# Internship
# at
# Fortis Memorial Research Institute, Gurgaon

**Submitted By**
**Sumeet Kaur Bajaj**

**Post Graduate Diploma in Hospital & Health Management**
**2012-2014**

**Institute of Health Management Research,**
**Jaipur**
**2014**

**Table of Contents**

# *1.0 INTRODUCTION TO FORTIS HEALTHCARE*

Fortis Healthcare Limited is a leading, pan Asia-Pacific, integrated healthcare delivery provider. The healthcare verticals of the company span diagnostics, primary care, day care specialty and hospitals, with an asset base in 5 countries, many of which represent the fastest-growing healthcare delivery markets in the world.

Fortis Healthcare is driven by the vision of becoming a global leader in the integrated healthcare delivery space and the larger purpose of saving and enriching lives through clinical excellence.

Fortis Healthcare is driven by the vision of saving and enriching lives through clinical excellence. Currently, the company operates its healthcare delivery network in India, Mauritius, Singapore, Sri Lanka and UAE with 75 hospitals, over 12,000 beds, 600 primary care centres, 191 day care specialty centres, 230 diagnostic centres and a talent pool of 23,000 people.

A number of factors make Fortis Healthcare the ideal choice for those looking for high quality diagnostic, medical or surgical services:

- A large network of integrated healthcare services across Asia-Pacific
- World class medical facilities with the latest technologies
- Medical specialists who have been trained in the best medical institutes across the world. They have been globally acclaimed and are renowned medical experts
- End-to-end services combined with personalized care to ensure a seamless stay
- Great value for money

Fortis Healthcare Limited is a leading, pan Asia-Pacific, integrated healthcare delivery provider.The healthcare verticals of the company span diagnostics, primary care, day care specialty and hospitals, with an asset base in 11 countries, many of which represent the fastest-growing healthcare delivery markets in the world.

Currently, the company operates its healthcare delivery network in Australia, Canada, Dubai, Hong Kong, India, Mauritius, New Zealand, Singapore, Sri Lanka, Nepal and Vietnam with 76 hospitals, over 12,000 beds, over 600 primary care centres, 191 day care specialty centres, over 230 diagnostic centres and a talent pool of over 23,000 people.

Fortis Healthcare is driven by the vision of becoming a global leader in the integrated healthcare delivery space and the larger purpose of saving and enriching lives through clinical excellence.

The company provides patient services including nuclear medicine and cardiac imaging,labs,scans, cardiology, cardiacpacing,electrophysiology, neurosciences, orthopedics, gyne-cology and obstetrics, pediatrics, maternity services, diagnostic services, pediatric

ophthalmology, neurophthalmology, internal medicine, general surgery, urology, nephrology, gastroenterology, mental health and behavioral sciences, rehabilitative services, Pulmonology and IVF etc.

| | |
|---|---|
| **Type** | Public BSE: 532843 |
| **Industry** | Health care |
| **Founded** | 2001 |
| **Founder(s)** | Vishal Bali |
| **Headquarters** | Delhi, India |
| **Owner(s)** | Malvinder Mohan Singh<br>Shivinder Mohan Singh |
| **Website** | http://www.fortishealthcare.com |

## *1.1Vision of Fortis Healthcare Limited*

To be a globally respected healthcare organization known for Clinical Excellence and Distinctive Patient care.

## *1.2Values of Fortis Healthcare Limited:*

| | |
|---|---|
| **Patient Centricity** | Commit to 'best outcomes and experience' for our patients.<br>Treat patients and their caregivers with compassion, care and understanding.<br>Our patients' needs will come first |
| **Integrity** | Be principled, open and honest.<br>Model and live our 'Values'.<br>Demonstrate moral courage to speak up and do the right things. |
| **Teamwork** | Proactively support each other and operate as one team.<br>Respect and value people at all levels with different opinions, experiences and backgrounds.<br>Put organization needs' before department / self interest. |
| **Ownership** | Be responsible and take pride in our actions.<br>Take initiative and go beyond the call of duty.<br>Deliver commitment and agreement made. |
| **Innovation** | Continuously improve and innovate to exceed expectations.<br>Adopt a 'can-do' attitude.<br>Challenge ourselves to do things differently. |

## *1.3Fortis Logo*

The **"Healing Hands"** logo—two hands fusing seamlessly with a human form, expresses our reassuring approach to healthcare and serves as a constant reminder of the patient-centricity that is fundamental to our ethos.

The logo reflects our commitment to achieving excellence in healthcare delivery by bringing together the best of technology, medical expertise, and patient care. It emphasizes the human values that govern every facet of our organization.

Green, the dominant colour, is representative of the health and well-being we seek to bring to those we minister to, while red indicates the dynamism with which we strive to make it a reality.

Distinctive, vibrant, memorable and contemporary, The Fortis Healthcare logo is a fitting visual signature of an organization that seeks to excel, lead and serve.

