IFC International Finance Corporation
WORLD BANK GROUP

Policy on Policies

DEPARTMENT	X HOSPITAL-WIDE	ISSUE DATE
Process owner	Quality department	-------
Title/description	Policy on policies	REVISION DATE
Policy no.	X-TQM-PP-01	-------

SECTION	CHANGE	EXPLANATION

Note: This section lists the latest changes in this document only. For detailed revisions, please refer to the sections referenced on this list.

|1| Purpose

- To standardize formatting, templates, and numbering systems for all hospital documentation.
- To establish the mandatory framework for developing administrative and clinical patient care policies.

|2| Scope

- To all employees within X Hospital.

|3| Definition

3.1. Author: The individual, committee, or entity responsible for drafting and originating a policy and procedure.

3.2. Multidisciplinary Policy and Procedure: A directive that impacts multiple clinical or administrative fields, requiring collaborative input and approval from all affected disciplines.

3.3. Policy: A formal statement of principle, framework, or standard that dictates organizational decisions and courses of action.

3.4. Policies and Procedures (P&P): Operational mandates governing hospital business, clinical practices, and regulatory requirements applicable to all departments and personnel.

3.5. Process Owner: The specific department or unit accountable for leading the implementation, monitoring, and maintenance of a policy and procedure.

3.6. Purpose: A concise statement explaining the intent, necessity, and rationale behind a policy and procedure.

3.7. TQM: Total Quality Management department.

3.8. X Hospital: [Insert full formal hospital name here].

|4| Policy

4.1. This policy governs the standardization, development, approval, distribution, maintenance, and deactivation of all hospital policies and procedures (P&Ps).

4.2. Every P&P document must feature unique identifiers, including a specific title, document tracking number, effective date, and scheduled revision date.

4.3. P&Ps must be kept current, dated, and systematically reviewed every two (2) years, or sooner if triggered by regulatory, legal, or operational changes.

4.4. Only the most recently approved and updated version of a P&P or organizational plan shall be accessible for active hospital use. Outdated versions must be archived immediately.

4.5. New or revised P&Ps must be systematically communicated to all relevant hospital staff to ensure immediate, compliant implementation.

4.6. P&Ps must be drafted by the relevant Department, Section, or Unit Head, or by designated committees and teams.

4.7. If a P&P is drafted at the unit or section level, it must be reviewed by the respective Department Head prior to submission.

4.8. The Total Quality Management (TQM) Director is responsible for tracking all documents in circulation and verifying that all affected departments, committees, and individuals have participated in the drafting process.

4.9. Multidisciplinary P&Ps require the collaborative development, review, and consensus of all affected department heads, clinical leaders, and relevant multidisciplinary committees.

4.10. Final approval of all P&Ps rests with executive leadership (e.g., Hospital Director, Medical Director, Director of Nursing) based on the scope, type, and organizational impact of the document.

|5| Procedures

5.1. Document Control and Lifetime Management

5.1.1. Identification: Every document must feature a unique title, tracking code, version number, effective date, and scheduled revision date.

5.1.2. Authority: The Total Quality Management (TQM) department holds sole authority over assigning codes, tracking versions, and uploading approved documents.

5.1.3. Review Cycle: All policies must be reviewed, updated, and re-approved every two (2) years, or sooner if triggered by regulatory changes.

5.1.4. System Communication: New or revised policies must be uploaded to the hospital intranet by TQM. The TQM department will notify staff via official email and internal memos.

5.1.5. Departmental Education: Department heads must ensure policy implementation through staff training, orientation, and regular competency assessments.

5.1.6. Version Control: TQM must remove obsolete document versions from active intranet folders immediately upon a new release.

5.1.7. External Documents: Policies and regulations originating from external authorities (e.g., Ministry of Health) must be cataloged by TQM before hospital-wide distribution.

5.1.8. Archiving: Obsolete documents must be digitally archived with an "OBSOLETE" watermark and retained for the minimum period required by local healthcare laws.

5.2. Formatting Standards

5.2.1. Page Layout: All documents must use standard A4 paper size, portrait orientation, and feature the official hospital logo in the header.

