MANAGEMENT REVIEW
September 26, 2018 (Wednesday)
10:30 am
Dr. Avenilo P. Aventura Hall

MINUTES OF THE MEETING

I. Attendance:

The Management Review was participated by 73 key personnel including members of the Executive Committee, Executive Director and Deputy Executive Directors for Nursing, Education Training and Research and Hospital Support Services.

Refer to the attached Attendance Sheet.

II. Call to order

The meeting was called to order by 10:30 AM, presided by Ms. Donnabelle Allauigan.

The minutes of the previous Management Review was summarized and review, with comments to improve reports and action plans from concerned Divisions.

Dr. Nerissa De Leon gave a brief overview on the requirement of ISO 9001:2015 with regards to Management Review.

III. Agenda

The agenda for this Management Review were the following and summarized on the table below:
1. Status of actions from previous management review
2. Changes relevant to Quality Management System
3. Information on performance and effectiveness of Quality Management System
4. Effectiveness of actions taken to address risks and opportunities
5. Opportunities for improvement

Agenda	Issues/Highlights/Decisions/ Recommendations Discussed	Action Plan (Who, What, When to Do)
1. Status of actions from previous management review (9.3.2a.)	Internal Quality Audit Findings: • Twenty-eight (28) Corrective Action Request Forms were issued to process owners for the Non-Conformity Findings from the December 2017 Internal Quality Audit and all of which are closed out as evaluated by the Internal Quality Auditors. Adequacy of Resources: • An appeal for additional Nursing and Medical Services manpower was already forwarded to DBM • There are no complaints of out-of-stock items and supplies, still, the Property and Supply Division reiterated the timeliness of requests to prevent such issues. • A Hospital Forms Committee	

	was created comprising of representatives from different services. The group has yet to meet to discuss the scope of the function of the committee and the duties and responsibilities of the members. Opportunities for Improvement: • IT improvement is already in the plan. • On-going construction of new patient-care areas would address issues I space limitations	
2. Changes in the external and internal issues that are relevant to the quality management system (9.3.2b.)	2.1. Last March 2018, the new Organizational Structure for Philippine Heart Center (PHC) was approved for implementation 2.1.1. PHC processes are now under four (4) services namely: • Medical Services • Nursing Services • Education, Training and Research Services • Hospital Support Services 2.2. The Mission and Vision statements were reviewed and subsequently revised to align it to the 2017-2022 Strategy Map of PHC. 2.2.1. Mission Statement: We shall provide comprehensive cardiovascular care enhanced by education and research that is accessible to all. 2.2.2. Vision Statement: The Philippine Heart Center is the leader in upholding the highest standard s of cardiovascular care, a self-reliant institution responsive to the health needs of the Filipino people by 2022. 2.3. The Quality Policy of PHC was presented and reiterated the importance of disseminating this to all employees: The Philippine Heart Center	2.1. The new Organizational Structure in now in effect all over the organization. 2.2. The new Mission and Vision Statements and Quality Policy are now posted at the Medical Arts Building Lobby and will be discussed and communicated during meetings. 2.3. There are no changes with regards to the quality policy statements.

	commits to provide the highest standard of comprehensive Cardiovascular Care Education and Research. We commit to satisfying all relevant statutory and regulatory requirements. We commit to continually improve our processes.	
3. Information on performance and effectiveness of Quality Management System (9.3.2c.)	3.1. External Audits and Certifications: - to help PHC to continually assess the effectiveness of its processes and initiatives, it subjects itself to external audits and certifications 3.1.1. Last January 2018, the Institute for Solidarity in Asia (ISA) conferred PHC's Performance Governance System as Institutionalized. 3.1.2. March 2018, after re-evaluation and verification of PHC's safety initiatives vis-à-vis the set standards, the Accreditation Canada International awarded PHC "Diamond" on meeting international standards of excellence in quality care and services. 3.2. Customer Satisfaction Feedback (9.3.2c1.): 3.3. Quality Objectives Monitoring (Balance Scorecard Report) (9.3.2c2., 9.3.2c3. 9.3.2c5.) - The Quality Objectives of PHC and of the different departments, divisions and units or sections are translated through Breakthrough Statements. - Dr. Juliet Balderas, the Officer-in-charge of the Office of the Strategy Management presented the January to June 2018 PHC accomplishment, with regards to Breakthrough Goals or the Balance Scorecard Summary Report in comparison to 2017 accomplishments	3.1. Continuous and at planned intervals (twice a year) monitoring of PHC's compliance to standards are being implemented through audits by the Internal Quality Audit Team. 3.2. 3.3. Quality Objectives Monitoring • Improve patient experiences especially in different frontline and other services and

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<td>3.3.1. Measures, targets and actual accomplishments

