

**Productivity and Development Center**  
**Technology Management Office**  
**2023 Project Accomplishment Report**

**Project Information**

Project Code	QEGXD
Project Title	GQMP 2023: Technical Assistance on Service Quality Improvement
Project Start	1 March 2023
Project End	31 August 2023
Project Price	PHP 740,000.00
Client Organization	Las Piñas General Hospital and Satellite Trauma Center
Status	Closed

**I. Project Team:**

Project Manager	Maria Veronica P. Angeles
Team Members	
Supervising Fellow	Samuel C. Rosal
Consultants/Resource Persons	Victoria S. Endaya

**II. Project Details****A. Project Description:**

Service quality is a measure of how an organization delivers its services compared to the expectations of its customers. Improving service quality can enhance an organization's reputation and have a direct impact on the satisfaction of customers. With this in mind, the Philippine government has prioritized service quality improvement towards citizen-centric public service in order to bring the government closer to the people.

Philippine government agencies should be responsive to the needs of their intended beneficiaries by improving productivity, in line with the Administration's thrust for seamless delivery of service and commitment to enhancing the social fabric through ensuring responsive, people- centered, technology-enabled, and clean governance as cited in the Philippine Development Plan 2017-2022.

This clear and compelling direction of the Administration further strengthens the need for government agencies to comply with Executive Order No. 605, Institutionalizing the Structure, Mechanisms, and Standards to Implement the Government Quality Management Program (GQMP), which was issued to all executive branch departments and agencies, government-owned and controlled corporations, and government financial institutions, state universities and colleges, and local government units to effect public sector performance by ensuring the consistency of products and services through quality processes;

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The DAP, as a member of the Technical Working Group on Advocacy and Capability-Building of the Government Quality Management Committee (GQMC), and as the National Productivity Organization, spearheads the development of productivity consciousness and promotes the principles, techniques, and practice of productivity and quality in key sectors of the economy. In line with this, the DAP aims to strengthen and expand the implementation of the Government Quality Management Program (GQMP) through effecting service quality improvement interventions for the GQMP Beneficiary Agencies.

Thus, the DAP has developed the Policies and Guidelines on the Provision of Technical Assistance on Strengthening Risk Management (SRM), Service Quality Improvement (SQI), and Capability-Building Intervention on QMS which details the scope and coverage of the technical assistance, eligibility requirements for program participation, including the screening and selection process.

The Technical Assistance on SQI focuses on effecting actual, measurable improvements in the quality of public service delivery, through the conduct of service quality assessment and provision of assistance in the implementation of appropriate actions to address areas for improvement.

**B. Project Objective:**

The project aims to effect actual, measurable improvement in the quality of frontline service delivery through the implementation of quick solutions within the project duration.

Specifically, it shall:

1. Determine service quality gaps based on process performance and feedback of key stakeholders/customers, and provide practical solutions to address the identified priority areas for improvement of frontline service delivery;
2. Enhance awareness on Service Quality Improvement (SQI); and,
3. Guide the implementation of agency action plans to effect actual, measurable improvement in the quality of frontline service delivery through the implementation of quick solutions within the project duration and through planning for the implementation of long-term solutions.

**C. Focus Area:** Public Sector Productivity

**D. Project Type:** GAA

**E. Project Beneficiary:** Health Sector

**F. Coverage:** NCR

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### **III. Project Accomplishments**

