AMALA COLLEGE OF NURSING

(An undertaking of Amala Cancer Hospital Society)
Amala Nagar P.O., Thrissur-680 555, Kerala, India.
Website : www.amalanursingcollege.org

First Cycle NAAC Accreditation 2022

CRITERION 8

B3 NURSING COLLEGE

8.1.3 Students exposed to quality of care and patient safety procedures followed in teaching hospital

Apex manual

Submitted to

THE NATIONAL ASSESSMENT AND ACCREDITATION COUNCIL

Apex Manual
Amala Institute of Medical Sciences
AMALA NAGAR, THRISSUR

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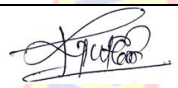
	Signature	
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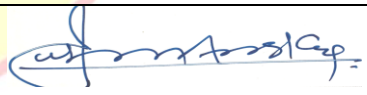
	Signature	
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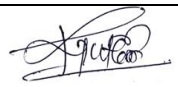
	Signature	

AMENDMENT SHEET

Sl. No.	Section no & Page no	Details of the Amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

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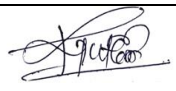
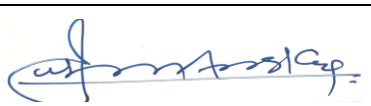
Fr. Deljo Puthoor CMI	Fr.Julious Arakkal CMI
	

CONTROL OF THE MANUAL

The authority over control of this manual is as follows:

Preparation	Approval & Issue
Accreditation Coordinator	Director

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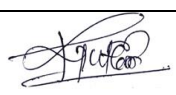
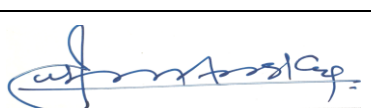
Distribution List of the Manual:

Sl. No.	Designation	Copy Type
1.	Director	Master Copy
2.	Quality Coordinator	Controlled Copy

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 mode.

PREPARED BY Accreditation coordinator	APPROVED BY Director
Fr. Deljo Puthoor CMI	Fr.Julious Arakkal CMI
	

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

Quality Coordinator is responsible for issuing the amended copies to the copyholders; the copyholder should acknowledge the same and he /she should return the obsolete copies to the Quality Coordinator for archiving/destruction.

If amendment regarding any point is required, the Quality Coordinator shall prepare the amendment and get approval from approval authority. It should be attached to the Master copy and details to be entered in its amendment sheet. Quality Coordinator should also attach the amendment with the controlled copy and enter the amendment details in the amendment sheets provided in the controlled copy.

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.

TABLE OF CONTENTS

1. Introduction to Organization

1.1 Amala Institute of Medical Sciences (AIMS) "Home for total Healing" named after Blessed Virgin Mary, is a multidisciplinary medical network of pedagogical, therapeutic, research and outreach programmes. On our Official Website, we bring to you an overview of Amala Institute of Medical Sciences (AIMS), its people, its achievements and a look into its future.

Amala Institute of Medical Science (AIMS) brings together a dedicated team of physicians, nurses and other healthcare professionals to provide the highest standards of medical treatment. Our full range of primary and specialty care medical services enables cross-specialty consultation, which assures outstanding treatment for each patient. Our extensive infrastructure offers extensive facilities comprising modern operating theatres, fully equipped intensive-care beds, a fully computerized and networked Hospital Information System (HIS), a fully digital radiology department and all clinical laboratory services.

1.2 History

Amala Institute of Medical Sciences (AIMS) named after Blessed Virgin Mary, is a multidisciplinary medical network of pedagogical, therapeutic, research and outreach programmes. AIMS trace its origin to Amala Cancer Hospital which was started in 1978. It is managed by the Devamatha Province of CMI Congregation founded by Blessed Cyriac Elias Chavara.

1.3 Management

Amala is managed by a team of CMI fathers appointed by the Trustee-in-Chief. There shall be a Director who will be assisted by a joint Director and few Associate Directors. The departments and functional units are divided among the directors whom are called priest In charge of a particular department. He shall be responsible for all initiatives and decisions within that department.

1.4 Institutions

1.4.1 Medical College

The medical college affiliated to the Kerala University of Health Sciences, can boast of state of the art facilities and infrastructure, be it the class rooms, the library, museums, laboratories, or hostels. We constantly seek to recruit brilliant staff and provide state-of-the-art infrastructure in an eco friendly ambience encouraging the students to become forward looking, dedicated doctors imbued with compassionate love towards all, especially the poor and the marginalized. We strive to impart value added education, blending curricular and co-curricular activities so as to make it a pleasurable experience.

1.4.2 College & School Of Nursing

Amala College of Nursing is a unit of Amala Institute of Medical Sciences, under the auspices of CMI Devamatha Province with an intake of 50 students. It is recognized by INC and KNC and is affiliated to Kerala University of Health Sciences. The college offers basic B.Sc. Nursing programme and M.Sc. Nursing programme. The School of Nursing offers GNM.

1.4.3 Amala Ayurveda Hospital

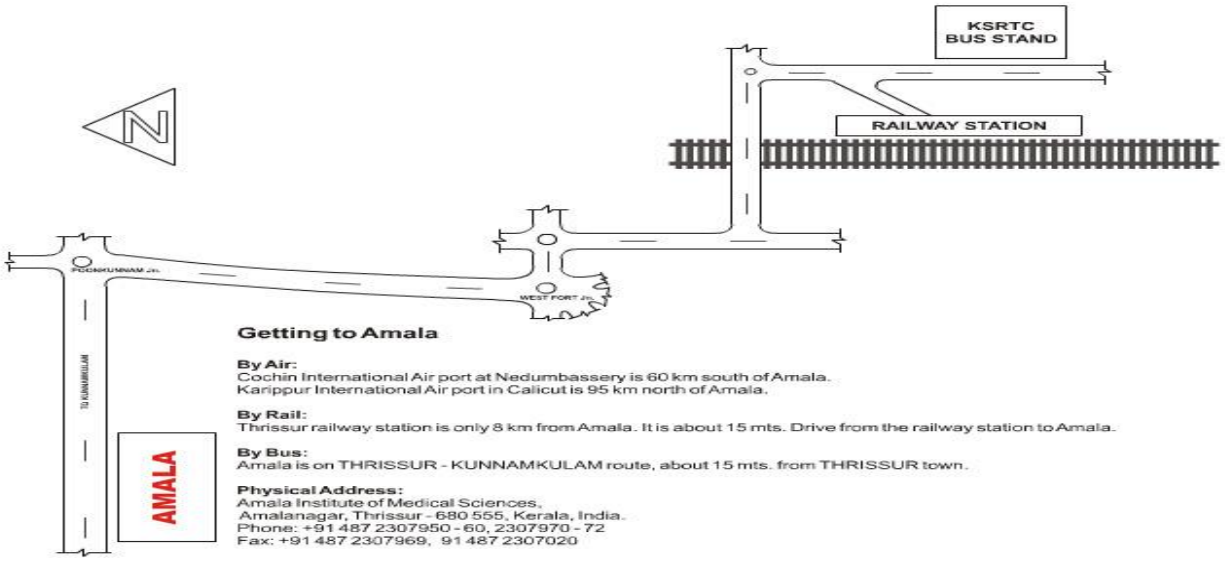
Amala Institute of Medical Sciences, a charitable institution founded by the Carmelite Fathers (CMI), has a modern Super Specialty Hospital with 1000 beds Medical College, Research Centre, Homoeopathic Hospital and an Ayurvedic Hospital with 100 beds in its campus, that are ISO 9001:2015 certified and NABH accredited Hospital. This is a unique institution where one can have modern medical facilities with advanced diagnosis and therapeutic techniques and also the holistic medical facilities of Ayurveda and Homoeopathy. Ayurvedic Hospital is currently doing research on Cancer and HIV/AIDS. Here, treatment is also given for all general diseases, including the ones which do not find effective.

1.4.4 Amala Cancer Research Centre

Amala Cancer Research Centre was established in 1982 and registered as a Society in 1984. It is recognized by the University of Calicut and Mahatma Gandhi University.

It undertakes scientific research in the area of cancer and other related branches of medical science, basic and in applied fields. The centre is recognized by the Indian Council of Medical Research, Council of Scientific and Industrial Research, Department of Science and Technology, Department of Biotechnology and Department of Atomic Energy. The Centre has published over 400 research papers during the last 27 years in reputed National and International journals.

1.5 Location Map



2. Vision

To be a foremost teaching hospital known for its excellence in holistic healthcare, quality education and research.

3. Mission

- Employing the best possible staff.
- Providing state-of-the-art facilities in an eco-friendly ambience.
- Imparting affordable, inclusive, quality health care to all.
- Catering to the physical, emotional and spiritual needs of the patients.
- Following merit-based, transparent and non-exploitative admission procedure.
- Challenging our students to become forward-looking, dedicated health care personnel with the hallmark of competence, integrity and compassion.
- Instilling in the staff and students respect for life at every stage of its growth and in all its manifestations.
- Inspiring the students to reach out to the poor and the marginalized, especially those in the rural areas.

- Promoting innovative research that will benefit the humanity.

4. Quality Policy

We are committed to provide world class health care by continually improving processes in creating an ideal work environment and providing safe and ethical medicines to our patients with loving care, to attain the goal of patient satisfaction.

5. Quality Objectives

- To provide efficient and timely medical care to all patients with a human touch
- To continuously monitor and deliver hospital services
- To provide continual and regular training to the skilled employees
- To constantly improve the level of performance of all the key processes in the organization, especially of our ward staff, and to the traditional ethical values in the practice of medicines and patient care by all members of the hospital
- To build an effective feedback system

6. Policies for Ethical Management

- The Management is responsible for effective delivery of services at Amala Institute of Medical Sciences
- The management shall stand responsible and accountable for all the management level decisions
- The management shall accept and deal with all legal issues that might rise against the organization following the laws and regulations established in the nation
- All medico legal cases shall be reported to the police station and shall not be concealed in favour of any individual
- All individuals involved management and related activities shall act and be seen to act, with integrity and professionalism, honesty, care and due diligence shall be integral to all activities
- Respect shall be demonstrated for each other and for the environment

- Confidential information shall be safeguarded
- Deliver patient care, research, education and support work with professional competence, intellectual honesty and high ethical standards
- Promote the communication of rights, responsibilities and information to foster informed decision making to provide the highest quality of care and safety
- Treat all internal and external members of the community with respect and dignity and without discrimination
- The Management sees that participants shall not engage in any activity that may create, or appear to create, a conflict of interest, such as accepting gifts or favours, providing preferential treatment, or publicly endorsing suppliers or products or any other stake holders
- Promote a safe, secure and healthy work environment for all
- Management shall protect the Hospital's physical, electronic and intellectual property
- Management ensures that all individuals shall continuously work to improve the organization

7. Service Standards

7.1 Compassionate care

- We deliver service in a manner that reflects compassion, empathy and caring. Compassion is demonstrated by listening to, accepting and responding to the distinct needs of each patient in each interaction.
- Exercise care when discussing patient information. We never discuss information about a patient in public areas of the hospital (elevators, stairwells, hallways and cafeterias).
- Demonstrate empathy by showing sensitivity to our patients' and families' needs including those of an emotional and spiritual nature.
- Include customers in discussions and decisions about their treatment and plan of care.