5.2.2. Margins: Top = 1.8 inches; Left and Right = 1.0 inch; Bottom = 0.5 inches.

5.2.3. Typography: Use Calibri font, size 12. Text must use sufficient line spacing and be justified. Bold and italic styling must be used sparingly for specific emphasis only.

5.2.4. Visual Elements: Shaded background screens behind text are prohibited. Any medical illustrations used must explicitly cite the original source.

5.2.5. Style and Vocabulary: Content must use clear language free of clinical jargon where possible. Abbreviations must be spelled out fully on first use, followed by the acronym in parentheses—for example: Quality and Patient Safety (QPS).

5.3. Structural Checklists and Multi-Level Numbering

5.3.1. Main Formatting Rules: Sections must follow sequential Arabic multi-level numbering (e.g., 1., 1.1., 1.1.1.). Main titles and section sequences cannot be interchanged.

5.3.2. First-Page Header Requirements: The first page header must include: Heading, Department Name, Title/

Description, Policy Number, Version Number, Effective Date, and Revision Date.

5.3.3. Policy and Procedure Layout: P&P drafts must strictly follow this ten-part structure:

Purpose | 2. Scope | 3. Definitions | 4. Policy | 5. Procedure | 6. Responsibilities | 7. Forms | 8. Attachments | 9. References | 10. Approval

5.3.4. Plan Document Layout: Structural plans must follow this eleven-part structure:

Purpose | 2. Scope | 3. Definitions | 4. Plan | 5. Procedure | 6. Responsibilities | 7. Evaluation & Indicators | 8. Forms | 9. Attachments | 10. References | 11. Approval

5.4. Document Coding System

5.4.1. Coding Structure: Every document code must follow a uniform, dash-separated matrix: [Hospital Prefix]-[Department]-[Document Type]-[Sequence Number].

5.4.2. Hospital Prefix: All codes must begin with the letter X.

5.4.3. Department Abbreviations: Use standard three-letter organizational codes (e.g., MS for Medical Services, NS for Nursing Services, FIN for Finance).

5.4.4. Document Type Abbreviations: Identify the file format using a two-letter acronym (e.g., PP for Policy and Procedure, FC for Flowchart, JD for Job Description).

5.4.5. Sequence Numbers: Apply a two-digit sequential number starting at 01.

- Example 1 (Medical Policy): X-MS-PP-01
- Example 2 (Nursing Job Description): X-NS-JD-03
- Example 3 (Finance Flowchart): X-FIN-FC-12

5.5. Document Generation Workflow

5.5.1. Inventory Gap Analysis: Department Heads and Committee Chairs must perform regular policy inventories against regulatory requirements to identify missing operational frameworks.

5.5.2. Initial Drafting: The relevant Department Head or Process Owner will draft missing or updated policies based on the inventory results.

5.5.3. Departmental Review: Drafts created at a unit or section level must be reviewed and signed off by the overarching Department Head before submission.

5.6. Multidisciplinary Policy Workflows

5.6.1. Collaborative Development: P&Ps impacting multiple departments or mandated by accrediting bodies (e.g., CBAHI, JCI) must be developed collaboratively by all affected stakeholders.

5.6.2. Feedback Loop: The primary Process Owner will draft the policy and route it to all involved departments for review and feedback.

5.6.3. Consensus Building: The primary Owner will integrate the feedback, revise the text, and return the final draft to the participating departments for final content validation.

5.6.4. Committee Integration: If a policy requires committee approval, the TQM Director must verify that the policy discussions, adjustments, and final approvals are officially recorded in the committee's minutes.

5.6.5. Final Auditing: The TQM Director will audit the final package to guarantee all affected departments participated before sending it to executive management for final sign-off.

5.7. Management of External Documents

5.7.1. External Document Classification: Directives received from outside sources—including the Corporate Office, Ministry of Health (MOH), CBAHI, and the Joint Commission International (JCI)—must be systematically cataloged and managed based on their origin and intent.

5.7.2. Centralized Corporate Policies: Corporate mandates that govern centralized functions must be logged into the TQM document control tracking system and implemented across the hospital exactly as written.

5.7.3. General Corporate Guidelines: Frameworks sent from the Corporate Office that establish general guidelines must be managed as follows:

5.7.3.1. The Quality and Operations office will maintain the master files and apply a "Corporate Policy" physical or digital stamp.