## *1.4List of Hospitals of the Fortis Healthcare Limited:*

| | | |
|---|---|---|
| Amritsar | Amritsar | Fortis Escorts Hospital |
| Bangalore | Bannerghatta Road | Fortis Hospital |
| Bangalore | Cunningham Road | Fortis Hospital |
| Bangalore | Nagarbhavi | Fortis Hospital |
| Bangalore | Rajajinagar | Fortis Hospital |
| Bangalore | Seshadripuram | Fortis Hospital |
| Chennai | Adyar | Fortis Malar Hospital |
| Dehradun | Dehradun | Fortis Escorts Hospital |
| Faridabad | Faridabad | Fortis Escorts Hospital |
| Gurgaon | Gurgaon | Fortis Memorial Research Institute |
| Jaipur | Jaipur | Fortis Escorts Hospital |
| Kangra | Kangra | Fortis Hospital |
| Kolkata | Rash Behari Avenue | Fortis Hospital & Kidney Institute |
| Kolkata | Anandapur | Fortis Hospital |
| Mohali | Mohali | Fortis Hospital |
| Moradabad | Moradabad | Fortis Vivekanand Hospital |
| Mumbai | Vashi | Fortis Hiranandani Hospital |
| Mumbai | Kalyan | Fortis Hospital |
| Mumbai | Mulund | Fortis Hospital |
| Mumbai | Mahim | S.L. Raheja Hospital |
| Mysore | Mysore | Fortis Cauvery Heart Hospital |
| New Delhi | Greater Kailash II | Fortis La Femme |
| New Delhi | Shalimar Bagh | Fortis Hospital |
| New Delhi | Vasant Kunj | Fortis Flt. Lt. Rajan Dhall Hospital |
| New Delhi | Okhla Road | Fortis Escorts Heart Institute & Research Centre |
| Noida | Noida | Fortis Hospital |
| Raipur | Raipur | Fortis Escorts Heart Centre |

## *2.0 Fortis Memorial Research Institute, Gurgaon (FMRI)*

FMRI is a multi-super specialty, quaternary care hospital with an enviable international faculty, reputed clinicians, including super-sub-specialists and specialty nurses, supported by cutting-edge technology. A premium, referral hospital, it endeavours to be the 'Mecca of Healthcare' for Asia Pacific and beyond. Set on a spacious 11-acre campus with 1000 beds, this 'Next Generation Hospital' is built on the foundation of 'Trust' and rests on the four strong pillars Talent, Technology, Infrastructure and Service.

TALENT: Fortis Memorial Research Institute's comprehensive medical programme is driven by reputed doctors, super- sub- specialists and specialty nurses, all committed to integrating their exceptional medical expertise, technology and innovation to offer best – in class treatments.

TECHNOLOGY: Fortis Memorial Research Institute has a complete spectrum of diagnostic and therapeutic technology, including several state-of the-art technologies that are first in the world, first in Asia and first in India.

- Radiation Therapy: First in the world - A collaboration between leading technology innovators Brain Lab and Elekta
- 3- Tesla Digital MRI - World's first digital broadband MRI
- Stem Cell - India's first stem cell lab in a hospital in collaboration with Totepotent Rx a, US based cell Therapy Company.
- Open Lab - India's first ever "see - through" glass lab with instant collection and real time processing of blood - samples.
- e- ICU- An advanced patient management system with two - way audio visual communication. It allows clinicians to access patient 24x7. First of its kind in the world.
- 256 Slice CT - A state of the art 256 Slice Brilliance iCT Scanner with the ability to capture an image of the entire heart in just two heart beats
- Bi- Plane Cath Lab - State-of-the-art Bi Plane Cardiac Cath lab to address cardiac and vascular interventions
- Brain Suite - One of its kind CT based Brain Suite, equipped with intra operative CT for brain and spine.
- Time of flight PET CT - An installation with Time of flight (TOF) reconstruction for exceptional image quality. Has the ability to detect lesions as small as 0.1 inches.
- Voice Modulated & Integrated Operating rooms - Two modular operating rooms integrated with equipment and controlled by common control panel.

INFRASTRUCTURE: With landscaped greens, tranquil water bodies, sculptures, sunlit interiors, Fortis Memorial Research Institute follows a design philosophy aimed at healing. The hospital has been built keeping in mind all round wellness – mind, body and soul. Simultaneously meet simple needs of the caring attendants by means of facilities as the Tummy Luck, Meditorium, R&R lounge, Holistic Health, Mamma Mia, Retail Therapy, Crèche, Health 4 U, Spa and Fortiplex, to meet the simple needs of caring attendants.

