	Quality Management Systems Procedure	
	Title: Quality Policy	
	Document Number- 001/QA/TVVP/2017	
	Issue Number- 01	
	Effective Date- 01. Dec.2017	
Review and Approved by: Smt. Karuna Vakati,IAS (Signed)		

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 and evaluation of quality related aspects within the system.

Objectives:

- To facilitate and oversee the implementation of the chosen strategies for overall Quality Assurance and Quality Improvement (QA/QI) initiative in the hospital in line with the quality policy of the TVVP
- To develop Annual plan for QA/QI in line with quality Assurance and Improvement plan as per the National Quality Assurance Standards
- To oversee improvement of the quality via National Certification including provision of guidance advice and necessary support for taking care of new processes and changes in the system required for any such certification

Purpose:

The purpose of the Quality Improvement efforts at all TVVP Hospitals is to ensure delivery of the best possible care for our patients. It is the goal of this plan to provide a mechanism and process to identify opportunities to improve care and services by measuring, assessing, and improving care in accordance with National Quality Assurance Standards.

Scope:

All employees and patients coming to the TVVP hospitals

Responsibility:

Quality Assurance Manager & Quality Assurance Team

Distribution:

Heads of respective hospitals &departments, Quality Assurance Manager, hospital employees

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Process Details:

The hospital follows a structured quality assurance and continuous monitoring programme, developed by District Quality Assurance Committee, on the basis of NQAS standards.

Structure for Quality Assurance:

The following structure has adopted by all our TVVP Hospitals for carrying out processes related to Quality Assurance:

Documentation system: Hospitals have developed its documentation on policies, procedures, programmes, guidelines etc. These have been developed by State Quality Team in consensus with Medical Superintendents of the TVVP hospitals, reviewed by Supervising Officers and have been approved by Commissioner, TVVP.

District Quality Team: Quality assurance related activities within the hospital is planned, undertaken, and controlled by District Quality Team which is a multidisciplinary team having representation from various clinical, non-clinical, and administrative departments. Details of team, its scope of work, frequency of meeting and mode of operations are detailed in the operational guidelines for Quality Assurance in Public Health Facilities (Page No: 25-27) published by Ministry of Health and Family Welfare, Govt of India.

District Quality Assurance Manager: The District Quality Assurance Manager has overall responsibility of coordinating the work of NQAS certification. His / her responsibility will include:

- To issue various documents to departments from time to time and train the trainers
- To keep a record of all the documentation of the hospital, in relation to certification
- To delegate the activities in departments and ensure its timely completion
- To regularly receive feedbacks from departments regarding status of their work related to certification preparation.
- To plan and execute regular assessment of the hospital by using NQAS checklists, collection of data related to KPIs, PSS in accordance with certification standards.
- To coordinate all such activities required for quality assurance and continuous monitoring of the hospital.

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

- Receive and retain all the documents and official correspondence related to certification from time to time
- To inform and orient the staff of their department on policies and procedures developed for their department
- To ensure the completion of all the work assigned to their department for NQAS certification preparation
- To organize regular training programmes for staff of their department on best practices.

1. The programme:

The programme is comprehensive and covers quality assurance of input, process and outcome. This has been developed by State Quality Assurance Team and implemented by various committees, DQAM and other personnel.

Quality assurance and continuous monitoring programme is developed for following areas

Departmental Score Cards

1	Accident & Emergency	6	Indoor Department
2	Outdoor Department	7	Nutritional Rehabilitation Centre
3	Labour Room	8	Sick New Born Care Unit
4	Maternity Ward	9	Intensive Care Unit
5	Paediatric Ward	10	Operation Theatre

Thematic Score Cards

1	Service Provision	5	Clinical Services
2	Patient Rights	6	Infection Control
3	Inputs	7	Quality Management
4	Support Services	8	Outcome

The departmental scores & outcome indicators / thematic scores / KPIs / PSS described in the page no: 63 to 70 of Operational Guidelines for Quality Assurance

in Public Health Facilities cover all parameters which are related to the quality of services and safety of patient, staff and visitors.

