



## Chapter IV

# Quality Management and Patient Safety (QM)



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### Introduction

This chapter is the responsibility of the Quality Management Director/leader and everyone in the hospital, especially the senior leaders whose role is essential to implement the Quality program. The senior leaders are expected to lead, support, and participate in the implementation of the MOH standards.

The Quality Management Director/leader is expected to work with all staff to educate them in the new language of quality and assist them in implementing the MOH standards.

Staff should not feel that the Quality Management staff are “policing” them. These thoughts should be avoided because this was part of the old Quality Assurance method that involved inspection and blaming individuals. We know now that the old method of Quality Assurance does not work.

The new method emphasizes education and positive encouragement instead of punishment. By using the new method, we can build a safer environment in which patient care is delivered by reducing the number of medical errors.

Only when everyone understands the new quality concepts and implements the MOH standards will staff truly feel that quality is the job of everyone in the hospital.

Scoring:



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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
QM.1.	There is a qualified and experienced Quality Management Director or leader who can apply quality concepts and principles and includes the following:					
	QM.1.1 The Quality Management Director has a degree in Healthcare Administration, Quality Management or Related healthcare field and/or certification in Quality Management and/or Risk Management.					
	QM.1.2 The Quality Management Director or leader has at least three years experience in Healthcare Quality Management or Improvement.					
QM.2.	The QM Director or leader reports to the Hospital Director.					
QM.3.	The QM department has the following resources (and others as needed) to carry out its scope of service.					
	QM.3.1 The QM department has sufficient working and meeting space to carry out its scope of service.					
	QM.3.2 The QM department has sufficient computers, photocopier, printers, phones, faxes as needed to carry out its' scope of service.					
	QM.3.3 The QM department has Internet access.					
QM.4.	The QM department has an operating budget recommended by the QM Director/leader addressing manpower, consumables, capital assets and educational needs.					
QM.5.	The QM department has sufficient staff to carry out its scope of service.					
QM.6.	The Quality Director or the Risk Manager is expected to identify and monitor high risk, problem prone and high cost areas:					
	QM.6.1 Invasive procedures.					
	QM.6.2 High risk procedures.					
	QM.6.3 Unusually expensive medications.					



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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	QM.6.4 All high-risk medications.					
QM.7.	There is a comprehensive hospital wide Quality Management and Patient Safety plan which includes but is not limited to:					
	QM.7.1 The Quality Management and Patient Safety initiative mission, vision, goals and objectives.					
	QM.7.2 Definitions of important Quality, Risk Management and Patient safety concepts.					
	QM.7.3 Defining the scope of activities and methodologies to be used for Quality Management, Continuous Quality and Performance improvement, Risk Management and Patient Safety.					
	QM.7.4 Identifying all levels of staff roles and responsibilities.					
	QM.7.5 Outlining the educational activities about quality concepts and Risk Management and Patient Safety that should be provided to hospital staff.					
	QM.7.6 Describing how the standards will be implemented and maintained.					
	QM.7.7 Describing how problem identification, information gathering, implementing actions, and evaluation of actions taken will occur (models like FOCUS – PDCA)					
	QM.7.8 Describing the method for the use of data (measurements), analyzing the data, and implementation and evaluation of improvements.					
	QM.7.9 Outlining how quality improvement projects are identified and prioritized by the leadership.					
	QM.7.10 Outlining that all Quality Improvement teams report to the Quality Improvement committee.					
	QM.7.11 Describing how quality improvement activities will be communicated to everyone in the organization. (Flow of information)					



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	QM.7.12 Describing how the plan is approved by the Quality Management committee and the Hospital Director.					
	QM.7.13 Reviewing the plan on an annual basis and making revisions as necessary.					
QM.8.	There is a Quality Management committee consisting of the leadership group that implements the QM plan and the hospital standards and this includes at least the following:					
	QM.8.1 All of the hospital leaders (the Hospital Director, Medical Director, Nursing Director, Quality Management Director/leader, Medical Records Director/leader, departmental heads).					
	QM.8.2 The Quality Management committee approves all Quality Management initiatives and provides oversight for the Quality Management program.					
	QM.8.3 The Quality Management committee receives reports from all teams, heads of departments, and other members assigned quality improvement projects.					
	QM.8.4 The Quality Management committee approves all hospital wide teams that are formed to solve a particular issue.					
	QM.8.5 The Quality Management committee provides feedback to their staff on quality improvement projects.					
QM.9.	The hospital leaders are actively involved in the quality campaign efforts and participate in:					
	QM.9.1 Quality Management, Risk Management and Patient Safety educational activities.					
	QM.9.2 FOCUS-PDCA based quality improvement teams.					
QM.10.	The hospital leaders encourage all hospital staff to participate in:					



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	QM.10.1 Quality Management, Risk Management and Patient Safety educational activities.					
	QM.10.2 FOCUS-PDCA based quality improvement teams.					
QM.11.	The hospital has an incident reporting system (occurrence /variance /accident) Policy and form (OVA) that staff follow and use when reporting adverse events.					
QM.12.	Sentinel events are identified in a policy that includes but is not limited to:					
	QM.12.1 Unexpected deaths.					
	QM.12.2 Suicide of a patient.					
	QM.12.3 Infant abduction or discharge to a wrong family.					
	QM.12.4 Hemolytic transfusion reaction.					
	QM.12.5 Surgery on the wrong patient or the wrong body part.					
	QM.12.6 Serious injury with loss of limb or function.					
QM.13.	The hospital has a process to handle Sentinel events and it includes:					
	QM.13.1 Formation of a team for studying the causes of the event (root cause analysis)					
	QM.13.2 Root cause analysis is to be performed within 10 working days					
	QM.13.3 Developing an action plan and review systems for improvement.					
QM.14.	The hospital supports Patient Safety by:					
	QM.14.1 Defining and adopting selected International Patient Safety Goals in the Quality and Patient Safety Plan.					
	QM.14.2 Establishing a Patient Safety Committee/Team with representation from medical, nursing, and pharmacy and safety departments.					