#### **A. Key Activities Implemented:**

Date	Activity
April 20, 25 and 26	<b>Pre-Assessment</b> <ul style="list-style-type: none"> <li>• Process Selection</li> <li>• Presentation of SWOT Analysis</li> <li>• Identification of the Core Processes</li> <li>• Ranking of Core Processes</li> </ul>
May 4 and 5	Introduction to Service Quality Assessment Service Quality Assessment of the Selected Processes <ul style="list-style-type: none"> <li>• Process Mapping</li> <li>• Service Quality Gap Identification</li> <li>• Service Quality Gap Description</li> <li>• Causes of Service Quality Gaps</li> <li>• Solutions to address the Service Quality Gaps</li> <li>• Ranking of Solutions</li> </ul>
May 8 to May 17	Service Quality Assessment <ul style="list-style-type: none"> <li>• Gathering of Documents</li> <li>• Document Review</li> </ul>
May 18	Presentation of SQA Results: <ul style="list-style-type: none"> <li>• Service Areas</li> <li>• Recommendations</li> <li>• Identification of priority recommendations for quick wins using the Stacey Matrix</li> </ul>
May 22	Onsite Observation, Interviews and Validation of SQA <b>Final Recommendations for action planning</b>
May 30,31, June 1	<b>Action Planning for Short Term Recommendations</b>
June 13	<b>General Orientation for SQI Implementation</b>
June 14, Aug 10 and 11	<b>Technical Assistance:</b> Personal and Organizational Change Management

#### **B. Major Outputs:**

- Service Quality Assessment Results
- Presentation of Recommendations on Service Quality Improvement
- Priority Improvement Action Plan

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**C. Project Impacts:**

Several project activities were successfully delivered by the DAP Project Team as per agreed schedule.

Conducted project activities were as follows:

- **Project Briefing** with the Medical Chief, Dr. Ignacia Fajardo and the SQI Core Team to give an overview of the assistance provided by DAP. The project team also gave them the criteria for choosing the critical process for assessment.
- **Process Selection Meeting.** The objective of the activity is to help the LPGen finalize the identified and shortlisted critical processes to be assessed based on the selection parameters.

Selected Service Areas:

- **Emergency Room (ER):** Timely Disposition of Patients - TAT of patient flow (dapat less than 6 hours)
- **Operating Room (OR):** Scheduling of Operation - ORMAT is not active; specifically, who is in charge? Final Recommendations for scheduling of doctors who are assigned
- **TeleMedicine:** Outpatient Department Teleconsultation - “sabog ang system, walang process of contacting patients, madaming complaints”

Core Process Selection for each Service Area:

The Core Processes and the SWOT Analysis for the ER, OR and TeleMed were identified and ranked to determine what core processes needed to be prioritized. The ranking of the core processes was based on the following:

- Customer Importance
- Gap in Performance
- Significance to Long Term Plan
- Urgency



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Ranked and Prioritized Core Processes for each Service Area:.

**Emergency Room**  
**Processes:** *Timely*  
*Disposition of Patients*

**Core Processes:**

- ☐ Triage/Encoding
- ☐ ER Med Assessment
- ☐ ER Doctor's Order
- ☐ Nurse Intervention
- ☐ Final Assessment
- ☐ Final Disposition
- ☐ Payment

**Operating Room Processes:**  
*Scheduling of Operation*

**Core Processes:**

- ☐ OR Notification
- ☐ Scheduling
- ☐ Pre-OP
- ☐ Intra-OP
- ☐ Post-OP

**TeleMedicine Processes:**  
*Outpatient Department*  
*Teleconsultation*

**Core Processes:**

- ☐ Registration
- ☐ Scheduling of Tele Appointment
- ☐ Consultation Proper
- ☐ Discharge

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- **Service Quality Assessment.** Introduction and Summary of Workshop Outputs

Process in Focus	Service Quality Assessment (SQA)			Service Quality Improvement (SQI)
	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
<b>Emergency Room Final Assessment Process:</b>  Timely Disposition of Patients	Patients' ER stay is 6 hours or more	The ER stay of the patient is experiencing delays.- specifically, documentary transition and task turn over between/among the triage officer, encoder/nurse attendant, treatment officer, other nurses.	Total TAT in the different areas is not monitored	ER1A: Implement a positive reinforcement,. with the use of an <b>ER Time Sheet</b> , to enhance responsibility and accountability of all involved in the documentation and task transitions. This includes the responsibility of obtaining the test results from the different department