7.2 Effective communication and education

- The purpose of communication is to provide clear, accurate information and to achieve mutual understanding by active listening and open, respectful dialogue.
- Acknowledge patients and families by smiling, making eye contact and offering assistance.
- Use language and terms the customer can understand and offer an interpreter when needed.
- Listen attentively to the customer and check for understanding.

7.3 Responsiveness

- By anticipating the needs of others and responding in a prompt manner, we consistently provide a high level of service, increasing the trust and confidence others have in us.
- Approach patients or visitors who appear lost and offer to assist them.
- Escort patients, families and visitors to their destination or to the person they need to see, if possible.
- Respond to customers in a timely manner, informing them of any delays or changes that may affect them.

7.4 Accountability

- We take responsibility to know, understand and perform in a professional and competent manner and we extend ourselves.
- Provide explanation to customers of the services/treatments they are going to receive.
- Take ownership of complaints or requests and follow through to resolution.
- Take care of equipment and facilities and report all problems immediately.
- Maintain a professional appearance and demonstrate pride in our work and our jobs.

7.5 Teamwork

- We work collaboratively, valuing the specific and necessary contributions of each member of the healthcare team.
- We work together with a shared goal of achieving excellence in addressing patient needs.
- Encouraging participation from all team members (the team consists of all patients, families, physicians and co-workers).
- Offering to help co-workers before being asked and asking for support when we need it.
- Working with others collaboratively in problem solving and decision making.

- Initiating, promoting and adapting to change and the process of continuous improvement.

7.6 Respect

- We value the unique qualities and needs of individuals and are committed to understanding and appreciating the diversity of cultures, opinions and experiences that patients, families and hospital staff bring to our environment.
- Respect the customer's knowledge of their medical condition.
- Show concern for the customer's privacy by closing the door before asking personal questions.
- Demonstrate awareness of cultural differences and respect for other people's opinions and experiences.

8. Scope of Services

8.1 Definition

Range of clinical and supportive services that are provided by Amala institute of Medical Sciences, Thrissur as a health care organization.

8.2 Policy

- The hospital shall orient all its employees regarding the scope of services
- Scope of services shall be displayed in all three blocks visible to all patients and visitors
- All displays shall be in English and Malayalam

Services Available

Clinical Services

Anesthesiology
Cardiology
Cardiac Surgery
Cardiac Anaesthesia
Dentistry

Dermatology and Venereology
Otorhinolaryngology (ENT)
Gastroenterology
General Medicine
General Surgery
Neuro & Spine Surgery
Neurology
Obstetrics & Gynaecology (OBG)
Nephrology & Dialysis
Nuclear Medicine
Ophthalmology
Orthopaedics and joint replacement
Pain and Palliative care
Paediatrics
Plastic Surgery
Psychiatry
Pulmonology
Immunology & Rheumatology
Physical Medicine and Rehabilitation
Thoracic Surgery
Medical Oncology
Surgical oncology
Radiation Oncology
Neonatology
Trauma and Critical Care
Urology
Vascular surgery

Laboratory Services and Transfusion Services

Blood Transfusion Services & Blood Bank
Clinical Biochemistry
Clinical Microbiology &Serology
Clinical Pathology
Cytopathology

Haematology
Histopathology

Diagnostic Services
Digital X-ray
CT-Scan
PFT
MRI Scan
PET
USS
EEG
MEG
Audiometry

Other services
Pharmacy
Social Work department
Dietetics
Physiotherapy
Ambulance Service
Mortuary Service

Services Not Available

Transplantation Services
Burns
MTP

9. Hospital Bed Strength

- Total Operational Beds -1089
- Total ICU beds- 136
- Total non ICU beds-953

10. Hospital Committees

HOSPITAL COMMITTEES 2021

Sl No.	Name of Committees	Frequency	Responsible person/team	Contact No.
1.	Medical Board Committee	Twice weekly	Dr. Betsy	80122
2.	Hospital Quality committee	Monthly	Quality dept.	6372
3.	Hospital Infection Control Committee	Monthly	HIC dept	1270
4.	Drugs & Therapeutic Committee	Once in three months	Dr. Lejo	4040
5.	CASH- Committee Against Sexual Harassment	Once in 4 months or when any incident occur.	Ms. Niji Vijayan	80693
6.	Grievance redressal & Disciplinary Committee	Half yearly or If any grievance occurs.	Dr. Joseph T John, Forensic Medicine	1168
7.	Clinical Audit Committee & Patient Care Audit (Mortality and Morbidity) Committee	Monthly	Quality dept.	6372
8.	Medical Record Audit Committee	Once in three months	Ms.Stefy, MRD-	80424
9.	CPR Analysis Committee	Once in three months	Quality dept.	6372
10.	Hospital Transfusion Committee	Once in three months	Dr. Nithya,	80234

11.	Safety & Disaster Management Committee	Once in three months	Quality dept.	6372
12.	Purchase & Condemnation Committee	Once in three months	Mr. Lucy, Purchase	1305
13.	Pharmacovigilence Committee	Once in three months	Dr. Prathibha	6480
14.	Patient Feedback Committee	Monthly	Quality dept.	80436
15.	Maintenance and Development Committee	Once in three months	Quality dept	6372
16.	Lab Committee	Once in three months	Dr. Joy, Pathology	80788
17.	Radiation Safety Committee	Once in three months	Mr. Siva, RSO	80874
18.	Clinico-Radiology Committee	Once in three months	Dr. Robert P Ambookan	80213
19.	OT Committee	Once in three months	Mr. Tony	80746
20.	Institutional Ethics Committee			
21.	Food and Hygiene Committee	Monthly	Ms. Reena	

10.1. Medical Board Committee (Every month)

Purpose

To review the over all functioning of hospital., policies and procedures.
To discuss the issues pertaining to the hospital functioning.
To make a plan and review it for delaing with community epidemic situation.

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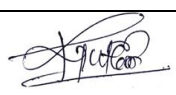
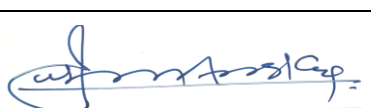
Fr. Deljo Puthoor CMI	Fr.Julious Arakkal CMI
	

Members

Chairman - Fr. Julius Arakal CMI, Director
Convener - Dr. Betsy Thomas, Principal
Secretary -Dr. Rennis K Davis, Prof and HOD Pulmonology Dept

Other Members

1. Fr. Jaison Mundanmany CMI, Associate Director
2. Fr. Deljo Puthoor CMI, Associate Director
3. Fr. Shibu Puthenpurackal, Associate Director
4. Fr. Antony Mannumel, Assistant Director
5. Dr. Rajesh Anto, Medical Superintendent
6. Dr. Rupesh George, Associate Prof, Cardiology (HICC Convener)
7. Dr. Saju C R, HOD Community Medicine Dept.
8. Dr. G. George, Prof &HOD General Medicine
9. Dr. Narayanan Potti. Prof. General Medicine
10. Dr. Paul.O.Raphael, Prof & HOD Anesthesiology Dept.
11. Dr. Ramaraj S, Prof & HOD Paediatrics Dept.
12. 12. Dr. Jobin Jose, Assistant Prof. Emergency Medicine
13. Sr. Likhitha MSJ, Chief Nursing Officer

Special Invitees

- Dr. Joe John Chirayath, Assistant Prof. Anaesthesiology Dept.
- Dr. Aiswarys Alex, Associate Prof. Microbiology Dept.

Committee Quorum Members-9

- MR/ Chairman/ Convener / Secretary (any of two)
- Members (7).

10.2. Hospital Quality committee (Every month)

Purpose

To develop Quality standards of the Hospital. Monthly analysis of activities of all departments of the Hospital to ensure proper implementation of standards and to find solutions for improvement.

Roles

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee

Frequency of meeting

Every month

Responsibilities and functions

- Planning of the quality management system
- Establishment, monitoring and review of quality indicators
- Ensuring the availability of resources as required by the quality management system
- Conducting management reviews
- Reviewing non-conformances related to services
- Reviewing internal audit reports
- Analysis of data on process and service measurements
- Analysis of patient satisfaction data and complaints
- Ensuring timely corrective and preventive actions
- Ensuring continual improvement of the quality management system

The Secretary will circulate the agenda before the meeting. Each committee meetings will have the following reports presented to the committee as a part of the regular proceedings:

- Previous meeting points
- Event analysis presentation (Patient Safety / General Safety Incidents)
- Patient complaint/feedback analysis presentation.
- Quality Indicator presentation.
- Report on Medication Errors / Adverse Drug Events
- Report on Incidence Report Analysis / Risk Management Assessment
- Sentinel Event Analysis Reports
- Report of Internal Audits
- Review of Committee Function
- Report on Employee Satisfaction and Training & Development Activities
- Report on Utilization of Services & Facilities
- Report on Quality and HIC budgeting.

Members

Chairman -Fr.Julious Arakkal, Director
Vice Chairman - Fr. Deljo Puthoor CMI, Associate Director
Secretary - Mr. Manikandan R- Quality Coordinator

Other Members

1. Fr. Jaison Mundanmany CMI, Associate Director
2. Fr. Shibu Puthenpurackal, Associate Director
3. Fr. Antony Mannumel, Assistant Director.
4. Dr. Betsy Thomas, Principal
5. Dr. Rajesh Anto, Medical Superintendent
6. Dr. Dijoe Davis, Associate Professor Orthopedics Dept(Patient Safety Officer)
7. Dr. Suresh Kumar, Prof & HOD Neuro Surgery dept
8. Dr.Nithya Menon, Assistant Prof Transfusion Medicine dept
9. Dr. Rakesh L John,Chief Medical Officer, Pain and Palliative Dept.
10. Dr. Lisha P V, Asst. Prof. Pulmonary Medicine dept.

