RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

DEPARTMENT: Nursing Service Division		**POLICY NUMBER:** DPOTMH-MPP-SURGCOM-ASC-P016-(01)	
TITLE/DESCRIPTION: **HOSPITAL INDICATORS/CONTINUOUS QUALITY IMPROVEMENT POLICY**			
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APPLIES TO: Ambulatory Surgical Center		**POLICY TYPE:** Multi disciplinary	

PURPOSE:

To provide government regulating bodies, accrediting organizations, and Metro Pacific Health-Quality Council (MPH-QC) with the quality indicators needed for quality improvement and as required by the aforementioned organization or bodies with written approval from the Executive Committee (ExeCom).

DEFINITIONS:

Quality indicators – are measurement tools, screens, or flags that are used as guides to monitor, evaluate, and improve the quality of patient care, clinical support services, and organizational functions that affect patient outcomes.

RESPONSIBILITY:

Quality Improvement Manager – responsible for coordinating with the other departments in identifying all Quality Indicators in the hospital.

Department Head – responsible for identifying and monitoring all identified Quality Indicators in their respective departments for possible use in the Quality Improvement Program.

POLICY:

1. The Dr. Pablo O. Torre Memorial Hospital (DPOTMH) advocates Patient Safety Measures. These patient safety measures include:
   - 1.1 Percentage of surgery patients with surgical complications or postoperative infection.
   - 1.2 Rates at which patients fall and incur injury during a hospital stay.
   - 1.3 Patient mortality rates by type of condition (e.g., heart attack, hip fracture, pneumonia) or by type of procedure (e.g., coronary artery bypass graft surgeries, valve surgeries, hip replacement).

2. The DPOTMH employs the following measures to actualize its patient safety advocacy.

- **Effectiveness measures**

  Percentage of patients receiving recommended hospital care for specific conditions such as heart attack; pneumonia care, Ventilator-Associated Pneumonia (VAP), Catheter-Associated Urinary Tract Infection (CAUTI), Central Line Associated Blood Stream Infection (CLABSI), Surgical Site Infection (SSI), and Hospital-Acquired Pressure Injury (HAPI).

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- **Patient-Centeredness Measures**

  Patients' reports on the care and service they received from the hospital. Provision of care instructions upon hospital discharge for certain conditions.

- **Timeliness Measures**

  Patients' reports on the timeliness of care and service they received from the hospital. Turn Around Time (TAT) in the Emergency Room, Laboratory, Admitting and Discharging Patients, Medical Records, etc.

- **Efficiency Measures**

  Utilization of hospital services or procedures as measured by the hospital discharge rate or average length of stay (ALOS); Readmission rates (72 hours, 120 days, and or 30 days).

- **Equity Measures**

  While not associated with any particular Institute of Medicine (IOM) domain, descriptive measures can convey the hospital's capacity for providing quality care and service. Examples include:
  - Number of beds and the types of services available.
  - Whether the hospital is accredited or has other types of specialty certification.
  - The use of electronic patient medical records or prescription ordering systems.
  - Percentage of physicians who are board-certified.
  - Nurse-to-patient staffing ratios.

3. Each department should fill out the Quality Indicator Form (QIF) and submit the duly accomplished QIF to Quality Improvement Department for monitoring and submission to the Metro Pacific Health Quality Council (MPH-QC) within the given deadline.

4. Other Quality Indicators may be required as the need arises or by regulating bodies such as the Department of Health (DOH), accrediting bodies like Accreditation Canada International (ACI), or by Metro Pacific Hospital Councils or groups.

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5. Other indicators that are found to be high risk, problem-prone, and high volume can be added as necessary. The Approved RMCI Quality Indicators are:

1. **Nursing Department**
   - 1.1.1 Length of Stay
   - 1.1.2 Unscheduled CS
   - 1.1.3 Elective CS Compliance Rate
   - 1.1.4 Occupancy Rates
   - 1.1.5 Patient Census (volume only)
   - 1.1.6 Availability of Essential Supplies(volume only)
   - 1.1.7 Nurse-to-Patient Ratio
   - 1.1.8 Readmission Rate Within 72 Hours On Same Diagnosis
   - 1.1.9 Readmission Rate Within 30 Days On The Same Diagnosis
   - 1.1.10 Hospital-Acquired Pressure Injury (HAPI)
   - 1.1.11 Mortality Rates
   - 1.1.12 Morbidity Rates
   - 1.1.13 Adverse Events
   - 1.1.14 Sentinel Events
   - 1.1.15 Medication Error
   - 1.1.16 Fall
   - 1.1.17 Near Miss
   - 1.1.18 Phlebitis
   - 1.1.19 Emergency Room (ER) Turn-Around-Time (TAT)
   - 1.1.20 Discharge Turn-Around-Time (TAT)
   - 1.1.21 Surgical Site Infection rate
   - 1.1.22 Central-Line Associated Blood Stream Infection (CLABSI)
   - 1.1.23 Ventilator-Associated Pneumonia (VAP)
   - 1.1.24 Catheter Associated Urinary Tract Infection (CAUTI)

