



# Nisa Premier Hospital Organizational Policies

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# Nisa Quality Policy

**Approved by:** Executive Management Committee

**Approval date:** 11<sup>th</sup> July, 2018

**Version number:** 2.0

## Vision

At Nisa Premier Hospital, our vision is to be a leading brand in healthcare service delivery in Nigeria and Africa, providing top class best practices to our customers at par with international standards.

## Mission

To build an environment of innovation for clinicians and be a hospital of choice for patients

## Policy Brief & Purpose

Nisa Premier Hospital is committed to achieving its vision by embracing the quality management system principles of ISO 9001:2015 and to continually apply it in the course of day-to-day interactions with all our customers; both internally and externally. The cardinal focus of our quality policy is to pursue excellence in patient care, staff welfare, technological advancement and environmental sustainability,

## Policy Elements

At Nisa Premier Hospital, our quality policy evolves from our profound understanding of functional quality elements, which include:

- Empathizing with our patients, assuring courteousness, knowledge, building confidence and trust, reliably performing our services in an accurate and dependable manner, being responsive to patients and ensuring a suitable healing environment for them at all times,
- Nurturing a quality mind set for our patients and customers to look out for through active engagements such as training, education, mentorship and administration,
- Conforming with the quality regulations and laws to effectively manage non-conformities within the organisation,
- Encouraging all customers' especially employees, to participate and take quality responsibilities.

- Ultimately, Nisa Premier Hospital's quality policy is to meet and exceed patients' expectation and impart lasting satisfaction by providing the best possible clinical outcomes.

# Nisa Code of Conduct

**Approved by:** Executive Management Committee

**Approval date:** October, 2019

**Version number:** 1.0

Please be reminded of the Nisa Codes of Conduct for ALL employees.

## 1. Identity Cards

Staff Identity Cards MUST always be worn when you are on the premises.

## 2. Attendance

Biometric attendance login machines are located at the main security gate and behind the Laboratory at Benue Building. It is your responsibility to sign in and out according to your regular departmental working hours. **Please note that late comers are being monitored.**

## 3. Dressing

As an employee of Nisa Hospital, you represent the image of the hospital. You are therefore expected to dress in a **corporate manner while on duty**; men should wear smart shirts and trousers (jackets/ties are optional) and women shall wear smart dresses, skirts or trousers with smart shirts/blouses.

**Please note that henceforth Jeans, Tee-shirts, Shorts, Leggings, Spaghetti straps and mini-skirts/dresses are strictly prohibited for ALL staff while on duty. Please also note that smart Jeans and Nisa branded Tee-shirts may only be worn as part of a hospital approved campaign.**

If you are expected to wear a uniform it must be clean and properly ironed. Please take care of your uniforms and repair any wear and tear promptly.

On Fridays depending on your role, you may wish to wear a Nigerian Traditional outfit but please be guided that these outfits should not be flamboyant in nature. Slippers may only be worn on these days to compliment the traditional outfit.

Shoes must be professional, smart and well cared for. **Please remember that we must maintain our corporate image at all times.** Be advised that all bags/handbags entering and leaving the premises are subject to inspection by the security team, please co-operate with them.

## 4. Personal Hygiene

Personal hygiene is of utmost importance and all staff must make a conscious effort not to further aggravate our patients' discomfort. All staff are expected to pay careful attention to personal washing/cleanliness habits and must use appropriate deodorants/body sprays especially in hot weather. Please avoid the use of strong/overpowering perfumes/lotions.

Please note that any make-up should be applied before resumption and must be light and professional.

## 5. Customer Service

All staff are expected to be customer-friendly when dealing with both internal or external customers. We must all be willing and ready to assist our customers/patients and solve any problems in a proactive manner.

Please remember to remain polite and always wear a smile. **REMEMBER YOU NEVER HAVE A SECOND OPPORTUNITY TO MAKE A FIRST IMPRESSION!**

## 6. Mobile Phones/Internet Use

Staff are discouraged from using their mobile phones while at work other than for official purposes. In the event you must take a call please deal with it quickly and professionally using a polite and low voice to avoid causing distractions and divulging confidential information. Please place your ringer on vibrate or silent and only take personal calls privately during breaks/ lunch time.

**Your phone will be seized if you are found playing with it phone during working hours.**

Personal use of the internet during working hours is strictly prohibited. The wearing of ear/headphones is also prohibited.

## 7. Socializing

All employees shall fulfil their job duties with integrity and respect toward patients, colleagues and the ownership of the hospital; you are expected to maintain a professional conduct in the workplace. Any personal matter that disrupts the smooth flow of your duty is discouraged. Please seek your supervisor's permission to deal with any urgent personal matters.