11. Dr. Jobin Jose, Assistant Prof. Emergency Medicine
12. Mr. Saiju C Edakkalathur, Chief Operating Officer
13. Mr. Franco Joseph, Chief Financial Officer
14. Sr. Likhitha MSJ, Chief Nursing Officer
15. Adv. Piljo Varghese, HR Manager
16. Er. Jijo Lazarus T, Civil Engineer
17. Er. Jose A. Mekkattukulam, Electrical Engineer
18. Er. Jomon Jose K, Biomedical Engineer
19. Mr. Joseph Varghese, PRO
20. Mr. S. Sivakumar, Chief Medical Physist & RSO
21. Ms. Lucy O F, Purchase officer
22. Sr. Rubin, Pharmacy In-charge
23. Sr. Lisanto Antony, Radiology In-charge
24. Sr. Elizabeth, Blood Bank In-charge
25. Sr. Helen Rose, Central Lab In-charge
26. Mr. Sanukrishna K S, Operations Executive
27. Ms. Reena Jijo, Chief Dietician
28. Ms.Litty Thomas, ICN In-charge
29. Mr. Saneesh Varghese, Welfare In-charge, MSW Dept.
30. Ms. Stefy Joseph, MRD In-charge

Committee Quorum Members-17

1. MR/Chairman/Vice Chairperson/ Secretary (any of two)
2. Principal/ Medical Superintendent/Patient Safety Officer (any of two)
3. Members (13).

10.3. Infection Control Committee (Every month)

Purpose

In order to establish and implement policies and procedures for effective infection control and prevention in the hospital.

Develop IC program of the Hospital. Evaluation and Analysis of HAI & Infection control activities and suggesting solutions to Management.

Roles

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Hospital Infection Control Officer

Elected Member and appointed by the committee, he/ she shall guide and coordinate all the infection control practices recommended by the committee. He/she shall ensure that the decisions of HIC committee shall be implemented. Refer to Infection Control Manual for detailed job description.

Frequency of meeting

Every month

Responsibilities and Functions

- To formulate infection control policies and procedures to publish Hospital Infection Control Manual
- To establish a practical system for identifying, reporting and evaluating infection in inpatients, selected outpatients and discharged patients
- To establish policy criteria for distinguishing between nosocomial and community acquired infections
- To develop a hospital antibiotic policy
- To develop guidelines for segregation and disposal of hospital wastes
- To establish a mechanism to investigate and identify the reservoir, source and method of transmission of each outbreak of nosocomial infection and institute appropriate measures to limit further spread from identified sources of contagion
- To establish and implement institution-wide policies and procedures

- To review and evaluate written policies and procedures pertinent to infection control (on asepsis, isolation and sanitary techniques) for all services on an annual basis and revised wherever necessary
- To review all Healthcare Epidemiology departmental policies annually
- To establish a system for reporting, evaluating and maintaining records of infections among patients and personnel and the ongoing collection and analytic review of data and action taken with subsequent dispersion of this data throughout the hospital
- To review the types of surveillance and reporting programmes implemented by Infection Control
- To provide input into the Hospital Employee Health Programme
- Maintain functional compliance with infection control policies and procedures
- Reviews the types of surveillance and reporting programmes implemented by Infection Control
- Reviews standard criteria for reporting all types of infections
- Reviews department and infection control policies and procedures every 2 years and recommends revisions to management
- Evaluates and approves the applicability and appropriateness of all action(s) taken to prevent and control infections based on records and reports of infections and infection potential among patients and hospital personnel
- Report's findings and recommendations through committee minutes to others
- The committee will report to the [Quality Management Committee] through forwarding the recordings of proceedings of the meeting
- Follows up to ensure compliance with recommendations made to eliminate hazardous situations
- Consults with other hospital staff as needed to implement an effective infection control programme
- Individual members report relevant findings, investigations, infection control problems, etc to the staff of the division / department they represent

Members

Fr. Julius Arakal CMI, Director- Chairperson
Fr. Deljo Puthoor CMI, Associate Director – Management Nominee
Dr. Betsy Thomas, Principal –Vice Chairperson
Dr. Rupesh George, Asso. Prof, Cardiology-Convener.
Dr. K V Suseela, Prof & HOD Microbiology-Secretary

Dr. Subi Das, Asst. Pro. Microbiology –HICO
Dr. Aiswarya Alex, Asso. Prof Microbiology –Asst. HICO
Dr. Vinitha Mary Joy, Senior Resident, Microbiology- Asst. HICO

Other Members

1) Fr. Jaison Mundanmany CMI, Associate Director
2) Fr. Shibu Puthenpurackal, Associate Director
3) Dr. Rajesh Anto, Medical Superintendent
4) Dr. Paul.O.Raphael, Prof & HOD Anesthesiology Dept.
5) Dr. Sandra Paulson, Senior Resident, Community Medicine.
6) Dr. Linto John, Asso. Prof. General Surgery Dept.
7) Dr. Anish S, Asst. Prof. General Medicine. Dept.
8) Dr. Lisha P V, Asst. Prof. Pulmonary Medicine dept.
9) Dr. Padmaja G. Nair, Prof & HOD, Pharmacology dept.
10) Sr. Likhitha MSJ, Chief Nursing Officer
11) Mr. Saiju C Edakkalathur, COO
12) Er. Jijo Lazarus T, Civil Engineer
13) Er. Jose A. Mekkattukulam, Electrical Engineer
14) Er. Jomon, Biomedical Engineer
15) Ms. Lucy, Purchase Officer
16) Mr. Manikandan R, Quality Co-ordinator
17) Ms. Litty, HICN In-charge
18) Sr. Daisy, GSOT In-charge
19) Sr. Deepa, SSOT In-charge
20) Ms. Biji, CVSOT In-charge
21) Mr. Sinto, CSSD In- charge
22) Mr. Jomon, Housekeeping Supervisor.

Committee Quorum Members-16

- MR/Chairperson/Vice Chairperson (any of two)
- Medical Superintendent/Convener/Secretary (any of two)
- Members (12)

10.4. Drugs & Therapeutic Committee (Quarterly- once in 3 months)

Purpose

Preparation & Updation of Hospital Formulary.
Ensuring selection, storage, dispensing of medicines etc. as per standards.
Evaluation of ADR etc.

Roles

Chairperson

The committee shall be headed by Chairperson nominated by management who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Quarterly- once in 3 months

Responsibilities and Functions

- Formulation and implementation of policies for safe and effective procedures for medication management
- Preparing all formats related to medication management.
- Organizing trainings regarding medication management.
- Preparation and Management of Formulary as per procedure.
- Review and updation of hospital formulary.
- Formulate Purchase policy and overlook the purchase of drugs, implantable prosthesis and medical consumables.
- Overlook safe and rational prescription of medications.
- Conducting prescription audits.
- Verification of documents pertaining to controlled drugs.

- Overlook the functioning of Pharmaco-vigilance Committee with respect to the management of adverse drug reactions.
- Ensure corrective and preventive actions for all medication errors reported.
- Evaluating Medication recalls as per AIMS/MOM/06.
- The decision of the committee will be finally taken by consensus of majority of members and that shall be implemented.

Members

1. Fr.Julious Arakkal CMI, Director
2. Fr. Jaison Mundanmany CMI, Associate Director
3. Fr. Deljo Puthoor CMI, Associate Director
4. Fr. Antony Mannumel CMI, Assistant Director
5. Dr. Rajesh Anto, Medical Superintendent
6. Mr. Saiju C Edakkalathoor , COO
7. Sr. Likhitha, Chief Nursing Officer
8. Dr. Abel Francis, Dept. of Dermatology
9. Dr. Aneena Chacko, Dept. of ENT
10. Dr. Anil Jose Thazhath, Dept. of Medical Oncology
11. Dr. Aparna Gulvadi, Dept. of Pediatrics
12. Dr. Dijoe Davis, Dept of Orthopedics
13. Dr. Geofi George Dept. of Cardiology
14. Dr. George . G, Dept of General Medicine
15. Dr. Jainy Joseph, Assist. Prof. of Ophthalmology

16. Dr. Jery Antony, Dept of Psychiatry
17. Dr. Jobin, Dept of Emergency Medicine
18. Dr. Lejo Jacob A, Pharmacy Incharge, Pharmacy Operations
19. Dr. Mariya Johnson, Clinical Pharmacist
20. Dr. Maryanne Poovathingal, Dept of Neurology
21. Dr. Narayanan Potti S, Dept. of General medicine
22. Dr. Prameela Menon, Dept. of Obstetrics & Gynaecology
23. Dr. Rennis Davis, Dept of Pulmonology
24. Dr. Robert Panakkal , Dept of Gastroenterology
25. Dr. Sreeraj V, Dept. of Medical Oncology
26. Dr. V. K. Prathibha, Dept of Pharmacology
27. Ms. Susmi Alphonsa Kurian, Asst. Quality Co-ordinator

Committee Quorum Members-12

- MR/ Chairman / Convener/ Secretary (any of two)
- Members (10)

10.5. CASH- Committee Against Sexual Harassment (Once in 4 Months or When any incident occur)

Purpose

To investigate complaints and grievance those related to sexual harassment at work place
Analysis of complaints regd. Sexual Harassment in the hospital (if any) and submission of suggestions to management for proper actions.

Definition

Sexual Harassment includes such behaviour as

- Physical contact and advances
- A demand or request for sexual favours
- Sexually coloured remarks
- Showing pornography
- Any other unwelcome physical verbal or non verbal conduct of sexual nature

Structure of Committee and roles

Chairperson

- The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

- Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
- They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

- Annually or when any incident occur

Responsibilities and functions

- To address issues regarding prevention and management of sexual harassment
- To address and investigate all the grievances reported which has a nature of sexual harassment
- To recommend the management measures to prevent such occurrences

Members

Dr. (Sr). Julia, Paediatrics Department - Chairperson
Fr. Julius Arakal CMI, Director – Vice Chairperson
Ms. Niji Vijayan, Clinical Psychologist – Secretary

Other Members

1. Fr. Deljo Puthoor CMI, Associate Director
2. Ms. PA Jayanthy Advocate (External Member)
3. Dr. Shiny John, Associate Professor, Psychiatry
4. Dr. Betsy Thomas, Professor, Obstetrics & Gynaecology
5. Dr. N. Sunilkumar Menon, Professor, Pediatrics
6. Adv. Piljo Varghese, HR Manager
7. Sr. Likhitha MSJ, Chief Nursing Officer
8. Ms. Aiona Liz, Clinical Psychologist
9. Ms. KK Elizabeth, Psychiatric Social Worker

Committee Quorum Members-7

- MR/Chairperson/ Secretary (any of two)
- Advocate
- Members (4)

10.6. Grievance redressal & Disciplinary Committee (Half yearly or If any grievance occurs)

Purpose

This document provides instruction and guidance to hospital staff on various issues pertaining to Disciplinary Action Committee

Analysis of grievances from employees and submission of suggestions to Management.

