LOGO
CENTRE NAME
CENTRE ADDRESS

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AMENDMENT SHEET

Sl. No.	Section No & Page No	Details of amendment	Reasons	Signature of preparatory authority	Signature of approval authority
1.					
2.					
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CONTROL OF THE MANUAL

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable.

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The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH.

The authority over control of this manual is as follow

Preparation	Approval	Issue
DOCTOR NAME	**DOCTOR NAME**	**DOCTOR NAME**
DESIGNATION OF DOCTOR	**DESIGNATION OF DOCTOR**	**DESIGNATION OF DOCTOR**

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Distribution List of the Manual:

S.No.	Designation
1.	Medical Record Department
2.	Reception
3.	Branch manager

1.0 PURPOSE:

- To guide and ensure the continuous improvement of quality services provided by CENTRE NAME
- To fix key indicators for the processes, to organize measurement process to assess the performance index on such key indicators.
- Scheduling of periodical measurement of performance index of key indicators explained above.
- To identify appropriate tools for continual improvement.

2.0 SCOPE: SERVICES & FACILITIES OF CENTRE

2.1 Hospital Wide – All Inpatient care areas

2.2 Applicable to all employees of the hospital

1. Ayurvedic Consultancy(आयुर्वेदिक परामर्श)
2. Abhyangam (अभ्यंगम)
3. Diet Consultation (आहार परामर्श)
4. Ayurvedic Medicine(आयुर्वेदिक दवाई)
5. I.P.D (आईपी डी)
6. Deepan (दीपन)
7. Pachana (पाचन)
8. Snehana (स्नेहन)
9. Swedana (स्वेदन)
10. Udavartan (उर्धवर्तन)
11. Panchkarma Treatment(पंचकर्मा चिकित्सा)
12. Vamanam (Emesis) (वमन)

13. Virechana (Purgation) (बिरेचन)
14. Nasyam (Nasal therapy) (नस्यम)
15. Raktamokshna (रक्तमोक्षण)
16. Matra Basti (मात्रा बस्ती)
17. Asthapana Basti अस्थापन बस्ती
18. Anuvasana Basti (Oil enema)अनुवासन बस्ती
19. Samsarjana Karma (संसर्जन कर्म)
20. Paschatkarma(पश्चात्कर्मा)
21. Shamanadi Chikitsa Special(विशेष समनादि चिकित्सा)
22. Shirodhara(शिरोधारा)
23. Shiro Pichu (शिरोपिच्चू)
24. Shirobasti,Janu Basti,Kati Basti, Greeva Basti (शिरोबस्ती, जानू बस्ती,कटी बस्ती, ग्रीवा बस्ती)
25. Rasayana Chikitsa (रसायन चिकित्सा)
26. Leech Therapy (जलौका)
27. Agni Karma (अग्नि कर्मा)
28. Alabu (cupping) अलाबु (कपिंग)
29. Vridha karma (विधा कर्मा)
30. Patra Pottali Pinda Sweda (पतरा पोटली पिंडा स्वेद)
31. Shashtika Shali Pinda Sweda (षष्टिका शाली पिंडा स्वेद)
32. Parisheka (परिषेक)
33. Panchkarma Poorvakarma (पंचकर्मा पूर्वकर्म)

RESPONSIBILTY:

3.0 Consultants / Doctors

3.1 All hospital staff

3.2 Core/Quality Assurance Committee

4.0 ABBREVIATION:

4.1 NABH : National Accreditation Board For Hospitals and Healthcare providers

4.2 CQI : Continuous Quality Improvement

5.0. Scope of Services at CENTRE NAME

a. Services Available: The services provided at Hospital are displayed and the staff are trained and oriented to this information

6. POLICY:

- CENTRE NAME NABH coordinator to meet the quality standards.
- Quality improvement programme shall be implemented by CQI committee.
- The Hospital management makes available adequate resources required for quality improvement program.
- CENTRE NAME has identified key performance indicators to monitor the clinical and managerial areas.

