national health authority

सत्यमेव जयते

Azadi Ka Amrit Mahotsav

Monitoring of Quality using Audit Tools

Summary

In this presentation following topics shall be covered:

- Parameters and Process of monitoring quality
- Components of Monthly Audit Checklist

Monitoring Quality

Why

Quality health care is defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge – A Strategy for Quality Assurance in Medicare

01

What

According to the Institute of Medicine (IOM) report, To Err Is Human,4 the majority of medical errors result from faulty systems and processes, not individuals

02

For Whom

- Internal Stakeholders – NHA, SHA, DIUs
- External Stakeholders - Beneficiaries

03

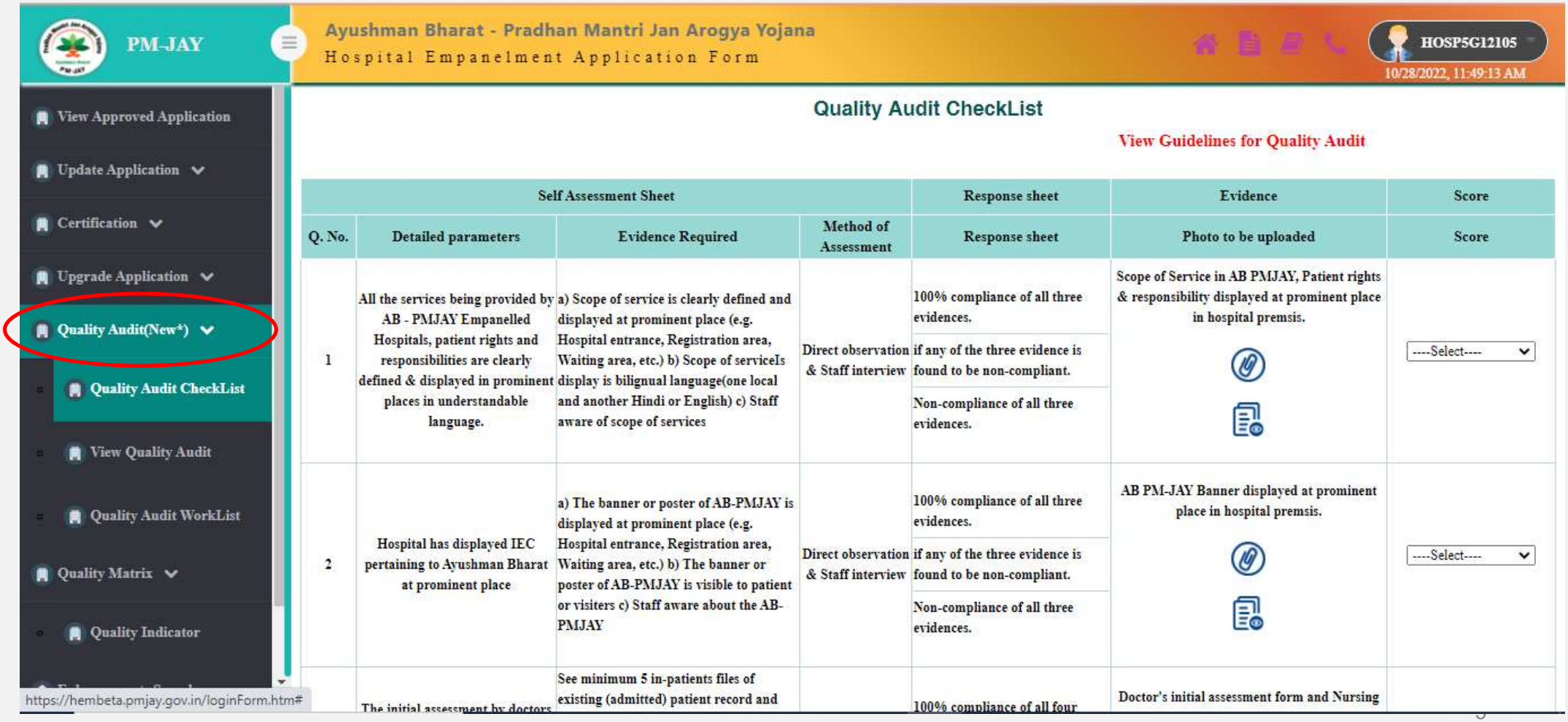
How

What gets measured, gets done - any attribute related to quality that is worthy of being monitored or managed needs to be measured, which means an appropriate measuring method should be used

04

Monthly Audit Checklist

Quality Audit Checklist in HEM

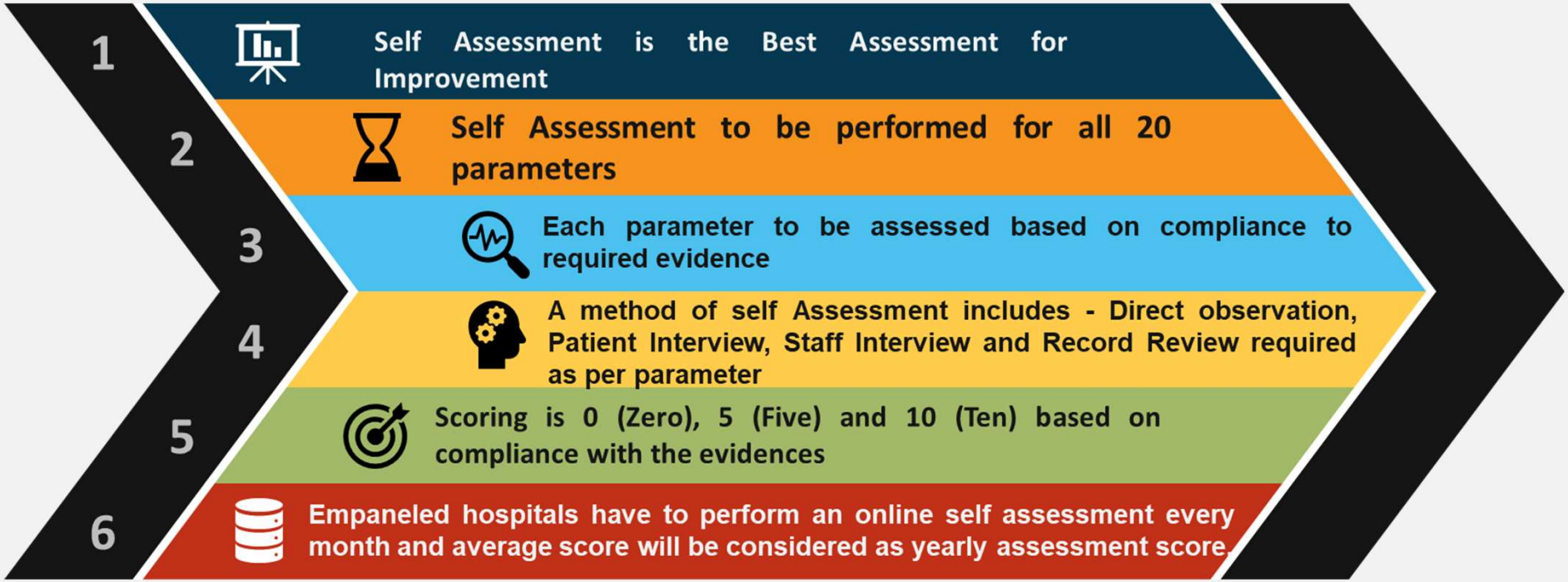


Quality Audit CheckList

View Guidelines for Quality Audit

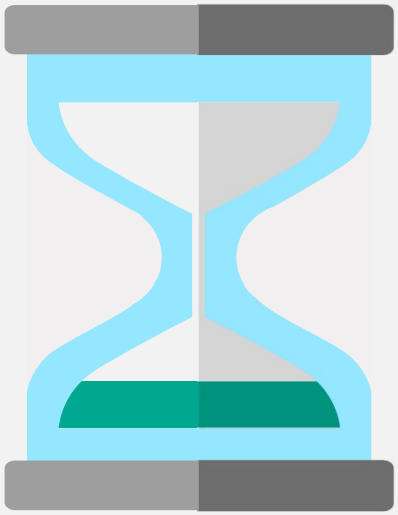
Self Assessment Sheet				Response sheet	Evidence	Score
Q. No.	Detailed parameters	Evidence Required	Method of Assessment	Response sheet	Photo to be uploaded	Score
1	All the services being provided by AB - PMJAY Empanelled Hospitals, patient rights and responsibilities are clearly defined & displayed in prominent places in understandable language.	a) Scope of service is clearly defined and displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b) Scope of serviceIs display is bilignual language(one local and another Hindi or English) c) Staff aware of scope of services	Direct observation & Staff interview	100% compliance of all three evidences. if any of the three evidence is found to be non-compliant. Non-compliance of all three evidences.	Scope of Service in AB PMJAY, Patient rights & responsibility displayed at prominent place in hospital premsis.	----Select----
2	Hospital has displayed IEC pertaining to Ayushman Bharat at prominent place	a) The banner or poster of AB-PMJAY is displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b) The banner or poster of AB-PMJAY is visible to patient or visiters c) Staff aware about the AB-PMJAY	Direct observation & Staff interview	100% compliance of all three evidences. if any of the three evidence is found to be non-compliant. Non-compliance of all three evidences.	AB PM-JAY Banner displayed at prominent place in hospital premsis.	----Select----
	The initial assessment by doctors	See minimum 5 in-patients files of existing (admitted) patient record and		100% compliance of all four	Doctor's initial assessment form and Nursing	

Introduction to Monthly Audit Checklist



Status of Quality Audits in HEM for the state of Kerala

NO. OF HOSPITALS THAT FILLED THE QUALITY AUDIT CHECKLIST



12

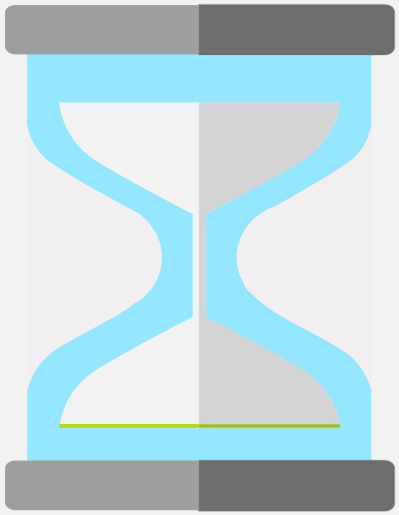
NO. OF QUALITY AUDIT CHECKLISTS SUBMITTED

27

NO. OF QUALITY AUDIT CHECKLISTS APPROVED

24

NO. OF QUALITY AUDIT CHECKLISTS REJECTED



1

Note: Total Hospitals in Kerala -746, Private – 546, Govt. - 200

Components of Monthly Audit Checklist

The Checklist can be divided into following components:

- Information Dissemination – IEC
- Clinical Services
- Documentation
- Medication Management
- Infection Control Practices
- Availability of Important licences
- Disaster Management
- Record Management – Internal Stakeholders & External Stakeholders

Information Dissemination - IEC

1. ALL THE SERVICES BEING PROVIDED BY AB - PMJAY EMPANELLED HOSPITALS, PATIENT RIGHTS AND RESPONSIBILITIES ARE CLEARLY DEFINED & DISPLAY AT PROMINENT PLACE IN UNDERSTANDABLE LANGUAGE.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
Scope of service is clearly defined and displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) in two language (one local language and another Hindi or English).	Direct observation & Staff interview	If all options available: a)Scope of service displayed at the entrance and visible to the patient and visitors b) Bilignual languages c) Staff aware of scope of services	10	Photo of Scope of Service in AB PMJAY, Patient rights & responsibility.
		If any options Incomplete: a)Scope of service displayed at the entrance and visible to the patient and visitors b) Bilignual languages c) Staff aware of scope of services	5	
		If all options not available: a)Scope of service displayed at the entrance and visible to the patient and visitors b) Bilignual languages c) Staff aware of scope of services	0	

1. ALL THE SERVICES BEING PROVIDED BY AB – PMJAY EMPANELLED HOSPITALS, PATIENT RIGHTS AND RESPONSIBILITIES ARE CLEARLY DEFINED & DISPLAY AT PROMINENT PLACE IN UNDERSTANDABLE LANGUAGE.