SERVICE: Woven into the fabric of the hospital are innovative services, where every attempt has been made to look after our patrons so that they feel cared-for and special. Angel: A welcoming face at the hospitality desk to make visitors feel special. Genie: A friendly and helpful companion to assist patients navigates the hospital. Concierge: A facilitation desk to assist patrons with various needs in and outside the hospital

### *2.1. Vision*

To be the ultimate healthcare destination - "Mecca of Medicine"

### *2.2. Mission*

To provide quaternary care to the community in a compassionate, dignified and distinctive manner

### *2.3. Motto*

"Best is the Least We Can Do"

## *3.0 Quality Department*

### *3.1. Objectives*

a. Satisfying patient needs
b. Enhancement of quality systems
c. Effective performance measurement & compliance systems
d. Continuous Improvement loop
e. Engage every employee in quality drive

### *3.2. Organization Structure – Quality*

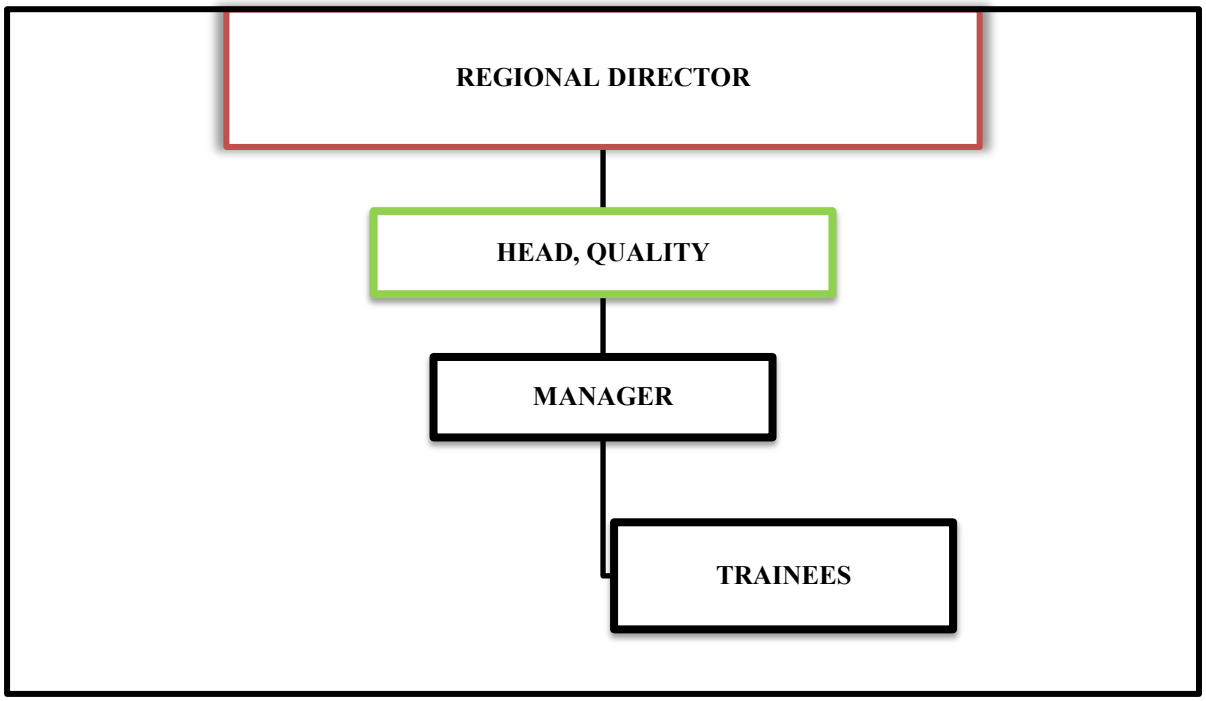



**Figure 1: Organization structure - Quality**

### *3.3. Annual Quality Improvement Plan*

**The purpose**

**"To create a world-class integrated healthcare delivery system in India, entailing the finest medical skills combined with compassionate patient care"**