Quality Policy:

- CENTRE NAME is committed to provide best quality, affordable and accessible, preventive, curative, promotive and comprehensive health care services to the community and assure the best outcome.
- We hereby assure quality healthcare to patients through reliable healthcare services, available medicines and maintainable equipment.
- We shall ensure efficiency of operations and effectiveness of treatment through our competent human resources.
- We shall review this policy for continuing suitability, adequacy and effectiveness.
- We shall achieve this through the quality objectives and targets set for various departments.

Safety Policy

CENTRE NAME will ensure that all the best practices are adopted for the provision of the best quality of healthcare, to guard the overall safety of patients and their attendants, employees, facilities & the environment.

- The Safety of all patients is the primary responsibility of all the hospital staff members.
- The Safety of Facility, Assets & the Environment is important to ensure the provision of quality services.

7. Procedure of quality and safety

All services and Departments utilize the established Quality Improvement Manual throughout the facility to improve targeted areas of concern.

The quality improvement plan has been prepared by a multidisciplinary committee of the hospital under the guidance of DOCTOR NAME Owner of CENTRE NAME. The Committee invited inputs from the staff members and has established the quality plan in collaboration with staff representatives; hence it has support and acceptance from the staff members at various levels.

a. Objectives

1. To focus on Quality of patient care.
2. To improve the performance of all professionals & protect patients
3. To monitor, measure, assess and improve performance and to enhance patient satisfaction.
4. To guard, measure and improve patient safety.
5. To inculcate an excellent hygienic treatment process
6. To involve all employees to participate in improving Quality
7. To search for pattern of non-compliance with goals, objectives & standards through:
    - Problem identification
    - Problem assessment
    - Finding the root cause
    - Solution Generation
    - Plan for the solution implementation
    - Implementation of corrective action
    - Monitoring

b. Scope:

1. Patient satisfaction
2. Improved Clinical Outcome
3. Reduction in Morbidity
4. Improved service quality of the hospital through increased efficiency & effectiveness.
5. Optimum Utilization of resources
6. Job Satisfaction along with growth of the employee & organization.

7. To facilitate and oversee the implementation of the chosen strategies for overall Quality Assurance and Quality Improvement (QA/QI) initiative in the organization in line with the quality policy of the hospital.

J. Continuous Quality Improvement (CQI)

Quality improvement is about ensuring that our focus is on improving, not just maintaining our services at Hospital. Quality improvement involves a focus on the safety, effectiveness, efficiency, acceptability, accessibility and appropriateness of services for consumers (who might be patients, relatives/parents, or the hospital and other health care professionals).

a. Purpose of continuous quality improvement is to-

1. Monitor patient and staff satisfaction
2. Monitor of quality indicators
3. Monitor of Adverse Drug reactions and medication errors
4. Monitor patient safety indicators
5. Monitor of medical audit results
6. Monitor Utilization of Facilities
7. Monitor Patient Satisfaction Rate
8. Monitor Employee Satisfaction Rate
9. Ensuring fire safety mock drill twice in a year.
10. Ensuring facility safety round twice a year in patient care areas and once a year in non-patient care areas

b. Goals of Continuous quality Improvement -

A. To utilize an interdisciplinary hospital-wide team approach to Quality improvement activities.

B. To maintain a Quality improvement team to be responsible for each key function and will evaluate the need for Quality improvement activities for the function on an ongoing basis by reviewing policies and procedures relating to that function and make necessary revisions as well as to establish priorities for measuring Quality to initiate Quality improvement measures in a prioritized manner.

C. To improve patient care guidelines relating to operative and other procedures, in a collaborative effort.

D. To utilize a standard format for documenting and reporting all Quality measures hospital- wide.

E. To collect data on staff views regarding Quality improvement activities
F. To establish priorities for Quality improvement activities
G. To develop a formal tool for prioritizing Quality improvement activities.
H. To strive to raise the benchmark in all aspects of service delivery and meet the quality standard expected for the same.
I. To ensure optimum utilization of resources in terms of human resource, infrastructural resource and financial resource.

c. Authority and Accountability:

1. Deputy Medical Superintendent (DMS)

- The DMS is responsible for providing support for the proper functioning of hospital- wide Quality improvement activities.
- The DMS provides support, direction, and/or assists with the resolution of problems or opportunities to improve care or services as needed.