2. HOSPITAL HAS DISPLAYED THE IEC PERTAINING TO AYUSHMAN BHARAT AT PROMINENT PLACE

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)The banner or poster of AB-PMJAY is displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b)The banner or poster of AB-PMJAY is visible to patient or visitors c) Staff aware about the AB-PMJAY	Direct observation & Staff interview	100% ompliance of all three evidences.	10	AB PM-JAY Banner displayed at prominent place in hospital premsis.
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

2. HOSPITAL HAVE DISPLAYED THE IEC PERTAINING TO AYUSHMAN BHARAT AT PROMINENT PLACE

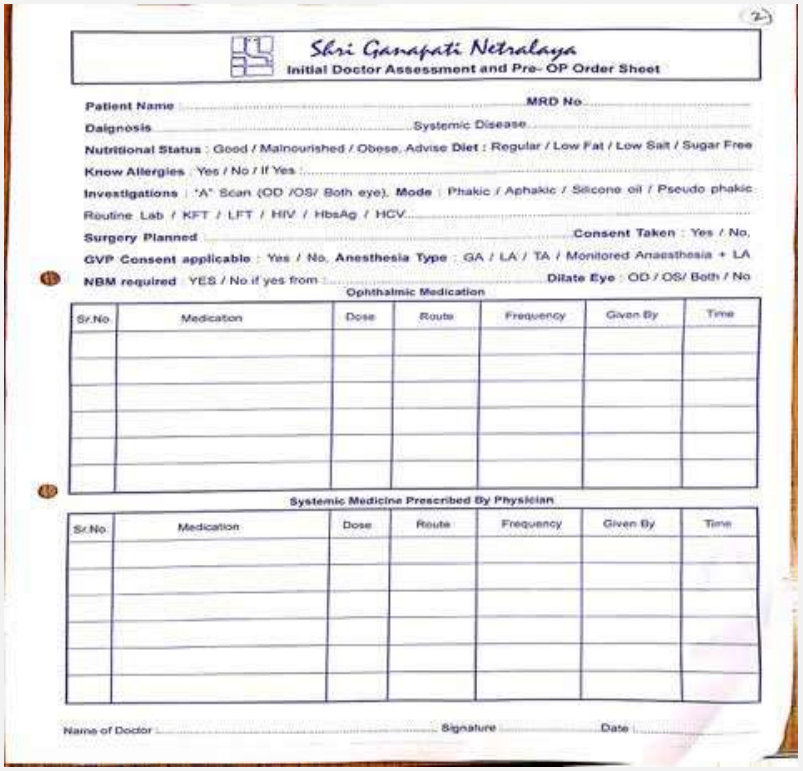
Clinical Services

3. THE INITIAL ASSESSMENT BY DOCTORS FOR IN-PATIENTS IS DOCUMENTED WITHIN 24 HOURS OR EARLIER AND THE PATIENT RECORD FILE HAVE CARE AND TREATMENT ORDERS WHICH IS SIGNED, NAMED, TIMED AND DATED BY THE CONCERNED DOCTOR.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 in-patients files of existing (admitted) patient record and check for: a) Availability of Initail assesment form b) Initial assemnent form filled by concerned personal c) Time of admission ,Time of initial assessment , Initial assesment start and completion time. d) Treatment orders are signed, named, timed and dated by the concerned doctor	Record review & Staff interview	100% ompliance of all four evidences.	10	Doctor's initial assessment form and Nursing initial assessment form.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

3. THE INITIAL ASSESSMENT BY DOCTORS FOR IN-PATIENTS IS DOCUMENTED WITHIN 24 HOURS OR EARLIER AND THE PATIENT RECORD FILE HAVE CARE AND TREATMENT ORDERS WHICH IS SIGNED, NAMED, TIMED AND DATED BY THE CONCERNED DOCTOR.

Doctor's Initial Assessment Form



Shri Ganapati Netralaya

Initial Doctor Assessment and Pre- OP Order Sheet

Patient Name ..... MRD No .....

Daignosis ..... Systemic Disease .....

Nutritional Status : Good / Malnourished / Obese. Advise Diet : Regular / Low Fat / Low Salt / Sugar Free

Know Allergies : Yes / No / If Yes :.....

Investigations : "A" Scan (OD /OS/ Both eye). Mode : Phakic / Aphakic / Silicone oil / Pseudo phakic

Routine Lab / KFT / LFT / HIV / HbsAg / HCV.....

Surgery Planned ..... Consent Taken : Yes / No.

GVP Consent applicable : Yes / No. Anesthesia Type : GA / LA / TA / Monitored Anaesthesia + LA

NBM required : YES / No if yes from :..... Dilate Eye : OD / OS/ Both / No

Ophthalmic Medication

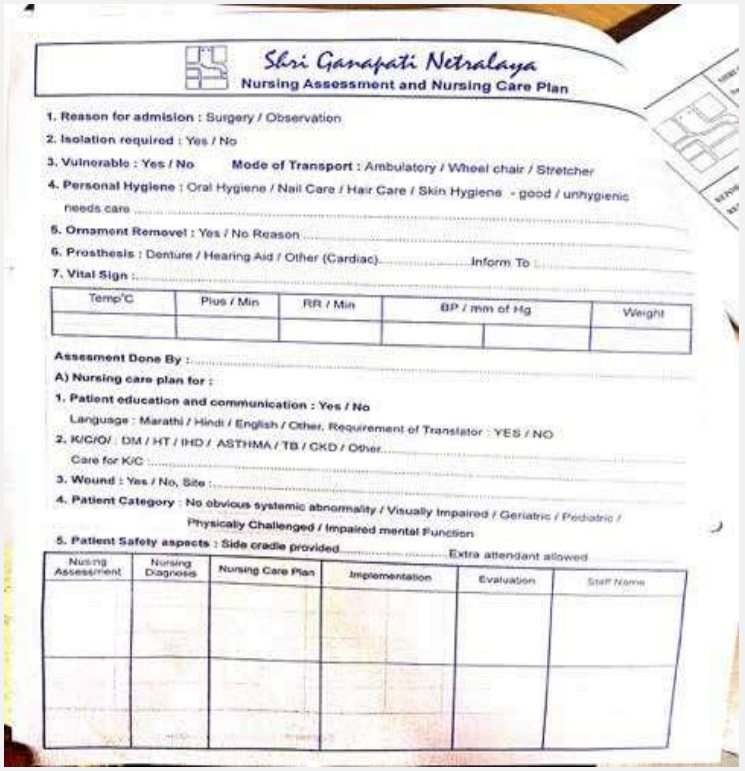
Sr.No	Medication	Dose	Route	Frequency	Given By	Time

Systemic Medicine Prescribed By Physician

Sr.No	Medication	Dose	Route	Frequency	Given By	Time

Name of Doctor ..... Signature ..... Date .....

Nursing Initial Assessment Form



Shri Ganapati Netralaya

Nursing Assessment and Nursing Care Plan

1. Reason for admision : Surgery / Observation
2. Isolation required : Yes / No
3. Vulnerable : Yes / No Mode of Transport : Ambulatory / Wheel chair / Stretcher
4. Personal Hygiene : Oral Hygiene / Nail Care / Hair Care / Skin Hygiene - good / unhygienic needs care .....
5. Ornament Removel : Yes / No Reason .....
6. Prosthesis : Denture / Hearing Aid / Other (Cardiac)..... Inform To :.....
7. Vital Sign :.....

Temp°C	Plus / Min	RR / Min	BP / mm of Hg		Weight

Assessment Done By :.....

A) Nursing care plan for :

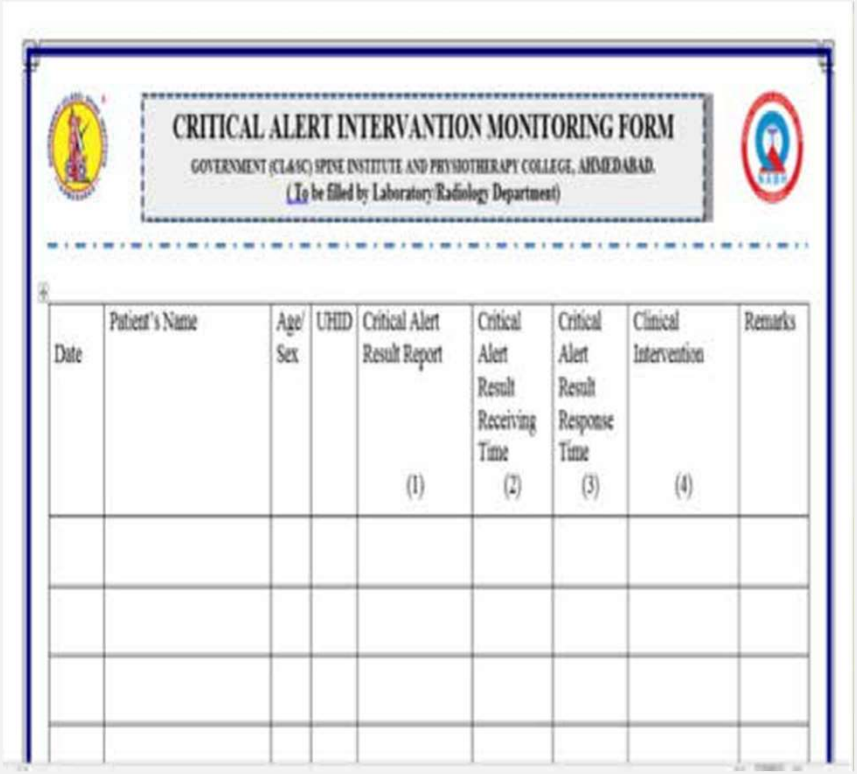
1. Patient education and communication : Yes / No
   Language : Marathi / Hindi / English / Other, Requirement of Translator : YES / NO
2. K/C/O/ : DM / HT / IHD / ASTHMA / TB / CKD / Other.....
   Care for K/C :.....
3. Wound : Yes / No, Site :.....
4. Patient Category : No obvious systemic abnormality / Visually Impaired / Geriatric / Pediatric / Physically Challenged / Impaired mental Function
5. Patient Safety aspects : Side cradle provided..... Extra attendant allowed

Nursing Assessment	Nursing Diagnosis	Nursing Care Plan	Implementation	Evaluation	Staff Name

4 . THE RESULTS OF THE DIAGNOSTIC (LABORATORY, RADIOLOGY, ETC.) TESTS SHOULD BE MADE AVAILABLE IN DEFINED TIME FRAME AND INTIMATED ABOUT THE CRITICAL RESULTS TO THE CONCERNED PERSONNEL IMMEDIATELY.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Time frame of diagonostic results are displayed in diagnostic department and followed. b)See minimum five cases of Critical value and check for: i)Critical result value identification time and informed time to concerned personnel. ii)Appropriate action taken by the concerned person for the critical result.	Direct observation, Record review, Patient interview & Staff interview	100% compliance of all three evidences.	10	Turn around Time, Critical value Chart are displayed in Diagnostic area. Registry maintained for TAT and Critical value
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

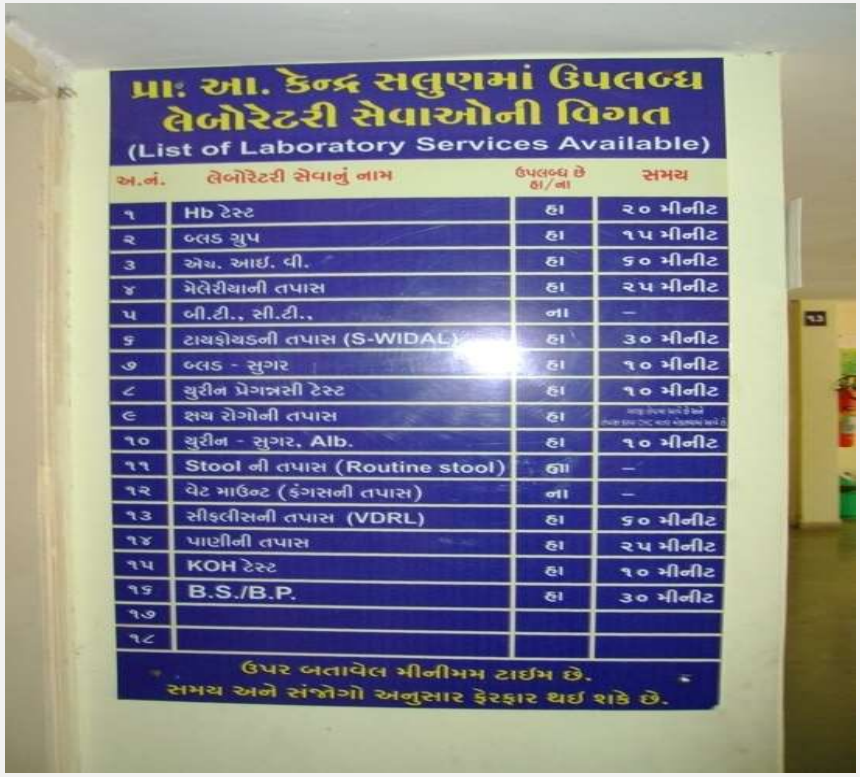
4. THE RESULTS OF THE DIAGNOSTIC (LABORATORY, RADIOLOGY, ETC.) TESTS SHOULD BE MADE AVAILABLE IN DEFINED TIME FRAME AND INTIMATED ABOUT THE CRITICAL RESULTS TO THE CONCERNED PERSONNEL IMMEDIATELY.