## 8. Sleeping

Sleeping while on duty is an offence and may result in summary dismissal from employment. Depending on your shift; any sleeping/rest must be done during the designated break period.

## 9. Solicitation of Favours

Any request for financial or other assistance/gifts from patients/contractors/clients is prohibited. However minor gratification given without inducement may be acceptable (politely decline if possible) but must be reported to your supervisor/ HR & Admin in case of any future misunderstanding of inappropriate behaviour.

## 10. Respect for Others and Hospital Property

Please remember to respect one another in the work environment; Management will not take lightly any insults/fighting among staff. Bad-mouthing colleagues in front of patients will not be tolerated. Please remember the patient always comes first; deal with any issues professionally and address matters via your supervisor/HR & Admin when appropriate.

Please respect all hospital property and ensure you report any maintenance issues promptly to the relevant authority.

# Grievance Policy

**Approved by:** Board of Directors

**Approval date:** December, 2019

**Version number:** 1.0

## Policy Brief & Purpose

At Nisa Premier Hospital, we seek to provide a workplace in which all employees feel that they are valued and are treated fairly. There may be times however when you have a complaint or dispute with a colleague, supervisor or the Company which can best be resolved through a formal procedure for dispute resolution. The Nisa Grievance policy is intended to encourage employees to communicate such grievances, that way we can foster a supportive and pleasant workplace for everyone. This policy explains how employees can voice their complaints in a constructive way.

## Scope

This Grievance policy applies to all employees including Interns, NYSC, IT and Volunteers, Visiting Consultants, Patients, Vendors and anyone else whom employees come into contact with at work regardless of position or status.

## Policy Elements

What is the definition of Grievance?

We define grievance as any complaint, problem or concern of an employee regarding something believed to be wrong or unfair relating to their workplace, job or co-worker relationships.

Employees can file grievances for any of the following reasons:

- Workplace harassment (please refer to our Workplace Harassment policy for guidance)
- Health and safety concerns
- Supervisor behaviour
- Adverse changes in employment conditions

This list is not exhaustive, however employees should try to resolve less important issues informally before they resort to a formal grievance process.

Employees can:

1. Reach out to their direct supervisor or HR unit
2. File a grievance form explaining the situation in detail
3. Refuse to attend formal meetings on their own
4. Appeal on any formal decision

Employees who face allegation have the right to:

1. Receive a copy of the allegations against them
2. Respond to the allegations
3. Appeal on any formal decision

The company is obliged to:

1. Have a formal grievance procedure in place
2. Communicate the procedure



3. Investigate all grievances promptly
4. Treat all employees who file grievances equally
5. Preserve confidentiality at any stage of the process
6. Resolve all grievances when possible
7. Respect our No Retaliation policy when employees file grievances with the company or external agencies.

## How to report a Grievance

Employees are encouraged to talk to each other to resolve their problems. When this is not possible, employees should know how to file a grievance:

1. Communicate informally with their direct supervisor. The supervisor will try to resolve the problem. When employees want to complain about their supervisor, they should first try to discuss the matter and resolve it between them. In that case, they are advised to request an informal meeting. Supervisors should try to resolve any grievance as quickly as possible. When they are unable to do so, they should refer to the Human Resource unit and cooperate with all other procedures.
2. If the grievance relates to a supervisor behaviour that can bring disciplinary action (e.g. sexual harassment or violence), employees should refer to our Workplace Harassment policy or report the next level supervisor or directly to the Human Resource unit.
3. Accommodate the procedure outlined below:

The Human Resource unit shall follow the procedure below:

1. Ask the employee to fill out a grievance form
2. Talk with the employee to ensure the matter is understood completely
3. Provide the employee who faces allegations with a copy of the grievance
4. Organize mediation procedures (e.g. arranging a formal meeting)
5. Investigate the matter or ask the help of an investigator when needed (management approval required)
6. Keep employees informed throughout the process
7. Communicate the formal decision to all employees involved
8. Take actions to ensure the formal decision is adhered to
9. Deal with appeals by gathering more information and investigating further
10. Keep accurate records

This procedure may vary according to the nature of a grievance. For example, if an employee is found guilty of sexual harassment, the company will begin disciplinary procedures.

All disputes between any employee and the Company are to be resolved in accordance with this procedure. Please note, however, that the Company reserves the right to modify this procedure at any time and nothing in this procedure shall be construed to constitute a contract between you and the Company or to constitute any part of a contract between you and the Company.