Large secondary care hospitals like District Hospitals can have survey on monthly basis. Smaller facilities like PHCs and CHCs may take PSS scores on quarterly basis, remaining all like departmental scores & outcome indicators / thematic scores / KPIs on monthly basis.

DQAM may be responsible for collecting the data / feedback.

For getting the valid results sample size should be adequate. Refer page no: 69 of Operational Guidelines for Quality Assurance in Public Health Facilities, 2013.

Data / feedback collected should be analyzed. Analysis should generate overall as well as area / attribute wise score. Lowest performing two attributes should be identified and root cause analysis should be done for them.

Action plan should be prepared on causes identified during root cause analysis including corrective and preventive action to be taken, time line and person responsible for taking action. Compliance to action should be reviewed monthly.

Procedure for implementing the Quality Assurance Programme in TVVP Hospitals is as follows:

- The programme which is applicable hospital wide and which is applicable for infection control is explicitly tabulated. Quality Assurance Team and Hospital Infection control committee shall implement monitor and improve the programme.

- The indicators developed by NQAS are incorporated in the reports. This 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 DQT.

- The programme applicable for laboratory, radiology, intensive care area and OTs shall be implemented through departmental in charge under the vigilance of District Quality Team. Each of these departments shall maintain a quality assurance register with the key characteristics of their department laid. 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.

Purpose	**Methodology**	**Responsibility**	**Remark**
Setting goals and objectives	Setting of vision, mission, quality policy & objectives and service standards through DQAC and approval of Commissioner - TVVP.	DQT & DQAM	Refer service standards
Infrastructure	Identifying infrastructural requirement including physical facility, manpower and equipment. This is determined on the basis of work load and change in scope of work	MS / RMO	Reference is taken from 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.	DQAM	Reference is taken from Operational Guidelines-NQAS
Compliance monitoring	Compliance is monitored and non-conformity is tracked for taking corrective and preventive actions. This is done through compliance monitoring registers kept in various departments	All the staff of the hospital and Quality Assurance Team / Departmental coordinator	Reference is taken from Operational Guidelines-NQAS
Walk through monitoring	Walk through monitoring or physical monitoring is done by designated member of DQT, Hospital infection control committee, hospital safety committee, DQAM, RMO and MS	DQT, Hospital infection control committee, hospital safety committee, DQAM, RMO and MS	Following aspects are specially looked for infection control, hospital safety, record maintenance and policy compliance

Indicator monitoring	A list of key performance 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 District Quality Assurance committee	DQAM and DQT	Refer Key Performance Indicators
Training and orientation	Necessary training is organized at regular intervals	DQT and DQAM	Refer all policies & SOPs
Continuous process	The contents of this programme are reviewed every month by District Quality Assurance Committee and quarterly by State Quality Assurance Committee for adequacy.	DQT / DQAM / SQT	Following aspects is reviewed every year: 1) Objectives and service standards 2) Adequacy of documentation 3) Monitoring and Evaluation 4) KPIs and PSS 5) Structure for implementation and targets

In line with our goal of providing quality services in our TVVP hospitals, we had developed and set our mission, vision, quality policy, and service standards.

Our Vision

"TVVP Hospitals provides comprehensive healthcare at free of cost for all sections of people of Telangana without any limitation of caste, colour, religion or ethnicity"

Our Mission

- ***To provide healthcare services to the patients ensuring best quality scientific and ethical standards.***
- ***To continuously upgrade the quality of medical practice and education.***
- ***To develop simple and innovative technologies for prevention, diagnosis and treatment of diseases.***

Quality Policy

TVVP hospitals arecommitted to our patients and their families with more emphasis on providing service excellence in healthcare with honesty & dignity by following National Quality Assurance Standards.

Quality Objectives:

- ***To promote a safe environment for patients and staff to facilitate a culture of quality throughout all TVVP hospitals in the state of Telangana.***
- ***To monitor, measure, assess and improve our performance to achieve service excellence and patient satisfaction.***
- ***To facilitate continuous learning and development of personnel.***
- ***To empower and involve all personnel in continual quality improvement.***

2. Service standards:

- 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.