2. Head of Departments

The HOD's are responsible for the following:

- Developing and implementing mechanisms designed to ensure the uniform quality of patient care processes within their department.
- Developing and implementing an effective and continuous program to measure, assess, and improve Quality.
- Continuously assessing and improving the Quality of care and services provided.
- 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.
- Participating intra and interdepartmental activities to improve organizational Quality as appropriate.
- Analyze and assess the effectiveness of their contributions to improving Quality.

3. NABH coordinator

4. CQI committee

d. The CENTRE NAME has:

- ❖ Identified the processes needed for the CQI and their application throughout the hospital

- ❖ Determine the sequence and interaction of these processes.
- ❖ Determine criteria and methods needed to ensure that both the operation and control of these processes are effective.
- ❖ Ensure the availability of resources and information necessary to support the operation and monitoring of these processes.
- ❖ Monitor, measures and analyses these processes and
- ❖ Implement the actions necessary to achieve planned results and continual improvement of these processes.

e. Planning:

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

- ❖ The hospital maintains a plan that describes the hospital's approach, processes, and mechanisms that comprise the hospital's Quality improvement activities.

- ❖ The Team approach serves as a means of collaboration between departments and disciplines in planning and providing systematic organization-wide improvements.

f. Designing:

Processes, functions or services are designed effectively based on:

- ❖ Mission
- ❖ vision
- ❖ CENTRE NAME
- ❖ Needs and expectations of patients, staff, and others.
- ❖ Baseline Quality expectations are utilized to guide measurement and assessment activities

g. Measurement:

- ❖ Data is collected for a comprehensive set of Quality measures to-
  a. Establish a baseline when a process is implemented or redesigned
  b. Describe process Quality or stability
  c. Describe the dimensions of Quality relevant to functions, processes, and outcomes
  d. Identify areas for improvement
  e. Determine whether changes in a process have met objectives
- ❖ Data is collected as a part of continuing measurement, in addition to data

collected for priority issues.

- ❖ Data collection considers measures of processes and outcomes.
- ❖ Data collection includes the following processes or outcomes at two levels, Clinical and Managerial structures, processes and outcomes:

Clinical structures, processes and outcomes

H. ASSESSMENT:

- The assessment process involves the relevant 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 it is possible to make improvement of existing processes, actions taken to improve the Quality Improvement processes, and whether changes in the processes resulted in improvement.
- Collected data is assessed at least annually and findings are documented and are forwarded through the proper channels.
- 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.
- Intense assessment is performed on the following:
    a. Major discrepancies between preoperative and postoperative diagnoses in pathology reports
    b. Significant adverse drug reactions
    c. Adverse events or patterns of adverse events during anesthesia use
    d. Unexpected patient death
    e. Wrong site/side/patient surgery

i. Internal communication:

- The top management has defined and implemented an effective and efficient process for communicating the Quality Policy, Objectives, Quality management requirements and accomplishments.

- This helps the hospital to improve the performance and directly involves its people in the achievement of the Quality Objectives.
- The Management actively encourages feedback and communication from people in the hospital as a means of involving them through the Monthly Meetings.

j. Documentation:

Quality Manual: this is an outline of hospital policies of CENTRE NAME together with the mission, vision and values of CENTRE NAME quality policy and patient safety priorities. quality manual also contains the structure and functions of the continuous quality improvement programme.

k. quality improvement programme supported by the management.

i. provision of resource for quality improvement programme.

Resources required are identified and provided as defined in the CENTRE NAME organization chart given in the Quality Manual and documented procedure to ensure that

- Implementation, maintenance and continual improvement of Quality management system
- To enhance patient satisfaction.

i. This includes the men, material, machine, money and method. These should be in a steady supply so as to ensure that the programme functions smoothly.

ii. Adequate funding

Adequate fund allocation is done by the organization for the smooth functioning of the programme.

iii. Identifies performance improvement targets:

Identifies organization and department level quality objectives, sets targets and monitors them once in six months and modify the targets annually.

The modified targets are shared with faculty and staff at regular intervals and takes regular feedback.