# No Retaliation Policy

**Approved by::** Board

**Approval date:** September, 2019

**Version number:** 1.0

## Policy Brief & Purpose

The Nisa No Retaliation policy describes our provisions towards employees who file reports for harmful, discriminatory or unethical behaviours. Whether accusations are true or false, our company wants to prevent victimization and other retaliatory behaviour towards the employee. We believe it is important that employees are not afraid to speak up about any issues. It is to our benefit to resolve them as soon as possible. An environment of fear can only be harmful in the long run.

We will follow all legal prohibitions for retaliation and will grant employees the right to speak about misconduct. At any case, we will make an effort to preserve legality and business ethics.

## Scope

This No Retaliation policy applies to all prospective, current or former employees of the company including IT, Interns, NYSC and Volunteers, Visiting Consultants, Patients and Vendors.

## Policy Elements

Retaliation is in general defined as any kind of negative action against a current or former employee that takes the form of punishment and creates a hostile, threatening or uncomfortable environment as a result of their reported complaint.

Actions that often bring about retaliation include but are not limited to:

- Complaints for workplace harassment or discrimination
- Complaints for company actions that harm the environment or society
- Participation in a pending investigation of misconduct or violations

Employees may file complaints internally to a manager, Human Resources or Legal Department. These employees are called "Whistleblowers".

At any case, we will follow our harassment-free workplace principles. Employees who report misconduct or suspected violation must be protected from retaliation. We do not want to silence complaints, but we encourage open communication in accordance with our open-door policy.

## Why do we need a No Retaliation Policy?

We need a no retaliation policy for two reasons.

1. When reports have a solid basis, we must consider them and take action. Retaliating against an employee who brought attention to inconsistencies or violations will harm our company's trustworthiness and reliability.

2. Secondly, any kind of retaliatory action, whether intentional or unintentional, may expose us to a serious legal risk.

It is important to note that this policy refers to circumstances when an employee's report is true as well as circumstances when the report is baseless. We do not consider the report's validity when it comes to no retaliation principles, as required by law.

Retaliation in the workplace may be expressed in a variety of ways. These include but are not limited to:

- Victimization
- Termination or illegal retraction of benefits
- Reduction of compensation
- Poor work performance evaluation
- Exclusion from corporate events or meetings
- Defamation of character (prominent in cases of former employees)

## Actions

Employees have the right to communicate problems, suggestions or issues to any manager. No retaliation policy applies to all official or unofficial reports. All complaints will be kept confidential and investigation will be as discrete as possible.

If an employee files a complaint with our company for another employee, we'll take it seriously and investigate thoroughly. If we need to act immediately during our investigation (like in cases of harassment) we will ensure the employee who filed the complaint will not be affected in any way. The alleged wrongdoer may see their employment or position suspended until the investigation is concluded.

## Disciplinary Consequences

1. Employees that are found guilty of retaliation will be subject to disciplinary action that may also result in termination.
2. Disciplinary action may also apply to employees who have repeatedly filed false or unreasonable complaints against us and are proven to have been intentionally lying, falsifying evidence, acting maliciously or for personal benefit. That way we can ensure that employees do not take advantage of our policy and act always in good faith.
3. In some cases, an employee who has filed a report may face disciplinary action on an unrelated offence. We will provide official documentation stating the reason of disciplinary procedures against the employee, along with evidence for their misconduct.

# Open-Door Policy

**Approved by::** Board

**Approval date:** September, 2019

**Version number:** 1.0

## Policy Brief & Purpose

Our open-door policy in business reflects our commitment to transparent and flexible communication between managers and team members.

The Nisa Open Door policy is intended to encourage open communication, feedback, and discussion about any matter of importance to an employee. Our open-door policy means that employees are free to talk with any manager at any time about any topic.

## Scope

This Open-Door policy applies to all employees including Interns, NYSC, IT and Volunteers, Visiting Consultants, Patients, Vendors and anyone else whom employees come into contact with at work.

We expect managers of all levels to keep their door open; and this refers to so much more than their office door. They should be ready to listen to their employees in person or over digital means we use at work (email or phone calls). They should establish a culture of trust and communication in their team. This also applies to senior management who shall remain approachable for everyone in the organization.

Employees are free to communicate their thoughts with upper management. Of course, this policy extends to Human Resources. If you have serious matters on your mind, ranging from concerns over your compensation to workplace harassment, feel free to come to us.

