अखिल भारतीय आयुर्विज्ञान संस्थान, ऋषिकेश
All India Institute of Medical Sciences, Rishikesh, 249203
Quality Cell

Letter No.:- QC/AIIMS/RISH/2026-001 **Date: 13.05.2026**

Minutes of Meeting

Five meetings (*23 & 30 March, 7 & 16 April, 2 May*) of the Quality Cell were convened from 23 March at 02:30 PM in the MS Office Board Room to decide **various quality checkpoints** that to be monitored in our institute. Brainstorming was done with ground reports by various DNSs as per their work divisions, created by last QC office order from Executive director office. After each meeting, chairperson and member secretary meet Medical Superintendent to update the major discussion action points as below. From **64 checkpoints 20 priority checkpoints** were finalised to be monitored for next 6months and with time, new checkpoints will be taken care.

The meeting was chaired by Prof. Latika Mohan with the moderator by Member Secretary, Dr PK Panda. It was attended by majority members of the Quality Cell including other hospital representatives. The **attendance is attached** for all meetings.

The following points were **discussed and decisions** were taken in these meetings:

1. The meeting was convened to formally initiate the Hospital Quality Cell and to establish a structured framework for quality monitoring, accountability, and continuous improvement across the institution. This marked the first official meeting of the Quality Cell, although preliminary and informal groundwork had already been undertaken prior to this session. The discussion was comprehensive and focused on defining priorities, building systems, and aligning stakeholders toward measurable outcomes; focused on hospital care delivery that should be **effective, expedited, equitable, and empathetic**, while upholding patient safety, ethical standards, and regulatory compliance across all clinical and administrative domains.
2. In order to ensure continuity and avoid duplication of effort, a formal handover from the previous quality team was taken. **Dr Pooja** handed over verbally about last QC functioning, mostly it was non-operational except incident reporting and safety awareness activities. Incident reporting and root cause analysis (RCA) initiative had demonstrated positive outcomes during its initial phase of 7-8 months; but later on due to non-actions oriented incident reporting there was a fall in reporting. It was decided to inform MS further to enforce these DMS functionaries with ground awareness activities including, avoiding any overlap or conflicts with QC activities vs DMS activities. Also, it was decided, there shouldn't be any direct actions to be forwarded to QC including any incident reports or grievances or patient safety issues, except for information since moto of QC is not to do hospital functionaries directly, rather **it monitors whether hospital services are quality centric or not.**
3. The overall operational model of the QC was re-structured w.r.t. recent ED order, with DMS-led monitoring and faculty level mentoring. This model includes priority based ground inspections, regular data validation, and randaom checks in critical areas, driven by key performance indicators. A **64-**

parameter checklist has been drafted on a trial basis, drawing from established guidelines. It is currently in a pilot phase and requires validation through on-ground realities. It was agreed that the checklist would be refined iteratively based on field feedback and finalized within a period of 6 months.

4. For DMS 1 functionaries, two immediate priority checkpoints that require focused attention - **critical-item stockouts and quality of drinking water** within the hospital, were identified as high-risk areas under DNS Mrs Vandana to monitor ground realities and submit gaps-action points in a week time. She reported that several outlets (OT, ICU, kitchen, overhead tanks) are currently not covered under routine testing. SOPs and centralized coordination with engineering are required to standardize processes. No consolidated list of critical items exists at present. Central pharmacy and stores have been tasked to develop a hospital-specific list and submit stock-out rate data within one month.
5. For DMS 5 functionaries, two critical checkpoints - **sample rejection data** (Microbiology, Biochemistry, Pathology) **and Diet prescription accuracy** were discussed and under DNS Mr Arun to monitor ground realities and submit gaps-action points in a week time. He reported that Standard turnaround times is defined (Emergency: ~2 hrs, IPD: ~3 hrs, OPD: ~18 hrs). However, current tracking systems and rejection-rate data are not available and must be established. Si6milarly, there was many gaps in diet implementation in the hospital. It was decided to interact with lab and Diet incharges and take their feedbacks and improve the quality services.
6. For DMS 6 functionaries, two critical checkpoints - **environmental cleanliness including biomedical waste segregation (BMW) and incident reporting rate** were discussed and under DNS Mr Amit to monitor ground realities and submit gaps-action points in a week time. Many gaps were identified including lack of BMW proper segregation, throwing waste anywhere, lack of proper RCA of incident reporting, no action points against any RCA, and ultimately decreasing reporting of incident reporting due to identified overloading responsibility on those who put the incident reports. Major issues were identified with lack of proper functionin5g of DMS system that sees these hospital functions. There is no regular monitoring system in both checkpoints. It was decided to discuss with MS and related DMS and sanitation incharge and incident reporting handlers to get their feedbacks so that quality action points to be considered.

7. For DMS 4 functionaries, four critical checkpoints - **Sepsis golden hour compliance, Pressure injury incidence, Code blue response time, and Mortality review completion** were discussed and under DNS Mr. Nikhil to monitor ground realities and submit gaps-action points in a week time. It was reported that there is lack of monitoring system in hospital, where sepsis 1-h bundles being followed. Also, there is no monitoring for pressure injury reports. It was decided to develop a mechanism how these missed checkpoints will be developed with time. There is no code blue response team in the hospital. It was decided to update MS to start a code blue team for those areas where CPR is likely to be un-attended immediately like corridors, OPDs, Dermatology/ Psychiatry/ Eye/ ENT/ Radiotherapy/etc. Lastly, mortality review by institute is going on smoothly every Friday. However, there is no data how individual

dept is doing own area mortality review. Hence, it was decided to update MS to release circular for dept mortality review and submit office the monthly data.