L. CLINICAL AUDIT: (CQI 6.A-E)

Clinical audit Committee:

Members

Roles & Responsibilities

- To provides the mechanisms for reviewing the quality of everyday care provided to patients with common conditions.
- To builds on a long history of doctors, nurses and other healthcare professionals reviewing case notes and seeking ways to serve their patients better.
- To addresses quality issues systematically and explicitly, providing reliable information;
- To confirm the quality of clinical services and identify if there is a need for improvement.

Frequency of Meeting: Monthly

m. Procedure for collection of data, interpretation and analysis of Quality Indicators: Collection of Data: Reports of all key indicators as per NABH norms will be submitted to the CQI committee at the end of every month by the Head of each department. All the data will be collected in the standardized format.

Analysis of Data: All the data will be assessed in the form of Structure, process and the outcome.

Structure: Structure includes the facilities provided to the staff. Formula used for calculation. Training or awareness of the set formulas / quality improvement programme is needed.

Process: Strict adherence of developed procedures in the daily work routine. In case of deviations same will be documented in the quality indicator reporting form with proper reasoning.

Out Come: Based on the reports received trend analysis will be done and the same will be reported to NABH coordinator and Management

KEY PERFORMANCE / QUALITY INDICATORS

Key Indicators Followed in CENTRE NAME

Ref. No	Quality Indicator	Formula	Data collection and analysis	Result
CQI 4.c.1	Incidence of falls	No. of falls 1X100		
		Total no. of patients		
CQI 4.g.4	Incidence of blood body fluid exposure	Number of blood body fluid exposures 1X1000 Number of in-patient days		
CQI 4.g.2	Percentage of near misses	Number of near misses reported 2X 100 Number of incident reports		
CQI 3.g.1	Percentage of re-scheduling of the procedure	Number of cases re- Scheduled 1X100 Number of anushastra karma performed in that month		
CQI 3.g.2	Percentage of vyapath observed by nasya/ Vaman / Virechan/ Vasthi/Swedan/ Snehan karma	No.of vyapath observed 1X100 Total no.of patients treated with the procedure		
CQI 4.c.3.4	Burn injury during treatment procedures	Number of patients with burn injury 1X100 Number of patients receiving treatment procedures that include heat Application		
CQI 4.d.5	Critical equipment down time	Sum of down time for all critical equipment in hours 1x10		

CQI 4.e.4	Time taken for discharge	Sum of time taken for discharge 2X 100		
		Total number of discharges		
CQI 3.c.2	Percentage of admissions with adverse drug reactions	No. of admissions with adverse drug reactions 1X100 Total no. of admissions		

Annexure-1

PATIENT SATISFACTION INDEX

SHORT-FORM PATIENT SATISFACTION QUESTIONNAIRE (PSQ-18)

These next questions are about how you feel about the medical care you receive.

On the following pages are some things people say about medical care. Please read each one carefully, keeping in mind the medical care you are receiving now. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings, good and bad, about the medical care you have received.

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Doctors are good about explaining the reason for medical tests	1	2	3	4	5
2. I think my doctor's office has everything needed to provide complete medical care	1	2	3	4	5
3. The medical care I have been receiving is just about perfect	1	2	3	4	5
4. Sometimes doctors make me wonder if their diagnosis is correct	1	2	3	4	5
5. I feel confident that I can get the medical care I need without being set back financially	1	2	3	4	5
6. When I go for medical care, they are careful to check everything when treating and examining me	1	2	3	4	5
7. I have to pay for more of my medical care than I can afford	1	2	3	4	5
8. I have easy access to the medical specialists I need	1	2	3	4	5

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
9. Where I get medical care, people have to wait too long for emergency treatment	1	2	3	4	5
10. Doctors act too businesslike and impersonal toward me	1	2	3	4	5
11. My doctors treat me in a very friendly and courteous manner	1	2	3	4	5
12. Those who provide my medical care sometimes hurry too much when they treat me	1	2	3	4	5
13. Doctors sometimes ignore what I tell them	1	2	3	4	5
14. I have some doubts about the ability of the doctors who treat me	1	2	3	4	5
15. Doctors usually spend plenty of time with me	1	2	3	4	5
16. I find it hard to get an appointment for medical care right away	1	2	3	4	5
17. I am dissatisfied with some things about the medical care I receive	1	2	3	4	5
18. I am able to get medical care whenever I need it	1	2	3	4	5

A. Purpose:

Incident and sentinel event reporting is an important part of error prevention. The purpose of this policy is to outline the requirements of the incident reporting and sentinel event management policy that will result in best patient outcomes and to provide a confidential mechanism of identification, tracking, trending, and follow-up of all incidents that poses an actual or potential safety risk to patients, families, visitors and staff. Variances include events ranging from “falls” to near misses or sentinel events with serious adverse outcomes, occurring in the hospital setting.