## Policy Elements

Managers should have their office door open so employees can approach them easily to:

- Ask for counsel or feedback
- Ask questions about a subject
- Express a complaint or concern
- Raise awareness for a problem
- Ask for resolution to an inside dispute or conflict
- Make suggestions for change
- Discuss other personal topics

## Benefits of the Open Door Policy

By helping to solve problems, managers benefit by gaining valuable insight into possible problems with existing methods, procedures, and approaches. While there may not be an easy answer or solution to every concern, your company's employees have the opportunity at all times, through the open-door policy, to be heard.

## How to use the Open-Door Policy

### Manager's responsibilities

As a manager we ask you to:

1. Listen to your team members is part of your duties. You should always be ready to discuss important subjects (like harassment – please refer to our **Workplace Harassment Policy**) as soon as possible, but you should also make time to listen to your team members' concerns or ideas.
2. Action is also important. Our company open door policy aims to translate good feedback to better results. This means it is your job to follow through with improvements that matter. Use your judgement to determine whether you should pass information to your own manager or create a plan to address what your team member has told you.
3. Always be transparent about what you are going to do. Don't promise anything that you are not sure you can deliver. Discuss with your team member, let them know your own thoughts and concerns. After all, communication works both ways.
4. Of course, we expect you to take any negative feedback or criticism in stride. You must not retaliate against or victimise team members. **If you are not sure how to handle the information you received, remember: your manager and HR doors are also open.**

### Employee's responsibilities

Communication is important and is built on mutual trust. This means that just as you trust your manager to listen to you, your manager trusts you to help them digest information better.

So, we ask you to:

1. Ask for an appointment in advance, whenever possible, if you want to talk about a significant or delicate matter.
2. Communicate with your manager whenever possible instead of going to a more senior manager first. You can bypass your manager in some cases: for example, if they are out of office, if they are involved in a harassment claim or if they consistently refuse to give you audience (which you can report to HR).
3. Try to resolve minor disputes with your colleagues before reaching out to your manager. Trust and communication should work horizontally as well as vertically in our company.
4. In general, speak up when you have an opinion about something. Also, inform us when you notice harassment, victimisation to others or any violation of our [Code of Conduct](#). We need all of you to ensure the workplace is safe and nice to work in for everyone (please also refer to our [Whistleblower Policy](#) if required).

## Disciplinary Consequences

### No Retaliation

The open-door policy includes the assurances that an individual employee who pursues his or her rights to talk to any level of management will experience no retaliation or interference from the employee's immediate manager. The manager should be included as needed. **Please also refer to our [No Retaliation Policy](#).**

# Pre-employment Medical Policy

**Approved by:** Executive Management Committee

**Approval date:** January, 2020

**Version number:** 1.0

## Policy Brief & Purpose

Our pre-employment medical examination has been designed to ensure that prospective employees can perform their jobs safely without placing risk to him/herself or others.

## Scope

This Pre-Employment Medical policy applies to all prospective employees including Interns, NYSC, Locum and Regular employees.

## Policy Elements

Following our responsibility to our patients and Nigerian Labour Act on Medical fitness for new employees, our pre-employment medical screening policy will be based on the employee's position, age and gender.

## Process

1. All offers of employment must be subject to the medical fitness of the prospective candidate.
2. HR is expected to notify the candidates that they may be contacted for medical screening which is part of the recruitment process during the interview.
3. The pre-employment medical investigation requires that the prospective candidate signs a non-disclosure [consent form](#) in which the candidate is expected to disclose any history of health issues. The consent form also states that the Hospital is not obligated to communicate the medical results to the candidates.
4. The pre-employment medical results are confidential and as such would be kept separately from personnel files.
5. The following investigations will be conducted for both clinical and non-clinical potential employees:
  - a. Physical examinations
  - b. Packed cell volume
  - c. Genotype & blood group
  - d. Urinalysis
  - e. Fasting blood sugar
  - f. Mantoux (tuberculosis)
  - g. Pregnancy (for females)
  - h. Additional screening for clinical staff (doctors, nurses, laboratory scientists/technicians, radiologists, PCAs, Pharmacists) includes Hepatitis B & C, HIV.
6. The laboratory is expected to treat the candidates as walk-in patients and as such the candidate's medical tests would not be documented on Medicplus.



7. The timeline for the pre-employment medical investigation would be 24 -72 hours (1 - 3 days), and based on the outcome of the screening offer of employment is made or not.
8. The cost of the pre-employment medical screening will be borne by the hospital.

### Pre-Employment Testing Consent Form

I hereby consent to submit to the following tests as shall be determined by Nisa premier Hospital in the selection process of applicants for employment, for the purpose of determining my current state of health.