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Process in Focus	Service Quality Assessment (SQA)			Service Quality Improvement (SQI)  <i>[consider the Strengths of the agency and the Stacey Matrix: Simple, Complicated, Complex, Chaotic]</i>
	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
		<p>There is a delay in testings and claiming results especially for non- mobile patients</p> <p>The nurse awaits the final disposition/decision of the</p>		ER1B: Install a paging system at the Treatment Officer area
			<p>High volume of patients</p> <p><i>possible lack of manpower in the laboratory or testing departments** not covered by the SQA</i></p>	ER 2: Review the Table of Organization, Recruitment and Retention process and match with the approved and updated plantilla

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		<p>senior resident/consultant which takes about one hour</p> <p>Patients are especially affected during peak times in the ER</p>	<ul style="list-style-type: none"> <li>➤ multiple assignments of residents assigned in the ER (absence of residents from other departments during referral)</li> <li>➤ 1<sup>st</sup> year residents- assigned to OPD and wards</li> <li>➤ 2<sup>nd</sup> year residents- assigned to ER</li> <li>➤ 3<sup>rd</sup> year residents- assigned to ICU</li> <li>➤ Junior consultants- can cover</li> </ul>	ER 3A: Assign dedicated ER residents.
			<ul style="list-style-type: none"> <li>➤ Incomplete accomplishment of documentation</li> <li>➤ Misplaced charts</li> </ul>	ER3B: Assign a nurse to specific patients, responsible for:



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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
			<ul style="list-style-type: none"> <li>➤ ER nurses ask the relatives of the patients to claim the test results for mobile and immobile patients</li> <li>➤ Nurse patient ratio from 2018 to 2022 (1:20, 1:23, 1:12, 1:14, 1:17, respectively)</li> </ul>	<ul style="list-style-type: none"> <li>➤ the usual ER Nurse tasks</li> <li>➤ the complete documentation and its safe keeping within the ER for the patient assigned to him/her</li> <li>➤ transitioning of the patient/documents to the next shift using the ER Time Sheet</li> <li>➤ Claiming all test results of the patient assigned to him/her</li> </ul>
				Other Solutions:  ER 4: Review of training policies and guidelines of each department (including

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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
				time and motion studies of charts)  ER 5: Review policies and guidelines regarding conduct of meetings of Emergency Department  ER 6: Overall collaborative meeting of stakeholders
		The allowable grace period for the start of operations is 45	OR Notification slip is not followed because of the delay of the Surgeon/doctor	OR1: Enhance the OR Notification slip to include

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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
<b>Operating Room Pre Operation Process:</b>  Scheduling of Operation	Grace period for start of operation exceeds the allowable 45 minutes	minutes. The delay happens right before the start of the scheduled operation in the OR.  The OR Notification Slip triggers the operation schedule  The team involved among others are:	for the following common reasons:  ➤ has no parking space ➤ is still in traffic, ➤ is still in another hospital (for different reasons)	the usual contents plus: the following:  ➤ “Received by” OR Nurse ➤ Confirmed schedule stamp with signature of the OR nurse ➤ Complete clearance requirements (Pre-operative Risk Evaluation) ➤ Actual Start Time of Operation

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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
		<p>surgeon and consultant/Attending Physician</p> <p>nurses- OR Nurse Supervisor, Scrub Nurse, Circulating Nurse, Nurse On Duty</p> <p>OR Head</p> <p>anesthesiologist</p> <p>pathologist</p> <p>The availability of all resources is not assured- OR, Human</p>		<p>OR 2A: Ensure copies of the OR Notification slip to the following</p> <ul style="list-style-type: none"> <li>➤ Doctor</li> <li>➤ Nurse supervisor</li> <li>➤ OR Ward</li> <li>➤ Anesthesiologist</li> </ul> <p>OR2B: Include reminders on the following:</p> <ul style="list-style-type: none"> <li>➤ Availability of parking</li> <li>➤ Overlapping schedule (rounds and other doctor duty)</li> <li>➤ Cancellation and postponement</li> </ul>