- To provide access to hospital and reasonable medical care to all patients who visit the hospital / ensure availability of beds / ensure treatment of emergency cases with at most care and promptness.

- The hospital has necessary manpower / infrastructure &equipment required for providing the services mentioned in service provision and system to ensure such services is in place.

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

- To ensure that all major equipment in the hospital are maintained efficiently in proper working condition by issuing timely work orders for Annual Maintenance Contracts / Comprehensive Maintenance Contracts for all the major equipment.

- Reliability and promptness of diagnostic investigation results is ensured by sending the samples for external quality assurance for all measuring equipment in the labs and whenever possible such reports will be made available.

- 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.

- To keep the hospital and its surroundings, clean, infection-free and hygienic by adhering to Swachata Guidelines for Public Health Facilities, 2015.

- 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. The patient's rights are protected as per National Quality Assurance Standards.

- A regular system of obtaining feedback / complaints from the patients and public is in place through call center based CFMS with dedicated number (Customer Feedback Management System) / Help Desk / Complaint boxesand periodic surveys. The inputs from these are continuously used for improving the service standards.

- 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.

- 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.

- 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.

- To Identify all condemnable items in the facility (Unserviceable / obsolete / condemned) and take necessary action for immediate condemnation / disposal. For more details refer Lr.No.104CH&FW/NHM/QA/2017.

- To follow Bio-waste Disposal 2016 guidelines through proper Segregation of waste, Collection, Transportation and disposal by outsourcing agency. Monitoring of infection control practices can be done by Infection Control Committee (ICC) which has been constituted as per G.O M.S No: 54.

- Hospital follows all policies, processes, programmes, committee meetings; regulatory guidelines, which have been prepared to meet the standards of NQAS.

3. <u>Initiatives of Internal and External Quality Assurance Programme:</u>

Internal Quality Assurance activities-

a. Housekeeping Checklist
b. Dietary checklist
c. Linen Checklist
d. Ambulance checklist
e. Running Quality controls in Laboratory
f. Running Quality Controls in CSSD
g. Microbiological Surveillance of critical areas such as labor room, OT complex, ICU, SNCU, NBSU, Post-operative wards for every 15 weeks through swabs and air samples.
h. Internal monitoring rounds by DQAM, Superintendent and Matron and preparation of action plan for gaps identified.
i. Overhead water tank cleaning by Municipality.
j. Overhead tanks and drainage cleaning by Civic authorities for every 03 months/ when required.
k. Water testing by RWS laboratory on Chemical and Biological indicators for every 15 days.
l. Gardening/ landscaping by Horticulture department.

External Quality Assurance Activities-

a. Validation of test results from CMC- Vellore/ AIIMS- New-Delhi
b. Obtaining Form- B for USG machine.
c. AERB clearance for X-ray machines.
d. Fire NOC from Fire department- Requested to instruct fire department to do help in assessment of fire requirements in obtaining fire NOC and also conducting training and mock drills for staff.
e. Electricity audit by electricity board.
f. Seismic staff assessment by E.E of TSMSIDC.
g. TLD badges can be procured and put to use by the x-ray technician. The same used TLD badge can be sent to BARC, Mumbai to determine the radiation exposure.

4. Standard Operating Procedures & Control:

Preparation of Document: Need for SOPs shall be identified on a continual basis through feedback of staff, addition of new services in line with NQAS. Once a need for a document is identified DQAM / MS along with the concerned personnel prepares the document specifying the details and responsibility of implementation. Document is prepared in prescribed format and its location is identified in master list of documents.

Review and Approval: All prepared documents are reviewed by appropriate head of the department / Medical Superintendent and approved by Commissioner-TVVP. No document without approval signature of Commissioner-TVVP shall be considered official. The stamp of 'CONTROLLED' shall be put on approved document.

Issue and distribution: An officially controlled document can be distributed and issued only after approval from Commissioner-TVVP. Only photocopy of the approved documents shall be issued and not the original document. The document shall be issued to departmental in charge or Head of the department. A record of document issuance shall be kept by DQAM, indicating name of issued document, date of issue, receiving person and signature of receiving person.