I agree that specimens for these tests may be collected from me to be tested by them or forwarded to a testing laboratory designated by the Hospital for analysis.

I further agree to and hereby authorize the release of the results of said tests to the Hospital. I understand that it is for the purpose of being employed at Nisa Premier Hospital.

I further agree to hold harmless the Hospital and its agents from any liability arising in whole or part out of the collection of specimens, testing, and use of the information from said testing in connection with the Hospital's consideration of my employment application.

I further agree that the Hospital is under no obligation to release my result to me or any other establishment.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and investigation form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

**Applicant's name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Position applied for:** \_\_\_\_\_

# Whistleblower Policy

**Approved by:** Executive Management Committee

**Approval date:** September, 2019

**Version number:** 1.0

## Policy Brief & Purpose

Every organization desires honesty from and among its employees. The presence of honesty allows for complete dedication to the organization's mission and success. By encouraging a whistle blowing culture, the organization promotes transparent structure and effective, clear communication. More importantly, whistleblowing can protect the organization's clients. For example, if a hospital employs a number of negligent staff members, other more ethically inclined, employees would need to bring such issues to the hospital's attention, protecting the organization from possible lawsuits or severe mishaps resulting in a patient's demise.

The Nisa Whistleblower policy is intended to encourage members of management, staff (paid and volunteer) and others to report suspected or actual occurrence(s) of illegal, unethical or inappropriate events (behaviours or practices) without the fear of retribution.

## Scope

This Whistleblower policy applies to all employees including Interns, NYSC, IT and Volunteers, Visiting Consultants, Patients, Vendors and anyone else whom employees come into contact with at work.

## Policy Elements

What is the definition of Whistleblowing?

Whistleblowing is the act of drawing public attention, or the attention of an authority figure, to perceived wrongdoing, misconduct, unethical activity within public or private organizations. Corruption, fraud, bullying, health and safety violation, cover-ups and discrimination are common activities highlighted by whistleblowers.

## How to report a Suspicious/Actual Activity

1. The Whistleblower shall promptly report the suspected or actual event to his/her supervisor.
2. If the Whistleblower would be uncomfortable or otherwise reluctant to report to his/her supervisor, then the Whistleblower could report the event to the next highest or another level of management, including to an appropriate Board member.
3. The Whistleblower can report the event with his/her identity or anonymously.
4. Supervisors, managers and/or Board members who receive the reports must promptly act to investigate and/or resolve the issue.
5. The Whistleblower shall receive feedback within ten business days of the initial report, regarding the investigation, disposition or resolution of the issue.



6. If the investigation of a report, that was done in good faith and investigated by internal personnel, is not to the Whistleblower's satisfaction, then he/she has the right to report the event to the appropriate legal or investigative agency.
7. The identity of the Whistleblower, if known, shall remain confidential to those persons directly involved in applying this policy, unless the issue requires investigation by law enforcement, in which case members of the organisation are subject to subpoena.

## Whistleblowing Responsibilities

1. Monitoring Officer - Head, Human Resources/Legal Officer (Whistleblowing register to be kept)
2. How to report - In person, in writing, by telephone (details to be made available)
3. Investigation Committee
  - Management
  - Internal Audit/External Audit (as appropriate to the case)
  - Board Member - Dr. Peter Nmadu (depending on severity of the case)

## Disciplinary Consequences

1. The Whistleblower shall receive [no retaliation](#) or retribution for a report that was provided in good faith – that was not done primarily with malice to damage another or the organisation.
2. A Whistleblower who makes a report that is not done in good faith is subject to discipline, including termination of the employee relationship, or other legal means to protect the reputation of the organisation and members of its Board and staff.
3. Anyone who retaliates against the Whistleblower (who reported an event in good faith) will be subject to discipline, including termination of employee status.
4. Crimes against person or property, such as assault, rape, burglary, etc., shall immediately be reported to local law enforcement personnel through the Head of Security.

# Workplace Harassment Policy

**Approved by:** Executive Management Committee

**Approval date:** 1<sup>st</sup> March, 2019

**Version number:** 1.0

## Policy Brief & Purpose

The Nisa Workplace Harassment policy expresses our commitment to maintain a workplace that's free of harassment, so all our employees can feel safe and happy. We will not tolerate anyone intimidating, humiliating or sabotaging others in our workplace. We also prohibit willful discrimination based on age, gender, ethnicity, race, religion or disability.

## Scope

This workplace harassment policy applies to all employees including Interns, NYSC, IT and Volunteers, Visiting Consultants, Patients, Vendors and anyone else whom employees come into contact with at work.