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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
		Capital, Equipment and other resources		➤ Coming on time
			Lack of OR nurses - Ideal is 103 nurses, actual is only 19 to maximize the 7 OR theaters	OR 3: Creation of letter addressed to Chief Nurse requesting to fill in the required Plantilla positions in the OR based on the DOH staffing pattern  OR 4: Recruitment and retention of Nurses
			OR Guidelines are not fully implemented	OR 5: Identification of ORMAT members

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<b>Process in Focus</b>	<b>Service Quality Assessment (SQA)</b>			<b>Service Quality Improvement (SQI)</b>  <i>[consider the Strengths of the agency and the Stacey Matrix: Simple, Complicated, Complex, Chaotic]</i>
	<b>Service Quality Gap that delays the Final Assessment</b>	<b>Service Quality Gap Description</b>	<b>Causes of Service Quality Gap</b>	<b>Solutions and Recommendation</b>
				OR 6: Review and update of existing Guidelines
			OR Notification is not digitized	OR 7: Creation of letter addressed to top management requesting for digitization of OR cases. scheduling with coordination with IHOMP  OR 8: Digitization of OR Notification

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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
<b>TeleMedicine Registration Process:</b> Outpatient Department	Complicated registration process	<ul style="list-style-type: none"> <li>➤ It takes at 5 clicks or more to register</li> <li>➤ Content is wordy- especially the welcome message and the disclaimer</li> </ul>	The registration process can be more user friendly (both for patients and the internal users)	TM 1: Improve hospital internet connectivity
	Communication with patients is 5 days after the registration	<p>No communication with patients after registration:</p> <ul style="list-style-type: none"> <li>➤ The OPD is not using the tele appointment system.</li> <li>➤ The telemedicine does not have an SOP (policies and guidelines)</li> </ul>	<p>No committee on Telemedicine mandated by the management</p> <p>Computers and software are slow and Internet connectivity is a challenge</p>	<p>TM 2A: Enhance the registration to a minimum/optimum number of clicks</p> <p>TM 2B: Centralize all the registration to Family Med for filtering (change the name of Family Med for telemedicine purposes);</p>

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Process in Focus	Service Quality Assessment (SQA)			Service Quality Improvement (SQI)  <i>[consider the Strengths of the agency and the Stacey Matrix: Simple, Complicated, Complex, Chaotic]</i>
	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
				<p>then filtered into 8 departments:</p> <ul style="list-style-type: none"> <li>➤ IM</li> <li>➤ ON</li> <li>➤ Pedia</li> <li>➤ Post surgery (with type of surgery)</li> <li>➤ Family Med</li> <li>➤ Pain Management</li> <li>➤ Rehab</li> <li>➤ Dental</li> </ul> <p>TM 3: Document the standard practice of the</p>



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	Service Quality Gap that delays the Final Assessment	Service Quality Gap Description	Causes of Service Quality Gap	Solutions and Recommendation
				<p>departments (4) using the telemedicine,</p> <p>TM 4: Initiate the creation of the tele medicine committee</p>

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- **Service Quality Improvement Recommendations using the Stacey Matrix for Quick Wins**

The Stacey Matrix is a technique for determining the proper management actions for a complex system. It was developed by Ralph Douglas Stacey as an aid in decision making. Today, it is no longer used only for decision making situations, but rather for selecting the appropriate project management method for a particular project.

### **ER Final Assessment Process**

#### **SIMPLE for Implementation**

**ER1A:** Implement a positive reinforcement, with the use of an **ER Time Sheet**, to enhance responsibility and accountability of all involved in the documentation and task transitions. This includes the responsibility of obtaining the test results from the different department.

