was postoperative infection which can beavoided?

35 Whether there was a complication because of faulty surgicaloperation?

36 Whether there was postoperative complication which could have beenavoided?

37 Whether there was any anesthetic complication which could have beenavoided?

Relating to Operation cases

38 Was consent for anesthesia and operationobtained?

39 Was there adequate indication forsurgery?

40 Was any normal tissue removed and if so was itjustified?

41 Was pre anesthetic assessment for anesthesia done andrecorded?

Relating to the Length of Stay of Patient

42 Was there any inordinate delay between admission and surgicaloperation?

43 Whether there was inordinate delay between admission and commencement of specific/definitivetreatment?

44 Whether there was inordinate delay between admission and ordering of laboratory or radiological investigations?

45 Whether there was inordinate delay in arriving at finaldiagnosis?

46 Was the length of stay of the patient in hospital longer than was reallynecessary?

47 Did he or she develop any ailment during stay in hospital necessitating longerstay?

Relating to Post event analysis

48 Whether post event analysis of CPR conducted andrecorded?

49 Whether post event analysis of blood transfusion conducted andrecorded?

50 Whether post event analysis of adverse drug event conducted andrecorded?

GUIDELINES CLINICAL AUDITS

THE DEFINITION OF CLINICAL AUDIT

"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 review of change. Aspects of the structure, process and outcome 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." (NICE, 2002)
The Hospital and its Medical practitioners will actively engage in audit and participate in one audit exercise annually that relates directly to their area of clinical practice. It is recommended that practitioners spend at a minimum one hour per month in audit activity.
Clinical audit is recognized as having three elements:

1. Measurement - Measuring a specific element of clinical practice

2. Comparison - Comparing results with the recognized standard (in circumstances where comparison is possible)

3. Evaluation - Reflecting the outcome of audit and where indicated, changing practice accordingly.

A structured programme of surgical audit is fundamental to the provision of quality health care. Clinical audit should be an integral and routine part of health care, not an exceptional or optional item and that the results of clinical audit programme must feed back into the service to give improved quality of care for patients. Audit will be utilized as a mechanism for the achievement of objectives that includes assessing and improving the quality of patient care, enhancing surgical education by promoting discussion between colleagues about practice and identifying ways of improving the efficiency of clinical care. Surgical Audit should be regarded as the systematic critical analysis of medical care, including procedures used for diagnosis and treatment, and the use of resources and the resulting outcome and quality of life for patients.

It would appear that the following process should be used to evaluate Surgical Audits:-
1. Regular systematic meetings for surgical audit within thehospital
2. All teams in a particular specialty (e.g. general surgery, dentistry, etc) may be involved.
3. All members of the team from residents to Consultant should participate
4. All patients admitted under each service should be included in the review process
5. All morbidity and mortality occurring in the department should be discussed
6. There should be a mechanism for altering practice based on the results of evaluation in an effort to improve results in the future.
7. The final stage of the "audit loop" should include re-evaluation of any alterations made in practice to verify that these alterations have produced the desired results
8. A written record should be kept of the audit process

There are several identifiable stages to complete a clinical audit:

Stage 1 identifying the topic for the clinical audit. Pick a topic you are interested in, where you suspect that standards could be improved, where the change you expect to recommend is possible.

Stage 2 Select the relevant audit standards. You may need to do a literature search for the standards in the area you have chosen

Stage 3 Draft a written protocol. This should include rational for doing the audit, population to be surveyed, time frame and data to be measured.

Stage 4 Carry out the data collection. Decide what data you need to collect. Produce a proforma sheet to gather the data from individual records.

Stage 5 Compare your data against the selected audit standard.

Stage 6 Identify the changes that you need to make to achieve the standard. Put in place any actions and plans to correct any shortfall between the actual activity and the selected standard.

Stage 7 Re-audit to complete cycle. Clinical audit is only of benefit when the audit loop is

closed and the services are improved. Audit should be relevant to scope of practice and the methodology must be adapted to those who are not in routine clinical practice. Such audits should include qualitative and quantitative measurements of activity. Where there are no known or available standards, data can be compared to historical records over time. This data should be subject to peer review if need be.

CQI-5

SENTINAL /OTHER EVENT REPORTING

PURPOSE:

A. To ensure prompt assessment and response to all incidents resulting in injury to Patients, employees, or visitors. To accurately document threats or actions of violence, inappropriate sexual behavior, fires and environmental emergencies. To accurately document incidents of propertydamage.

B. To accurately document events and to identify staff response to theevents.

C. To identify contributing factors/conditions that led to the incident and to identify steps taken to prevent the recurrence of a similarincident.

D. To provide accurate, timely information for an ongoing incident reportdatabase.

POLICY:

A. As a measure of improving patient safety all hospital staff shall be vigilant to identify and report the events which are undesirable and needs to be act upon for corrective and preventiveaction.

Following undesirable events shall be reported as soon as the occurrence of these events comes in to notice.

a. Patient fall

b. Medicationerror

c. Restraint relatedinjury

d. Abscondedpatient

e. Diagnostic errors (Like wrong test, mismatch of reportsetc.)

f. Violation of patient'srights

g. Development of pressure sores

h. Missing medicalrecord

i. Others

B. Employees who witness or are aware of an incident are responsible for completing an Incident Report at the time they become aware of theincident.