## Policy Elements

What is the definition of harassment in the workplace?

Harassment includes bullying, intimidation, direct insults, malicious gossip and victimization. Please see below some instances that we consider as harassment but not limited to the following:

- Bullying, violence, threats, attempts or acts of physical force.
- Sabotaging someone's work on purpose.
- Engaging in frequent or unwanted advances of any nature.
- Commenting derogatorily on a person's ethnic heritage or religious beliefs.
- Starting or spreading rumours about a person's personal life.
- Ridiculing someone in front of others or singling them out to perform tasks unrelated to their job against their will.

Sexual harassment is illegal and we will seriously investigate relevant reports. If an employee is found guilty of sexual harassment, they will be terminated.

## How to address Harassment

If you're being harassed, whether by a colleague, patient or vendor, you can choose to talk to any of these people:

**Offenders:** If you suspect that an offender doesn't realize they are guilty of harassment, you could talk to them directly in an effort to resolve the issue. This tactic is appropriate for cases of minor harassment (e.g. inappropriate jokes between colleagues.) Please avoid using this approach with patients or third parties.

**Your manager:** If patients, vendors or team members are involved in your claim, you may reach out to your manager. Your manager will assess your situation and may contact Human Resources if appropriate.

Human Resources: Feel free to reach out to HR in any case of harassment no matter how minor it may seem. For your safety, contact HR as soon as possible in cases of serious harassment (e.g. sexual advances) or if your manager is involved in your claim.

Please be assured that anything you disclose will remain confidential.

## Disciplinary Consequences

Punishment for harassment depends on the severity of the offence and may include counselling, reprimands, suspensions or termination.

# Clinical Governance Policy

Approved by: Executive Management

Approval date: September 2022

Version number: 1.0

## 1. Introduction

It is the vision of the Nisa Medical Group to provide top-class best practices to our customers on par with international standards. Achieving this vision can only be possible in an atmosphere of strong and effective governance of all aspects of our clinical processes. The Clinical Governance framework in Nisa is established to spearhead all efforts to ensure continuously improved, patient-centred care by building a culture of excellence in healthcare delivery.

This will be achieved by:

1. making optimum use of available resources to achieve safe and effective healthcare delivery that produces the best possible healthcare outcomes for our patients, understanding that poor patient outcomes in terms of morbidity, mortality, wasted healthcare resources, litigation and indemnity incur far greater costs to the organization.
2. continuously anticipate and control the impact of human factors and system errors on our clinical services through monitoring, measurement and analysis of clinical decisions, interventions and outcomes in order to reduce risk and harm.
3. Work with clinicians, support staff and management of Nisa to achieve collective accountability for continuous improvement of clinical service delivery.

The implementation of the clinical governance framework in Nisa is based on the following pillars of clinical governance:

1. [Patient, Public & Staff Involvement](#)
2. [Research & Clinical Audit](#)
3. [Staffing & Staff Performance Management](#)
4. [Clinical Effectiveness](#)
5. [Risk Management](#)
6. [Evidence-based Medicine](#)
7. [Education](#)

## 2. Structure, Responsibility and Accountabilities

Even though clinical governance in Nisa will be spearheaded by committees, groups and individuals outlined in this section, it must be constantly emphasized that it is the responsibility of everyone in the organization to achieve its goals. The core structure, accountabilities and responsibilities for our clinical governance framework are as follows

1. The Board of Directors - The board is responsible for creating the impetus for our goals of safe, good-quality patient services and holding the chief executives and top management of Nisa accountable for achieving these goals.
2. Top management - The Chief Executive Officer (CEO), General Managing Director (GMD) and the Executive Management Committee (EMC) are responsible for holding all staff to acceptable

standards of service delivery and ensuring the resources and enabling environment for achieving excellence in healthcare delivery are available throughout the organization.

3. Clinical Governance Committee (CGC) – The Clinical Governance Committee has authority and influence across the hospital on all matters pertaining to patient safety and service quality. The CGC’s key responsibility is to maintain standards of practice, lead improvements in patient care and promote a culture of safety, quality and accountability in line with the 7 recognized pillars of clinical governance. The CGC reports directly to the Medical Director. It provides advice to the board, the CEO, GMD and EMC. It leads change in attitudes, clinical policy, systems and processes and provides consistent and timely guidance to all key stakeholders. The CGC has a formal link with the EMC, enabling direct communication and information sharing. Collaborative decision-making forms part of this relationship so that the CGC and EMC are equal partners in decision-making processes that affect or impact on patient safety and clinical service quality.