**ER1B :** Install a paging system at the Treatment Officer area.

**ER 3A:** Assign dedicated ER residents.

**ER3B :** Assign a nurse to specific patients, responsible for:

- the usual ER Nurse tasks
- the complete documentation and its safe keeping within the ER for the patient assigned to him/her
- transitioning of the patient/documents to the next shift using the ER Time Sheet
- Claiming all test results of the patient assigned to him/her

**Note: TAT does not cover the waiting time of the patient. As the number of patient increases, the amount of waiting time increases. Below is an Illustration of the process (TAT with waiting time included) from the Triage Officer to the Encoder. The additional residents and nurses lessens the waiting time of the patients.**

<b>Patient no./Process</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
Filling up of Screening and Triage Form	1 min	1 min	1 min	1 min	1 min	1 min	1 min	1 min	1 min	1 min
Waiting Time	0 min	0 min	0 min	0 min	0 min	0 min	0 min	0 min	0 min	0 min
Verification of the Screening and Triage	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins

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Form										
Waiting Time (at most)	0 min	5 mins	10 mins	15 mins	20 mins	25 mins	30 mins	35 mins	40 mins	45 mins
Encoding of patient data and giving the blue card to the treatment officer (depending if the needed resident is in the ER)	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins	5 mins
Waiting time (at most)	0 min	5 mins	10 mins	15 mins	20 mins	25 mins	30 mins	35 mins	40 mins	45 mins
Total time spent in the ER from filling up the screening and triage form until encoding	11	21	31	41	51	61	71	81	91	101

**OR Pre-Operation Process SQI Recommendations:**

**SIMPLE** for implementation

**OR1** : Enhance the OR Notification slip to include the usual contents plus: the following:

- “Received by” OR Nurse
- Confirmed schedule stamp with signature of the OR nurse
- Complete clearance requirements (Pre-operative Risk Evaluation)

**OR 2A:** Ensure copies of the OR Notification slip to the following

- Doctor
- Nurse supervisor
- OR Ward
- Anesthesiologist

**OR 2B:** Include reminders on the following:

- Availability of parking
- Overlapping schedule (rounds and other doctor duty)
- Cancellation and postponement
- Coming on time

**OR 7** : Creation of letter addressed to top management requesting for digitization of OR cases. scheduling with coordination with IHOMPMP

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**TeleMedicine Registration Process SQI Recommendations:**

**SIMPLE** for implementation

**TM 1:** Improve hospital internet connectivity

**TM2A:** Enhance the registration to a minimum/optimum number of clicks

**TM2B:** Centralize all the registration to Family Med for filtering (change the name of Family Med for telemedicine purposes); then filtered into 8 departments:

- IM
- ON
- Pedia
- Post surgery (with type of surgery)
- Family Med
- Pain Management
- Rehab
- Dental

The recommendations are intended for the improvement of the following Key Performance Indicators (KPIs) of the following processes:

- **Emergency Room Final Assessment Processes:** Patients' stay in the ER- for more than 6 hours to be 6 hours or less on the average.
- **Operating Room Pre Operation Processes:** Start of OP for more than 45 minutes to be within the allowable time of 45 mins
- **TeleMedicine Registration Processes:** Simpler registration process and overall user-friendly telemedicine for both the patients and the internal stakeholders. For the registration clicks of more than 5 to 5 clicks or less

**Quick Wins: Baseline Data and Results of Actin Planning  
Implementation of SQI Recommendations as of 31 August 2023**

Process in Focus	Service Quality Improvement (SQI)  <i>[consider the Strengths of the agency and the Stacey Matrix: Simple, Complicated, Complex, Chaotic]</i>	Baseline Data prior to June 2023	Implementation Results- from July 1 to (on or before) Aug 31, 2023  <i>(indicate if implementation is</i>