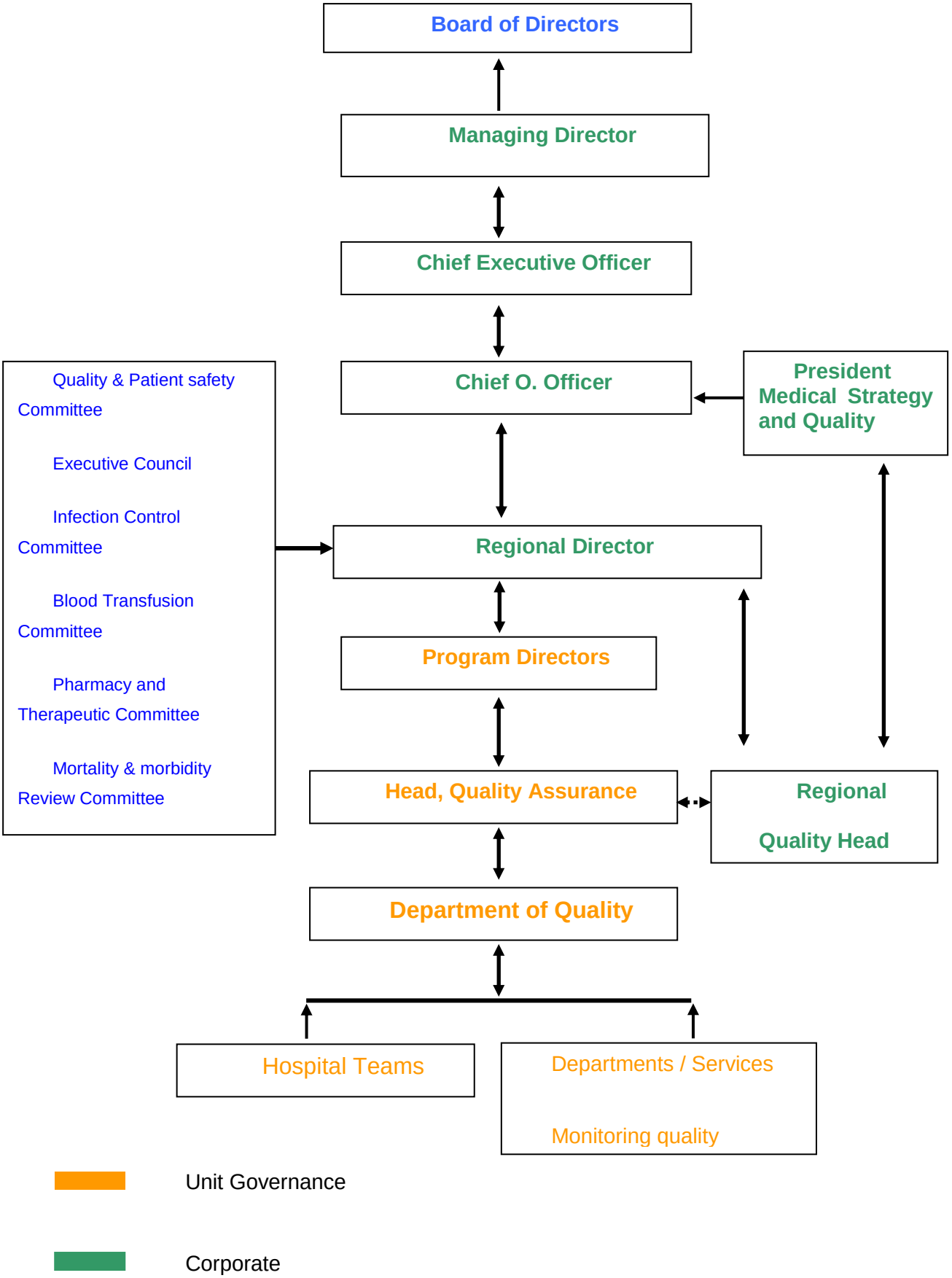
**— Late Dr. Parvinder Singh,**

**Founder Chairman, Fortis Healthcare Ltd.**

Quality Improvement Plan is to provide a leadership driven framework and an organizational structure to:

- Achieve the mission and strategic goals of, Gurgaon Fortis Memorial Research Institute (FMRI).
- Integrate the hospital Quality Improvement (QI) activities into a
- Comprehensive interdisciplinary program
- Ensure that the Medical Staff, Nursing Staff, professional staff
- Demonstrate a consistent endeavor to deliver safe, effective and optimal patient care
- Ensure quality services in an environment of minimal risk

### 3.3.1 *Communication Flow for Quality Improvement Activities*



### 3.3.2 *Quality Policy*

Fortis Memorial Research Institute (FMRI) is committed to deliver Highest Quality of Healthcare to Enhance Patient Satisfaction and meet their Expectations through Well Defined Quality Systems, World Class Professionals, State-of-Art Technology, Humane and Compassionate Care

***Goals***

In keeping with its mission and values, FMRI has developed a Quality Improvement Plan committed to the continuous designing, monitoring performance, analyzing data, and improving and sustaining organizational performance. The hospital mission supports an environment where Quality improvement efforts are an integral component of daily functioning.

***Objectives***

- Systematically plan, monitor performance, analyze current Performance, improve and sustain improvements of processes and outcomes of patient care through interdisciplinary teams, clinical service, department activities and peer review;
- Provide a mechanism for establishing/resetting organization-wide QI Priorities;
- Address internal and external customer's needs and expectations;
- Promote interdepartmental and interdisciplinary communication with a scientific approach to problem solving;
- Facilitate dissemination, discussion and understanding of clinical and Management data among medical staff and hospital staff members;
- Develop performance measures consistent with the organizational Strategic plan;
- Integrate organizational performance improvement activities;
- Measure the organization's key outcomes, activities, and processes to Support safety, improvement, innovation, and learning;
- Provide a mechanism by which medical staff and hospital staff members are educated in QI principles and processes;
- Develop an environment that encourages and empowers staff to identify and address issues through the QI process;
- Support compliance with accreditation standards and regulatory agency requirements.

***Priorities for Improvement***

The priorities for improvement for the year 2014-2015 are as follows:

- To achieve Accreditation
- Focus implementation of Safe surgical safety checklist
- Focus on implementation of preventive care measures (bundles) for high risk infection control processes

- Improve patient safety through focus on designing, implementation and monitoring processes to achieve International Patient Safety Goals identified by the Joint Commission International.
- Category wise focused training.
- Improving clinical process and outcome (based on clinical audit outcome).