CRITICAL ALERT INTERVANTION MONITORING FORM

GOVERNMENT (CLASC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE, AHMEDABAD.
(To be filled by Laboratory/Radiology Department)

Date	Patient's Name	Age/ Sex	UHID	Critical Alert Result Report (1)	Critical Alert Result Receiving Time (2)	Critical Alert Result Response Time (3)	Clinical Intervention (4)	Remarks



પ્રા: આ. કેન્દ્ર સલુણમાં ઉપલબ્ધ લેબોરેટરી સેવાઓની વિગત
(List of Laboratory Services Available)

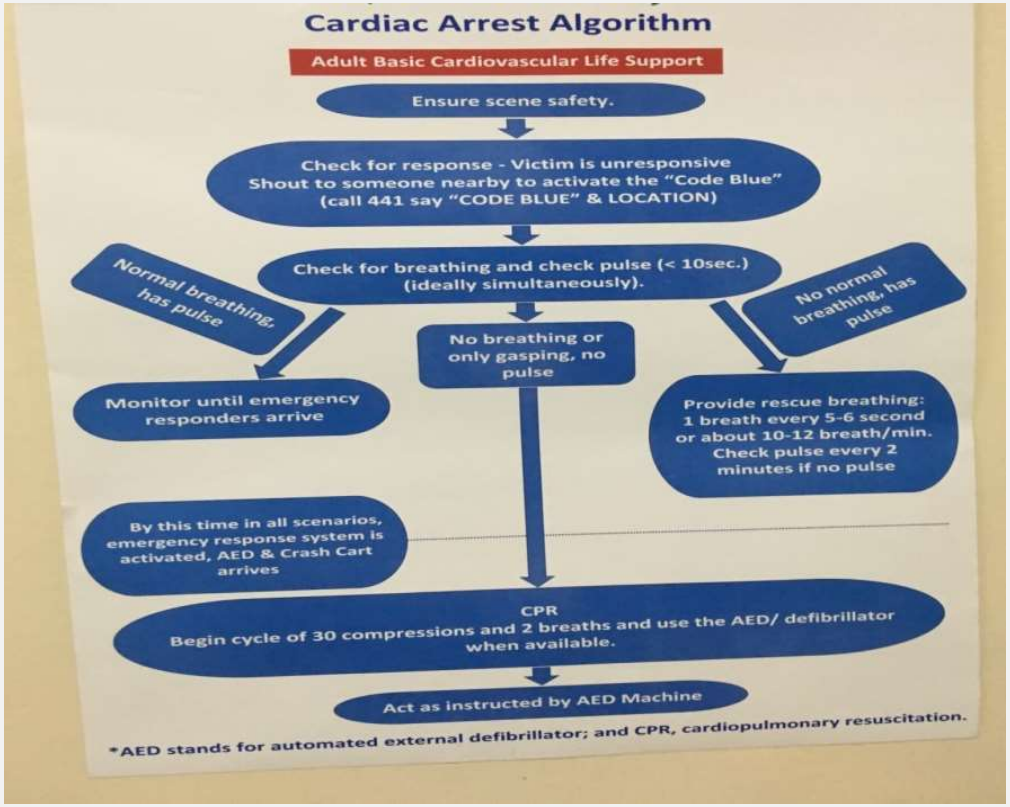
અ.નં.	લેબોરેટરી સેવાનું નામ	ઉપલબ્ધ છે હા/ના	સમય
૧	Hb ટેસ્ટ	હા	૨૦ મીનીટ
૨	બ્લડ ગ્રુપ	હા	૧૫ મીનીટ
૩	એચ. આઇ. વી.	હા	૬૦ મીનીટ
૪	મેલેરીયાની તપાસ	હા	૨૫ મીનીટ
૫	બી.ટી., સી.ટી.,	ના	–
૬	ટાયફોયડની તપાસ (S-WIDAL)	હા	૩૦ મીનીટ
૭	બ્લડ - સુગર	હા	૧૦ મીનીટ
૮	યુરીન પ્રેગન્નસી ટેસ્ટ	હા	૧૦ મીનીટ
૯	ક્ષય રોગોની તપાસ	હા	
૧૦	યુરીન - સુગર, Alb.	હા	૧૦ મીનીટ
૧૧	Stool ની તપાસ (Routine stool)	હા	–
૧૨	વેટ માઉન્ટ (ફંગસની તપાસ)	ના	–
૧૩	સીફલીસની તપાસ (VDRL)	હા	૬૦ મીનીટ
૧૪	પાણીની તપાસ	હા	૨૫ મીનીટ
૧૫	KOH ટેસ્ટ	હા	૧૦ મીનીટ
૧૬	B.S./B.P.	હા	૩૦ મીનીટ
૧૭			
૧૮			

ઉપર બતાવેલ મીનીમમ ટાઇમ છે.
સમય અને સંજોગો અનુસાર ફેરફાર થઇ શકે છે.

5. EVENTS DURING CARDIO-PULMONARY RESUSCITATION ARE RECORDED AND MOCK DRILLS CONDUCTED AT REGULAR INTERVAL; SEQUENCE OF CPR IN PICTORIAL MANNER SHOULD BE DISPLAYED.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Policy for cardio-pulmonary resuscitation b)CPR process flow chart displayed in patient care area c)Staff aware of steps in cardio-pulmonary resuscitation d)Documentation of Regular mock drill conducted, variations observed in each drill and CAPA taken by respective personnel's.	Direct observation, record review & Staff interview	100% compliance of all four evidences.	10	Documents of CPR mock drills conducted at regular intervals and CPR chart display in patient care area.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

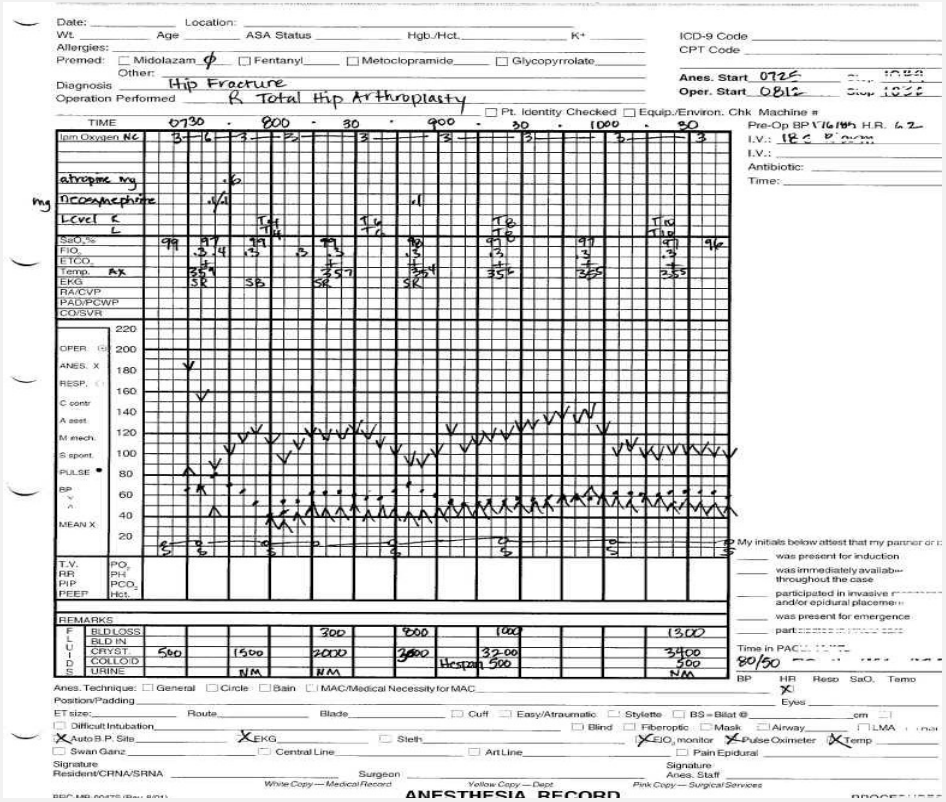
5. EVENTS DURING CARDIO-PULMONARY RESUSCITATION ARE RECORDED AND MOCK DRILLS CONDUCTED AT REGULAR INTERVAL; SEQUENCE OF CPR IN PICTORIAL MANNER SHOULD BE DISPLAYED.

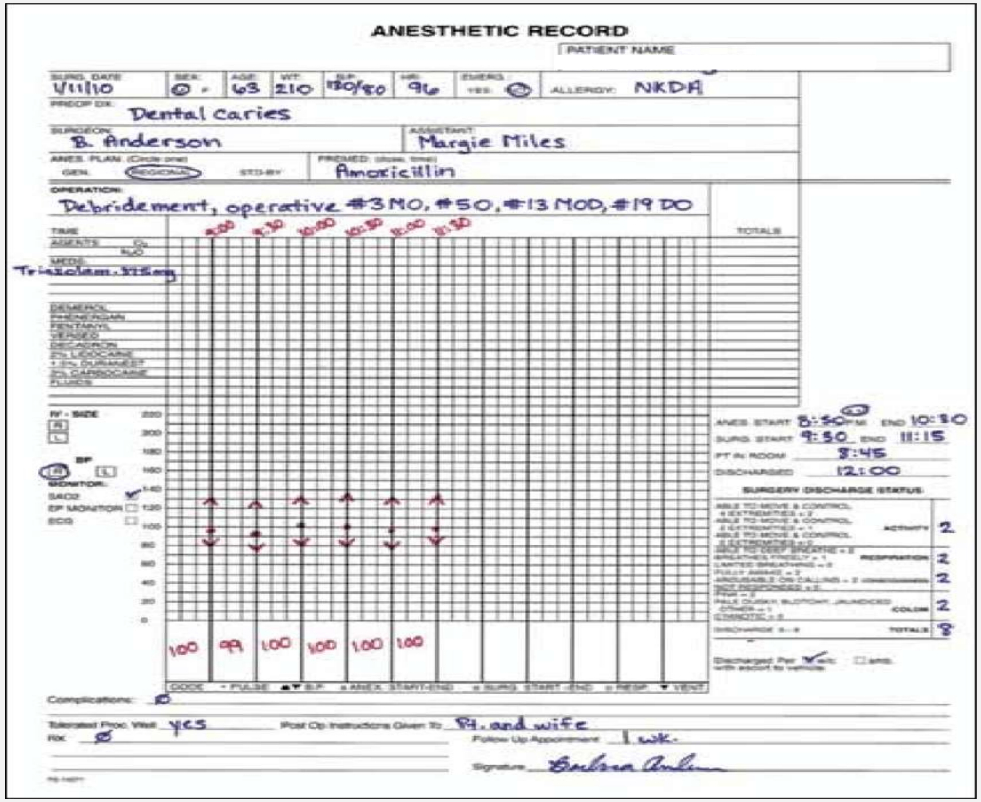


6. THE REGULAR AND PERIODIC MONITORING OF ANAESTHESIA COMPONENTS LIKE RECORDING OF HEART RATE, CARDIAC RHYTHM, RESPIRATORY RATE, BLOOD PRESSURE, OXYGEN SATURATION, AIRWAY SECURITY AND PATENCY AND LEVEL OF ANAESTHESIA SHOULD BE DONE.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 post-operative files of previous month and check for: a) Availability of completely filled Pre-anaesthesia, during anaesthesia and post- anaesthesia form in each patient file. b) Pre-anaesthesia consent is duly signed by patient or patient relatives and countersigned by anaesthetists in each patient file.. c) Complete documentation (e.g. Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway security recorded) in each patient file.	Record review & Staff interview	100% compliance of all three evidences.	10	a)Complete documentation: Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway security b)Pre-anaesthesia consent duly signed by pt. or pt. relatives and countersigned by anaesthetists
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

6. THE REGULAR AND PERIODIC MONITORING OF ANAESTHESIA COMPONENTS LIKE RECORDING OF HEART RATE, CARDIAC RHYTHM, RESPIRATORY RATE, BLOOD PRESSURE, OXYGEN SATURATION, AIRWAY SECURITY AND PATENCY AND LEVEL OF ANAESTHESIA SHOULD BE DONE.



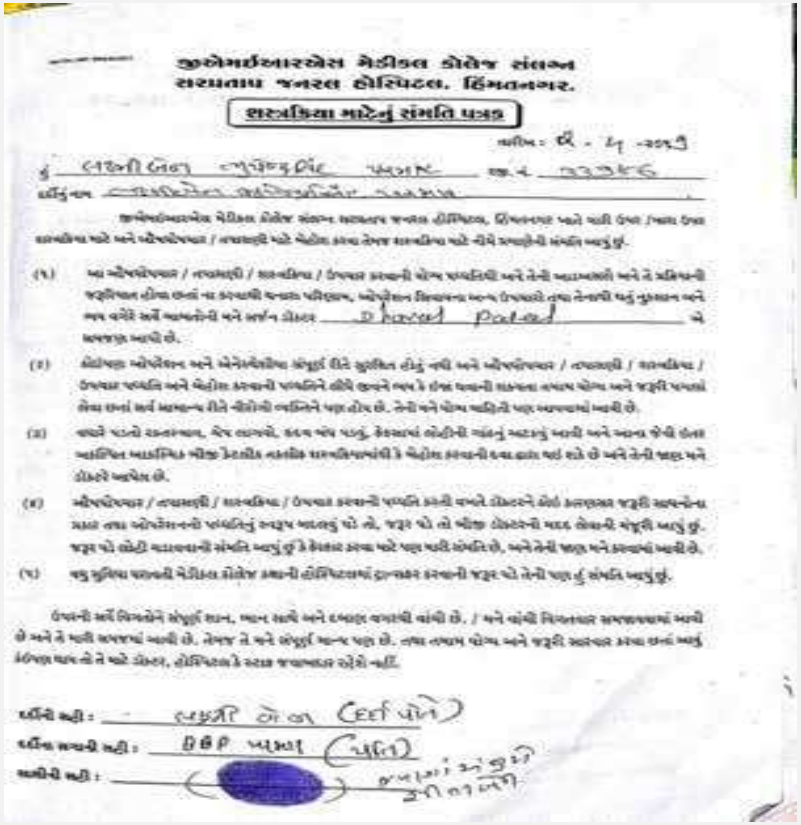


Documentation

7. INFORMED CONSENT ABOUT THE INFORMATION ON RISKS INVOLVED, BENEFITS, ALTERNATIVES FOR THE PROCEDURES, SURGEON WHO WILL PERFORM THE REQUISITE PROCEDURE IN AN UNDERSTANDABLE LANGUAGE