C. An Incident Report must be completed anytime there is an injury (regardless of Severity) to patients, employees or visitors. An Incident Report must be completed in the event of damage or loss of hospital and/or patient property. When possible, a photograph of the damaged property will be taken by security and given to theAdministrator

D. An Incident Report must be completed whenever physical skills are used to move a patient to seclusion orrestraints.

E. All Incident Reports must be filled out completely including patient's hospital number, patient's unit, date of injury, time of injury, etc. When completing an Incident Report that involves an injury (or property damage) to a patient or employee resulting from another patient, the hospital number of the patient who caused the injury must be provided in the "Description of Incident" portion of the report. The acting In Charge's name will be stated on thereport.

F. The actual incident report will not be noted in the patient'schart.

G. Quality Assurance Committee will monitor and evaluate data

H. generated by the reporting process as part of the Hospital's performance improvementactivities.

I. TYPES OF SENTINEL EVENTS

(1). Surgical Events: Wrong body part/ Procedure, Retained Instrument, Death during the procedure, Anesthesia related Events

2). Patient Protection events: Suicide, Attempted suicide, Self harm, internal injury, Nosocomial infection

(3). Care Management events: Hemolytic reaction, Medication Errors

(4). Device or Product Events: Contaminated drugs and device, Unintended use, Breakdown or failures

(5).Environmental Events: Burn, Slip, fall, Electric shock,

(6)Criminal Events: Impersonation, Abduction, Sexual Assault, Physical assault on the grounds of health Care facility

In case of observation of any such event by any staff during or beyond the duty hours, kindly report to the management promptly for necessary action and documentation

DEFINITIONS:

Events – Any unusual or unexpected occurrence that results in injury or injury to patients, staff, or visitors. Threats or actions of violence, inappropriate sexual behavior, fires and environmental emergencies, any event that results in damage or potential damage to or loss of hospital property, patient property or specified employee property.

RESPONSIBILITIES:

All employees are responsible for safety and reporting safety concerns to their immediate supervisor and then to Top Management.

A. Quality Manager will maintain a database of all Incident Reports. All Incident Reports

B. will be assigned a severity rating and categorized according to type of injury by the Quality Manager.

C. TheQualityManagerwilltakeappropriateactiontodecreasethepotentialforrepeatincidents

D. Employees must complete an Incident Report at the time they become aware of an Incident. All Incident Reports must be completed prior to the end of the shift. Employees must notify their supervisor/In charge of all incidents before the end of the shift. An Incident Report must be completed for all patient, staff or visitor injuries, regardless ofseverity.

E. Nurses must assess the injury and administer first-aid as necessary. Nurse Supervisors must be notified of all incidents before the end of the injured employee'sShift.

F. Nurse Supervisors/Immediate Supervisors must take steps to ensure all injury reports Submitted to them by employees are acted upon appropriately. Any Hazardous Condition reports Generated from an incident must be forwarded to the Quality Manager after the Supervisor/In charge completes their section of thereport.

PROCEDURE:

An Incident Report must be completed anytime a patient, employee or Visitor is injured regardless of severity. An employee who witnesses an incident must complete the Incident Report. In the event of an unobserved injury, the employee who first becomes aware of the injury must complete an incidentreport.

The filled in format shall be send to Quality Assurance committee for analysis, action, and maintaining the record of occurrence of such events.

The Quality Manager will review all Incident Reports and will assign severity Rating and injury type. All severity and higher rated injuries will be reported to the Medical Superintendent.

A monthly statistics shall be calculated by the committee for occurrence of such events, which shall be presented to hospital authorities.

Following details shall be provided in case of occurrence of an undesirable event (A format can be developed for this or an online mechanism can be developed for reporting these details)

1. Patient details – (name / MRDnumber)
2. Date of occurrence–
3. Time -
4. Department /Area

5. Reported by–
6. Category–
    a. Patient fall
    b. Medicationerror
        i. Wrongpatient
        ii. Wrongdrug
        iii. Wrongroute
        iv. Wrongtime
        v. Wrong rate ofadministration
        vi. Other
    c. Restraint relatedinjury
    d. Absconded patient
    e. Diagnostic errors (Like wrong test, mismatch of reports etc.)
    f. Violation of patient's rights
    g. Development of pressure sores
    h. Missing medical record
    i. Others
7. Brief description of event
8. Severity of the event

Minor event

Major event

9. Action taken / to betaken

Statistics to be maintained for occurrence of such events (every month)

1. Number of unwanted eventsoccurred

No. and percentage of following (% to total number of events)

2. Minorevents
3. Majorevents
    a. Patient fall
    b. Medicationerror
        i. Wrongpatient
        ii. Wrongdrug
        iii. Wrongroute
        iv. Wrong rate ofadministration
        v. Other
    c. Restraint relatedinjury
    d. Patient burns
    e. Absconded patient
    f. Diagnostic errors (Like wrong test, mismatch of reports etc.)
    g. Violation of patient's rights
    h. Development of pressure sores
    i. Missing medical record
    j. Others