***Authority and Accountability***

**A. Board of Directors**

a) The Board of Directors bear the ultimate responsibility for the quality of patient care and services provided by the organization's medical staff members and other professional and support staff.
b) The Board of Directors is responsible for Quality improvement activities within the organization.
c) The Board of Directors will review periodic reports of findings, actions and results from Quality improvement activities in order to assess the program's efficiency and effectiveness.
d) The Board of Directors delegates and directs the Hospital Administration and the Medical Staff to
    i. Recommend the strategic direction
    ii. Implement Quality improvement efforts
    iii. Assess and prioritize the Quality improvement activities
    iv. Provide resources and support systems for Quality improvement function related to patient care services and safety
    v. Develop mechanisms to ensure that all patients with the same health problem are receiving a comparable level of care
    vi. Evaluate the Quality Improvement Plan annually and improve the mechanism as needed

**B. Managing Director**

a) The Managing Director is responsible for providing support for the proper functioning of hospital-wide Quality improvement activities.
b) The Managing Director provides the Board of Directors with pertinent information regarding Quality improvement activities.
c) The Managing Director provides support, direction, and/or assists with the resolution of problems or opportunities to improve care or services as needed.

**C. Organization Leaders**

The Organization's Leaders are responsible for the following:

a) Developing and implementing mechanisms designed to ensure the uniform quality of patient care processes throughout the organization.
b) Developing and implementing an effective and continuous program to measure, assess, and improve Quality.

c) Continuously assessing and improving the Quality of care and services provided.
d) Adopting an approach to Quality improvement that includes planning the process for improvement, setting priorities for improvement, assessing Quality systematically, implementing improvement activities based on assessment, and maintaining achieved improvements.
e) Participating in cross-organizational activities to improve organizational Quality as appropriate.
f) Communicating information relevant to cross-organizational Quality improvement activities to appropriate individuals.
g) Allocating adequate resources for assessing and improving the organization's governance, managerial, clinical, and support processes, by assigning personnel, as needed, to participate in Quality activities; providing adequate time for personnel to participate in Quality improvement activities, creating and maintaining information systems and appropriate data management processes to support collecting, managing, and analyzing data to facilitate ongoing improvement in Quality, and providing for staff training in Quality improvement methods.
h) Analyze and assess the effectiveness of their contributions to improving Quality.

**D. Quality & Patient Safety Committee (QPS)**

a) Frequency of review of committee is Annual. In case of any revision in membership, it will be communicated to the member duly signed by Regional Director.
b) The Quality & Patient Safety Committee is responsible for overseeing Quality improvement activities.
c) The Quality & Patient Safety Committee provides guidance and support for hospital-wide Quality improvement efforts and is responsible to the Director for its actions.
d) Members of the Quality & Patient Safety Committee will include the Regional Director, Program Director, HOD Quality Assurance, Chief of Nursing, and Heads of Departments of hospital-wide key functions.
e) The Quality & Patient Safety Committee will meet quarterly and as often as necessary to carry out its required functions.

**E. Department of Quality Assurance**

a) The Department of Quality Assurance comprises of professionals (one clinical and one semi clinical) dedicated to the improvement of quality in healthcare.
b) The Division is headed by Head Quality Assurance who oversees all the functions of the Department of QA and is also responsible for coordinating all Quality Improvement activities in the Organization.
c) The Department Division is responsible for the following:
    i. Fostering a culture that promotes a commitment to continually improving the quality of patient care and services

ii. Providing education to key personnel, as needed, on the approaches and methods of Quality improvement teams and activities
iii. Assessing and prioritizing process improvement projects
iv. Monitoring and evaluating the progress of Hospital Teams
v. Managing the flow of information to ensure follow-up
vi. Reporting Quality improvement activities to the Quality Steering Committee.
vii. Assigning process improvement activities to the appropriate cross-functional teams
viii. Assisting and providing guidance to teams as needed
ix. Assisting and coordinating departments and teams in the transition to hospital-wide team efforts in Quality improvement activities
x. Overseeing facilitate & safety in hospital

***Performance Improvement Principles***

The principles of CQI reflect a concept of working continuously to better meet customer needs and exceed their expectations.

The principles of CQI are:

**a) Customer Focus:**

Knowledge and understanding of internal and external customer needs and expectations;

**b) Process View of Work:**

Analysis of processes for redesign and variance reduction using a scientific approach;

**c) Innovation:**

Seeking new and different ways to meet customer needs and exceed expectations;

**d) Measurement:**

Management through knowledge, decisions are based on knowledge confirmed with facts and data driven by an understanding of variation.

**e) Organizational Involvement:**

All members have mutual respect for the dignity, knowledge, and potential contribution of others. Everyone is engaged in improving the processes in which they work.