5.7.3.2. Individual hospital units must use these guidelines as baseline references to draft unit-specific policies that comply with corporate directives.

5.7.4. Regulatory and Accreditation Directives (MOH, CBAHI, JCI): External regulations requiring mandatory hospital-wide implementation must follow this strict approval and control pipeline:

5.7.4.1. Documents must be submitted directly to the TQM office for registration, formatting control, and tracking.

5.7.4.2. Digital copies must be stored on the hospital's secure shared network within their respective manual folders in their original file format.

5.7.4.3. The Medical Director must officially authorize these external documents for hospital use by signing an approval statement that includes any specific local application instructions.

5.7.4.4. TQM must update these files immediately upon receiving newer versions from the source, processing older copies through the hospital's standard obsolete document archiving workflow.

5.7.5. Reference-Only External Documents: External policies provided strictly for informational purposes are classified as "Uncontrolled Documents." The TQM department must stamp these files with "**FOR REFERENCE ONLY**" before distributing them to the relevant departments.

5.8. Tracking Document Revisions and Modifications

5.8.1. Mandatory Revision History: Every policy, procedure, and plan must include a dedicated Revision History Table to track modifications over time.

5.8.2. Change Identification During Reviews: Specific changes made to text must be clearly logged in the tracking table during the regular two-year (biennial) review cycle or during off-cycle updates triggered by new operational requirements.

5.8.3. Logging Unchanged Policies: If a policy undergoes its regular biennial review and requires no modifications, the reviewer must explicitly log "No Changes Made" alongside the review date in the revision table.

5.8.4. Change Summarization Rules: If a document is modified, the author must provide a concise summary of the change in the revision table to direct readers to the updated material.

- **Examples of acceptable logs:** "Policy updated to incorporate new MOH regulatory standards," "Section 4.2 expanded for operational clarity," or "Workflow steps modified to align with new electronic health record system.

|6| Responsibility

6.1. Author and Process Owner

6.1.1. Policy Drafting: Drafts new or updated policies using the approved hospital formatting templates.

6.1.2. Stakeholder Collaboration: Gathers necessary input from all affected departments and modifies the draft based on their feedback.

6.1.3. Compliance Integration: Verifies that all relevant risk management, clinical safety, and regulatory compliance issues are addressed in the document.

6.1.4. Submission and Workflow Management: Initiates the approval workflow, attends alignment meetings, and submits completed drafts to the TQM department for regulatory review.

6.1.5. Deployment: Receives final, authorized documents from TQM and distributes them to relevant staff for departmental implementation.

6.1.6. Eligible Roles: The designated Process Owner must be a Department Head, Hospital/Polyclinic Director, Corporate Manager, Corporate Executive Director, Vice President, President, or an explicitly authorized designee.

6.2. Total Quality Management (TQM) Department

6.2.1. Compliance Auditing: Reviews all submitted policy drafts for completeness, operational relevance, and alignment with national and international healthcare standards (e.g., CBAHI, JCI).

6.2.2. Content Optimization: Proposes necessary revisions, structural adjustments, or cross-departmental changes to the Author before final processing.

6.2.3. Endorsement: Controls the document parameters, assigns index codes, and formally recommends finalized policies to executive leadership for sign-off.

6.3. Medical Director

6.3.1. Clinical Authorization: Provides final approval and signature for clinical, medical, and nursing policies and procedures following successful TQM review.

6.3.2. Strategic Adjustments: Proposes content updates or operational changes to clinical policies during the review process as necessary.

6.3.3. Committee Oversight: Commissions and organizes clinical committees to draft, evaluate, or overhaul specific medical protocols and patient care guidelines.

6.4. Hospital Director

6.4.1. Administrative Authorization: Provides final executive approval and signature for administrative, financial, operational, and hospital-wide policies following successful TQM review.

6.4.2. Operational Adjustments: Proposes adjustments to operational workflows or administrative standards during the review process as necessary.