Details on the membership and activities of the CGC are given in the section [“Terms of reference of the Clinical Governance Committee.”](#)

4. The Quality Improvement Department (QID) – The QID is responsible for driving continuous improvement in all aspects of service delivery in the hospital by ensuring the implementation and sustenance of a quality management system based on requirements of applicable standards, monitoring, evaluating, analyzing and reporting on the performance of the quality management system using applicable metrics and indices as well as periodic auditing of hospital processes to ensure conformance to aforementioned standards. The QID serves as a secretariat for the CGC and assists with actioning of resolutions of the committee.
5. Research, Development and Training arms: They assist the CGC in implementing training and research activities relevant to its goals and provide feedback to the CGC on training needs and research opportunities as required.
6. As mentioned previously, everyone in the organization is ultimately responsible in one way or another for contributing to the success of clinical governance in Nisa. Engagement of all staff must occur through coordinated efforts to train and retrain on best-practice and right attitudes, empowerment of leaders and managers to motivate, mentor and guide staff towards continuous improvement in service delivery, fostering a culture of reporting and open/confidential disclosure via appropriate channels on system errors and relevant clinical incidents so that corrective actions can be taken as necessary and so on.

As required, the clinical governance committee may delegate functions to subgroups, committees or individuals who will report back to the CGC in a standardized manner.

### 3. Implementation of Clinical Governance in Nisa

The CGC considers there to be “seven pillars” of clinical governance and are committed to developing, maintaining and demonstrating these across the Nisa Organization as follows:

#### A. Patient, Public & Staff Involvement

- i. Obtaining customer feedback through structured patient feedback surveys (digital and printed) for outpatients and inpatients and for specific clinical service points eg. Cardiology, A&E, Theatre, Labour Ward etc.
- ii. Annual staff surveys and actions to address identified issues with staff welfare and working conditions

- iii. Analysis & reporting of customer feedback and patient satisfaction ratings for services by the Quality Improvement Department via QID reports
  - iv. Actions to address and resolve patient complaints through root cause analysis and appropriate corrective action.
    - v. Patient forums
    - vi. Patient representation/direct input in the CGC or relevant patient safety committee
- vii. Training and deployment of quality ambassadors throughout the organization to support clinical incident reporting, identification of system errors, data collection and analysis for clinical audits and research, propagating right attitudes and fostering a culture of continuous improvement etc.
  - viii. Incident reporting, open disclosure and whistleblowing

## B. Research & Clinical Audit

- i. Comprehensive clinical process audits by QID and close out of all identified observations and non-conformities with process owners and management
  - ii. Implementation of clinician-led clinical auditing as part of clinical staff performance requirements and appropriate actions to address the findings of these audits.
  - iii. Continuous auditing framework based on customer feedback and day-to-day non-conforming outputs identified
    - iv. General hospital audits involving all departments
  - v. Establishment of a Research and Development Unit and local Ethics Committee to drive research activity in the hospital and rapidly ramp up the publishing of Nisa-generated research work in reputable medical journals.

## C. Staffing & Staff Performance Management

- i. Periodic review of the adequacy of staffing and actions to address deficiencies.
  - ii. Annual licensing mandates and checks for clinical staff
  - iii. Implementation of Personal & Professional Staff Development Plans
  - iv. Implementation of a departmental performance management framework
    - v. Ensuring practice/career progression with additional qualifications
    - vi. Mandatory clinical training and best practice support [see Education](#)

## D. Clinical Effectiveness

- i. Fostering a culture of non-prejudicial Incident reporting, whistleblowing and open disclosure using structured incident reporting tools (digital and printed)
  - ii. Reporting on relevant clinical metrics by the QID via monthly QID reports
- iii. Monthly morbidity and mortality reviews and the actioning of resolutions from these meetings by the CGC
  - iv. Audit of clinical documentation
- v. Development, review and approval of clinical policies, guidelines and protocols by the CGC
  - vi. Mandatory clinical training and best practice support [see Education](#)
  - vii. Increased and improved clinical audits
- viii. Monitoring, measurement, analysis and reporting on relevant clinical KPIs with actions to address any deficiencies

## E. Risk Management

- i. Actions to address reported incidents/system errors and mitigate risk caused by these factors

- ii. Development of a hospital “Never Events Policy”
  - iii. Risk and opportunity registers:
    - a. Determination of internal and external issues and consequent risks to clinical processes. Risks should then be subjected to appropriate risk analysis into high, medium and low risk.
    - b. Maintenance and periodic review of risk and opportunity registers detailing the above in all clinical departments as well as the development of actions to address the identified risks (commensurate to risk analysis done) and opportunities.
    - c. The effectiveness of the actions developed to address risks and opportunities identified should be periodically evaluated and adjustments made accordingly.