Maintenance of document:

Master copy: Master copy of all documents shall bear the original signature of Superintendent. Master copies will be kept in separate under the custody of DQAM.

Issued copy: Responsibility of maintenance of issued copies lies with receiver of the document (departmental in charge) In-charge shall keep a checklist of all documents received and maintained by him/her. All issued documents are to be kept at workplace and prevented from loss, tampering or unofficial change in

contents. The issued copy shall be available and accessible to all the staff of the department and they shall be encouraged to read it.

Addition of new document: Any new document to be added in officially controlled documents of the hospital shall be added in appropriate Area of Concern of NQAS.

Amendments: Need for amendments in an existing document are identified through staff feedback and DQT meetings.

For minor amendments, (like spelling mistake, grammatical error etc.) the rectification shall be done by pencil in issued document by departmental in-charge and in master document by DQAM. All such minor amendments shall be reported to State Quality Team, who shall maintain a record of all such amendments in document amendment sheet.

For major amendments, (like change in content of the document) the amendment shall be done by DQAM and approved by Commissioner-TVVP. Amended copy shall be given revision number and revision date. All such amended documents shall be distributed and issued to departments through a circular which shall specify to replace the existing document with revised document and destroy the obsolete copy.

Review of documents: All documents shall be reviewed once in a year, by DQAM, HODs and DQT. Based on the review following decision shall be taken

- Continue with the existing document: In this case a circular shall be circulated indicating that the documents to be continued to use in its present form
- Revision of the issue: In this case a new issue of the complete documentation set shall be printed and all modifications and amendments shall be incorporated. Revision number on each document shall be given '00' and issue number shall be changed to next higher number.

Obsolete documents: A copy of all obsolete documents shall be retained in documentation control file under the custody of DQAM. All obsolete documents shall be labeled with pen as 'OBSOLETE'

Monitoring: Quality coordinator shall periodically check the availability, upkeep and updating of the official controlled documents issued in wards and departments. Any non-conformity to document control procedure shall be recorded in compliance monitoring register and appropriate action shall be taken.

Records of document control: The records related to document control shall be kept by DQAM. All records shall be kept in 'Document Control' File. The file should contain:

- Master list of all document
- Distribution and issue record
- Record of amendments
- Obsolete documents

5. Preventive Actions by using Quality methods and tools:

The DQAM shall be perpetually vigilant and identify potential sources of non-compliance and areas that need improvement. These may include trend analysis of specific parameters such as turnaround time, risk analysis and introducing proficiency testing for self-assessment.

Where preventive action is required, a plan is prepared and implemented. All preventive actions must have control mechanisms and monitor for efficacy in reducing any occurrence of non-compliance or producing opportunities for improvement.

Corrective Actions by using Quality methods and tools:

The DQAM takes all necessary corrective action when any deviation is detected in Quality Management System.

Root Cause Analysis

Deviations are detected by:

- Patient complains/feedbacks
- Non-compliance receipt of items/sample
- Non-compliance at Internal/external Quality Audit
- DQT Reviews

The DQT conducts and coordinates the detailed analysis of the nature and root cause of non-compliance along with the responsible persons from the respective sections.

Selection and Implementation of Corrective Actions

Potential corrective actions are identified and the one that is most likely to eliminate the problem is chosen for implementation. Corrective action is taken into consideration the magnitude and degree of impact of the problem. All changes from corrective action is documented and implemented.

Monitoring Of Corrective Actions

The Medical Superintendent and DQAM shall monitor the outcome parameters to ensure that corrective actions taken have been effective in eliminating the problem.

Additional Audits

When the magnitude of non-compliance cases doubts on the departments' overall compliance with documented procedure, additional audits are conducted.

6. **Quality Improvement and Patient Safety priorities 2010**

- Standardize our systems, processes, policies and procedures across the hospital.
- Adopt, implement and monitor compliance of the International Patient Safety Goals.
- Optimize Electronic Health Records which will eliminate medical errors and improve patient care.
- Develop training programs for all employees on principles and practice of healthcare quality.
- Achieve NQAS certification.

7. **Risk Management Framework**

Refer "Reporting of adverse incident's policy"