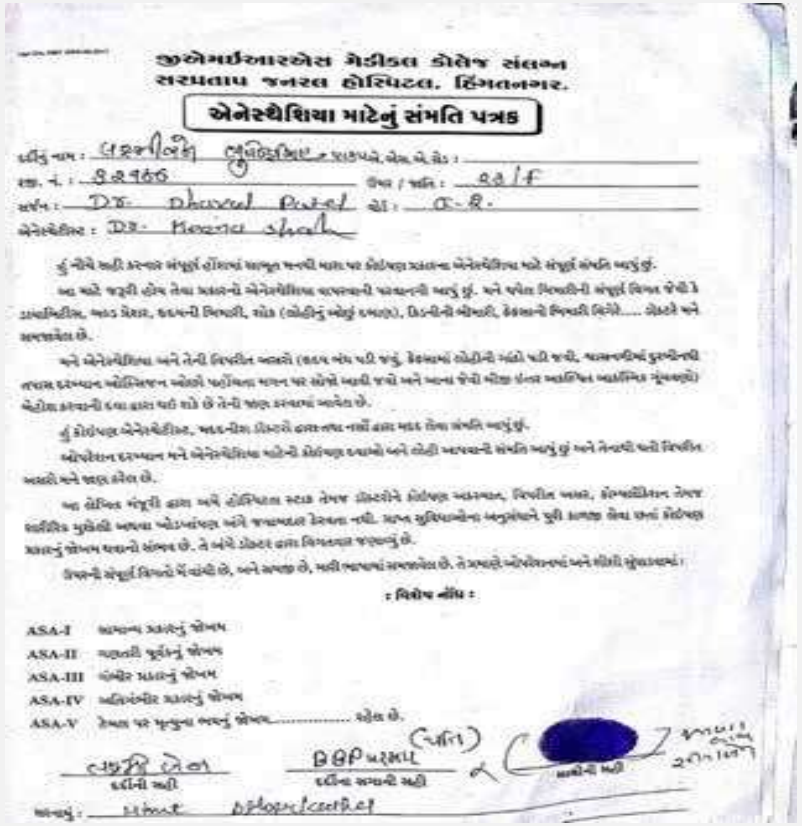
Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)SOP developed for taking the informed consent from patient or patient relative. b)See minimum 5 in-patients files of previous month and check availability of: i)Clearly defined information on risks involved, benefits, alternatives for the procedures by surgeon who will perform the requisite procedure in an understandable language. ii)Informed consent is duly signed by patient or patient relative and countersigned by concerned surgeon. iii)Post operative notes by concerned surgeon.	Direct observation, record review & Staff interview	100% compliance of all four evidences.	10	Informed consent form and Post operative notes in patient files.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

7. INFORMED CONSENT ABOUT THE INFORMATION ON RISKS INVOLVED, BENEFITS, ALTERNATIVES FOR THE PROCEDURES, SURGEON WHO WILL PERFORM THE REQUISITE PROCEDURE IN AN UNDERSTANDABLE LANGUAGE



જીએમઈઆરએસ મેડીકલ કોલેજ સંલગ્ન
સરદાર જનરલ હોસ્પિટલ, હિંમતનગર.

શસ્ત્રક્રિયા માટેનું સંમતિ પત્રક



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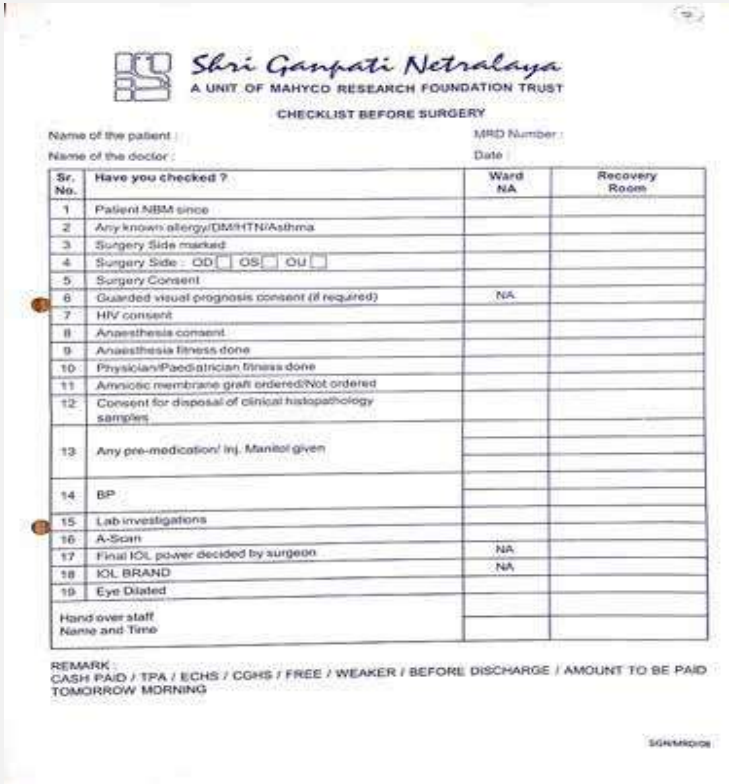
સરદાર જનરલ હોસ્પિટલ, હિંમતનગર.

એનેસ્થેસિયા માટેનું સંમતિ પત્રક

8. THE DOCUMENTED PROCEDURE IS DEFINED AND ADHERED TO, FOR THE PREVENTION OF ADVERSE EVENTS LIKE WRONG SITE, WRONG PATIENT AND WRONG SURGERY.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 post-operative files of previous month and check: a)Availability of WHO safety checklist. b)WHO safety checklist is filled and signed by anaesthetist(before induction of anaesthesia), surgeon (before skin incision) and OT incharge(before patient leaves OT)	Record review & Staff interview	100% compliance of all two evidences.	10	WHO safety checklist signed by OT Incharge, anaesthetist and surgeon
		if any of the two evidence is found to be non-compliant.	5	
		Non-compliance of all two evidences.	0	

8. THE DOCUMENTED PROCEDURE IS DEFINED AND ADHERED TO, FOR THE PREVENTION OF ADVERSE EVENTS LIKE WRONG SITE, WRONG PATIENT AND WRONG SURGERY.



Shri Ganpati Netralaya
A UNIT OF MAHYCO RESEARCH FOUNDATION TRUST

CHECKLIST BEFORE SURGERY

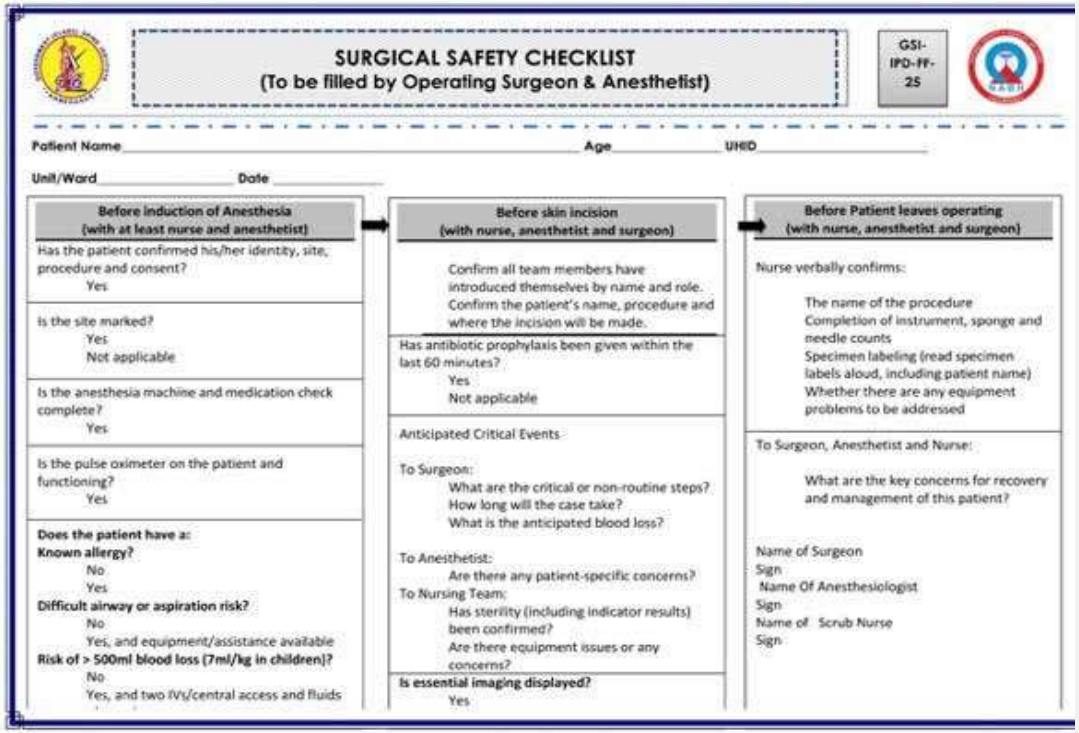
Name of the patient : MRD Number :
Name of the doctor : Date :

Sr. No.	Have you checked ?	Ward NA	Recovery Room
1	Patient NBM since		
2	Any known allergy/DM/HTN/Asthma		
3	Surgery Side marked		
4	Surgery Side : OD ☐ OS ☐ OU ☐		
5	Surgery Consent		
6	Guarded visual prognosis consent (if required)	NA	
7	HIV consent		
8	Anaesthesia consent		
9	Anaesthesia fitness done		
10	Physician/Paediatrician fitness done		
11	Amniotic membrane graft ordered/Not ordered		
12	Consent for disposal of clinical histopathology samples		
13	Any pre-medication/ Inj. Mannitol given		
14	BP		
15	Lab investigations		
16	A-Scan		
17	Final IOL power decided by surgeon	NA	
18	IOL BRAND	NA	
19	Eye Dilated		
	Hand over staff Name and Time		

REMARK :
CASH PAID / TPA / ECHS / CGHS / FREE / WEAKER / BEFORE DISCHARGE / AMOUNT TO BE PAID TOMORROW MORNING

SGNMRD/08

Checklist Before Surgery



SURGICAL SAFETY CHECKLIST
(To be filled by Operating Surgeon & Anesthetist)

GSI-IPD-FF-25

Patient Name _____ Age _____ UHID _____

Unit/Ward _____ Date _____

Before induction of Anesthesia (with at least nurse and anesthetist)

Has the patient confirmed his/her identity, site, procedure and consent?
Yes

Is the site marked?
Yes
Not applicable

Is the anesthesia machine and medication check complete?
Yes

Is the pulse oximeter on the patient and functioning?
Yes

Does the patient have a:
Known allergy?
No
Yes
Difficult airway or aspiration risk?
No
Yes, and equipment/assistance available
Risk of > 500ml blood loss (7ml/kg in children)?
No
Yes, and two IVs/central access and fluids

Before skin incision (with nurse, anesthetist and surgeon)

Confirm all team members have introduced themselves by name and role.
Confirm the patient's name, procedure and where the incision will be made.

Has antibiotic prophylaxis been given within the last 60 minutes?
Yes
Not applicable

Anticipated Critical Events

To Surgeon:
What are the critical or non-routine steps?
How long will the case take?
What is the anticipated blood loss?

To Anesthetist:
Are there any patient-specific concerns?
To Nursing Team:
Has sterility (including indicator results) been confirmed?
Are there equipment issues or any concerns?

Is essential imaging displayed?
Yes

Before Patient leaves operating (with nurse, anesthetist and surgeon)

Nurse verbally confirms:

The name of the procedure
Completion of instrument, sponge and needle counts
Specimen labeling (read specimen labels aloud, including patient name)
Whether there are any equipment problems to be addressed

To Surgeon, Anesthetist and Nurse:

What are the key concerns for recovery and management of this patient?

Name of Surgeon
Sign
Name Of Anesthesiologist
Sign
Name of Scrub Nurse
Sign

WHO Surgical Safety Checklist

9. DOCUMENTED PROCEDURE FOR MANAGEMENT OF MEDICATION ARE DEFINED AND IMPLEMENTED E.G. SOUND ALIKE AND LOOK ALIKE MEDICATIONS ARE STORED SEPARATELY

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Defined list of sound alike and look alike medications b)Display of the sound alike and look alike medications list in all patient-care area c)Sound alike and look alike medications are stored separately in pharmacy and all patient-care area	Direct observation, Record review & Staff interview	100% compliance of all three evidences.	10	a)List of sound alike and look alike defined and displayed in all patient-care area b) Sound alike and look alike medications are stored separately in pharmacy and all patient-care area
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

9. DOCUMENTED PROCEDURE FOR MANAGEMENT OF MEDICATION ARE DEFINED AND IMPLEMENTED E.G. SOUND ALIKE AND LOOK ALIKE MEDICATIONS ARE STORED SEPARATELY

Medication Management

10. LISTING AND STORAGE OF HIGH RISK MEDICATIONS TO BE DONE & ORDERS SHOULD BE VERIFIED BEFORE THEIR DISPENSING.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)The list of High risk medications are available b)Updated legal licence available if narcotics are stored and used. c)The high risk medications are stored separately in secure enviorment (double lock). d)Check patient file for documentation verification.	Direct observation, Record review & Staff interview	100% compliance of all four evidences.	10	a) List of High risk medication b)High Risk Medications are kept under lock and key in separate drawer c)Legal liscence for narcotics if narcotics are stored and used.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

Note: Exp – NABH 5th edition

10. LISTING AND STORAGE OF HIGH RISK MEDICATIONS TO BE DONE & ORDERS SHOULD BE VERIFIED BEFORE THEIR DISPENSING.

11. VERIFICATION OF DOSAGE, ROUTE, TIMING AND EXPIRY DATE BEFORE ADMINISTERING THE MEDICATION SHOULD BE DONE.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Defined SOP for process of administration of medication Ð b) Check minimum 5 in-patients files of previous month and look for implemented process as defined in SOPs (dosage, route, timing and expiry date before administering the medication) c)Medication orders are clear, legible, dated, named and signed by the concerned doctor	Direct observation, Record review & Staff interview	100% compliance of all three evidences.	10	a) Policy of Management of Medications b)Patient files with Medication orders that are clear, legible, dated, named and signed by the concerned doctor.
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