Roles

Chairperson

Director shall be Chairperson for the committee by default

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Half yearly or If any grievance occurs

Policy

As an employee of Amala hospital the employees are expected to follow the service rules and a code of conduct. Any breach in the behaviour or performing any of the following acts (details – HR manual) by an employee shall demand disciplinary action to be taken by the Disciplinary Action Committee

Any breach in discipline by an individual or a group can be referred to the Disciplinary Action committee.

The committee will look into every single incident/situation or act and if necessary, will conduct an enquiry and submit its report and recommendation.

The committee might appoint a team to investigate the incident.

Depending on the severity of the incident/situation or act based on the analysis of investigation report the committee would decide on one of the following disciplinary action to be taken against the employee.

- Fine
- Warning
- Increment stoppage
- Demotion
- Suspension
- Dismissal

Members

Chairman -Fr. Julius Arakal CMI, Director
Secretary - Dr. Joseph T John, Head of Forensic Medicine
Joint secretary – Dr. Abel Francis, Associate Professor Dermatology

Other Members

1. Fr. Deljo Puthoor CMI (Associate Director)
2. Dr. Rajesh Anto, Medical superintendent
3. Mr. Saiju C Edakkalathur, Chief Operating Officer(COO)
4. Adv. Piljo Varghese, HR Manager

5. Sr. Likhitha MSJ, Chief Nursing Officer
6. Sr. Jyothish, CSC, Lecturer, College of Nursing
7. Ms. Niji Vijayan, Clinical Psychologist

Committee Quorum Members-6

- MR/ Chairman /Secretary /Joint Secretary(Two)
- Members (4)

10.7. Clinical Audit Committee & Patient Care Audit (Mortality and Morbidity) Committee (Monthly)

Purpose

To establish an audit system to review the delivery of care to identify deficiencies so that it may be remedied.

Analysis of clinical audit findings to improve quality of health care services offered to patients.

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of Meeting

Monthly

Responsibilities and functions

- Formulating policies for clinical audit
- Identification of topics for clinical audit

- Setting Standards and deriving audit checklist
- Analysis of Audit done by clinical audit team
- Identifying deficiencies in system and recommending changes for correction

Members

Chairman – Dr. Rajesh Anto, Medical Superintendent
Vice Chairman - Fr. Deljo Puthoor CMI, Associate Director
Convener - Dr, Betsy Thomas, Principal
Secretary - Dr. Dijoe Davis, Associate Professor Orthopaedics Dept

Other Members

1. Dr. Anoj Katukkaran, Prof. & HOD, Obstetrics & Gynecology Dept.
2. Dr. Charles k, Prof & HOD Ophthalmology Dept.
3. Dr. Jayakumar T G, Prof & HOD Cardiology Dept.
4. Dr. S. Narayanan Potti, Prof. General Medicine Dept.
5. Dr. Rajkumar, Assistant Prof. General Surgery Dept.
6. Dr. Mathew, Asst. Professor, Radiation Oncology
7. Dr. Sreeraj V, Asst. Professor, Medical Oncology & Haematology
8. Dr. Shiji Joseph, Assistant Prof. Paediatrics Dept.
9. Dr. Anu Mary Mani, Assistant Prof Psychiatry Dept.
10. Dr. Raji C, Senior Resident, Dental Surgery Dept.
11. Dr. Sojan George K, Senior Consultant Gastroenterology Dept.
12. Dr. Ajaykumar K K, Cardiothorasic Dept.
13. Dr. Vinayakumar, Prof & HOD, ENT Dept.
14. Dr. Gopakumar, Cardiothrocic Surgery Dept.
15. Dr. Ajith T A, Prof. Biochemistry
16. Sr. Likhitha MSJ, Chief Nursing Officer
17. Mr. Manikandan R, Quality Co-ordinator
18. Ms.Litty, ICN In-charge

Committee Quorum Members-12

- MR/ Chairman / Secretary (any of two)
- Members (10)

Method

What is clinical audit?

- Aim of clinical audit is to measure the gap between ideal practice (determined from evidence and guidelines) and actual practice.
- Clinical audit is a quality improvement process to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
- Structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria.
- Audit aims to improve the systems in which individuals work.
- Indicated changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.
- Audit can bring about change and improve practice and clinical effectiveness.

Key points:

Clinical audit is a multi-disciplinary activity where structure, process and outcomes of care are selected and evaluated against explicit criteria. Most of the clinical audits are also 'multi-sectorial', that is, they may involve health and social services, primary and acute care providers, education and health.

1. Clinical audit is measuring current patient care and outcomes against explicit audit criteria/standards.
2. There is an expectation from the outset that practice will be improved.

Advantages of Clinical audit- For Healthcare Professionals

- Increases knowledge and skill
- Measure current practices
- Identify training needs
- Provides Workable standards
- Resolves problems
- Ensure appropriate use of skills and resources

- Improves team working & level of communication
-

Areas which may be selected for audit

Structure:

Audits the environmental factors within which care is delivered. Audit criteria may be:

- Building- Eg. Cleanliness, State of repair, Privacy etc
- Equipments- Eg. Status of functioning in need, regular verification etc
- Patient Notes- Security & Confidentiality of Patient Records etc
- Patient care areas

Process

Audit focus on the clinical care received by patients. It may focus on:

- Investigations
- Treatment
- Procedure

Outcome

They examine the change in the health status of a patient following a particular treatment intervention. Criteria such as:

- Response to treatment in terms of pain relief or change in levels of disability
- Response to treatment in terms of reaction to treatment e.g. soreness, increased pain or disability within a specified time frame.
- Degree by which patients can manage their symptoms following advice delivered.

How to audit?

- Measure baseline
- Set standards
- Measure practice through data collection and analysis
- Assessment of performance against standard
- Identify opportunity for improvement

- Suggest change
- Implement change
- Evaluate change
- Review standard if required

METHODOLOGY

1. **Selection of topic**

Topic should be well defined and focused. Eg: Post operative infection/complication

2. **Setting Standards**

a. To be set prior to study
b. Target to be realistic
c. To be based on objective measures
d. Criteria to be well justified

3. **Worksheet preparation & Methodology of administration**

a. Simplest
b. Only Essential data collected
c. Suitable sample size & Sampling technique
d. Probability of bias to be considered

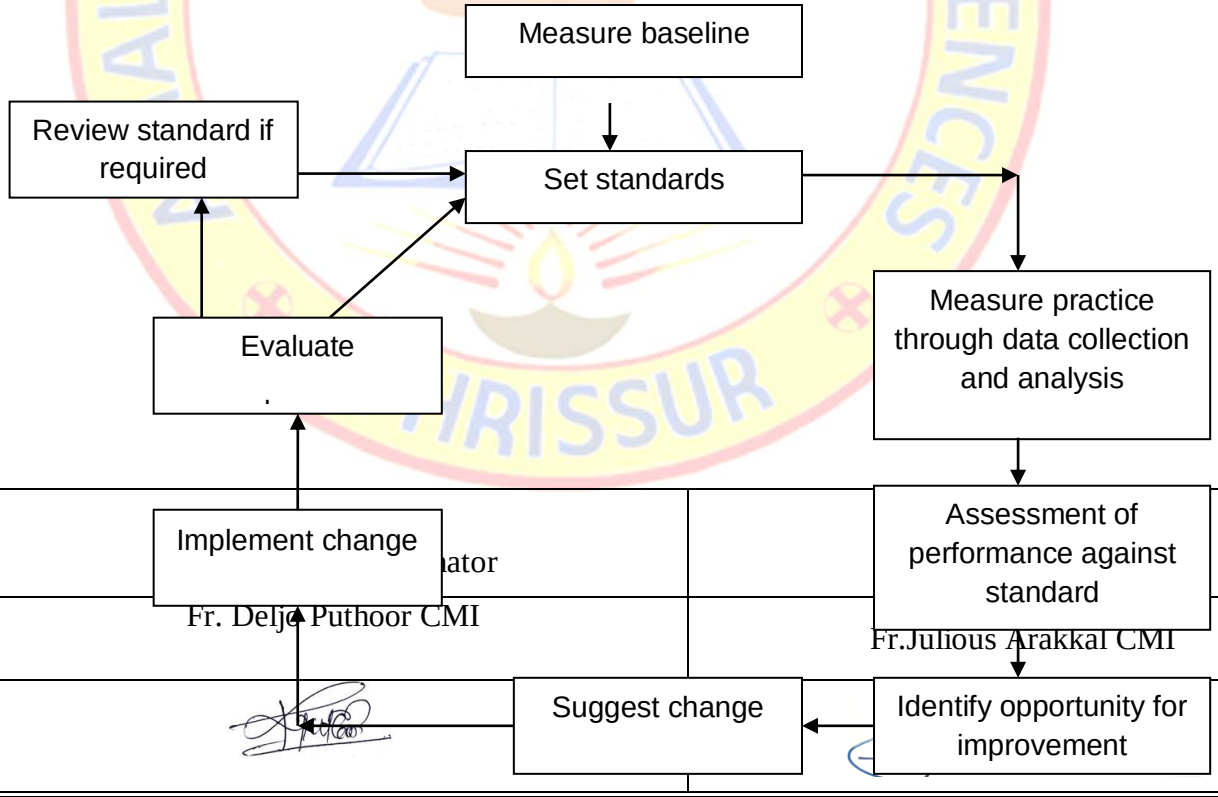
4. **Tabulation of evaluation**
5. **Interpretation**

a. Deficiency of care recognised
b. Specific solutions proposed
c. Training needs identified
d. Planned program for change
e. All staff involved
f. Active feedback
g. Audit evaluated

Checklist

Sl. No	Question	Criteria
1	Why was the audit done?	Reason for choice a. Should be clearly defined b. Should include potential for change
2	How was the audit done	a. Criteria choice ✓ Should be relevant to the subject ✓ Should be justified b. Preparation and planning should show adequate team work and methodology in carrying out the audit c. If standards are set they should be appropriate and justifiable
3	What was found	✓ Interpretation of the data ✓ Should use all relevant data to allow appropriate conclusion to be drawn
4	What next	Detailed proposal for change should show explicit details of the proposed change

The Audit Cycle



10.8. Medical Record Audit Review Committee (Once in three months)

Purpose

This committee provides instruction and guidance on medical documentation and various issues pertaining to Medical record.