Measure: Health Outcomes of Regional Heart Centers Z-Benefit Cardiac Cenetr Mortality
Target = 3.7%
Actual = 2.9%
(Target Met = GREEN)
Measure: Health Outcomes of PHC Net Mortality Rate
Target = 5.0%
Actual = 4.9%
(Target Met = GREEN)
Measure: % of Client with Very Satisfactory Rating
Target = 60.0%
Actual = 53.6%
(89.3% Accomplishment = YELLOW)
Measure: % No Balance Billing
Target = 93.0%
Actual = 90.1%
(96.9% Accomplishment = YELLOW)
Measure: Number of Cardiovascular procedures with health outcomes at par or better than global benchmarks
Target = 7
Actual = 14
(Target Met = GREEN)
Measure: Number of PHC research/programs on prevention adopted as national policy

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<td>facilities (i.e. cashier, billing, pharmacy, security, janitorial)

➢ Divisions and Sections from Hospital Support Services are to start giving-out satisfaction surveys in different areas by October 2018

Social Service Division to review their target, how they compute it and how they present their accomplishment by October 2018
Medical and Nursing Services shall use CABG Clinical Pathways to all patients who will undergo CABG, even if they are not enrolled in the Z-Benefit, by October 2018

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	Target = 5 Actual = 6 (Target Met = GREEN) • Measure: Compliance rate to CP's of targeted diseases Target = 60.0% Actual = 54.2% (90.4% Accomplishment = YELLOW) • Measure: Hospital Admission for Hypertension Complications Target = 19.0% Actual = 15.1% (Target Met = GREEN) • Measure: Number of Regional Heart Centers with a multi-disciplinary team certified by PHC Target = 8 Actual = 8 (Target Met = GREEN) • Measure: % of preventive research over total research outputs Target = 5.0% Actual = 32.7% (Target Met = GREEN) • Measure: Number of researches published and or presented Target = 44.0% Actual = 73.7% (Target Met = GREEN) • Measure: Number of stakeholders & policy makers with formal engagements Target = 6 Actual = 9 (Target Met = GREEN) • Measure: Number of ongoing patient engagement projects for stakeholders Target = 16 Actual = 31 (Target Met = GREEN) • Measure: Number of	

	priority procedures with its multi-disciplinary team meeting competency standards Target = 4 Actual = 5 (Target Met = GREEN) • Measure: % Employees attendance in values formation and good governance sessions Target = 44% Actual = 50.7% (Target Met = GREEN) • Measure: Number of functional Regional Heart Centers established Target = 8 Actual = 8 (Target Met = GREEN) • Measure: Number of Hospital Awards per year Target = 3 Actual = 6 (Target Met = GREEN) • Measure: Number of infrastructure projects essential to patient safety completed Target = 5 Actual = 11 (Target Met = GREEN) • Measure: Number of infrastructure essential to client satisfaction completed Target = 5 Actual = 11 (Target Met = GREEN) • Measure: Number of registries for targeted procedures/ policies installed Target = 7 Actual = 9 (Target Met = GREEN) • Measure: Number of net IT systems for operational efficiency installed Target = 4 Actual = 8 (Target Met = GREEN)	• • Medical and Nursing Services in coordination with the Philhealth coordinator and nurse case manager to strictly monitor the proper, complete and timely accomplishment of Philhealth and Z-Benefit forms by October 2018 • •

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Measure: % of Major projects in the Annual Procurement Plan delivered as scheduled
Target = 50.0%
Actual = 66.7%
(Target Met = GREEN)
Measure: % of medical supplies and medicines in the Annual Procurement Plan delivered as scheduled
Target = 25.0%
Actual = 31.1%
(Target Met = GREEN)
Measure: % of QFS covered by DOH MAP reckoned at the end of the 1st quarter of the following year
Target = 65.0%
Actual = 50.4%
(77.5% Accomplishment = YELLOW)
Measure: % of Philhealth Reimbursements
Target = 15.0%
Actual = 13.2%
(88.0% Accomplishment = YELLOW)
Measure: % increase in gross hospital revenue
Target = 12.0%
Actual = 10.7%
(89.2% Accomplishment = YELLOW)
Measure: % of PHC units with budget utilization raet of at least 90% based on zero-budgeting
Target = 45%
Actual = 15.4%
(51.3% Accomplishment = RED)
Overall PHC

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3.4.4. Non-conformity findings:

All services to include in meetings the discussion of the breakthrough targets, Mission, Vision and Quality Policy statements of PHC starting October 2018.
Medical and Nursing Services to strictly monitor the implementation of the said Required Organizational Practice, to device initiatives like placing alerts or reminders on the first page of the order sheets by October 2018
All Services to ensure timely updating of the breakthrough accomplishments on the breakthrough posters by October 2018