11. VERIFICATION OF DOSAGE, ROUTE, TIMING AND EXPIRY DATE BEFORE ADMINISTERING THE MEDICATION SHOULD BE DONE.

MEDICATION ERROR MONITORING

GOVERNMENT(CLASS) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE
AHMEDABAD

NAME OF DEPARTMENT: _____ NAME OF AUDITOR: _____ Month: _____

Right Patient	Right Drug	Right Dose	Right Route	Right Frequency	Right Time	Right Documentation	Correct Cut Tablet Strip Labelling	Correct Preparation of Drug (Correct IV Fluid Rate)	Medication Reconciliation	Adverse Drug Reaction	Doctor's Registration Number	Remarks

5. **PROCESS DETAILS:**

Sr. NO.	STEPS	RESPONSIBILITY
1	Writing of medication orders	Consultant/ Resident Doctor
2	In case of verbal order, signature shall be taken within **24 hours** of order. Refer document 'verbal orders for medications'	Attending Consultant
3	Inform the patient about the prescription	Staff Nurse
4	Medicine is provided as per doctor's orders. Medications from Hospital' brought from outside Provided by staff nurse/ Self administration	Staff Nurse
5	Checking of UHID number, Name of Patient, expiry date, dosage (mg, gm), frequency of medicines while receiving	Staff Nurse
6	Keep these Seven 'R' in mind before giving medicine. 1) Right Patient 6)Right frequency 2) Right dose 7)Right documentation & Right Disposal 3) Right Route 4) Right time 5) Right drugs	Staff Nurse

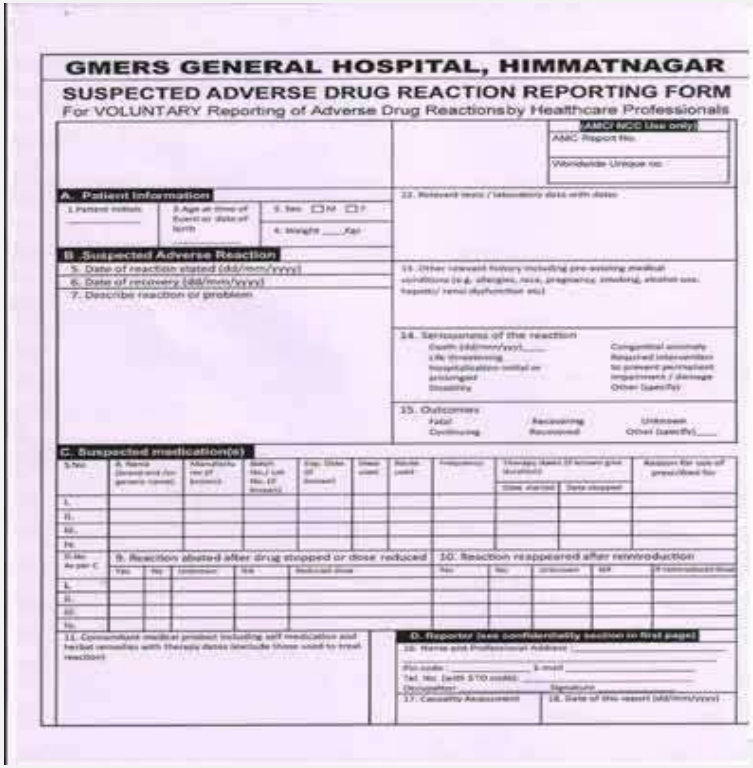
PREPARED BY	REVIEWED BY	APPROVED BY	ISSUED BY
QUALITY TEAM GOVT SPINE INSTITUTE	HMO GOVT SPINE INSTITUTE	DIRECTOR GOVT SPINE INSTITUTE AHMEDABAD	ACCREDITATION CO-ORDINATOR

PAGE 1 OF 2

12. ADVERSE DRUG EVENTS ARE COLLECTED, ANALYSED BY THE TREATING DOCTOR AND PRACTICES ARE MODIFIED (IF NECESSARY) TO REDUCE THE SAME.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Clearly defined policy for the adverse drug events. b)Adverse drug events are reported to concerned authority and record is available b) Corrective and preventive action taken for Adverse drug events.	Record review & Staff interview	100% compliance of all three evidences.	10	Records of adverse drug events kept with CAPA.
		if any of the three evidence is found to be non-compliant.	5	
		Non-compliance of all three evidences.	0	

12. ADVERSE DRUG EVENTS ARE COLLECTED, ANALYSED BY THE TREATING DOCTOR AND PRACTICES ARE MODIFIED (IF NECESSARY) TO REDUCE THE SAME.



GMERS GENERAL HOSPITAL, HIMMATNAGAR

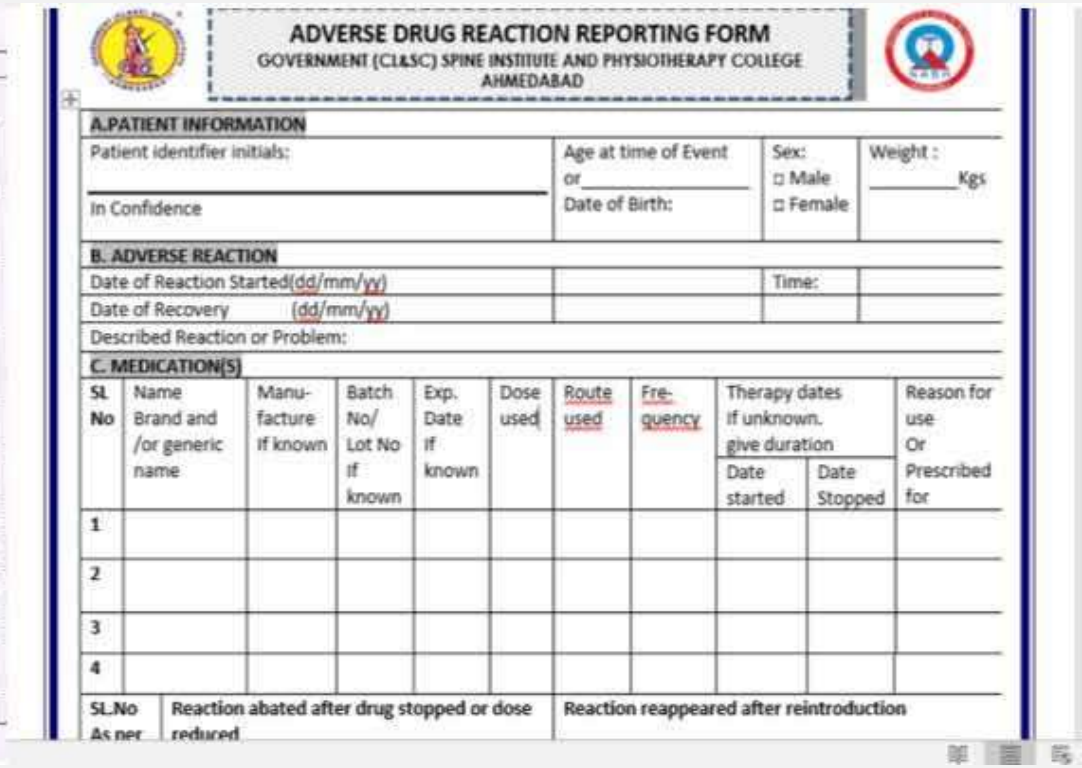
SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY Reporting of Adverse Drug Reactionsby Healthcare Professionals

A. Patient Information

B. Suspected Adverse Reaction

C. Suspected medication(s)



ADVERSE DRUG REACTION REPORTING FORM

GOVERNMENT (C1&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

A.PATIENT INFORMATION

Patient identifier initials: In Confidence	Age at time of Event or Date of Birth:	Sex: □ Male □ Female	Weight : Kgs

B. ADVERSE REACTION

Date of Reaction Started(dd/mm/yy)		Time:	
Date of Recovery (dd/mm/yy)			
Described Reaction or Problem:			

C. MEDICATION(S)

SL No	Name Brand and /or generic name	Manu-facture If known	Batch No/ Lot No If known	Exp. Date If known	Dose used	Route used	Fre-quency	Therapy dates If unknown, give duration		Reason for use Or Prescribed for
								Date started	Date Stopped	
1										
2										
3										
4										

SL.No As per	Reaction abated after drug stopped or dose reduced	Reaction reappeared after reintroduction

Infection Control Practices

13. THE HOSPITAL INFECTION CONTROL COMMITTEE IS CONSTITUTED AND FUNCTIONAL WITH DEFINED SURVEILLANCE METHOD FOR TRACKING AND ANALYSING APPROPRIATE INFECTION RATES.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a) Availability of infection control committee formation letter with list of members's. b)List of identified high risk areas. c)Defined SOP for tracking and analysing infection rates. d)Minutes of the meeting of infection control committee. e)Corrective and preventive action taken to prevent infection.	Record review & Staff interview	100% compliance of all five evidences.	10	a) SOPs are defined for Infection control b)Minutes of the meeting of infection control committee with corrective and preventive action
		if any of the five evidence is found to be non-compliant.	5	
		Non-compliance of all five evidences.	0	

13. THE HOSPITAL INFECTION CONTROL COMMITTEE IS CONSTITUTED AND FUNCTIONAL WITH DEFINED SURVEILLANCE METHOD FOR TRACKING AND ANALYSING APPROPRIATE INFECTION RATES.

2.INFECTION CONTROL COMMITTEE

COMPOSITION OF COMMITTEE

Sr. No.	Designation Organization	Designation Committee
1	Director	Chairman
2	Microbiologist	Infection Control Officer &Member Secretary
3	Assistant Professor (Ortho)	Member
4	Assistant Professor (Anaesthesia)	Member
5	Resident Medical Officer – (RMO)– Accreditation Coordinator	Member
6	PIU Engineer- Civil	Member
7	PIU Engineer – Electrical	Member
8	Assistant Nursing Superintendent	Member
9	Infection Control Nurse	Member
10	Linen keeper	Member
11	Sanitary Inspector	Member
12	CSSD Technician	Member

HAI -FORM

GOVERNMENT(CL&SC) SPINE INSTITUTE AND PHYSIOTHERAPY COLLEGE AHMEDABAD

HEALTH CARE ASSOCIATED INFECTION SURVEILLANCE FORM

Patient UHID :	Gender : F / M	Age:
Patient Name :		
Date Of Admission : Tra.In Date:		Ward/Unit :
Birth Weight (grams) : (if applicable)		
Admission Diagnosis:		Final Diagnosis :
Surgery performed: Yes / No If Yes Type of operation :		Date & Duration of Surgery :
Elective/Emergency :		Major/Minor:
OT:		Anaesthesia Type: General/Spinal/Local
Shifted from other Hospital : Yes / No		Date Of Discharge :

INDWELLING DEVICES

DATE	URINARY CATHETER PUT ON	CENTRAL LINE PUT ON

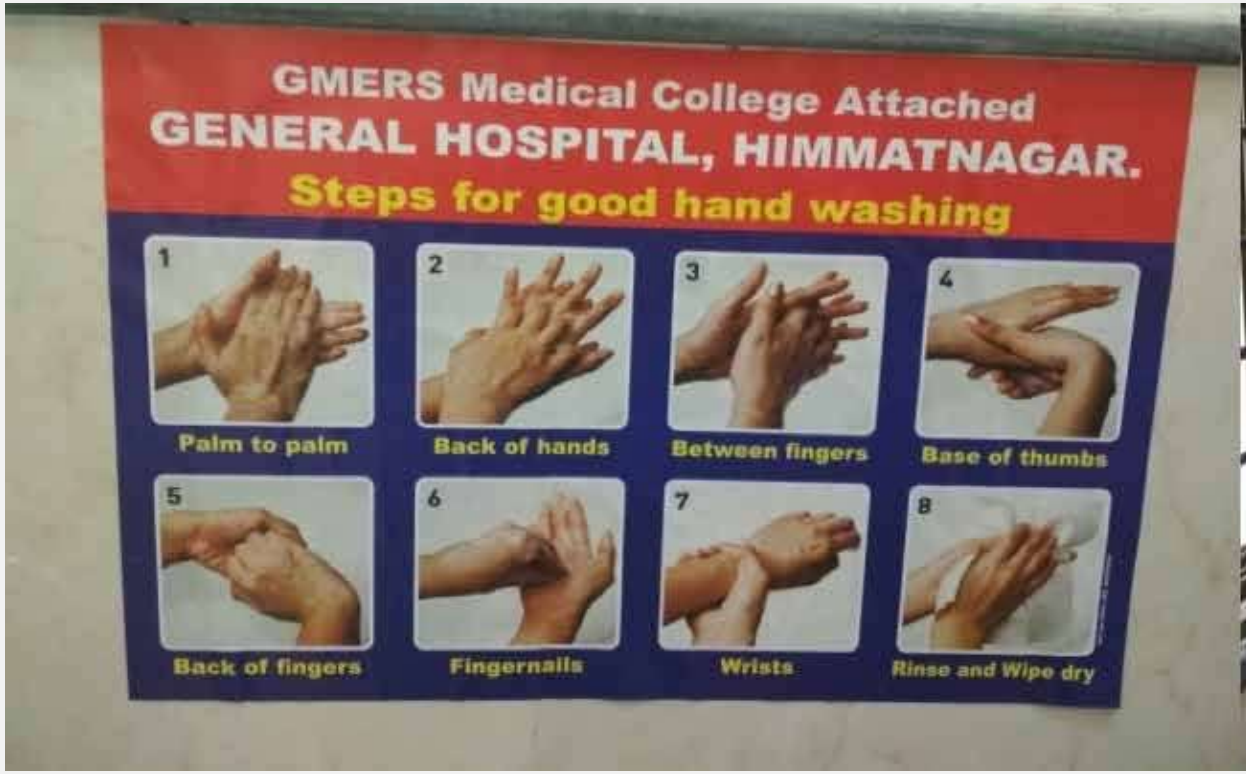
HEALTH CARE ASSOCIATED INFECTION MONITORING

	CAUTI					CRBSI		SSI						LAB REPORTS					
DATE	Fever/ Hypothermia	Burning urine	Urgency/ Frequency	pain at renal angle or suprapubic	Turbid Urine	Tachy-cardia	Hypo-tension	BT: Yes/ No	ICU Stay (Post op day)	**Wound Type:-** clean/ contaminated /Dirty	**Wound Dressing** Pus/ Discharge (Post Operative Day): Yes/No	**Type of SSI:** Superficial SSI/Deep/ Organ/Space Involvement	Other Symptoms	Urine CS	Blood CS	Swab/ Pus CS	Radiology Reports	Anti-biotics taken	Remarks

14. ALL THE HEALTHCARE PROVIDERS SHOULD HAVE EASY ACCESSIBILITY TO THE HAND WASHING FACILITY IN ALL PATIENT CARE AREAS. HAND HYGIENE STEPS TO BE DISPLAYED AT EACH HAND WASHING FACILITIES.