***Quality Improvement Methodology***

**a) Plan**

Planning for the improvement of patient care and health outcomes includes a hospital-wide approach.

i. The organization maintains a plan that describes the organization's approach, processes, and mechanisms that comprise the organization's Quality improvement activities.
ii. The Team approach serves as a means of collaboration between departments and disciplines in planning and providing systematic organization-wide improvements.
iii. The organization utilizes the **Plan – Do – Study – Act** Quality Improvement Model as the framework for improving Quality.

**b) Design**

In order to design effective processes, functions or services, the following key elements are considered when relevant and available:

i. The process design is based on the organization's mission, vision, and strategic plan.
ii. Consideration is given to the needs and expectations of patients, staff, and others.
iii. Research into current literature and practice guidelines
iv. Design is consistent with sound business practices
v. Baseline Quality expectations are utilized to guide measurement and assessment activities

**c) Measure**

Data collection as the basis of all Quality Improvement activities provides a means of measuring Quality through which informed decisions can be made.

i. Data is collected for a comprehensive set of Quality measures based on the priorities established for the organization in order to
   - Establish a baseline when a process is implemented or redesigned
   - Describe process Quality or stability
   - Describe the dimensions of Quality or stability
   - Describe the dimensions of Quality relevant to functions, processes, and outcomes
   - Identify areas for improvement
   - Determine whether changes in a process have met objectives
ii. Data is collected as a part of continuing measurement, in addition to data collected for priority issues.
iii. Data collection considers measures of processes and outcomes.
iv. Data collection includes at least the following processes or outcomes:
   - Patient assessment

- Operative and other invasive and noninvasive procedures that place patients at risk
- Laboratory safety & quality
- Diagnostic Radiology safety & quality
- Processes related to medication use
- Processes related to anesthesia and sedation
- Processes related to the use of blood and blood components'
- Processes related to medical records content, availability and use
- Processed related infection control surveillance and reporting
- Processed related to clinical research
- Processes related to timely procurement of drugs & supplies
- Reporting as required by law
- Risk management activities
- Utilization management
- Needs, expectations, and satisfaction of patients
- Staff expectations and satisfaction
- Processes related to patient and staff safety
- Financial Management activity
- Patient Demographics and Diagnoses

**d) Assess**

The assessment process involves the necessary disciplines or departments to draw conclusions about the need for more intensive measurement. A systematic process is used to assess collected data in order to determine whether specifications for newly designed processes were met, the level of Quality and stability of important existing processes, priorities for possible improvement of existing processes, actions taken to improve the Quality Improvement processes, and whether changes in the processes resulted in improvement.

i. Collected data is assessed at least quarterly and findings are documented and are forwarded through the proper channels as outlined in this plan.

ii. A pre-determined level of Quality, or threshold, which would trigger a more in-depth review, is established for each Quality measure to assist in the assessment of the data collected. The reference used may include the following:

- Internal comparisons in Quality of processes and outcomes are made over time
- Quality comparison of data is made about processes with up-to- date information
- Quality comparison of data is made about processes and outcomes with other hospitals utilizing reference databases when possible

iii. The assessment process includes the use of statistical process control techniques/tools as appropriate. Training for use of statistical process control is provided to the hospital leaders where needed; team members/staff are educated regarding statistical process control techniques on an 'as needed' basis.

iv. When assessment of data indicates, a variation in Quality, more intensive measurement and analysis will be conducted and in addition, the department/service or team will reassess its Quality measurement activities and re-prioritize them as deemed necessary. Intensive assessment is initiated when statistical analysis shows the following:
   - Important single events, levels of Quality, and patterns or trends that vary significantly and undesirably from those expected
   - Quality that varies significantly from other organizations
   - Quality that varies significantly and undesirably from recognized standards

v. Intense assessment is performed on the following that are categorized as sentinel events:
   - Major discrepancies between preoperative and postoperative diagnoses in pathology reports
   - Confirmed major transfusion reactions
   - Significant adverse drug reactions
   - Significant medication errors
   - Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use
   - Unexpected patient death
   - Wrong site/side/patient surgery
   - Infectious disease outbreak

vi. When findings of the assessment process are relevant to an individual's Quality, the pertinent information will be provided to the **Director** for determining their use in peer review and/or periodic evaluations of a licensed independent practitioner's competence at reappointment

vii. When a Quality measurement does not reach the predetermined acceptable level of Quality, or if it is reached, but evaluation indicates the Quality is not acceptable, the Quality improvement process should continue. If the level of Quality shows no improvement for the time frame established by the established department/service or team plan, an intensive evaluation should be conducted with input from the Quality Steering Committee regarding the need for continued measurement.

viii. When no opportunities to improve are found after two quarters of data collection, the Quality measure should be re-evaluated to determine the need to continue measurement, and re-prioritization of Quality measurements should occur.