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			<p>a. simple- within the duration of the project</p> <p>b. complicated or complex- still subject for discussions and action planning)</p>
<p><b>Emergency Room Final Assessment Process:</b></p> <p>Timely Disposition of Patients</p>	<p>ER1A: Implement a positive reinforcement, with the use of an <b>ER Time Sheet</b>, to enhance responsibility and accountability of all involved in the documentation and task transitions. This includes the responsibility of obtaining the test results from the different department</p> <p>ER1B: Install a paging system at the Treatment Officer area</p>	<p>Average Number of time (hours and mins) that a patient stays in the ER until final assessment:</p> <p>7 hours</p> <p>Average number of time (Mins and seconds ) that the treatment officer walks out to the encoder to call on the next patient:</p> <p>1-2 min for each station when the patient is called</p>	<p>Average Number of time (hours and mins) that a patient stays in the ER until final assessment:</p> <p>ongoing monitoring and implementation of ER time sheet</p> <p>Average number of time (Mins and seconds ) that the treatment officer calls out the next patient using the paging system: almost no delay noted for each station when the patient is called (please check data improvement below)</p>

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**ER Time Sheet** (content and format was determined), for enhancement to incorporate existing data sheets used.

Name of Patient: _____						
Other Relevant Details of Patient: _____						
ER Resident on Duty/Signature: _____						
Nurse assigned to the patient: _____						
Service Provider	Start Time	End Time	Output	Name of Service Provider	Signature	Remarks, if any
Nurse Attendant			1. Screening and Triage Form			
Triage Officer			2. Initial Assessment and Triage Classification			
Encoder/Nurse Attendant			3. Patient Registration/ ED Record			
Treatment Officer/Resident (other departments)			4. Assessment history, PE (with ED)			
Treatment Officer/Resident (of the department)			5. Initial Diagnosis and Treatment (with ED)			
Treatment Officer			6. Doctor's Order (with ED), <u>prescriptions</u> When applicable: Laboratory Request			
Nurse assigned to patient			7. Carried out Doctor's order (i.e. medication, diagnostics), notes on ED record			
			8. Copy of Lab or test results			
			9. Accomplished ER Notes on ER Records			
Treatment Officer/Resident of other departments			10. Final Disposition form (admit or discharge)			

Time of patient stay in ER prior to SQI (June 2023): 7 hours

[illegible]

Time of patient stay in ER after SQI Implementation (July 2023)  
For admission: between 1 hour and 50 mins to 4 hours and 4 mins



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For sending home: Between 1 hour and 30 minutes to 5 hours and 16 min

ARRIVAL					TREATMENT								ADMISSION							DURATION OF DISPOSITION (IN HOUR(S))				
NAME OF PATIENT	TRIAGE		ENCODING		IRIN	SERVICE	TREATMENT OFFICER	TIME SEEN		DIAGNOSTIC/ORDERS		DISPOSITION/TIME		DISPOSITION	REMARKS	ADMITTING SERVICE	ADMITTING DOCTOR	RECEIPT / ASSESSMENT OF REFERRAL			DIAGNOSTIC/ORDERS		DISPOSITION	REMARKS
	DATE	TIME	DATE	TIME				DATE	TIME	DATE	TIME	DATE	TIME					DATE	TIME					
1	Calala, Glenda	6/6/2022	6:45 PM	6/6/2022	6:49 PM	160170	EM	DR. JORDAN DELA CRUZ	6/6/2022	6:49 PM	6/6/2022	6:49 PM	6/6/2022	1:22 AM	REFERRED FOR M. 6/6/2022 ENT	M	DR. J. DELA CRUZ	6/6/2022	1:22 AM	6/6/2022	1:30 AM	ADMITTED	4hrs and 42min	
2	Fornesa, Ralfo	6/6/2022	1:10 AM	6/6/2022	1:26 AM	606010	EM	DR. JORDAN DELA CRUZ	6/6/2022	1:26 AM	6/6/2022	1:26 AM	6/6/2022	6:00 AM	REFERRED FOR M. 6/6/2022 ENT	PHED	DR. J. DELA CRUZ	6/6/2022	6:00 AM	6/6/2022	6:00 AM	ADMITTED	1hr and 20min	
3	Mendoza, John	6/6/2022	6:30 AM	6/6/2022	6:30 PM	606016	PHED	DR. JORDAN DELA CRUZ	6/6/2022	6:30 AM	6/6/2022	6:30 AM	6/6/2022	10:00 AM	REFERRED FOR M. 6/6/2022 ENT	PHED	DR. J. DELA CRUZ	6/6/2022	10:00 AM	6/6/2022	10:00 AM	ADMITTED	1 hr and 30 min	