Roles

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of Meeting

Once in 3 Months

Roles and Responsibilities

- To prepare the policies pertaining to medical documentation
- To develop and design various forms and formats used in medical documentation

- To facilitate, guide and advice for sustaining a regular, objective, explicit and effective method of quality assurance through a system based on peer review
- To examine, review and suggest remedial measures for any complaints (written/verbal) regarding medical care
- To examine and review case(s) of longer stay then benchmark and/or specific issue in the hospital, as a routine practice
- To guide and advise upon review and documentation of existing clinical practices
- Performing Medical System Audits through conduct of random review of medical / surgical cases handled by the hospital using a retrospective audit of case sheets; to ensure that the treatment and care provided confirmed to the various systems and protocols established by the hospital for treatment, diagnosis, care and administration
- Performing Medical Documentation System Audit
- Periodic reviews of medical records (active and discharged patients) based on a representative sample based on statistical principles
- The review should focus on timeliness, legibility and completeness of medical records
- Taking corrective and preventive measures based on the findings; including interacting with various clinicians / departments to improve the medical documentation system.

Members

Chairman – Dr. Rajesh Anto, Medical Superintendent
Vice Chairman - Fr. Deljo Puthoor CMI, Associate Director
Secretary - Ms. Stephy, MRD In-Charge

Other Members

1. Dr. Anoj Kattukaran, Professor & HOD Obstetrics & Gynaecology Dept.
2. Dr. Rajkumar, Assistant Prof. General Surgery Dept.
3. Dr. Davis Paul, Prof and HOD Respiratory Medicine dept.
4. Dr. Paul Gopu, Assistant Prof Radiation Oncology Dept.
5. Dr. Shiji Joseph, Assistant Prof. Paediatrics Dept.
6. Dr. Dijoe Davis, Associate Professor Orthopaedics Dept

7. Dr. Sujatha, Senior Resident, General Medicine Dept.
8. Dr. Anu Mary Mani, Assistant Prof Psychiatry Dept.
9. Dr. Sojan George K, Senior Consultant Gastroenterology Dept.
10. Dr. Joe Jacob, Associate Professor Neurology Dept.
11. Dr. Resmi Mary Philip, , Senior Resident, Dermatology Dept
12. Dr. Raji C, Junior Resident, Dental Surgery Dept.
13. Sr. Likhitha MSJ, Chief Nursing Officer
14. Mr. Manikandan R, Quality Co-ordinator
15. Ms.Litty, ICN In-charge

Committee Quorum Members-10

- MR/ Chairman /Secretary (any of two)
- Members (8)

10.9. CPR Analysis Committee (Once in 3 Months)

Purpose

Evaluation of CPR activities held in the hospital in a stipulated time frame, analysis of its shortcomings and deriving solutions.

Roles

Chairperson -The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary- Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Quarterly-Once in 3 months

Responsibilities and functions

- Formulating policies and standard operating procedure for uniform resuscitation
- Ensuring adherence to resuscitation guidelines and standards

- Periodic revision of guidelines and procedures
- Defining the role and composition of the resuscitation team
- Ensuring availability of resuscitation equipment and appropriate resuscitation drugs
- Planning adequate provision of training in resuscitation
- Determining requirements for and choice of resuscitation training equipment
- Audit of resuscitation outcomes
- Periodic post event analysis of all code blue events
- Recording and reporting critical incidents in relation to resuscitation
- Conducting mock drills regularly. Mock drills shall be conducted if no code blue events occurred for 30 consecutive days
- Training of Staff members on BLS and ACLS

Members

Dr. Rajesh Anto, Medical Superintendent – Chairperson
Dr. Paul O Raphael, Prof & HOD Anaesthesiology –Vice Chairperson
Dr. Rupesh George, Associate Prof. Cardiology – Vice Chairperson
Mr. Manikandan R, Quality Co-ordinator & Code Blue Coordinator – Secretary

Other Members

1. Fr. Deljo Puthoor CMI, Associate Director
2. Dr. Binu Puthur Simon, Assistant Professor Anaesthesiology
3. Dr. Mathew, Asst. Professor, Radiation Oncology
4. Dr. Edwin J George, Associate Professor, General Medicine
5. Dr. Dijoe Davis Associate Professor Orthopedics
6. Dr. Linto John, Asso. Prof. General Surgery Dept.
7. Dr. Lisha P V, Asst. Prof. Pulmonary Medicine dept.
8. Dr. N. Sunilkumar Menon, Professor Pediatrics
9. Dr. Sr.Merly John, CNO
10. Ms. Litty, ICN In-charge
11. Ms, Tonia Thomas, ICU Co-ordinator
12. Ms. Lincy, ICU Co-ordinator

13. Mr. Renny A L, Security Supervisor.

Committee Quorum Members-9

- MR/Chairperson/Vice Chairperson/ Secretary(any of two)
- Members (4)

10.10. Hospital Transfusion Committee (Quarterly- One in 3 months)

Purpose

- The committee shall be responsible for defining and monitoring rational use of blood and blood products
- Ensuring safe Blood transfusion & associated legal formalities in the Hospital. Verification of proper usage of blood & components.

Structure of Committee and roles

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Once in three months

Responsibilities and functions

- To establish broad policies for blood transfusion therapy (Refer Annexure-II)
- Develop criteria audits of transfusion practice
- Enhance quality patient care through objective assessment of ongoing blood and blood component therapy

- Review and analyze the statistical reports of the transfusion services
- Audit blood use with emphasis on the following:
  - Blood products transfused
  - Adverse reactions
  - The transmission of infectious diseases and other adverse effects of blood transfusion
- Review the findings of problem areas and evaluate their improvement
- Promote continuing education in transfusion practices for the hospital staff
- The assessment of safety and adequacy of the blood supply
- Annual review of the written policies and procedures of the hospital transfusion services to ensure they conform to the standards set by the NACO and KSACS
- Submit reports to the hospital organization in charge of the overall quality assessment program. This includes recommendation for improvement or corrective actions when needed.

Members

Chairperon – Dr. Vinu Vipin, HOD Transfusion Medicine Department.
Vice Chairman - Fr. Jaison Mundanmany CMI, Associate Director
Secretary - Sr. Elizabeth, Blood Bank in-charge

Other Members

1. Fr. Deljo Puthoor CMI, Associate Director
2. Dr. Rajesh Anto, Medical Superintendent
3. Dr. Krishnakumar Marar Professor & HOD Surgery
4. Dr. Anoj Kattukaran, Professor & HOD OBG
5. Dr. Rajagopal P, Asst Prof Anaesthesiology
6. Dr. Saurabh Radhakrishnan -Medical Oncologist
7. Dr. Alvin Treesa George -Asst.professor of medicine

8. Dr. Kishore, Asst. Prof. Orthopaedics
9. Dr. V Gopakumar, Chief Cardiovascular Surgeon
10. Dr. Regunath Assistant Professor & HOD Nephrology
11. Dr. Ramraj Paediatrics Professor & HOD
12. Dr. Anoob John Senior Consultant, Gastroenterology Dept.
13. Dr. Jobin Jose, Assistant Prof. Emergency Medicine
14. Dr. Sunu Lazar Cyriac, Asst. Professor, Medical Oncology.
15. Sr. Likhitha MSJ, Chief Nursing Officer
16. Mr. Manikandan R, Quality Co-ordinator
17. Ms. Litty, ICN In-charge

Committee Quorum Members-11

- MR/ Chairman /Secretary(any of two)
- Members (9)

10.11. Safety & Disaster Management Committee (Quarterly- Once in a month)

Purpose

- The safety committee role is to establish and maintain a progressive patient safety program to provide safe and effective care to the patient of Amala Hospital by creating an environment conducive.
- Ensuring safety of everyone- including staff & patients- in the Hospital and premises through safety measures & trainings.

Structure of Committee and roles

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.
They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Every month

Responsibilities and functions

- Coordinates development, implementation and monitoring of the safety plans and policies.
- Promote a culture of safety throughout the hospital through staff education programme and trainings and internal campaigns through workplace posters, awards and incentives.
- Conduct patient education materials for educating patients and families on their role in ensuring safety at the hospital.
- Conduct a thorough safety inspection of the campus once a year; to mapping potential safety risks to patients and employees. The documented findings of the safety inspection will be submitted to Quality Management Committee with suitable recommendations for actions.

- Conduct root-cause analysis for all reported safety related incidents and ensure appropriate corrective and preventive actions.
- Analyze all reported Sentinel Events (safety related) and plan and ensure corrective and preventive actions.
- Review and update the list of sentinel events (safety related) periodically based on the emerging studies published.
- Issue and circulate sentinel event (safety related) alerts to all departments / units of the hospital.
- Compile performance statistics for safety related indicators and analyze the same for trends. The report of the analysis done shall be submitted to the Hospital Management Committee.
- Overlook Laboratory and Radiation safety practices.
- Conducting mock-drills for fire and other identified hospital emergencies.

Members

Chairman - Fr. Julius Arakal CMI,Joint Director
Vice Chairman - Fr. Shibu Puthenpurackal, Associate Director
Secretary - Mr. Nikhil, Fire Safety Officer

Other Members

1. Fr. Deljo Puthoor CMI, Associate Director
2. Dr. Rajesh Anto, Medical Superintendent
3. Dr. Dijoe Davis, Associate Professor Orthopedics Dept(Patient Safety Officer)
4. Mr. Saiju C Edakkalathur, Chief Operating Officer(COO)
5. Sr. Likhitha MSJ, Chief Nursing Officer
6. Er. Jose A. Mekkattukulam, Electrical Engineer
7. Er. Jijo Lazarus T, Civil Engineer
8. Er. Jomon Jose, Biomedical Engineer
9. Mr. Siva Kumar, Chief Medical Physist & RSO
10. Sr. Lizanto Antony, Radiology Incharge
11. Mr. Sanukrishna, Operations Executive.
12. Mr. Manikandan R, Quality Co-ordinator

13. Ms. Litty, ICN In-charge
14. Mr. Joy Puthoor, CRO
15. Mr. Jomon Housekeeping Supervisor.
16. Mr. Renny A L, Security Supervisor.

Committee Quorum Members-10

- MR/ Chairman /Vice Chairperson/ Secretary (any of two)
- Medical Superintendent /Patient Safety Officer/Secretary (any of two)
- Members (6)

10.12. Purchase & Condemnation Committee (Quarterly-Every Three month)

Purpose

- This committee shall overlook into the purchase of capital assets and materials. They also manage the condemnation and disposal of equipments and other materials.
- Development & implementation of proper Purchase and disposal policies& procedures as per the demand of Hospital and NABH Norms.