**e) Improve**

When opportunities for improving Quality are identified, a systematic approach is used to redesign the involved process, or to design a new process. The leadership, through the Quality Steering Committee will establish hospital-wide priorities.

i. When an opportunity for improvement is identified by a department or service, the department/service will determine if other disciplines or departments that have an impact on the process in the design/redesign of the process. If other

disciplines or departments are involved, the opportunity for improvement will be referred to the appropriate established team.

ii. The appropriate team/department will establish priorities for improvement based on the guidelines established in this plan. When necessary, Head Quality Assurance will assist the team or department/service in establishing priorities.

iii. The appropriate team will use the Plan-Do-Study -Act approach to

- Establish an action plan
- Identify Quality expectations
- Establish Quality measures
- Implement actions on a trial basis when possible
- Compare the results of the action taken to the Quality expectations
- Develop a new action plan when the desired result is not achieved
- Incorporate effective actions into the hospital's standard operating procedures
- Verify that improvements are maintained through Quality measurement and assessment activities

iv. When opportunities are identified through Quality Improvement findings, educational needs are determined and efforts taken to provide the necessary education.

***Guidelines for Prioritizing Opportunities for Improvement***

i. Priorities are established based on following priorities

- organization's mission, vision and strategic plan
- patient outcome
- element of risk to patients
- volume of patients involved
- problem prone areas
- newness of the service or process involved
- patient satisfaction
- cost to implement
- regulatory compliance
- impact on efficiency

ii. Considering these elements, the team members, having knowledge and expertise in the given area, will evaluate the priorities for the team.

iii. When necessary, Head QA will assist in prioritizing Quality measurement efforts for the team, or will make recommendations regarding prioritizing.

iv. The Quality & Patient Safety Committee will establish priorities for Quality improvement efforts for the organization as a whole, based on the above guidelines.

v. Based upon these criteria, the QI priorities for FY 13-14are

- Reduction in incidences of Needle Stick Injury
- Reduction in incidences of return to ICU

***Quality Improvement Activities***

Quality improvement activities will include, but not be limited to the following:

**a) Departments/Services**

Quality Improvement activities are carried out and are documented by each department/service.

**b) Teams**

Teams will adopt the same methodology as utilized by departments/services.

**c) Director**

i. It is the responsibility of the Director to oversee mechanisms used to conduct Quality improvement activities and to make recommendations to the Director regarding the organization of the Quality improvement activities, and the results of efforts to improve care.
ii. The Program Director supports and provides participation on interdisciplinary teams as needed, based on the activities of the team.
iii. Relevant findings, conclusions, recommendations, and actions taken to improve care, are communicated to the appropriate Consultant staff members periodically at the Consultants Open Forum meetings, and to appropriate individuals by letters.
iv. Clinical Audit: Cases with clinical care concerns will undergo clinical audit. The cases will be forwarded to the Clinical Audit Committee for review, and any further action will be taken based upon recommendation of the committee.

**d) Screening Measures**

i. Quality measures will be used hospital-wide to screen for adverse or unusual occurrences or potential problem areas, and as a means of identifying opportunities to improve care or services as deemed necessary by Head QA.
ii. When concerns regarding standards of care are raised, Medical Audit of the individual case will be obtained by forwarding the case to the Director.
iii. Results of screening will be aggregated quarterly for trending purposes, and will be forwarded to the appropriate department/service for review

**e) Patient Feedbacks**

i. Patient feedbacks are utilized to evaluate the needs and expectations of patients.
ii. The Quality Steering Committee reviews a summary of the findings periodically.
iii. When opportunities for improvement are noted, pertinent information is forwarded to the appropriate department or individual for review and evaluation and action as necessary.

**f) Surgical and Other Invasive Procedures**

i. Review of operative and other procedures is performed by Operating Theater Committee at least quarterly.
ii. Necessary recommendations are forwarded to the Director.

iii. Pertinent information regarding findings is communicated to the Director.

iv. Operative and Other Procedures: Continuing measurement will include review of the following:

⇒ Surgical Site Infection rates

⇒ Patient outcomes

⇒ Incidence of wrong site/side/patient surgery

⇒ Adverse anesthesia events

v. The OT Committee will determine priority areas to be included in the review of Operative and Other Procedures Review.

vi. The OT Committee will initiate a team effort for data collection, aggregation, and analysis of the selected Quality measures.

vii. The OT Committee will forward a summary of their findings to the Director, along with any actions taken to improve care.

viii. Director will review the findings and make any further recommendations to the OT Committee, or take any additional action/s necessary to improve care.

**g) Medication Usage**

i. The Pharmacy and Therapeutic Committee, coordinated by a Clinical Pharmacologist, carries out the Medication Usage functions at least quarterly.

ii. The Pharmacy and Therapeutic Committee takes necessary actions or recommendations are forwarded to the appropriate department, Medical Director, or responsible individuals.

iii. Pertinent information regarding findings is communicated to the appropriate individual/s, to the Director and to the Head QA.

iv. Medication Usage processes include measurement of at least the following:

- Medication errors
- Adverse drug reactions (All significant drug reactions undergo an intensive assessment)
- Antibiotic usage

v. The Pharmacy and Therapeutic Committee is also responsible for the development and maintenance of the drug formulary as well as approval of policies and procedures relating to the selection, distribution, and handling, use, and administration of drugs.

vi. The Committee reviews all significant untoward drug reactions.