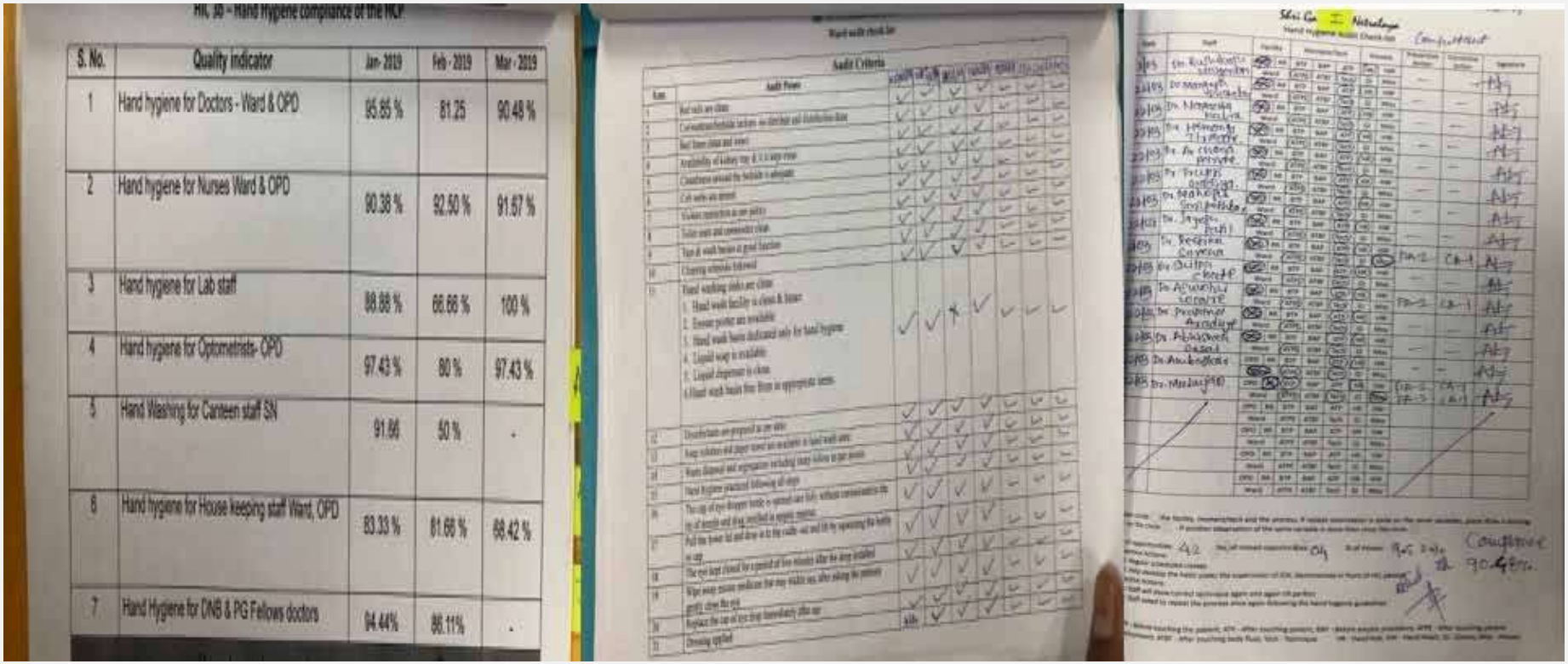
Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Hand washing facility available in all patient care areas b)Staff aware about the hand hygiene practices and follows the steps of handwashing (WHO handwashing steps). c)Work instruction displayed in all handwashing points at all patientcare areas d)Hand hygiene audit and CAPA done regularly.	Direct observation, Record review & Staff interview	100% compliance of all four evidences.	10	a)Hand hygine techniques are displayed at every hand washing area. b) Training record of hand hygiene trainings given to all staff members. c)Hand hygine audits done
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

14. ALL THE HEALTHCARE PROVIDERS SHOULD HAVE EASY ACCESSIBILITY TO THE HAND WASHING FACILITY IN ALL PATIENT CARE AREAS. HAND HYGIENE STEPS TO BE DISPLAYED AT EACH HAND WASHING FACILITIES.



14. ALL THE HEALTHCARE PROVIDERS SHOULD HAVE EASY ACCESSIBILITY TO THE HAND WASHING FACILITY IN ALL PATIENT CARE AREAS. HAND HYGIENE STEPS TO BE DISPLAYED AT EACH HAND WASHING FACILITIES.

Hand Hygiene Audits

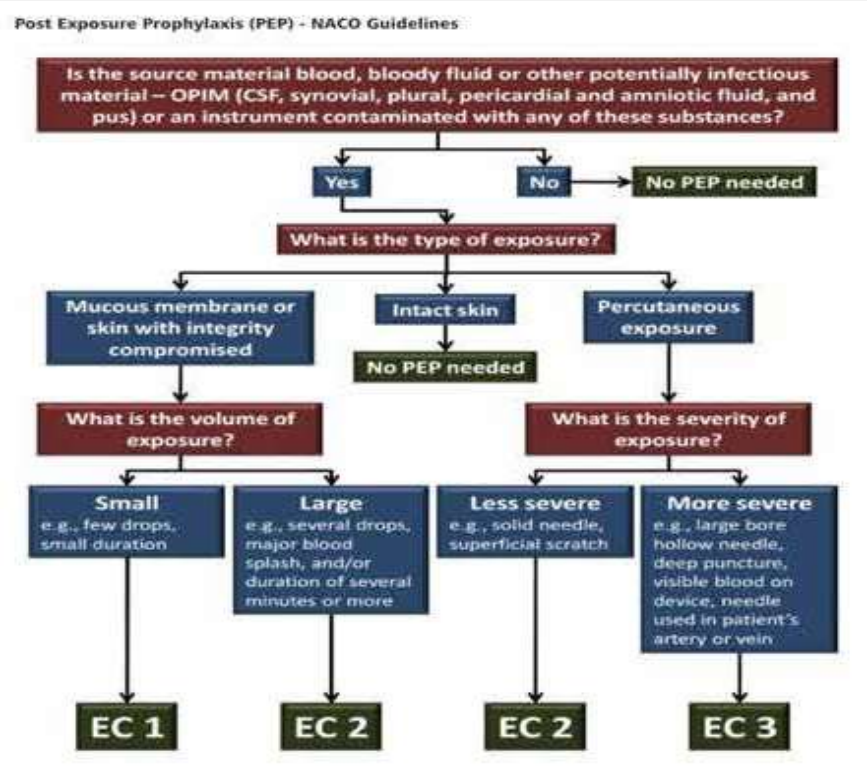


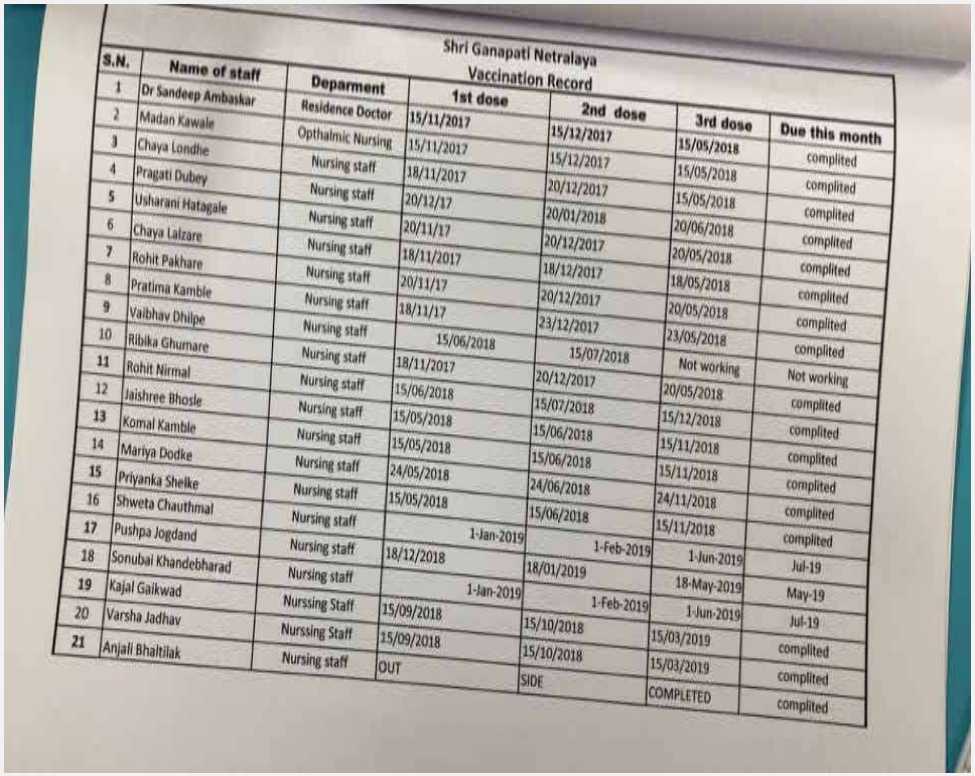
S. No.	Quality indicator	Jan- 2019	Feb - 2019	Mar - 2019
1	Hand hygiene for Doctors - Ward & OPD	95.65 %	81.25	90.48 %
2	Hand hygiene for Nurses Ward & OPD	90.38 %	92.50 %	91.57 %
3	Hand hygiene for Lab staff	88.88 %	66.66 %	100 %
4	Hand hygiene for Optometrists- OPD	97.43 %	80 %	97.43 %
5	Hand Washing for Canteen staff SN	91.66	50 %	-
6	Hand hygiene for House keeping staff Ward, OPD	83.33 %	81.66 %	66.42 %
7	Hand Hygiene for DNB & PG Fellows doctors	94.44%	86.11%	-

15. STAFF MEMBERS SHOULD BE PROVIDED WITH THE ADEQUATE AND APPROPRIATE PRE AND POST EXPOSURE PROPHYLAXIS

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)The Vaccination (Inj. TT, Hepatitis – B, Typhoid)and medical checkup record available of all concerned staff members b)Hospital provided Personal protective equipment to concerned staff. c)Staff uses Personal protective equipment while conducting any procedure/activity. d)Display of Post exposure prophylaxis chart in all patient care areas	Direct observation, Record review & Staff interview	100% compliance of all four evidences.	10	a) Staff vaccination record. b)PPE Equipments used by staff while conducting any procedure/activity. c)Post exposure prophylaxis chart in patient care area.
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

15. STAFF MEMBERS SHOULD BE PROVIDED WITH THE ADEQUATE AND APPROPRIATE PRE AND POST EXPOSURE PROPHYLAXIS





Shri Ganapati Netralaya
Vaccination Record

S.N.	Name of staff	Deparment	1st dose	2nd dose	3rd dose	Due this month
1	Dr Sandeep Ambaskar	Residence Doctor	15/11/2017	15/12/2017	15/05/2018	complited
2	Madan Kawale	Opthalmic Nursing	15/11/2017	15/12/2017	15/05/2018	complited
3	Chaya Londhe	Nursing staff	18/11/2017	20/12/2017	15/05/2018	complited
4	Pragati Dubey	Nursing staff	20/12/17	20/01/2018	20/06/2018	complited
5	Usharani Hatagale	Nursing staff	20/11/17	20/12/2017	20/05/2018	complited
6	Chaya Lalzare	Nursing staff	18/11/2017	18/12/2017	18/05/2018	complited
7	Rohit Pakhare	Nursing staff	20/11/17	20/12/2017	20/05/2018	complited
8	Pratima Kamble	Nursing staff	18/11/17	23/12/2017	23/05/2018	complited
9	Vaibhav Dhilpe	Nursing staff	15/06/2018	15/07/2018	Not working	Not working
10	Ribika Ghumare	Nursing staff	18/11/2017	20/12/2017	20/05/2018	complited
11	Rohit Nirmal	Nursing staff	15/06/2018	15/07/2018	15/12/2018	complited
12	Jaishree Bhosle	Nursing staff	15/05/2018	15/06/2018	15/11/2018	complited
13	Komal Kamble	Nursing staff	15/05/2018	15/06/2018	15/11/2018	complited
14	Mariya Dodke	Nursing staff	24/05/2018	24/06/2018	24/11/2018	complited
15	Priyanka Shelke	Nursing staff	15/05/2018	15/06/2018	15/11/2018	complited
16	Shweta Chauthmal	Nursing staff	1-Jan-2019	1-Feb-2019	1-Jun-2019	Jul-19
17	Pushpa Jogdand	Nursing staff	18/12/2018	18/01/2019	18-May-2019	May-19
18	Sonubai Khandebharad	Nursing staff	1-Jan-2019	1-Feb-2019	1-Jun-2019	Jul-19
19	Kajal Gaikwad	Nurssing Staff	15/09/2018	15/10/2018	15/03/2019	complited
20	Varsha Jadhav	Nurssing Staff	15/09/2018	15/10/2018	15/03/2019	complited
21	Anjali Bhaltilak	Nursing staff	OUT	SIDE	COMPLETED	complited