Roles

Chairperson

The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary

Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Invited members for technical evaluation:

Based on the nature of equipment to be purchased or condemned engineers or doctors from the respective departments shall be called for technical evaluation.

Frequency of meeting

Quarterly-Every Three month

Responsibilities and Functions

- Formulating policies related to purchase and condemnation
- The department identifies the need and the total requirement of resources
- Planning purchase and budgeting
- Identifying vendors and seeking quotation
- Calling technical committee for technical inputs
- Conducting technical evaluation and analysis
- Negotiation with vendors
- Overall purchase manager
- Evaluation of equipments for condemnation
- Approves condemnations and close the accounts as per procedure

Members

Chairman -Fr. Julius Arakal CMI, Director
Vice Chairman - Fr. Deljo Puthoor CMI, Associate Director
Secretary - Ms. Lucy, Purchase Officer

Other Members

1. Fr. Jaison Mundanmany CMI, Associate Director
2. Dr. Betsy Thomas, Principal
3. Dr. Rajesh Anto, Medical superintendent
4. Mr. Franco Joseph, CFO
5. Mr. Saiju Edakalathoor, COO
6. Mr. Jomon, Bio Medical Engineer
7. Mr. Jose A. Mekkattukulam, Electrical Engineer

Committee Quorum Members-6

- MR/ Chairman /Vice Chairperson/ Secretary(any of two)
- Members (4)

10.13. Pharmacovigilance committee (Quarterly-Every Three month)

Members

Chairperson -Dr. Padmaja G. Nair, Professor and HOD Pharmacology
Vice Chairman - Fr. Jaison Mundanmany CMI, Associate Director
Secretary - Dr. V.K. Prathibha, Asst. Prof Pharmacology
Other Members

1. Fr. Deljo Puthoor CMI, Associate Director
2. Dr. Rajesh Anto, Medical Superintendent
3. Dr. Jose Jacob, Prof. & HOD, Biochemistry
4. Dr. V T Krishnadas Menon, Asst. Prof. Community Medicine
5. Sr. Likhitha MSJ, Chief Nursing Officer
6. Dr. Lejo Jacob, Pharmacy In-charge
7. Mr. Manikandan, Quality Coordinator
8. Ms. Litty, ICN In-charge

Committee Quorum Members-6

1. MR/Chairperson/ Secretary (any of two)
2. Members (4)

10.14. Patient Feedback Committee

Chairman - Fr.Deljo Puthoor CMI, Associate Director
Vice Chairman - Mr.Saiju C Edakkalathur, COO
Secretary - Ms.Susmi Alphonsa Kurian, Asst.Quality Coordinator

Members

1. Mr.Manikandan R, Quality Coordinator
2. Mr. Saneesh Varghese, Welfare In-charge, MSW Dept.

3. Ms.Salina Skaria , ANM Coordinator
4. Ms. Jeemol Binu, Front Office
5. Mr. Sarath Chandran, PRO

Committee Quorum Members-5

- MR/Vice Chairperson/ Convener/Secretary (any of two)
- Members (3)

10.15. Maintenance and Development Committee

Purpose

- To analyze the Maintenance and Development activities of the organization
- To plan for the developmental projects/activities in the future.
- To evaluate the ongoing renovation works.

Roles

Chairperson -The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary- Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Quarterly-Once in 3 months

Responsibilities and functions

- To ensure safety aspects of the organization.
- To plan for the developmental projects/activities in the future.
- To review Recently completed projects.
- To evaluate the ongoing renovation works.
- To review Projects under planning.

Members

Fr. Julius Arackal CMI, Director- Chairperson
Fr. Shibu Puthenpurackal CMI, Associate Director- Vice Chairperson
Mr. Saiju Edakalathur, COO-Convener
Er. Jijo Lazarus, Civil Engineer- Secretary
Other Members

1. Fr. Jaison Mundanmany CMI, Associate Director
2. Fr. Deljo Puthoor CMI, Associate Director
3. Fr. Antony Mannumel, Assistant Director.
4. Mr. Franco Joseph, CFO
5. Er. Jose A. Mekkattukulam, Electrical Engineer
6. Er. Jomon Jose K, Biomedical Engineer
7. Er. Manikandan, Construction Engineer
8. Mr. Sujith, Software Development dept
9. Mr. Manikandan R, Quality Co-ordinator
10. Mr. Bineesh, IT Hardware

Committee Quorum Members-8

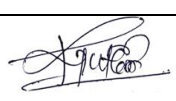
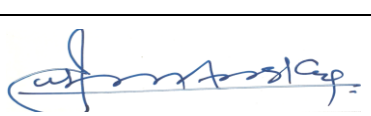
- MR/ Chairperson /Convener / Secretary (any of two)
- Members (6)

10.16. Lab Committee Meeting

Members

Fr. Julius Arackal CMI, Director- Chairperson
Fr. Jaison Mundanmany CMI, Associate Director- Vice Chairperson
Dr. Joy Augustian, Lab Director- Convener
Sr. Helen, Lab In-charge- Secretary

Other Members

PREPARED BY Accreditation coordinator	APPROVED BY Director
Fr. Deljo Puthoor CMI	Fr.Julious Arakkal CMI
	

1. Fr. Deljo Puthoor CMI, Associate Director
2. Dr. Rajesh Anto, Medical superintendent
3. Dr. Anoj Kattukaran, Prof. & HOD,OBG
4. Dr. Jose Jacob, HOD Biochemistry
5. Dr. KV Suseela, HOD Microbiology
6. Dr. Ramraj, Prof. & HOD Pediatrics
7. Dr. Krishnakumar Marar Prof. & HOD – General Surgery
8. Dr. Vinayakumar, Prof. & HOD – ENT
9. Dr. Sr. Merlin, CHF, CNO
10. Sr. Elizabeth, Blood Bank In-charge
11. Sr. Merine, Microbiology In-charge
12. Mr. Manikandan R, Quality Co-ordinator
13. Ms. Litty, ICN In-charge

Committee Quorum Members-9

- MR/Chairperson/ Convener/Secretary (any of two)
- Members (7)

10.17. Radiation Safety Committee

Members

Fr. Jaison Mundanmany CMI, Associate Director- Chairperson
Fr. Deljo Puthoor CMI, Associate Director- Vice Chairperson
Mr. Sivakumar, Chief Medical Physist and RSO- Secretary

Other Members

1. Dr. Sibu, Nuclear Medicine.
2. Sr. Lis Anto, Radiology In-charge
3. Mr. Joby PJ, Medical Physist
4. Mr.Manikandan R, Quality Coordinator
5. Ms. Dincy Davis, Nuclear Medicine Technologist
6. Sr. Daisy, GOT In-charge.

7. Sr. Deepa, SSOT In-charge.
8. Ms. Biji, CVSOT In-charge.
9. Ms. Beena, Cath Lab In-charge.

Committee Quorum Members-6

- MR/ Chairperson/ Vice Chairperson /Secretary (any of two)
- Members (4)

10.18. Clinico-Radiology Committee

Roles

Chairperson -The committee shall be headed by Chairperson elected by members who shall overlook the functioning of the committee and system.

Secretary- Elected secretary shall be responsible for coordination of meetings, documentation of minutes and communication of decisions to respective members.

They shall also coordinate with quality department regarding the functioning of committee.

Frequency of meeting

Quarterly-Once in 3 months

Responsibilities and functions

- Review the functioning of Radiology and imaging services.
- Review the QIs related to Radiology and imaging services.
- Any other issues pertaining to Radiology and imaging services.

Members

Chairman – Fr. Julius Arakkal CMI, Director
Vice Chairman - Fr. Jaison Mundanmany CMI, Associate Director
Convener -Dr. Robert P Ambookan, Prof & HOD Radiodiagnosis
Secretary - Sr. Lisanto Antony, Radiology In-charge

Other Members

1. Dr. Deljo Puthoor CMI, Associate Director

2. Dr. Betsy Thomas, Principal
3. Dr.Rajesh Anto, Medical Superintendent
4. Dr. Anoj Kattukaran Prof & HOD, OBG
5. Dr. C. Jayaprakash, Prof & HOD, Orthopedics
6. Dr. Ramaraj, Prof & HOD, Paediatrics
7. Dr. Krishnakumar Marar, Prof & HOD - Surgery
8. Dr .Paul O Raphael, Prof & HOD - Anaesthesia
9. Dr. Joy Augustine Prof & HOD - Pathology
10. Dr. Jobin Jose, Assistant Prof. Emergency Medicine
11. Dr.G. George, Prof & HOD, General .Medicine
12. Dr. Vinayakumar, Prof & HOD, ENT
13. Dr. Charles. K. Skariah, Prof & HOD, Ophthalmology
14. Dr. Jayakumar , Prof & HOD, Cardiology
15. Dr. Rennis Davis, Prof & HOD, Pulmonology
16. Dr. Robert. P.Panakkal, Prof & HOD, Gastroenterology
17. Dr. Gopakumar, HOD –Cardiothrocic Surgery
18. Dr. Jomon Raphael, Prof & HOD, Radiation oncology
19. Dr. Sunu Lazar Cyriac, Senior Consultant, Medical oncology & Haematology
20. Dr. Jacob Kurian, Prof & HOD, Onco. Surgery
21. Dr. Siji .J. Chiramel, Prof & HOD, Dentistry
22. Dr. HariKrishnan, HOD Urology
23. Dr. Regunath, Associate Prof. Nephrology
24. Mr. Manikandan, Quality Coordinator

Committee Quorum Members-14

- MR/ Chairman / Vice Chairperson / Convener /Secretary (any of two)
- Members (12)

10.19.OT Committee

Frequency of meeting (Quarterly-Once in 3 months

Responsibilities and functions

- Review the functioning of all OTs.
- Review the QIs related to OTs.