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1.1.25 Surgical Site Infection

1.1.26 Hand Hygiene Compliance

1.1.27 Needle Stick/ Sharps Injury / Blood and Body Fluid Exposure

1.1.28 Cancelled OR Procedures

2. **Pharmacy Department**

2.1.1 Adverse Drug Reactions

2.1.2 Medication Reconciliation

2.1.3 Antimicrobial Stewardship

2.1.4 Patient Counseling

2.1.5 Inventory Turnover Rate

2.1.6 Stock Out Rates

2.1.7 Expiration Rate

2.1.8 Number of Controlled Substances Handled and Being Prescribed By Hospitals

2.1.9 Cases of Dispensing Error and Rate

3. **Radiology Department**

3.1.1 Turn-Around-Time (TAT)

3.1.2 Waiting Time

3.1.3 Patient Care

3.1.4 Expired Contrast and Supplies

3.1.5 Safety Signages

4. **Medical Records Department**

4.1.1 Documentation in the Medical Records

4.1.2 Cesarean Rate

4.1.3 Deficient Charts

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5. **Marketing Division**
    - 5.1.1 Patient Satisfaction Rate (for in and out patients)
    - 5.1.2 Patient Complaints
6. **Laboratory**
    - 6.1.1 Availability of Blood and Blood Products
    - 6.1.2 Blood culture Contamination
    - 6.1.3 Critical Value Reporting Failure
    - 6.1.4 Specimen Identification Errors
    - 6.1.5 Turn Around Time of Disorder
    - 6.1.6 Incident Report
    - 6.1.7 Blood Units Rejected
    - 6.1.8 Blood Units Returned to Laboratory
    - 6.1.9 Expired Blood Units
    - 6.1.10 Percentage of inpatient with laboratory result of <5 hours Turned around time
7. **Safety**
    - 7.1.1 Risk Assessment Report (RAR)
8. **Medical**
    - 8.1 Appropriateness of Admission
9. **Chief Risk**
    - 9.1 Percentage of patient in Basic Accommodation with zero co-payment
    - 9.2 Percentage of Return to Hospital of the Philhealth Claim

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PROCEDURE (SOP):

1. TQD-QA determines areas in which there are high volume, high risk, and/or problem-prone. Discuss this with many persons.
2. Form a team to discuss what might be feasible to measure and what has been high volume, high risk, and/or problem prone.
3. Meet again and have the Total Quality Division (TQD) assist you with completing an indicator form. The Total Quality Division (TQD) will assist you in designing the monitoring/tracking tools also.
4. Meet with the team and TQD and present the indicator form and monitoring/tracking tools. Determine WHO will be responsible for the data collection, and what are the inclusions and exclusions and send the information to the Total Quality Division. Who will receive the reports? This will be documented.
5. The members of the team educate their staff on how to use the tracking tool, what data elements will be collected, and the purpose of doing this. Responsibility is assigned and the data is collected on an ongoing basis.
6. The data will be examined by the Total Quality Division and reports will be generated for designated positions.
7. When analysis warrants a close look, a team is formed to:
   - 7.1 Analyze the data further
   - 7.2 Implement FOCUS PDCA

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THE FOCUS PDCA FORMAT

STEP 1 (Start the FOCUS Format)

F – Find / Identify a problem/s.

1. _____
2. _____
3. _____

O – Organize a Team that understands the problem.

1. Assign person/s in charged of monitoring or collecting needed information
2. Assign a person in charged of developing forms to be used in the monitoring.
3. Assign a person who will coordinate with other sections to verify related information.
4. And other functions needed as delegated by the team leader.

C – Clarify the process related to the problem identified.

1. Discuss and understand the operational process involved in the problem. (if possible present it through a flowchart diagram).

U – Uncover the Root Cause/s of the problem.

Use tools like:

1. Fishbone Diagram
2. Pareto Diagram
3. Why Diagram
4. And, others

S – Select a process to improve or a problem to solve using the SMART method.

