CQI 1. Structured Quality Assurance & Monitoring Program

A quality improvement program will be developed in a collaborative matter by a committee as under.

Chairperson: Dr. Sachit Anand Arora (Principal)

Members

Dr. Megha Breja (Quality Manager)

Mr. Vijay Sharma (Director Admin)

Dr. Mousumi Goswami (Professor & HOD, Pedodontics)

Dr. Shivjot Chhina (Professor & HOD, Periodontics)

Mandate – The committee shall oversee the Quality Improvement Program - development, implementation and monitoring. The committee shall also recommend actions required to improve the program including requirement of any additional external assistance.

Frequency of meeting – Once every month till achieving accreditation. Thereafter once every quarter.

Designated person for coordinating and implementing quality improvement program is Dr. Megha Breja.

QIP is included in induction and in-service training programs. Quality indicators, their implications and requisite follow-up actions are communicated periodically through training programs.

As part of quality improvement, a number of performance indicators are being captured. These provide inputs on performance of various activities, processes and procedures in the dental hospital. Those requiring improvement are identified by a systematic review process by the top management.

The responsibility to sustain and maintain the program rests with Dr. Sachit Anand Arora who will ensure that the program is updated as required. He will also be responsible for conducting clinical and other audits.

The purpose of this Quality Improvement Manual is to lay down program for improvement of quality in patient care in ITSDH.

The manual lays down Quality Policy, Safety Policy, QA program for dental services, Indicators to be captured and Procedures to be followed.

Quality Policy

ITSDH is committed to provide dental practice that is safe, effective, efficient, timely and patient centric and in conformance with the dental health care standards set forth by National Accreditation Board for Hospitals and Healthcare Providers.

Safety Policy

ITSDH will ensure that patient safety is in conformance with the dental health care standards set forth by National Accreditation Board for Hospitals and Healthcare Providers

Adaptation of Patient Safety Goals – Following IPSG have been adopted in the ITSDH

- Identifying patients correctly: Patients shall be identified by at least two identifiers – Name and CR No.
- Improve staff communication: Patient handovers by a staff member to other shall be handed over by specifically mentioning and recording – Name of the patient, diagnosis, purpose of handing over and current condition of the patient.
- Use medications safely: All medications shall be used keeping in mind – Right drug, dose, route, frequency, and time and looking out for adverse reactions.
- Prevent Infections: observe standard precautions, stringent sterilization processes and monitor for infections in all cases
- Identify patient safety risks: regular safety rounds and follow-up
- Preventing mistakes in surgery: using surgical safety check list.

Quality Assurance Program for Surgical Services

QA program for surgical services comprises of:

- Appropriate diagnosis and care plan for each patient
- Provision of services by credentialed and privileged personnel
- Regular checking of functioning of therapeutic equipment
- Implementation of Surgical Safety Checklist
- Detection, reporting, recording and Corrective and Preventive Actions (CAPA) for each adverse event
- Surveillance of minor OT environment

The aspects as mentioned above shall be regularly reviewed and monitored

Quality Assurance Program for Laser & Diagnostic Services

QA program for laser and diagnostic services comprises of:

- Appropriate and rational utilization of diagnostic modalities available in ITSDH
- Provision of services by credentialed and privileged personnel
- Regular checking of functioning of laser and diagnostic equipment

The aspects as mentioned above shall be regularly reviewed and monitored

CQI 2. Key Clinical Indicators

Indicators as given at Annexure - I shall be captured and monitored regularly. The table at Annexure also gives data collection forms that are to be used, computation formulae and manner of reporting for each.

Data collection sheet for each indicator shall be preserved for a period of one year.

CQI 3. Key Performance Indicators

Key performance indicators selected for monitoring at ITSDH are given at Annexure–I.

CQI 4. Management Support for QIP

The management shall support quality improvement activities by allocating funds for the same in its annual budget.

The designated budget will be sufficient to meet all significant concerns relating to quality and patient safety.

Quality improvement program will utilise tools, techniques and methods for obtaining data to compute indicators, work-out efficiency of its functioning and measures for improvement.

CQI 5. Clinical Audit

Clinical Audits shall be conducted quarterly.

Clinical audit methodology and a few suggested topics are given at Annexure–II.