Members

Chairman – Dr. Paul.O.Raphael, Prof & HOD Anaesthesiology Dept
Vice Chairman - Fr. Deljo Puthoor CMI, Associate Director
Secretary - Mr. Tony Thomas, OT Co-ordinator

1. Fr. Deljo Puthoor CMI, Associate Director.
2. Dr.Rajesh Anto, Medical Superintendent
3. Dr. Anoj Kattukaran Prof & HOD, OBG
4. Dr. C. Jayaprakash, Prof & HOD, Orthopedics
5. Dr. Vinayakumar, Prof & HOD, ENT
6. Dr. Charles. K. Skariah, Prof & HOD, Ophthalmology
7. Dr. Gopakumar, HOD –Cardiothrocic Surgery
8. Dr. Jacob Kurian, Prof & HOD, Onco. Surgery
9. Dr. Siji .J. Chiramel, Prof & HOD, Dentistry
10. Dr. Suresh Kumar, Prof & HOD Neuro Surgery
11. Dr. HariKrishnan, HOD Urology
12. Sr. Likhitha MSJ, Chief Nursing Officer
13. Sr. Daily GOT In-charge
14. Sr. Deepa, SSOT In-charge
15. Mr. Manikandan R, Quality Co-ordinator
16. Ms. Litty, HICN In-charge

Committee Quorum Members-10

- MR/ Chairman /Vice Chairperson/ Secretary (any of two)
- Members (8)

10.20. Institutional Ethics Committee

Members

1. Dr. Fr.Jolly Andrews, Vice Principal, Christ College, Irinjalakuda, Thrissur and Chairman
2. Dr. Betsy Thomas, Principal & Member Secretary
3. Dr. Rajee Reghunath, Principal, Amala College of Nursing
4. Adv.Sebi Joseph, Legal Expert
5. Ms.Celin Kakkassery, Ex-Municipal Chairperson
6. Dr. P.Bagavathiammai, Professor & Head of Pharmacology and Vice Principal
7. Dr. Asha A.Dharwadkar, Professor of Physiology
8. Dr. S.Narayanan Potty, Professor of General Medicine

Term

One year

Functioning

- The Ethics Committee (EC) will abide by the following applicable regulatory guidelines:
  - Good Clinical Practice (GCP), as per Government of India, Drugs & Cosmetics Act and rules there under, Rule 122-DAA, & Schedule Y.
  - ICMR Guidelines for Biomedical Research on Human Subjects.
  - International Conference on Harmonization (ICH) Guidelines for Good Clinical Practice and Declaration of Helsinki.
- The EC shall ensure and safeguard the rights, safety and well being of all trial subjects. Special attention shall be paid to trials that may include vulnerable subjects.
- The EC shall conduct continuing review of each on-going trial at intervals appropriate to the degree of risk to human subjects, at least once per year.

- When a trial is to be carried out with the consent of the trial subject's legally acceptable representative, the EC shall determine that the proposed protocol and/or other document(s) adequately address the relevant ethical concerns and meet applicable regulatory requirements for such trials.
- Where the protocol indicates that the prior consent of the trial subject or the subject's legally acceptable representative is not possible, the EC shall determine that the proposed protocol and/or other document (s) adequately address the relevant ethical concerns and meet applicable regulatory requirements for such trials (i.e., in emergency situations).
- The EC shall review both the amount and method of payment to subjects to defray expenses and/or compensation for any loss of income of the participant and to ensure that this does not amount to coercion, undue influence, misrepresentation or fraud on the trial subjects. Payments to a subject shall be on a prorated basis, and not wholly contingent on completion of the trial by the subject.
- The EC shall ensure that information regarding payment to subjects including the methods, amounts and schedule of payment to trial subjects and compensation in case of trial related injury or illness, is set forth in the written informed consent form and any other written information to be provided to subjects. The method of prorating payment shall be specified.

Structure and Roles

The EC shall be multi-disciplinary and multi-sectoral in composition.

The EC will be constituted in the following pattern:

(i) A Chairperson

(ii) A Member Secretary

(iii) 5-15 members from the following background:

- Basic Medical Scientists
- Clinician
- Legal expert
- Social Scientist / representative of non-governmental voluntary agency/ philosopher / ethicist / theologian or a similar person
- Lay person from the community

The EC shall have representation of both genders.

The Chairperson of the EC will be from outside the institution.

The Member Secretary will belong to the same institution and shall conduct the Business of the committee.

Procedure for membership appointment

- The head of the hospital will nominate the members of EC, who collectively have the qualifications and experience to review and evaluate the science, medical aspects, and ethics of the proposed trial
- Conflict of interest will be avoided when making appointments, but where unavoidable there will be transparency with regards to such interest
- EC may invite subject experts as independent consultants who may provide special review of selected research protocols, if needed. They will not take part in decision making process which will only be made by the members of the EC
- Term for EC member will be for 2 years
- Appointment of member can be renewed on the basis of contribution
- Member can discontinue from membership of EC after giving at least one month advance notice
- Member can be disqualified if there is long period of non availability or inadequate contribution
- All members should maintain absolute confidentiality of all discussions during the meeting and sign a confidentiality form
- Conflict of interest should be declared by members of the EC

Quorum requirements

- Minimum 5 members are required to compose the quorum without which a decision regarding the research shall not be taken. Chairperson and Member secretary should also be present for review of each protocol along with these 5 members
- No quorum should consist entirely of members of one profession
- Quorum will include at least one representative from the following group:
  - One basic medical scientist (preferably one pharmacologist)
  - One clinician
  - One legal expert or retired judge

- One social scientist/ representative of non-government organization/Philosopher/ ethicist/theologian or a similar person
- One lay person from the community

- All decisions will be taken in meetings and not by circulation of project proposals

10.21. Food and Hygiene Committee

Chairman – Fr. Jaison Mundanmany CMI, Associate Director
Convener – Dr. John George, Community Medicine Department
Secretary – Ms. Reena, Chief Dietician)

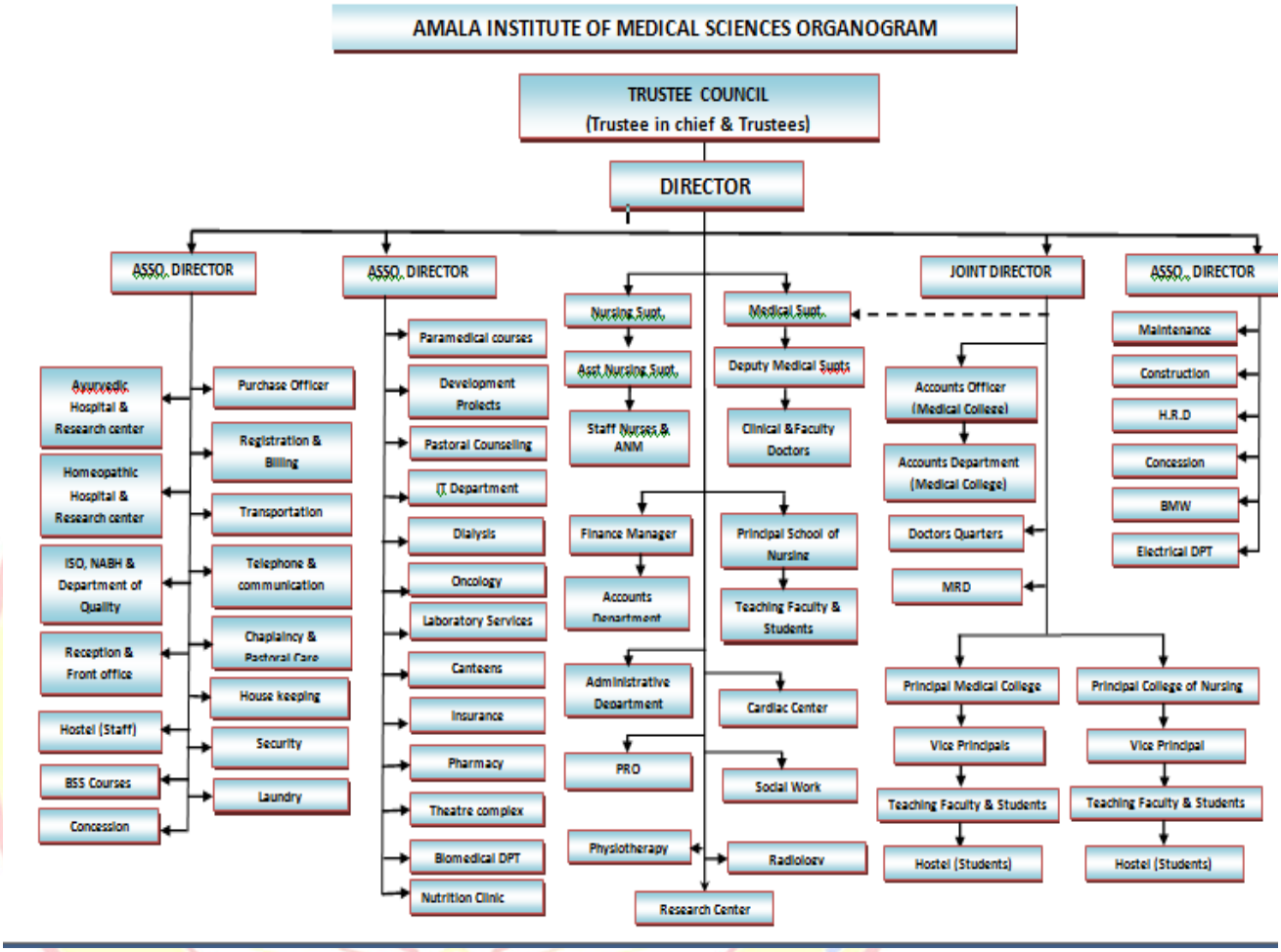
Ex. Officio Members

1. Fr. Shibu Puthenpurackal CMI, Associate Director
2. Dr. Betsy Thomas, Principal
3. Dr.Rajesh Anto, Medical Superintendent

Members

1. Dr. Dijoe Davis, Associate Professor Orthopedics Dept
2. Dr. Geethalakshmi, Microbiology.
3. Mr. Binu, Health Inspector.
4. Mr. Anoop Health Inspector.
5. Er. Jijo Lazarus T, Civil Engineer.
6. Sr. Mini, HIC Department

11. Organogram



12. Statutory and Regulatory requirements

The following are the statutory and regulatory requirements applicable:

PREPARED BY Accreditation coordinator	APPROVED BY Director
Fr. Deljo Puthoor CMI	Fr.Julious Arakkal CMI

SL.NO	LICENSE NAME	LICENSE NUMBER	DATE OF ISSUE	VALID UP TO	Remarks
GENERAL/ ADMINISTRATION					
1	BIOMEDICAL WASTE MANAGEMENT AND HANDLING AUTHORIZATION	PCB/HO/TSR/ICO-R1/14/2018	31.07.2018	30.06.2023	
2	REGISTRATION CLINICAL ESTABLISMENT	N/A	N/A	N/A	N/A
3	REGISTRATION WITH LOCAL AUTHORITIES	B 1-3076/2021-22-249	4/9/2021	3/31/2022	
4	FIRE NOC	No.G/2339/2020	5/29/2020	5/29/2021	*RENEWAL CERTIFICATE ISSUE PENDING DUE TO COVID 19*
5	LICENSE FOR DIESEL STORAGE	N/A	N/A	N/A	
6	LICENSE TO STORE COMPRESSED GAS	S/HO/KL/03/91 (S33494)	27.02.2017	30.09.2021	
7	REGISTRATION FOR BOILER	N/A	N/A	N/A	N/A
8	SANCTION/ LICENSE FOR LIFTS	114/EIR/1,2,4,5,6,7,8,9	1/22/2021	1/31/2022	
9	REGISTRATION FOR MODALITY	MODALITY LIST IN EXCEL UPLOADED			