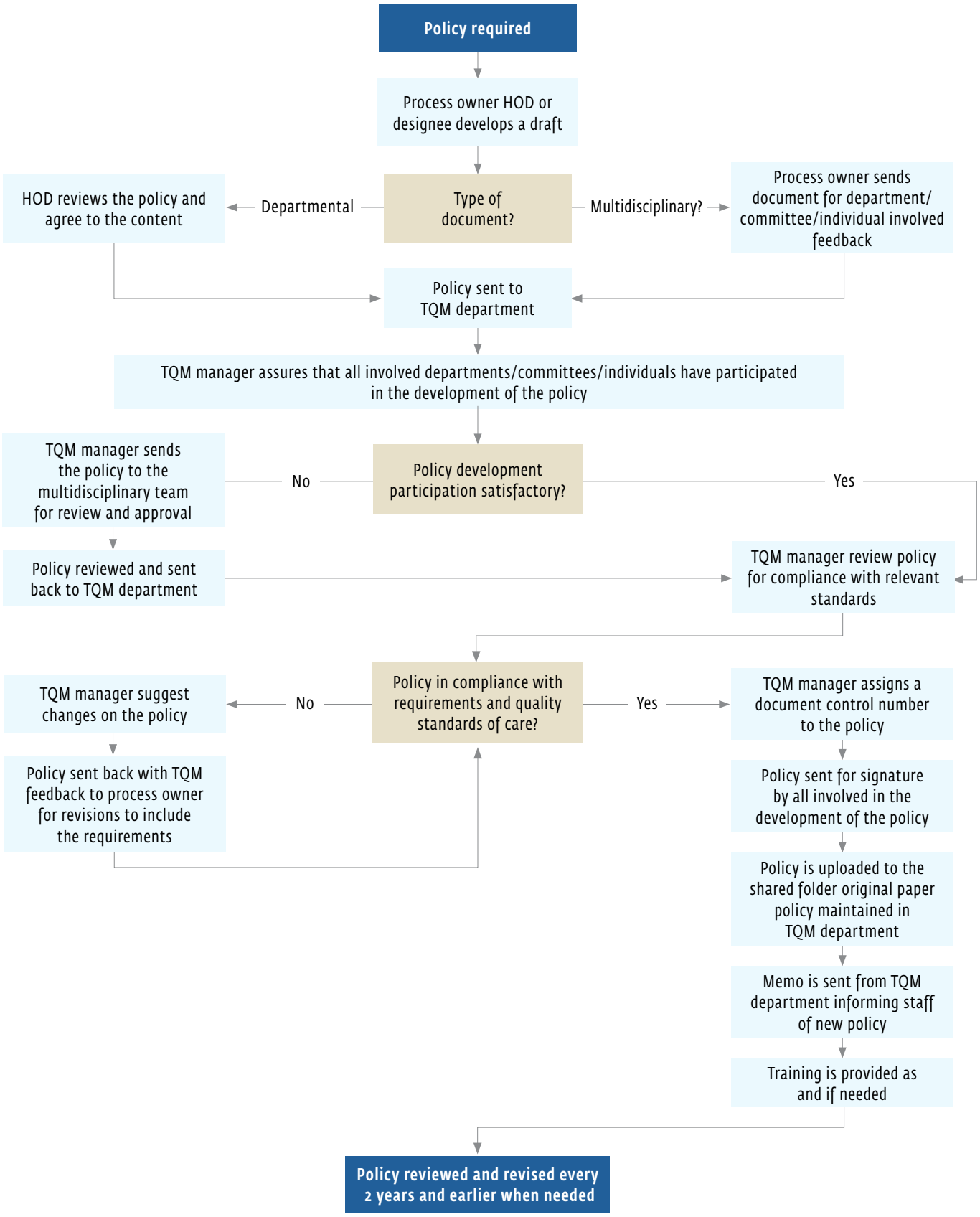
6.4.3. Special Taskforce Mobilization: Appoints specialized administrative committees or task forces to develop, review, or restructure operational policies.

|7| Forms

7.1 None

|8| Attachments

8.1 Policy and procedure Development and Approval Flow Chart



|9| References

9.1 JCI Hospital Standards 8h Edition, Standard MOI.02.00.

|10| Approvals

DESIGNATION & NAME	SIGNATURE
Prepared by: TQM Director XYZ	
Reviewed by: Operation Director XYZ	
Reviewed by: Nursing Director XYZ	
Approved by: IT Director XYZ	
Approved by: Medical Director XYZ	