**h) Blood Usage**

i. The Blood Usage Review functions are carried out by the Transfusion Committee at least four monthly.

ii. The following blood use processes are measured on an ongoing basis:

- Monitoring blood and blood component effects on patients
- Blood wastage in OT
- Cross match Vs Transfusion ratio
- Blood Expiration
- Review of transfusion reactions (All confirmed transfusion reactions undergo an intensive assessment)

iii. The Blood Transfusion Committee takes necessary actions or recommendations for action are forwarded to the Director

**i) Infection Control**

i. The Infection Control functions are carried out by the Infection Control Committee at least quarterly.

ii. The Review includes approval of policies and procedures relating to Infection Control, review and evaluation of infection statistics, focused review on infection concerns and/or issues as appropriate, review and input into the hospital's Employee Health Program.

iii. The Infection Control Committee takes necessary actions or recommendations for action are forwarded to the Director and Head QA.

iv. The following infection control measures are measured on an ongoing basis:

- Central line associated blood stream infection
- Ventilator associated pneumonia
- Surgical site infection
- Urinary catheter associated infection
- Hand hygiene
- Needle stick injury

**j) Mortality & Morbidity Review Committee**

***Clinical Audits***

i. The medical audits are conducted through peer review process. The necessary corrective actions are then communicated to the medical teams and implemented.

ii. Review of implementation of corrective actions is then reviewed by Regional Director.

***Patient Safety Program***

The purpose of the Patient Safety Program is to reduce mortality and morbidity and to improve patient care by the identification, analysis and reduction of risks, which could cause or have caused preventable patient injury or impairment of patient safety.

The priorities of the 2014-2015 Plan is to:

i. Review and modify organizational processes to ensure compliance with the International Patient Safety Goals

ii. Measurably improve the FMRI organizational safety culture

- The Quality & Patient safety Committee and senior administrative leaders will be regularly and thoroughly briefed regarding the results of:
  - Root Cause Analyses of near miss, adverse events and sentinel events
  - Safety culture measurements and performance improvement initiatives implemented to improve this culture, including Patient Safety Rounds
  - Progress towards patient safety risk and hazard reduction

- ❖ Identify and address processes that have a high risk of causing patient harm, using internal and external data.

  Continue the analysis of high-risk processes for proactive risk assessment:

  - ➢ Medication Management System
  - ➢ Reducing risk of patient harm due to falls
- ❖ Keystone Critical Care Unit Patient Safety Measures
  - ➢ BSI prevention
  - ➢ VAP prevention
  - ➢ Sepsis management
- ❖ Promote organizational culture of patient safety
  - ➢ Review, revise and promote patient-safety continuing education for current employees
- ❖ Surgical safety measures
  - ➢ SSI prevention
  - ➢ Compliance to surgical safety checklist (adopted from WHO)

***Communication Plan***

The method of communication of the Quality Improvement efforts is as follows:

**a) Head Quality Assurance**

i. Head Quality will coordinate Quality Improvement efforts.

ii. Head Quality Assurance will forward problem areas, or areas of concern to the appropriate team for consideration via the Team Leader. When it is recognized that team efforts overlap those of another team, the Quality Steering Committee will advise the appropriate Team Leaders to coordinate the Quality Improvement efforts.

**b) Teams**

i. Teams will report Quality Improvement efforts to the Team Leader of the specific function

ii. Team Leaders will make a report of findings to the Head Quality Assurance

iii. Department of QA Team will present a report to the Quality Steering Committee as scheduled

iv. Written reports will be presented to the Quality Steering Committee and documented in meeting minutes

v. Written summary is periodically provided to the Board of Directors

**c) Departments**

i. Department Managers will provide the Quality Indicators data to the Incharge QA

ii. Department of QA Team will present a verbal and written report to the Quality & Patient Safety Committee periodically, as outlined by the reporting schedule approved by the Committee

iii. Written report is provided to the Regional Director .
iv. Written summary is periodically provided to the Board of Directors

**d) Education**

i. Education of Quality Improvement efforts and methodologies will be provided to the staff on orientation, and will include information regarding data collection, aggregation, and statistical process control as the need arises with participation in the process.
ii. Education regarding Quality Improvement methods and activities will be provided to the organizational leaders on an ongoing basis.

***Annual Appraisal***

**a) Departments/Services and Teams**

Each department or service and active interdisciplinary team will evaluate quality Improvement efforts annually. The annual evaluation will be forwarded to the Directors and the Head Quality Assurance

**b) Review of Plan**

The Quality Improvement Plan will be reviewed and evaluated annually by the Quality Steering Committee. The annual appraisal will consider the achievement of the goals and objectives of the plan, the efficiency of the plan, and the effectiveness of the plan. Head Quality Assurance can make recommendations to the Quality Steering Committee for revisions and improvements in the Quality Improvement efforts.

**Signatures of Approval**

The Quality Improvement Plan will be approved annually by the Coordinator of Quality Steering Committee and the Hospital Director on behalf of the Board of Directors for FMRI.