10	LICENSE TO OPERATE (CT/IR)	15-LOEE-29880, 17-LOP-236120, 14-RLXE-11743, 21-LOP-615928	22-01-2020 15-12-2017 26-05-2017 28-04-2021	22-01-2025 15-12-2022 26-05-2022 28-04-2026	
11	RSO LEVEL I	21-RSO-6542005	8/11/2021	8/11/2024	
12	LICENSE TO OPERATE NUCELAR MEDICINE LAB	17-NMLICENSE-237292	12/19/2017	12/19/2022	
13	LICENSE TO PROCURE RADIOACTIVE MATERIAL (DIAGNOSTIC/ THERAPY)	20-NMSRCPROC-520539	8/3/2020	8/3/2021	
14	RSO LEVEL II	21-RSO-652392	8/7/2021	8/7/2024	
15	LICENSE TO OPERATE RADIATION THERAPY DEPARTMENT	AERB/RSD/RT/KL 008/2010/6550 21-LIC-617013 16-LIC-105447 21-LIC-617012	26-07-2010 03-05-2021 10-05-	03-05-2026 10-05-2021 03-05-2026	

			2016 03-05-2021		
16	LICENSE TO PROCURE SOURCE/ RADIOACTIVE MATERIAL	21-PROCUREMENT-787532	8/25/2021	8/25/2022	
17	RSO III	21-RSO-654205	8/11/2021	8/11/2024	
18	BLOOD BANK	050/28C/KER/DC-CLAA/97	01.01.2018	31.12.2022	
19	LICENSE FOR MTP	N/A	N/A	N/A	N/A
20	TRANSPLANTATION REGISTRATION	N/A	N/A	N/A	N/A
21	DRUG - BULK LICENSE	134244/134245	5/6/2014	5/5/2023	
22	DRUG -RETAIL LICENSE	102421/102422/134242/134243/134244/134245	5/6/2014	5/5/2023	
23	NARCOTIC LICENSE	01/2013-14	01.04.2019	31.03.2022	

24	CANTEEN F & B LICENSE	11320008000845	11/26/2020	11/25/2021	
25	LICENSE FOR POSSESSION AND USE OF METHYLATED SPIRIT, DENATURED SPIRIT AND METHYLATED ALCHOHOL	R2-164/2020	01.04.2021	31.03.2022	*METHYLATED SPIRIT*
26	LICENSE FOR POSSESSION OF RECTIFIED SPIRIT AND ENA	25/91-92	01.04.2021	31.03.2022	*RECTIFIED SPIRIT*
27	EMPLOYEE PROVIDENT FUND	2732108005605		8/12/2021	
28	EMPLOYEE STATE INSURANCE	54000170160001400		7/31/2021	
29	PAN	AAATA4065B			
30	BUILDING OCCUPANCY/ COMPLETION CERTIFICATE	C4-8315/13	11/5/2013		
31	LICENSE FOR ELECTRICAL INSTALLATIONS	02/2016-2017/11-11-2016	11/16/2016		
33	X-RAY(INCLUDING PORTABLE AND CATH LAB)	MODALITY LIST IN EXCEL UPLOADED			

34	CT SCAN MACHINE	15-LOEE-29880, 17-LOP-236120	22-01-2020 15-12-2017	22-01-2025 15-12-2022	
35	PNDT ACT RGISTRATION	PNDT/TSR/15/02	21.03.2021	21.03.2026	
36	AUTHORIZATION TO TREAT THYROID CANCER PATIENTS USINF I-131	21-NMLICENSE-587105	2/5/2021	2/5/2026	
37	AUTHORIZATION TO USE RADIOPHARMACEUTICALS IN HUMANS	21-NMLICENSE-587106	2/5/2021	2/5/2026	
38	CONSENT FOR USE OF RADIOISOTOPES IN NUCLEAR MEDICINE	20-NMSRCPROC-520539	8/3/2020	8/3/2021	
39	LICENSE FOR NUCLEAR MEDICINE	17-NMLICENSE-237292	12/19/2017	12/19/2022	
40	APPROVAL OF ROOM LAYOUT PLAN FOR RADIATION THERAPY FACILITIES	AERB/RSD/RT/KL 008/208/248	4/1/2008		
41	AUTHORIZATION TO PROCURE RADIATION SOURCE FOR RADIATION THERAPY	21-PROCUREMENT-787532	8/25/2021	8/25/2022	

14. POLICY ON ACCESS, ASSESSMENT AND CONTINUITY OF CARE POLICIES (Refer Chapter wise Policy- AIMS /CP / AAC-01)

15. POLICY ON CARE OF PATIENTS(Refer Chapter wise Policy- AIMS /CP / COP-02)

16. POLICY ON MANAGEMENT OF MEDICATION (Refer Chapter wise Policy- AIMS /CP / MOM-03)

17. POLICY ON PATIENT RIGHTS AND EDUCATION (Refer Chapter wise Policy- AIMS /CP / PRE-04)

18. POLICY ON HOSPITAL INFECTION PREVENTION AND CONTROL (Refer Chapter wise Policy- AIMS /CP / HIC-05)

19. POLICY ON PATIENT SAFETY AND QUALITY IMPROVEMENT (Refer Chapter wise Policy- AIMS /CP / PSQ-06)

20. POLICY ON RESPONSIBILITIES OF MANAGEMENT (Refer Chapter wise Policy- AIMS /CP / ROM-07)

21. POLICY ON FACILITY MANAGEMENT AND SAFETY (Refer Chapter wise Policy- AIMS /CP / FMS-08)

22. POLICY ON HUMAN RESOURCE MANAGEMENT (Refer Chapter wise Policy- AIMS /CP / HRM-09)

23. POLICY ON INFORMATION MANAGEMENT SYSTEM (Refer Chapter wise Policy- AIMS /CP / IMSP-10)

24. POLICY FOR CONTROL OF DOCUMENTATION

Purpose

Provide guidelines for the control, revisions and issue of documents

Policy

Documentation System

The Documentation will have the following framework.

- Apex Manual which contains ,Introduction to HCO chapter wise policies with respect to NABH standards ,policies on various committees' Terms of Reference
- Chapter wise Procedures
- Infection Control Manual,
- Safety Manuals
- Quality Manuals
- Department wise operating Manual

Preparation and issue of Documents

- All Hospital related documents should be controlled at preparation, approval and issue stage.
- The preparation, approval and issue authority for various documents are given as below.

	Document	Preparation and Recommendation	Approval
1.	Hospital Apex Manual	Quality Team	Director
2.	Chapter wise Procedures	Prepared in Consultation with end users and recommended by Quality Coordinator	Director

3.	Infection Control Manual	Prepared by HIC Committee Members and Recommended Quality Coordinator	Director
4.	Safety Manual	Prepared by Safety Committee Members and Recommended Quality Coordinator	Director
5.	Laboratory Safety Manual	Prepared in Consultation with end users and recommended by Lab Director	Director
6.	Laboratory Manual and Operating Procedures	Prepared in Consultation with end users and recommended by Lab Director	Director
7.	Department wise Manual	Prepared in Consultation with end users and recommended by Quality Coordinator	Director

Co pies

The document copies with respect to Hospital document shall be given as below.

Master Copy

Master Copy is the copy with the original signatures. This copy shall be available with Director. It shall bear a stamp seal as “MASTER COPY” on reverse of the pages.

Controlled Copy

Its circulation is controlled and bears stamp seal as “CONTROLLED COPY” on each page. Whenever any revision is made in any one of the documents, all the Controlled Copy Holders shall be issued with the amendments, to be incorporated and attested by issuing authority Quality Coordinator

Uncontrolled Copy

Uncontrolled Copy means all those copies that need not be controlled for distribution and revision status. It bears stamp seal as “UNCONTROLLED COPY”.

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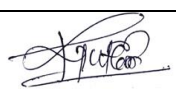
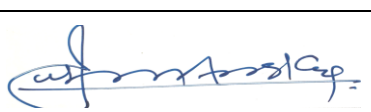
Fr. Deljo Puthoor CMI	Fr.Julious Arakkal CMI
	

Obsolete Copy

"Obsolete Copy" is an obsolete version of the Master Copy. It bears stamp seal as "OBSOLETE".

Issue / Distribution of Documents:

- Quality Coordinator shall decide the distribution of each document and the same shall be recorded in the Document Distribution List
- Distribution could be physical copies which is controlled or through Hospital information system in electronic form
- All documents that needs to be distributed in multiple points and which requires many papers for distribution shall be distributed in electronic form
- Quality Coordinator has the authority for issue of documents, arrange to get requisite number of copies (as per Document Distribution List) and then stamp them as 'CONTROLLED COPY'.
- Quality Coordinator shall issue the documents and take the acknowledgement from the copyholder as per the distribution sheet in the Document Issue / Acknowledgement Register
- Quality Coordinator shall maintain a Master List of Documents which shall be updated after receiving the acknowledgement from the authorized copyholders. The authorized custodian of documents shall also maintain a Master List of Documents held by him/her.
- The initial issue status of the entire document is "version 01"

Revisions

- The Quality team in consultation with the end users evaluates the need for revision at least once a year.
- If there is any of the clauses requires to be amended the documented is revised.
- The revisions of any document carry "version (01+n) where n is the number of revision done.
- Any HOD may raise a request for need for document change through a Document Change Request and shall submit the request to the Quality Coordinator

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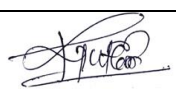	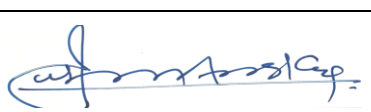

- Quality Coordinator shall scrutinize the nature and reason for change and shall decide on incorporating the change.
- The amended document shall have its revision status changed to the next revision number. Effective date for implementation is shall also to be noted.
- The recipients of the amended documents shall hand over the "OBSOLETE" documents to Quality Coordinator.
- Quality Coordinator shall destroy all the obsolete copies except his/her copy, and he/she shall file the same in a separate file after stamping the document as "OBSOLETE".
    - Refer **AIMS /CP / IMS – 10**