16. THE PROPER IMPLEMENTATION AND REGULAR MONITORING OF BIO-MEDICAL WASTE SEGREGATION AND COLLECTION IN ALL THE PATIENT CARE AREAS OF THE HOSPITAL AND STAFF SHOULD BE TRAINED IN HANDLING THE BIO-MEDICAL WASTE AND PROVIDED WITH ALL PERSONAL PROTECTIVE MEASURE.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)Updated license available for Bio-Medical Waste Management practice as per BMW Rule 2016 b)SOP defined for the process of BMW as per Pollution control guidelines. c) Staff follows the SOP. d)Waste management bins available and BMW guideline chart is displayed in all patient care area e)Personal protective measures (e.g. gloves, mask, apron, gum boots, heavy duty rubber gloves, etc.) are used by all categories of staff handling Bio-Medical Waste. f)Infection control committee visits common biomedical treatment facility.	Direct observation, Record review & Staff interview	100% compliance of all six evidences.	10	a) Updated license of BMW. b) Available biomedical waste bins and displayed chart in patient care area. c) Biomedical waste storage area
		if any of the six evidence is found to be non-compliant.	5	
		Non-compliance of all six evidences.	0	

16. THE PROPER IMPLEMENTATION AND REGULAR MONITORING OF BIO-MEDICAL WASTE SEGREGATION AND COLLECTION IN ALL THE PATIENT CARE AREAS OF THE HOSPITAL AND STAFF SHOULD BE TRAINED IN HANDLING THE BIO-MEDICAL WASTE AND PROVIDED WITH ALL PERSONAL PROTECTIVE MEASURE.

BMW Disposal

16. THE PROPER IMPLEMENTATION AND REGULAR MONITORING OF BIO-MEDICAL WASTE SEGREGATION AND COLLECTION IN ALL THE PATIENT CARE AREAS OF THE HOSPITAL AND STAFF SHOULD BE TRAINED IN HANDLING THE BIO-MEDICAL WASTE AND PROVIDED WITH ALL PERSONAL PROTECTIVE MEASURE.

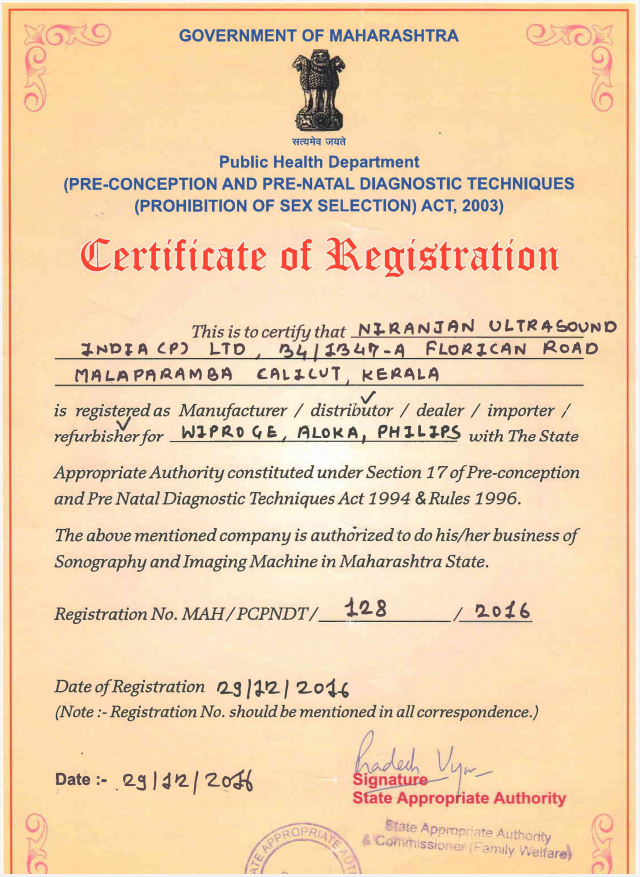
BMW Storage

Availability of Important Licenses

17. A DEFINED MECHANISM TO BE THERE FOR REGULAR UPDATING OF THE LICENCES / REGISTRATION / CERTIFICATIONS.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See the relevant statutory documents.	Record review	All aplicable legal liscence are upto date	10	List of applicable legal licences and MOU/Agreement with date of issue and validity is maintained.
		If any applicable legal liscence is expired or not available	5	
		Non availability of legal liscence	0	

17. A DEFINED MECHANISM TO BE THERE FOR REGULAR UPDATING OF THE LICENCES / REGISTRATION / CERTIFICATIONS.



GOVERNMENT OF MAHARASHTRA

सत्यमेव जयते

Public Health Department

(PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT, 2003)

Certificate of Registration

This is to certify that NIRANJAN ULTRASOUND INDIA (P) LTD, 34/1347-A FLORICAN ROAD MALAPARAMBA CALICUT, KERALA

is registered as Manufacturer / distributor / dealer / importer / refurbisher for WIPRO GE, ALOKA, PHILIPS *with The State Appropriate Authority constituted under Section 17 of Pre-conception and Pre Natal Diagnostic Techniques Act 1994 & Rules 1996.*

The above mentioned company is authorized to do his/her business of Sonography and Imaging Machine in Maharashtra State.

Registration No. MAH/PCPNDT/ 128 / 2016

Date of Registration 29/12/2016

(Note :- Registration No. should be mentioned in all correspondence.)

Date :- 29/12/2016

Signature

State Appropriate Authority

State Appropriate Authority & Commissioner (Family Welfare)

DRUG NATIONAL AUTHORITY

The National Drug Policy and Authority (Issue of Licences) Regulations 1995

Licence to Operate a Retail Pharmacy

This is to certify that the business trading under the name of

is licensed to operate a retail pharmacy

at the Physical Location

and Postal Address K'LA

with Supervising Pharmacist

having Registration No FIN:

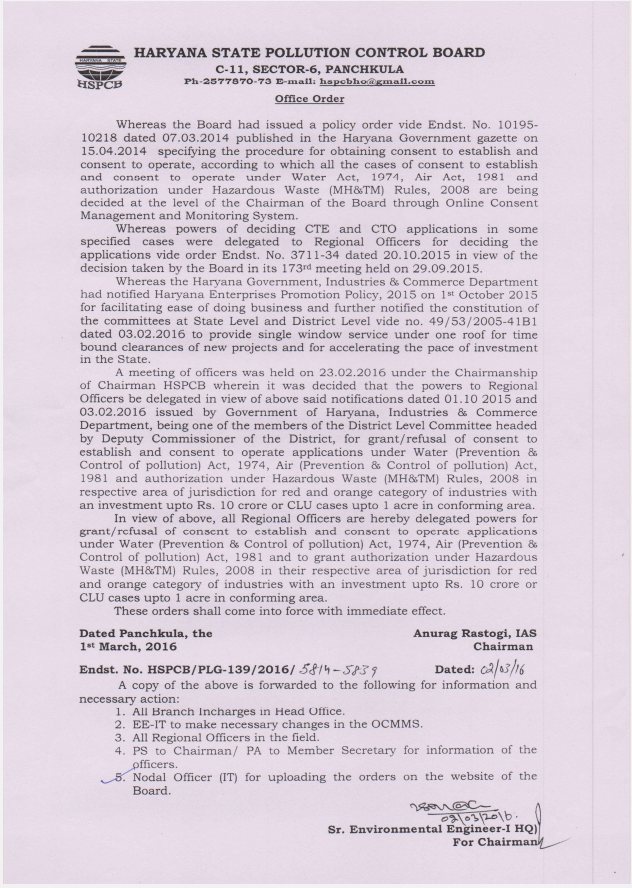
Licence No. Valid up to 31-Dec-16

Fee Paid Ushs 300,000 Issue Date 09-Dec-16

LICENCED DEC 2016

(Secretary to the Authority)

This Licence must be prominently displayed in the premises to which it refers



HARYANA STATE POLLUTION CONTROL BOARD

HSPCB

C-11, SECTOR-6, PANCHKULA

Ph-2577870-73 E-mail: hspcbho@gmail.com

Office Order

Whereas the Board had issued a policy order vide Endst. No. 10195-10218 dated 07.03.2014 published in the Haryana Government gazette on 15.04.2014 specifying the procedure for obtaining consent to establish and consent to operate, according to which all the cases of consent to establish and consent to operate under Water Act, 1974, Air Act, 1981 and authorization under Hazardous Waste (MH&TM) Rules, 2008 are being decided at the level of the Chairman of the Board through Online Consent Management and Monitoring System.

Whereas powers of deciding CTE and CTO applications in some specified cases were delegated to Regional Officers for deciding the applications vide order Endst. No. 3711-34 dated 20.10.2015 in view of the decision taken by the Board in its 173rd meeting held on 29.09.2015.

Whereas the Haryana Government, Industries & Commerce Department had notified Haryana Enterprises Promotion Policy, 2015 on 1st October 2015 for facilitating ease of doing business and further notified the constitution of the committees at State Level and District Level vide no. 49/53/2005-41B1 dated 03.02.2016 to provide single window service under one roof for time bound clearances of new projects and for accelerating the pace of investment in the State.

A meeting of officers was held on 23.02.2016 under the Chairmanship of Chairman HSPCB wherein it was decided that the powers to Regional Officers be delegated in view of above said notifications dated 01.10 2015 and 03.02.2016 issued by Government of Haryana, Industries & Commerce Department, being one of the members of the District Level Committee headed by Deputy Commissioner of the District, for grant/refusal of consent to establish and consent to operate applications under Water (Prevention & Control of pollution) Act, 1974, Air (Prevention & Control of pollution) Act, 1981 and authorization under Hazardous Waste (MH&TM) Rules, 2008 in respective area of jurisdiction for red and orange category of industries with an investment upto Rs. 10 crore or CLU cases upto 1 acre in conforming area.

In view of above, all Regional Officers are hereby delegated powers for grant/refusal of consent to establish and consent to operate applications under Water (Prevention & Control of pollution) Act, 1974, Air (Prevention & Control of pollution) Act, 1981 and to grant authorization under Hazardous Waste (MH&TM) Rules, 2008 in their respective area of jurisdiction for red and orange category of industries with an investment upto Rs. 10 crore or CLU cases upto 1 acre in conforming area.

These orders shall come into force with immediate effect.

Dated Panchkula, the 1st March, 2016

Anurag Rastogi, IAS Chairman

Endst. No. HSPCB/PLG-139/2016/ 5814-5839 **Dated:** 02/03/16

A copy of the above is forwarded to the following for information and necessary action:

1. All Branch Incharges in Head Office.
2. EE-IT to make necessary changes in the OCMMS.
3. All Regional Officers in the field.
4. PS to Chairman/ PA to Member Secretary for information of the officers.
5. Nodal Officer (IT) for uploading the orders on the website of the Board.

02/03/2016

Sr. Environmental Engineer-I HQ)

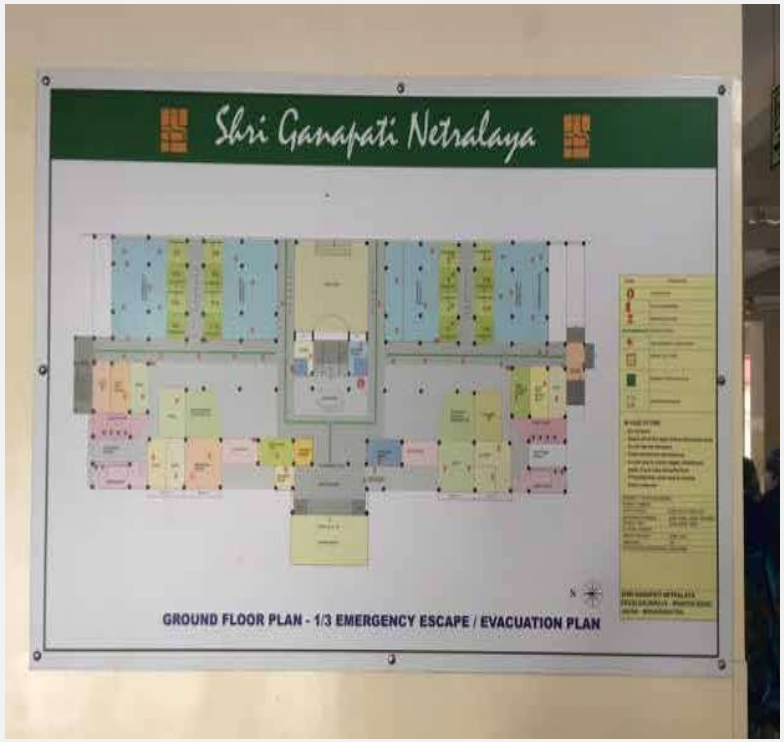
For Chairman

Disaster Management

18. SAFE EXIT PLAN FOR FIRE AND NON-FIRE EMERGENCIES SHOULD BE DOCUMENTED AND ENSURE THE AWARENESS AMONGST THE HOSPITAL STAFF AND FIRE MOCK DRILLS SHOULD BE CONDUCTED AT LEAST TWICE IN A YEAR.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)SOP defined and implemented for safe exit plan in case of fire and non-fire emergencies. b)Sinages displayed of do's and don't's in case of fire c)Display of fire exit plan in all patient care areas. d)Record of Mockdrill's conducted and CAPA done	Direct observation, Record review & Staff interview.	100% compliance of all four evidences.	10	a)All the signages are displayed with fire exit plan. b)Document of mock drills conducted at regular intervals
		if any of the four evidence is found to be non-compliant.	5	
		Non-compliance of all four evidences.	0	

18. SAFE EXIT PLAN FOR FIRE AND NON-FIRE EMERGENCIES SHOULD BE DOCUMENTED AND ENSURE THE AWARENESS AMONGST THE HOSPITAL STAFF AND FIRE MOCK DRILLS SHOULD BE CONDUCTED AT LEAST TWICE IN A YEAR.