CQI 6. Sentinel Events

It is an unexpected/unanticipated incident, related to system or process deficiencies, which leads to death or major/enduring loss of function to a patient, visitor, or an employee. Serious injury specifically includes loss of limb or function.

Major/enduring loss of function refers to sensory, motor, physiological or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum of two weeks period and is not related to an underlying condition.

The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the individual's illness or underlying condition):

- Suicide of any individual receiving care, treatment, or services in a staffed around-the-clock setting or within 72 hours of discharge from a 24-hour setting
- Abduction of any individual receiving care, treatment or services
- Rape (The determination of "Rape" is to be consistent with applicable law and regulation)
- Assault
- Homicide of a staff member, visitor, or vendor while on site at the health care organization
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery, on the wrong patient, wrong site, or wrong procedure. Unintended retention of a foreign object in a patient after surgery or other invasive procedures.

A sentinel event poses a continuing threat to patient care and safety and is reflective of serious underlying system/process deficiencies in the organization and will also potentially undermine public confidence in the hospital.

Thus a sentinel event calls for immediate action to examine the event in depth so as to determine why the incident occurred and how to reduce the likelihood of reoccurrence.

Reporting Sentinel Event:

The employee identifying the Sentinel Event, or the employee to whom the Sentinel Event is first reported, shall be responsible for initiating the completion ***SENTINEL EVENT REPORTING FORM (Provided in SOP-ROM)*** prior to the end of their duty for that day.

The form is available in the office of the Principal.

All sentinel event reports must be finally submitted to the Principal.

As soon as the sentinel event is reported (including those affecting staff), root cause analysis is conducted. The root cause analysis will be performed by the Quality Assurance Team of the hospital and a written report will be submitted to the Quality Management Committee.

The report will focus on:

a. Related deficiencies in organizational systems and processes.
b. Appropriate risk reduction activities in order to minimize the likelihood of occurrence of such risks in the future
c. Establishment of a plan for improvement clearly mentioning responsibilities for implementation, when actions will be implemented, how the effectiveness of the actions shall be evaluated

CAPA will be carried out for each such event and the incident will be discussed in the committee.

Annexure-I

QUALITY INDICATORS

Indicator	Description	Numerator	Denominator	Multiplier factor
Percentage of completed initial assessments		Number of completed initial assessments for a given period	Total number of patients in that period	100
Percentage of adverse anesthesia events	Adverse anesthesia events include events which happen during the procedure like hypoxia, arrhythmias, syncope etc.	Total number of patients who developed adverse anesthesia event	Total number of patients who underwent anesthesia	100
Surgical site infection rate	Involves patients developing SSI within 30 days of surgery	No. of patients developing SSI after surgery	No. of patients undergoing same surgeries	100
Incidence of Needle stick injuries	Exposure means injury due to any sharp	Number of Parenteral exposures in a month	Number of all patients	100
Number of reporting errors per 100 investigations	Number of reporting errors picked up before and after dispatching of report. (It shall include transcription errors also)	Number of reporting errors picked up before and after dispatching of Report	100 investigations	100
Number of times Re-RCT is done per 100 completed RCT cases	Number of times RCT was done again due to incorrectly done procedure	No. of Re-RCT cases	100 RCT	100
No. of times crown is re-fabricated per 100 crowns	Number of times crown is fabricated again due to deficiencies in technique	No. of crowns re made	100 Crowns	100
Percentage of employees provided pre exposure		Number of employees who were due to be provided pre-	Number of employees who were provided pre-exposure	100

prophylaxis		exposure prophylaxis	prophylaxis	
Average Waiting Time in OPD in minutes		Total waiting time of all patients in OPD for a given period	Total patients seen in OPD for that given period	-
Patient satisfaction rate OPD in %		Number of patients who gave score of '4' or above for a given period.	Total number of patient satisfaction surveys collected for that period.	100
Employee satisfaction rate		Number of employees who gave score of '4' or above for a given period.	Total number of employee satisfaction surveys collected for that period.	100
Waiting time for diagnostics		Total waiting time of all patients registered for a diagnostic services	Number of patients studied	-
Average number of variations observed per mock drill	Data from mock drills for Code Blue and Code Red	Total Number of variations observed	Total Number of drills conducted	-
Average down time per Critical equipment in days		Total duration of equipment down time in days in a month	Total Number of equipment days available in a month	-
Percentage utilization of Implant center		Number of hours of utilization in a month	Number of hours of availability in a month	100

ANNEXURE – II

CLINICAL AUDIT

What is audit?