B. Definitions:

i. Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

ii. Variance: defined as any event or circumstance not consistent with the standard routine operations of the hospital and its staff or the routine care of a patient/visitor.

iii. Near Miss (close call or good catch): Serious error or mishap that has the potential to cause an adverse event, but fails to do so by chance or because it was interrupted. Errors that did not result in patient harm, but could have, can be categorised as near-misses.

iv. No harm: This is used synonymously with near miss. However, some authors draw a distinction between these two phrases. A near-miss is defined when an error is realised just in the nick of time and abortive action is instituted to cut short its translation.

In no harm scenario, the error is not recognized and the deed is done but fortunately, the expected adverse event does not occur. The distinction between the two is important and is best exemplified by reactions to administered drugs in allergic patients. Incident Reporting: the web based or paper form used to report facts surrounding a patient safety.

v. Sentinel Event - A relatively infrequent, unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.

Major and 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 period of two weeks and is not related to an underlying condition.

vi. Root Cause Analysis (RCA): A structured process that uncovers the physical, human, and latent causes of any undesirable event in the workplace. Root Cause Analysis (RCA) is a method of problem solving that tries to identify the root causes of faults or problems that cause operating events. By focusing correction on root causes, problem recurrence can be prevented. The process involves data collection; cause charting, root cause identification and recommendation generation and implementation.

C. Scope: Management /hospital employees/ Patients.

D. Responsibility: CQI committee

E. Abbreviations:

NABH: National Accreditation Board for Hospitals and Health care

Providers CQI: Continuous Quality Improvement

IRP: Incident Reporting

policy SEP: Sentinel Event

Policy RCA: Root Cause

Analysis

F. Reference:

NABH: Guidebook to accreditation standards for Ayurveda hospitals, 2nd Edition, April 2016.

NABH: Annexure to accreditation standards for Ayurveda hospitals, 2nd Edition, April 2016.

G. Policy: The sentinel event policy applies only to events that meet the following criteria:

1. Para Surgical events

- Para surgical performed on the wrong body part
- Patra surgical performed on the wrong patient
- Wrong para surgical procedure performed on the wrong patient
- Patient physical deformity during or immediately post-para surgical procedure

2. Panchkarma events:

- Thermal injuries by swedan karma mainly in pakshaghat patients
- Fall or slip in procedure room
- Vasti, Virechan and Vaman vyapath leading to serious illness
- Severe haematemesis (Mallory weiss tear) by vaman karma
- Shock after swedan karma
- Severe dehydration leading to shock and death by virechan karma

3. Device or product events (Patient death or serious disability associated with):

- The use of contaminated and expired drugs, devices, products supplied by the organization

4. Patient protection events

- Patient death or serious disability associated with elopement from the health care facility
- Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability
- Intentional injury to a patient by a staff member, another patient, visitor, or other
- No socomial infection or disease causing patient death or serious disability

4. Environmental events

Patient death or serious disability while being cared for in a health care facility associated with:

- a burn incurred from any source
- a slip, trip, or fall
- an electric shock
- fire accidents

5. Care management events

- Medication error leading to the death or serious disability of patient due to incorrect administration of drugs, for example:
    - omission error
    - dosage error
    - dose-preparation error
    - wrong-time error

- wrong rate of administration error
- wrong administrative technique error
- wrong-patient error

- Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.

6. Criminal events

- Suicide attempt of the patient
- Abduction of a patient
- Sexual assault on a patient within or on the grounds of the health care facility
- Death or significant injury of a patient or staff member resulting from a physical assault or other crime that occurs within or on the grounds of the health care facility.

In all cases, a sentinel event requires immediate action to examine the event in depth, to determine why the incident occurred and how to reduce the likelihood of recurrence.