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	QM.14.3 Charging the Patient Safety Committee/Team with implementing and monitoring the patient safety goals and recommending actions for improvement.					
QM.15.	The hospital adopts a process that requires (2) patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products or					
QM.16.	There is a process for preventing wrong site, wrong procedure, and wrong person surgery that includes:					
	QM.16.1 Documentation of the verification process pre-operatively of the correct person, procedure, and site.					
	QM.16.2 A process to mark the operative site in a standardized method and symbol with permanent ink by the person performing the operation and/or procedure. [For organs, mark on the Body Diagram form in the appropriate area (left or right)]					
	QM.16.3 A documented "time out" conducted in the location where the procedure will be done, just before starting the operation, and involves the entire operating room staff using speech to verify correct patient identity, correct site, agreement on the procedure to be done, correct patient position, and availability of any needed equipment.					
QM.17.	There is a standardized list of abbreviations, acronyms, and symbols that are permitted for use in the hospital and it includes a list of abbreviations, acronyms, and symbols NOT to be used.					
QM.18.	Infusion pumps have "free-flow" protection.					
QM.19.	All alarm systems for patient care equipment (such as Infusion Pumps heart monitors, ventilators and pulse oximeters), have documented preventative maintenance, inspection and testing on a regular basis.					



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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
QM.20.	All staff are trained in the safe use of alarm systems for patient care equipment and the use of appropriate settings for sound.					
QM.21.	There are coordinated, comprehensive, and continuous educational activities on quality, Patient Safety and Risk Management concepts and tools taught by staff who are qualified in the field and educational activities include:					
	QM.21.1 Concepts of Quality Management, Patient Safety and Risk Management					
	QM.21.2 How to work in teams.					
	QM.21.3 Use of data, display of data					
	QM.21.4 Quality Improvement tools.					
	QM.21.5 Risk Management tools.					
	QM.21.6 Quality learning and improvement cycle (PDCA or other).					
	QM.21.7 Decision-making tools.					
QM.22.	The leadership develops and implements a set of measurements and indicators that are collected and aggregated on a regular basis and is used for quality improvement and strategic planning					
QM.23.	There are structure measurements (indicators) based on the mission and scope of services that may include but is not limited to:					
	QM.23.1 Availability of essential supplies and equipment.					
	QM.23.2 Availability of medical records.					
	QM.23.3 Availability of blood and blood products.					
	QM.23.4 Availability of emergency medications.					
	QM.23.5 Vacancy rates in all departments.					
QM.24.	There are process measurements (indicators) based on the mission and scope of services that may include but is not limited to:					



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	QM.24.1 The timing and use of antibiotics prior to surgery.					
	QM.24.2 Blood and blood products administration.					
	QM.24.3 Documentation in the medical record.					
	QM.24.4 Delays of physician answering nurses phone calls/beeps, and/or pages.					
QM.25.	There are outcome measurements (indicators) based on the mission and scope of services that may include but is not limited to:					
	QM.25.1 Mortality rates.					
	QM.25.2 Nosocomial Infection rates.					
	QM.25.3 Staff satisfaction.					
	QM.25.4 Patient satisfaction.					
	QM.25.5 Unplanned returns to operating room.					
	QM.25.6 Unplanned transfer to critical care area.					
	QM.25.7 Resuscitation of patients (Cardiac/respiratory arrest).					
	QM.25.8 Readmission to the hospital within 3 days of discharge.					
	QM.25.9 Adverse events (falls, injuries, pressure ulcers).					
	QM.25.10 Sentinel events.					
	QM.25.11 Patient complaints.					
	QM.25.12 Medication errors.					
	QM.25.13 Conscious sedation.					
	QM.25.14 All invasive and high-risk procedures.					
	QM.25.15 Increased length of stay.					
QM.26.	There are quality control results from the laboratory and radiology.					



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QM.27.	Staff that analyze aggregated data for trends and variances on a regular basis are qualified and:					
	QM.27.1 He/she is familiar with use of data display and data analysis techniques.					
QM.28.	Data is compared internally by historical trends and externally by benchmarks (when available).					
QM.29.	The Quality Management Committee identifies and prioritizes recommendations for quality improvement projects based on the organization's prioritization criteria and the analysis of trends.					
QM.30.	Quality Management teams are selected by the leadership and these teams use quality tools to improve processes.					
	QM.30.1 Membership of the quality improvement teams is determined by the leadership (Hospital Director, Medical Director, Administrative Director, Nursing Director).					
	QM.30.2 The teams include staff who have working knowledge of the process.					
	QM.30.3 The teams include a facilitator.					
	QM.30.4 The teams include a designated 'team leader' who is an identified leader within the organization.					
	QM.30.5 The teams use a learning cycle (PDCA or other) for process improvement.					
	QM.30.6 The teams use CQI tools (Pareto charts, brainstorming, affinity diagrams, fishbone charts, multivote, etc).					