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	Accomplishment = 134.2%, Outstanding 3.4. Internal Quality Audit Results (9.3.2c4., 9.3.2c6.) 3.4.1. February 2018 IQA yielded a total of 48 findings: • 40 Non-conformities • 8 Opportunities for Improvement • 40 Corrective Action Requests were closed-out by the end of July 2018 3.4.2. September 2018 Audit findings yielded 102 findings: • 59 Non-conformity findings • 22 Opportunities for Improvement • 21 Positive/ Noteworthy observations 3.4.3. Noteworthy observations include: • Risk Registry is discussed in meetings at the Nuclear Medicine Division • Satisfaction Survey is used as a tool for improvements in the Social Service Division • The manual of the Department of Surgery and Anesthesia is excellently formatted • There is now means to document complaints received in QA and at Patient Services Division • Employees have up-to-date licenses • There are means to cascade the minutes of the meeting to all staff who were not able to attend the meeting 3.4.4. Summary of Non-conformity findings: • Awareness of staff with regards to breakthrough targets, Mission, Vision and Quality Policy	•

	statements of PHC • Use of error-prone abbreviations • Updating of Breakthrough Accomplishments • Proper waste segregation • Retention and disposition policy of PHC	
4. Effectiveness of actions taken to address risks and opportunities (9.3.2e.)	4.1. Institutional Risk Registry that was formulated from the 3 strategic objectives of PHC was discussed and all DM's and DC's were given the instruction to align their risks to it. 4.1.1. Strategic Objective: Provide tertiary healthcare services using best practice standards: Risk Events • Non-compliance to Standards of Care and to Clinical Standards • Non-compliance with the set timelines of the Citizen's Charter for the provision of hospital services	• Top Management to conduct operational review meetings related to clinical processes • Top Management to conduct operational review and monitor all services' compliance with the Citizen's Charter • Patient Services Division and QA to create a complaints escalation policy and a registry where complaints are

	• Patient's complaints are not handled on time • Inadequate plantilla positions for the current organizational structure • Aging and inadequate facilities, equipment and technology • Insufficient fund resource from the government • Occurrence of natural calamities, fire and security threats 4.1.2. Strategic Objective: Replicate PHC expertise in cardiovascular care nationwide through excellence in education	summarized whether it is resolved or not and to whom it was referred to • Human Resource Division shall provide staff profiling to monitor employee productivity • Appeal to DBM regarding additional manpower • Top Management and Engineering and Maintenance Division to continually upgrade the hospital facilities based on infrastructure and equipment plan • Top Management to ensure and monitor that utilization of allocated funds are maximized • Finance Services Department to review and modify income/revenue-generating activities to meet the operating needs of PHC • EMD to periodically monitor PHC's structural stability • Hospital Safety Committee to conduct regular safety drills (fire and earthquake) • Top Management to collaborate with different government agencies (DOH, NDRMMC, QC, LGU's, etc.) • • Top Management to prioritize assigning of competent trainees from Regional Heart Center with incomplete cardiovascular team • Consortium of training programs with Regional Heart Center to provide specialists for regions

	and training Risk Event • Unreadiness of Regional Heart Centers satellite to provide trainees to complete the multidisciplinary Cardiovascular Team (External) 4.1.3. Prioritize research in all three levels of prevention of cardiovascular diseases Risk Events • Inadequate number of medical specialists knowledgeable in research • Delay in approval of research protocols • Insufficient funds for cardiovascular research projects	• Top Management and OSM to monitor health outcomes of performance of the Regional Heart Centers. • Top Management to look into increasing the number of plantilla positions for medical specialists in research • Top Management to provide research incentives and grants • Top Management to review and reconstitute (add alternate members) the composition of IERB • Top Management to look into increasing the funding for research • Top Management to enhance linkages with other government research institutions
5. Opportunities for improvement (9.3.2f.)	5.1. Employee Satisfaction assessment 5.2. Evaluation of suppliers and out-sourced services and other frontline services 5.3. Preventive maintenance and calibration plan or schedule	5.1. HRD to conduct regular employee satisfaction assessment satring October 2018 5.2. HSS to formulat evaluation tool by October 2018 5.3. EMD to cascade in different areas the preventive maintenance/calibration plan/schedule 5.4. Medical and Nursing Services to observe strict

	5.4. Eradicate the use of error-prone abbreviations in order sheets	implementation and monitoring of the said ROP and as an initiative, to place alerts/reminders on the first page of order sheets
6. Others	6.1. Stage 1 Audit of AJA is scheduled on October 9. - The Audit Itinerary was briefly discussed - Top Management, OSM, ISO, Team and Department Managers are require to be present on October 9, 9AM at the Staff Lounge and Executive Conference Room 6.2. OSM to produce the SWOT analysis output during the 2017 strategy refresh 6.3. Dr. Abanilla stressed that it is important for everyone to participate and comply whit what is being asked for by the ISO Team.	

IV. ADJOURNMENT

The meeting was adjourned at 1:30PM.

Prepared by:

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Donnabelle C. Allauigan
ISO Team Chairperson

Approved by:

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Joel M. Abanilla, MD
Executive Director