H. Guidelines/Procedure:

i. Whenever a sentinel event occurs, the occurrence report shall be immediately reported to the Resident Medical Officer (RMO) / Deputy Medical Superintendent (DMS).

ii. The attending consultant shall be notified immediately when the incident/ sentinel event/ variance involves a patient.

iii. If a patient or visitor is injured in a common area (i. sidewalks, stairwell, elevator, waiting area, etc.) the hospitals security shall be responsible for completing the incident/Variance/ Sentinel event report.

iv. The employee identifying the Variance/ Incident/ Sentinel Event, or the employee to whom the Variance/ incident/ Sentinel Event is first reported, shall be responsible

for initiating the completion of the Variance/ Incident/ Sentinel event Report Form prior to the end of their scheduled shift of duty.

v. Upon completion of the Variance/ Incident/ Sentinel Event Report, the reporting employee will submit the report to RMO. In case the RMO is not available; the report shall be directly submitted to DMS then all sentinel event reports must be finally submitted to the CQI committee.

vi. As soon as the sentinel event is reported, the CQI committee will conduct an Event Root Cause Analysis to determine the proximate cause of the event and the processes and the systems related to its occurrence.

vii. All sentinel events shall be analyzed within 24 working hours of occurrence.

viii. The root cause analysis will be performed by the Root Cause Analysis team (RCA). This team summarizes each variance/ incident/ event and refers them to the department(s) involved for investigation and resolution as needed.

ix. A resolution/ corrective action related to conducting proactive risk reduction activities and the patient outcome shall be forwarded to the CQI Committee.

Members of Root Cause Analysis team (RCA) - CQI committee, DMS / RMO with the Staff involved in the event

1 A written summary of the Root-Cause Analysis of a Sentinel Event/ incident shall focus primarily on organizational systems and processes. The Root-Cause Analysis must include:

- Determination of the **"direct" or "proximate" cause** of the Sentinel Event/ incident and the **processes and systems related to its occurrence**.
- **Analysis** of the related systems and processes.
- Analysis of special causes in **clinical processes** and common causes in **Organization processes**
- Determination of appropriate **risk reduction activities** in order to minimize

the likelihood of such risks in the future.

• Establishment of a plan to address identified opportunities for **improvement or formulation of a rationale** for not undertaking such changes.

• **Identification of who is responsible for implementation** and how the effectiveness of the actions shall be evaluated.

- Formulate recommendations and improvement plan.

2 When monitoring performance of specific clinical processes, certain events always elicit intense analysis. Based on the scope of services provided, intense analysis is performed on the following:

a. Significant adverse drug reactions

b. Significant medication errors and hazardous conditions

c. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative period (including pathological diagnoses, during the pathologic review of specimens removed, during surgical and invasive procedures).

d. Significant adverse events associated with panchkarma and anesthesia.

If the root cause analysis determines that the incidence is related to an **organizational systems or process problem**, the team will utilize the organizational performance improvement model **FOCUS-PDCA (Find Organize Clarify Uncover Select Plan Do Check Act)** to design, implement and evaluate an improvement plan to correct the system issue and/or problem.

If the root cause analysis finds the incident/ sentinel event to be caused by the performance and/or competence of a practitioner holding clinical privileges, the corrective action will be managed under the supervision and direction of the DMS and CQI.

I. Identified Sentinel Events:

Following are the Sentinel Events identified and defined by the National Institute of Ayurveda

1. Adverse Drug Reactions
2. Bed Sores
3. Hospital acquired infection
4. Fall from Bed
5. Fall / skid in washroom
6. Scalds and burns by swedana karma mainly in pakshaghata patients
7. Serious events by panchkarma procedures

Annexure-

ROOT CAUSE ANALYSIS (RCA) TEMPLATE		
This template provides the key stages of a roost cause analysis (RCA). Once the cause of a problem has been identified you then define the necessary follow-up actions required to address it. This enables you and your organization to build on and learn from such experiences.		
PROJECT TITLE:		DATE:
EVENT DESCRIPTION		
TIMELINE LEADING UP TO THE EVENT		
Date	Sequence of Events	
TIMELINE LEADING UP TO THE EVENT		
Date	Sequence of Events	
INVESTIGATIVE TEAM	METHODS USED	