	ARRIVAL					PHN	SERVIC OFFICER	TREATMENT										TOTAL HOURS DISPOSITION TIME
	IMAGE		REGISTRATION		TREATMENT OFFICER			START OF TREATMENT		DIAGNOSTICS/ ORDERS		DISPOSITION TIMEDATE		DISPOSITION	REMARKS			
	NAME OF PATIENT	DATE	TIME	DATE				TIME	DATE	TIME	DATE	TIME	DATE			TIME		
1	FLORES, JEAN	6/6/2022	7:52 0 AM	6/6/2022	8:00 0 AM	606015	SM	DR. BORRACIO	6/6/2022	8:40 AM	6/6/2022	8:40 AM	6/6/2022	11:30 0 AM	SENT HOME		3 hrs and 38 mins	
2	OCEJA, CHARLEN	6/6/2022	9:25 AM	6/6/2022	9:46 AM	625475	SM	DR. BORRACIO	6/6/2022	9:50 AM	6/6/2022	10:00 AM	6/6/2022	3:00 PM	SENT HOME		5 hrs and 16 mins	
3	RIALA, ANGEL	6/7/2022	9:00 AM	6/7/2022	9:12 AM	625719	SM	DR. MORTIEL	6/7/2022	9:15 AM	6/7/2022	9:15 AM	6/7/2022	10:40 AM	SENT HOME		1 hr and 20 mins	
4	KAHAL, ALI ALANO	6/6/2022	12:21 00 AM	6/6/2022	12:45 0 AM	625543	SM	DR. TUGRES	6/6/2022	12:50 AM	6/6/2022	12:50 AM	6/6/2022	3:00 AM	SENT HOME		2 hrs and 39 mins	
5	MASUELA, MARILYN	6/7/2022	5:50 0 PM	6/7/2022	5:54 PM	161661	SM	DR. TUGRES	6/7/2022	5:56 PM	6/7/2022	5:56 PM	6/7/2022	1:00 AM	SENT HOME		4 hrs and 10 mins	
6	REY, JEROME	6/6/2022	2:21 0 AM	6/6/2022	2:42 AM	625533	SM	DR. TUGRES	6/6/2022	2:44 AM	6/6/2022	2:45 AM	6/6/2022	4:15 AM	SENT HOME		1 hr and 54 mins	
7	TABICO, CONRAD O	6/7/2022	11:30 00 PM	6/7/2022	11:38 PM	625199	SM	DR. TUGRES	6/7/2022	11:38 PM	6/7/2022	11:38 PM	6/7/2022	2:30 AM	SENT HOME		3 hrs	
8	ITABLE, JEAN	6/6/2022	1:10 0 AM	6/6/2022	1:13 AM	625546	SM	DR. TUGRES	6/6/2022	1:15 AM	6/6/2022	1:15 AM	6/6/2022	3:30 AM	SENT HOME		3 hrs and 20 mins	
9	ROSACRA, CY	6/7/2022	9:40 0 PM	6/7/2022	10:01 PM	625525	SM	DR. TUGRES	6/7/2022	10:03 PM	6/7/2022	10:03 PM	6/7/2022	12:15 AM	SENT HOME		2 hrs and 35 mins	
10																		

**Productivity and Development Center  
Technology Management Office  
2023 Project Accomplishment Report**



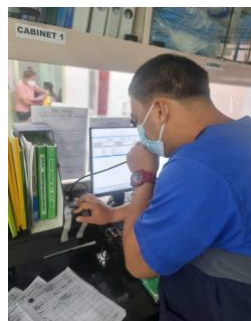
Prior to Installation of paging system (July 2023): **1-2 min for each station when the patient is called.**



**Now: 3 paging stations**

1. Nurse Station
2. Triage Area
3. E-med Consultation Area

After installation of paging system (June 2023) and after installation (July 2023): **almost no delay noted for each station when the patient is called.**



Speakers **newly installed:**

1. ER and Laboratory Waiting Area
2. Near Pharmacy/Main Lobby

ER 3A: Assign dedicated ER residents.