8. For DMS 3 functionaries, three critical checkpoints - **Bed Occupancy Rate, Bed Turnover Interval with Discharge turnover, and RTI response compliance** were discussed and under DNS Mr Kamlesh to monitor ground realities and submit gaps-action points in a week time. It was observed that while occupancy data is being collected, there is no structured review or optimization mechanism. Similarly, no formal system exists for tracking bed turnover intervals. The discharge process was identified as a major concern due to lack of standardization, delays, and patient inconvenience. It was observed that a large proportion of patients are discharged after 5 PM, which is considered suboptimal for patient convenience and bed management efficiency. While non-Ayushman discharges are relatively quicker (30 minutes to 1 hour), Ayushman cases take significantly longer, averaging several hours and sometimes extending up to a full day. Daycare discharge system was noted with major faults. It was decided to update MS to look after immediately on daycare discharge policy. Similarly, another concern was for occupancy exceeding 100%. There was a strong consensus that the current data lacks clarity and standardization. The members emphasized the need to distinguish clearly between census beds and non-census beds (such as stretchers), ensure exclusion of non-relevant areas like OPD and OT from bed occupancy calculations, and verify how data is being generated in the NIS system. It was suggested that emergency data be analyzed separately, as short-stay patients (less than 24 hours) should ideally not be included in standard bed occupancy metrics. It was also proposed to conduct a short observational study to map the current discharge workflow, followed by development of a standardized hospital-wide SOP to streamline discharge timing and processes.

9. For MS direct functionaries, four critical checkpoints - **Hospital Acquired Infection (HAI) rates, Adverse Drug Reaction (ADR) reporting rates, Medical Record completeness, and Departmental Key Performance Indicators (KPIs)** were discussed and under DNS Mr Jino to monitor ground realities and submit gaps-action points in a week time. Undder HICC, Surgical Site Infection (SSI) are not being monitored, except for Pediatric Surgery, with lack of standardized protocols, structured follow-up mechanisms, and interdepartmental coordination. It was further highlighted that infection reporting remains largely passive, resulting in under-reporting and limiting the reliability of data for quality assessment. Additionally, the need for random third-party audits of care bundle compliance was emphasized to ensure data authenticity and prevent over-reporting of compliance. The discussion also highlighted critical gaps in hand hygiene practices, particularly among outsourced and auxiliary staff such as housekeeping personnel and patient support staff (Seva Veers). While structured training programs exist for nursing staff, there is inconsistency in training coverage, induction, and compliance monitoring among non-clinical and newly inducted personnel. It was strongly recommended that all individuals entering clinical areas must undergo mandatory certification by HICC covering hand hygiene, biomedical waste management, and relevant vaccinations (e.g., Hepatitis B), prior to deployment. Also, HICC to be

coordinated through a discussion about their feedbacks and what action points to be considered. Regarding ADR reporting, it was observed that the current reporting mechanism, managed by the Department of Pharmacology under the Pharmacovigilance Programme, is functional but significantly underutilized. Despite the presence of reporting systems, including forms, telephonic communication, and digital platforms, the actual number of reported ADRs remains disproportionately low for a hospital of this capacity. Key challenges identified include lack of awareness, unclear reporting pathways, dependency on individual initiative, and high workload among clinical staff. It was also noted that while severe reactions may be identified, milder or delayed reactions (such as drug-induced liver or kidney injury) are often missed or not formally documented. The need for strengthening awareness, simplifying reporting processes, integrating digital platforms, and establishing a clear, centralized reporting mechanism was emphasized. One action suggested to interact with Pharmacovigilance and pharmacy teams and set-up a pharmacy indent checkpoint in ehospital/NextGen to report any existing ADR before indentation is submitted. There is a major gap w.r.t. medical record completeness and Dept KPIs. It was highlighted that through MS, there will be a circular to each dept to submit their KPIs, atleast quarterly basis, including updating a monitoring system who is ensuring to complete medical records.

10. **Two RTI queries** regarding frameworks, advisories, and standards related to patient rights, dignity of care, and quality assurance norms, particularly focusing on the availability of essential medicines and consumables during hospital admission were received to reply and discussed. It was noted that while the hospital has an established Quality Cell with defined functionalities aimed at ensuring patient rights, dignity, transparency, and ethical practices, there is currently no specific framework, SOP, or documented policy addressing the assured availability of essential medicines and consumables. Accordingly, it was agreed that the RTI response shall state "*that no such specific document is available with the hospital, and relevant existing orders pertaining to Quality Cell functions will be attached*". This was dispatched to relevant DMS to reply.

In conclusion, all the meetings established a clear direction for the QC, emphasizing structured processes, measurable outcomes, and accountability at all levels. The next meeting was always schedule, where progress on action items, initial findings from ground checks will be reviewed.

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1. PPS to Executive Director & CEO, Dean (academic), and MS for information
2. All Concerned Members and Office Copy