S-specific **M**-manageable **A**-attainable **R**-realistic **T**-time bounded

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STEP 2 (Start the PDCA Format)

P – Plan

1. Make an Introduction to the Problem
   1.1 Theme Selection (why do you select this problem?)
   1.2 Background of the study (when the study begin and what period does it cover?)
   1.3 Establish Target Setting
2. Start Gathering data
3. Present data gathered in graphical format
4. Present the Root Cause Analysis
5. Establish Corrective Actions based on the Root Causes

Sample Table:

ROOT CAUSE	CORRECTIVE ACTION	PERSON RESPONSIBLE	TIME FRAME	REMARKS

D – Do

1. Start doing the Corrective Actions according to the time frame.

C – Check

1. Evaluation of the outcome of the Corrective Actions.
   1.1 Comparison of Past and Present data.

A – Act

1. Depending on the results of the evaluation:
   1.1 If the result is positive, standardize the corrective actions implemented.
   1.2 If the result is negative, rethink, reanalyze, and go back again to the PD and C steps.

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WORK INSTRUCTION:

KEY TASKS	PERSON RESPONSIBLE
1. Determines areas in which there are high volume, high risk, and/ or problem-prone.	TQD
2. Forms team to discuss what might be feasible to measure and what has been high volume, high risk, and/or problem-prone.	
3. Assists with completing an indicator form and designing the monitoring/tracking tools.	
4. Educates their staff on how to use the tracking tool, what data elements will be collected, and the purpose of doing this, Responsibility is assigned and the data is collected on an ongoing basis.	Department Heads

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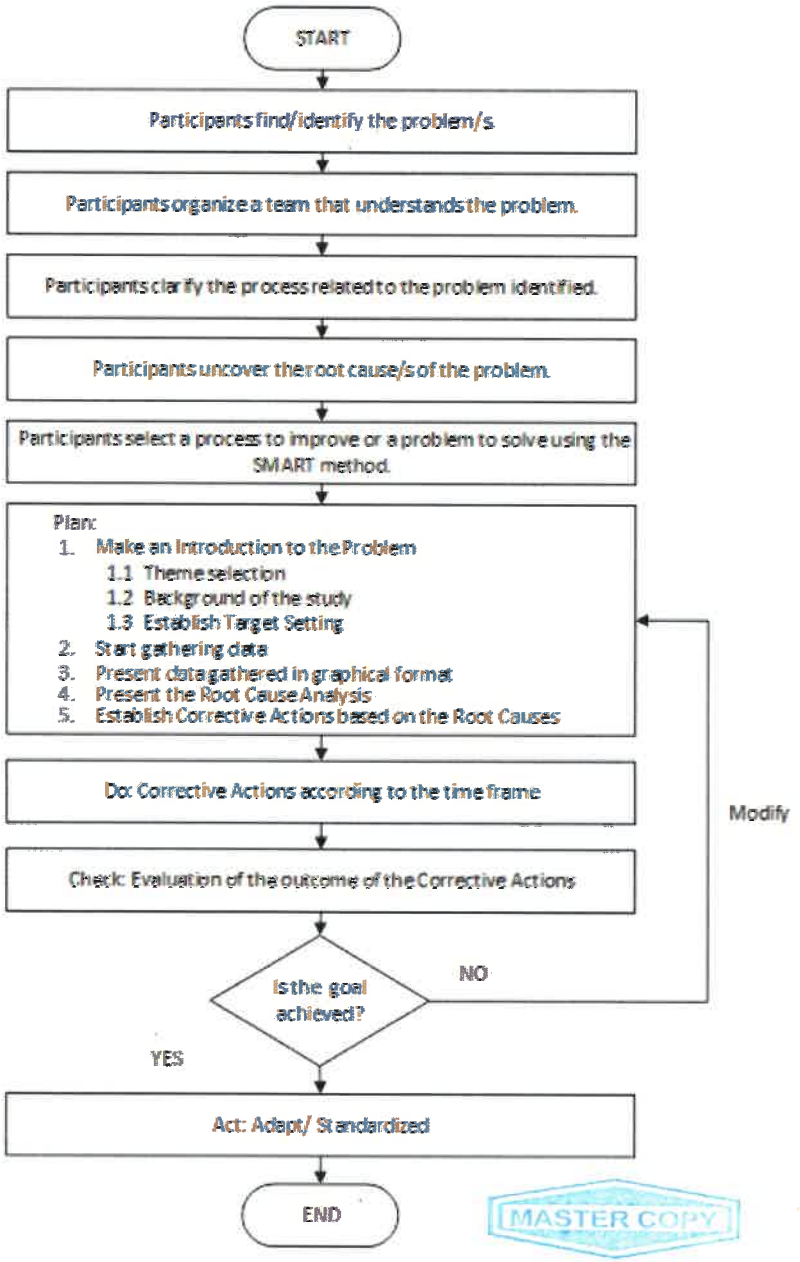
WORK FLOW:

PDCA Format



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FORMS:

1. QA-F001 (01)-Non-Conformity Report (NCR)
2. QA-F002 (01) A-Root Cause Analysis Report
3. QA-F002 (01) B-Cause and Effect Diagram

EQUIPMENT: N/A

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