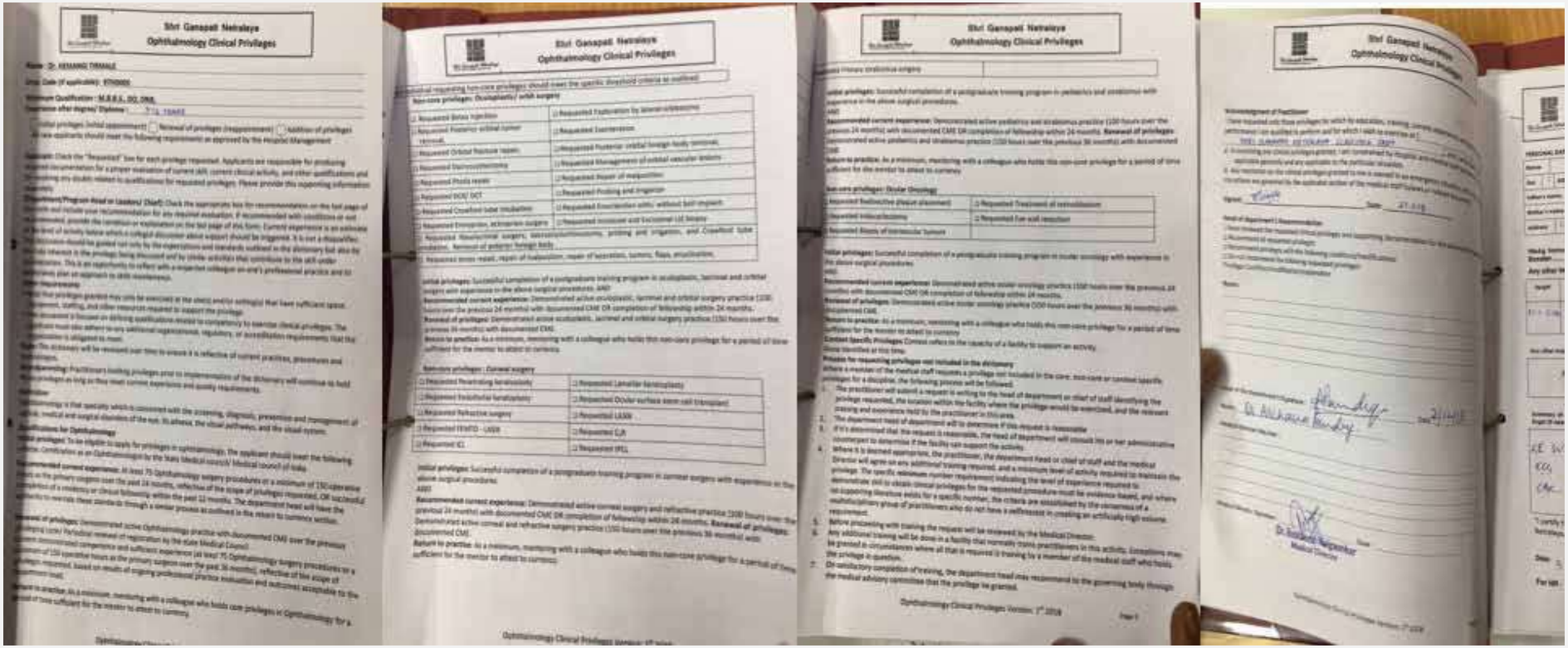


Record Management – Internal Stakeholder & External Stakeholder

19. THE SERVICES PROVIDED BY THE MEDICAL PROFESSIONALS AND NURSING STAFF SHOULD BE IN LINE WITH THEIR QUALIFICATION,TRAINING AND REGISTRATION.

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
See minimum 5 personal files of staffs (e.g. Consultant RMO & Nurses, etc.) and check for their qualification, training and privelaging a)Medical professionals are granted previlages to admit and care of patients in consonance with their qualification, training, experience and registration. b)Medical professionals admit and care care for patients as per their privelaging. c)Nursing staff is granted previlages in consonance with their qualification, training, experience and registration. d)Nursing professional care for patients as per their privelaging. e) System developed for updating the personal files of staff.	Record review & Staff interview	100% compliance of all five evidences.	10	All files are maintained by HR Dept. with all the the required details
		if any of the five evidence is found to be non-compliant.	5	
		Non-compliance of all five evidences.	0	

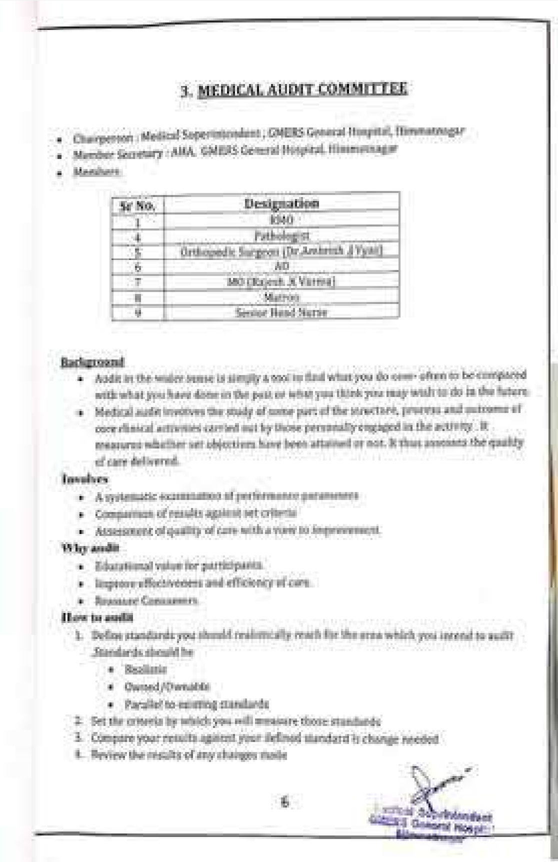
19. THE SERVICES PROVIDED BY THE MEDICAL PROFESSIONALS AND NURSING STAFF SHOULD BE IN LINE WITH THEIR QUALIFICATION,TRAINING AND REGISTRATION.



20. UP TO DATE AND CHRONOLOGICAL DETAILS OF THE PATIENT CARE SHOULD BE AVAILABLE IN THE MEDICAL RECORD INCLUDING DISCHARGE SUMMARY

Evidence Required	Method of Assessment	Response sheet	Mark	Available evidence (Photo to be uploaded)
a)SOP defined for the process of keeping medical record file of discharge patient, MLC and Death case b)Staff is aware and follows the process defined in SOP c)See minimum 5 files from medical record (e.g. Surgery, Medicine, MLC, Death, LAMA, etc.) and check the chronological account of patient care. i) Availability of checklist for maintainaing records in chronological order d) Medical record audit with corrective and preventive action.	Record review & Staff interview	100% compliance of all five evidences.	10	a)All the files in MRD section are arranged in chronological order. LAMA Death and MLC files are kept seperately. b) Checklist for maintaining records in chronological order in patient file. c) Summary of medical record audit.
		if any of the five evidence is found to be non-compliant.	5	
		Non-compliance of all five evidences.	0	

20. UP TO DATE AND CHRONOLOGICAL DETAILS OF THE PATIENT CARE SHOULD BE AVAILABLE IN THE MEDICAL RECORD INCLUDING DISCHARGE SUMMARY



3. MEDICAL AUDIT COMMITTEE

- Chairperson : Medical Superintendent ; GMERS General Hospital, Himmatnagar
- Member Secretary : AMA, GMERS General Hospital, Himmatnagar
- Members:

Sr No.	Designation
1	RMO
4	Pathologist
5	Orthopedic Surgeon (Dr.Ambrish J.Vyas)
6	AO
7	MO (Rajesh .K Varma)
8	Matron
9	Senior Head Nurse

Background

- Audit in the wider sense is simply a tool to find what you do now- often to be compared with what you have done in the past or what you think you may wish to do in the future.
- Medical audit involves the study of some part of the structure, process and outcome of core clinical activities carried out by those personally engaged in the activity . It measures whether set objectives have been attained or not. It thus assesses the quality of care delivered.

Involves

- A systematic examination of performance parameters
- Comparison of results against set criteria
- Assessment of quality of care with a view to improvement.

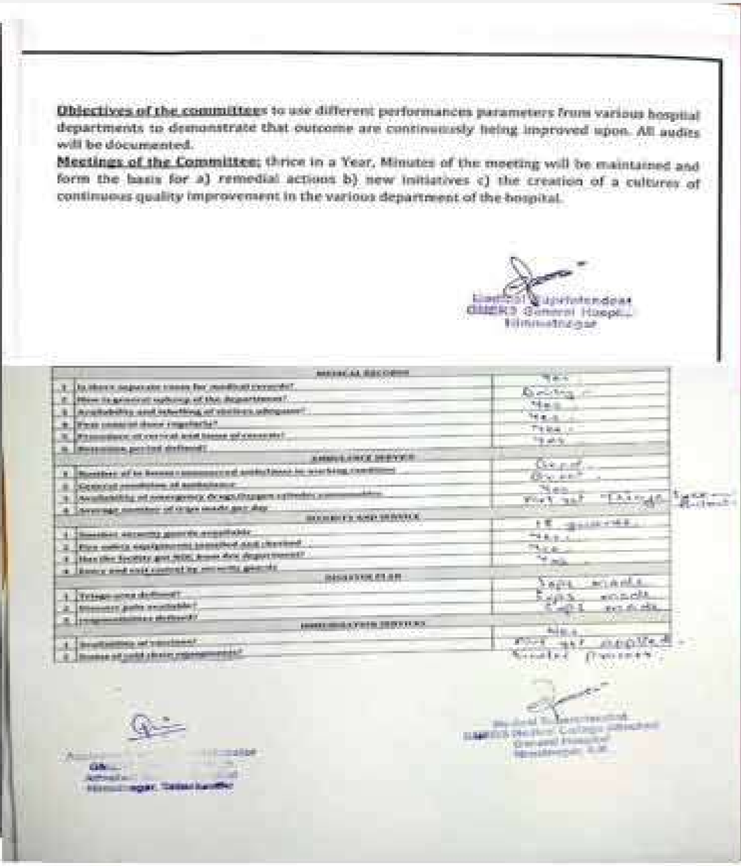
Why audit

- Educational value for participants.
- Improve effectiveness and efficiency of care.
- Measure Consumers

How to audit

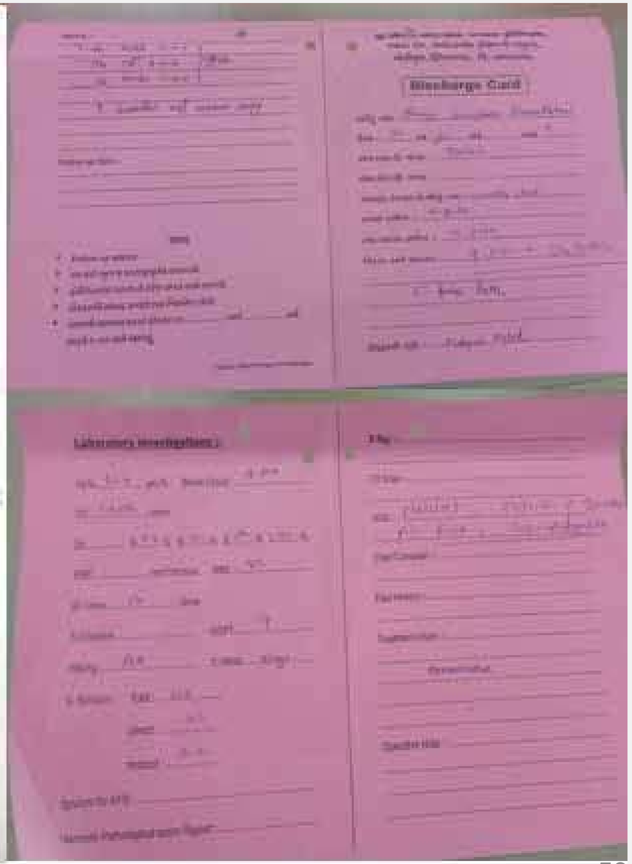
1. Define standards you should realistically reach for the area which you intend to audit Standards should be
   - Realistic
   - Owned/Ownable
   - Parallel to existing standards
2. Set the criteria by which you will measure those standards
3. Compare your results against your defined standard is change needed
4. Review the results of any changes made

6



Objectives of the committee: to use different performances parameters from various hospital departments to demonstrate that outcome are continuously being improved upon. All audits will be documented.

Meetings of the Committee: thrice in a Year, Minutes of the meeting will be maintained and form the basis for a) remedial actions b) new initiatives c) the creation of a cultures of continuous quality improvement in the various department of the hospital.




thank you