#### F. Evidence-based Medicine

- i. The CGC will be responsible for ensuring that all clinical policies, guidelines and protocols are in keeping with current best practice and established scientific knowledge in order to ensure clinical care and decision-making is evidence-based. They will also be responsible for initiating periodic reviews of existing policies, guidelines and protocols to ensure they are up-to-date with current best practices.
- ii. The CGC will also spearhead efforts to ensure decisions for clinical care and service delivery are made after consideration of all relevant data and that these decisions will be in the best interest of the patient.

#### G. Education

- i. Establishment of a framework for mandatory clinical training and best practice guidance of staff to ensure they are constantly delivering healthcare services at par with applicable standards. The mandatory training will cover relevant clinical core competencies required by staff of different cadres.
- ii. Collaboration with the hospital’s training arm to provide other training as required by staff.
- iii. Enabling staff to attend relevant professional, conferences, symposia and webinars especially those required for professional development, recertification and licensing.

## 4. Terms of reference of the Clinical Governance Committee

The Clinical Governance Committee is central to the implementation and sustenance of effective clinical governance in Nisa as detailed above and will be responsible for setting direction and strategy for achieving this. Its function will be guided by the following terms of reference:

#### A. Membership

The committee will comprise the following standing members:

- i. The Clinical Director who serves as head of the committee
- ii. Leadership of the Quality Improvement Department (QID), namely the head and assistant head of the department who will also provide secretarial support to the committee.
  - iii. Heads of all clinical departments and units including:
    - a. Accident & Emergency Department
    - b. Family & Specialty Medicine
    - c. ICU/Anaesthesia

- d. Infection Prevention & Control
- e. IVF
- f. Laboratory
- g. Labour Ward
- h. Neonatology
- i. Nursing Services
- j. Obstetrics and Gynaecology
- k. Paediatrics
- l. Pharmacy
- m. Radiology
- n. Surgery
- o. Theatre

From time to time, the head of the committee may request the presence of external experts or other members of staff as required by the committee.

Members of the board, the CEO, the GMD and the Medical Director may attend meetings of the CGC at their discretion.

Standing members are expected to appoint a representative to attend meetings on their behalf if they are unable to.

A quorum of the committee will comprise the presence of 50% of all members.

## B. Meeting structure

- i. The committee will hold meetings on the 2<sup>nd</sup> and 4<sup>th</sup> Wednesdays of every month with a fixed agenda and will not exceed 2 hours duration (3:00pm – 5:00pm).
  - ii. The head of the committee has the right to determine agenda items for the committee as deemed appropriate and will ensure the agenda items are aligned with the clinical governance framework.
- iii. Any meeting requiring decision-making that does not meet the requirements of a quorum will be rescheduled for consideration by the full membership.

## C. Secretariat

The secretarial function of the committee will be subserved by the QID or as otherwise appointed by the head of the committee and the Medical Director, with the following responsibilities:

- i. to record, type and distribute action points and resolutions to members within seven days of meetings and ensure a copy of the previous meeting's agenda, action points and resolutions are placed on a master file.
  - ii. use a standard template for meeting agendas based on reporting schedule requirements.
  - iii. ensure the head of the committee has approved each agenda before every meeting.
    - iv. keep accurate records of CGC proceedings.
    - v. keep a rolling action plan for matters arising from each meeting.
    - vi. keep a decision register for CGC decisions.
    - vii. keep a rolling issues register.
  - viii. call for agenda items and ensure necessary papers conform to expected guidelines/template.
- ix. distribute the agenda and associated papers for each agenda item for upcoming meetings to members at least five days prior to meeting date.
- x. communicate issues (under the direction of the head of the committee) that need to be addressed by relevant parties within seven working days of meetings.



- xi. prepare periodic reports of the committee as required for the Medical Director, GMD, CEO or the board as required.

#### D. Reporting

- i. The CGC shall report to the EMC on a fortnightly basis on their action points and resolutions (as generated by the CGC secretariat) to enable top management input, actions, support and relevant feedback to the GMD, FCEO and Board as applicable.
- ii. The CGC shall receive reports from all clinical departments and the QID as required and requested by the head of the committee.

The CGC may demand reports from any department or personnel within the hospital as required and requested by the head of the committee and they shall be required to respond or present themselves before the committee as requested.