It is the process of reviewing of delivery of care to identify deficiencies so that they may be remedied.

What is clinical audit (CA)?

It may be defined as peer review for evaluation of medical care through retrospective and concurrent analysis of medical record.

What is the primary aim of CA?

To improve the quality of healthcare services rendered to the patients.

What is CA not?

A fault-finding mission

A punitive action

An external quality-control method

To be conducted by any professional other than medical professional.

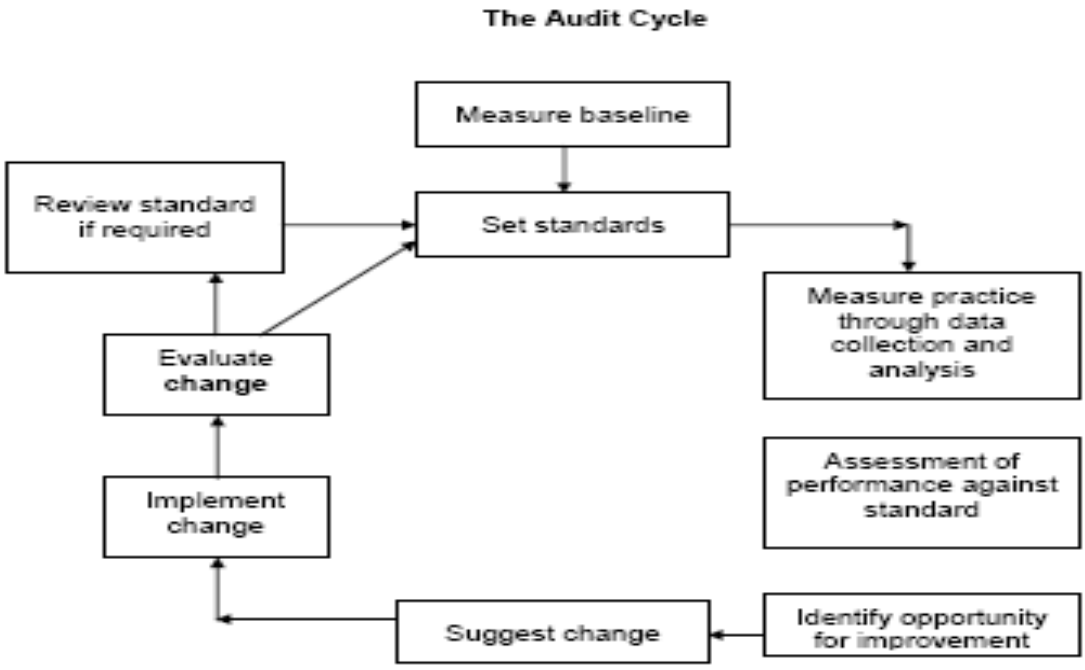
Who will carry out CA?

Clinical Audit Committee consisting of principal/coordinator/Hospital Administrator, Clinical Representatives of all disciplines.

What are the prerequisites?

- Good record-keeping
- Should be carried out by fair and impartial professionals
- Clinicians, nursing and other staff as well as patient anonymity to be maintained
- Initiative should come from within
- Purpose should be simple and clearly stated
- Intention should be to effect change for the better

How to audit?



Methodology

Selection of Topic

- Should be common because it is common or high risk or bear high cost/
- Should be having local clinical concern or known wide variance in clinical practice.
- Topic should be well defined, focused and amenable to standard setting.

Some topics

- Specific surgeries
- Vulnerable groups
- Post-operative infection/complications

Setting of standard

- To be set prior to the study
- Criteria to be based on objective measures
- Criteria should be well justified.
- Target should be set at realistic level for defined patient groups and take into account local circumstances.
- Use of explicit criteria should be preferred

Why audit?

- It improves quality of care
- It is an aid to continuous medial education
- There is a sense of personal and professional achievement.

What are the key questions to be asked while doing clinical audit?

- What do we do?
- Do we do what we think we do?
- What should we do?
- Are we doing what we should be doing?
- How can we improve what we do?
- How we improve?
- Monitoring and reporting of audit activity