Number of dedicated ER residents: **4 (1 resident on duty per department - IM,OB,Pedia, Surgery)**

Number of dedicated ER residents: **4 (1 dedicated resident per department - IM,OB,Pedia, Surgery)**





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		ER Medicine Dept:  6 consultants  8 residents  TOTAL MDs: 18	ER Medicine Dept:  6 consultants  8 residents  TOTAL MDs: 18
	<b>Update:</b> <ul style="list-style-type: none"> <li>Meeting with the clinical department on the need for an organic resident that will man the ER at ALL times.</li> <li>Meeting DONE on 12 July 2023</li> <li>Creation/Approval of the proposed <b>guidelines regarding the dedicated resident</b> for each department. This contributed to the lessening of the patients' stay in the ER as indicated in the updated reports above.</li> <li>On-going creation</li> </ul>		

	ER3B: Assign a nurse to specific patients, responsible for: <ul style="list-style-type: none"> <li>➤ the usual ER Nurse tasks</li> <li>➤ the complete documentation and its safe keeping within the ER for the patient assigned to him/her</li> <li>➤ transitioning of the patient/documents to the next shift using the ER Time Sheet</li> <li>➤ Claiming all test results of the patient assigned to him/her</li> </ul>	Number of dedicated nurse specific to the patient: <p><b>No dedicated nurse assigned to specific patients</b></p> <p>1 nurse per 17 patients</p> <p>4 nurses per shift</p> <p>15 nurses</p> <p>13 nurse attendant</p>	Number of dedicated nurse specific to the patient: <p>On-going hiring</p> <p><b>One nurse is assigned for 2 departments</b></p> <p>One nurse assigned in OBS, handles all admitted and non-admitted patients of all departments</p> <p>On-going implementation of</p>
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			<b>Daily Work Activities From with the Approved Guidelines</b>
	<p><b>Update:</b></p> <ul style="list-style-type: none"><li>• Meeting with ER Nursing personnel regarding utilization of daily work activities (DWA) form.</li><li>• There is an existing form</li><li>• DWA form suggestions:<ul style="list-style-type: none"><li>○ Since it is generic for the whole of nursing service, <b>a Group Leader (GL) will be created by the ER nursing staff on how to fill out the form whenever the nurse is assigned to the ER</b></li></ul></li></ul> <p><b>This contributed to the lessening of the patient's stay in the ER as indicated in the updated reports above.</b></p> <ul style="list-style-type: none"><li>• On-going coordination with HR and Nursing Head</li></ul>		

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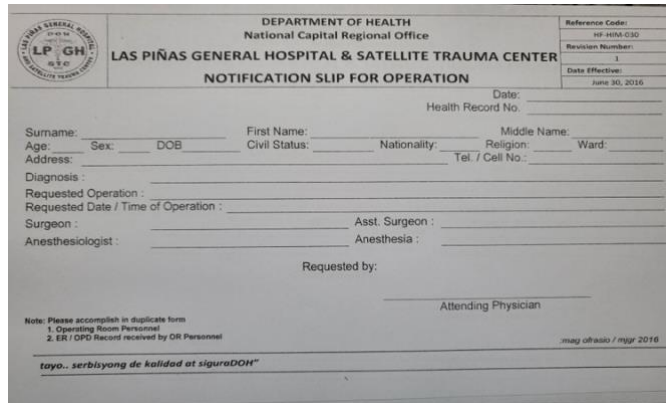
Process in Focus	Service Quality Improvement (SQI)  <i>[consider the Strengths of the agency and the Stacey Matrix: Simple, Complicated, Complex, Chaotic]</i>	Baseline Data prior to June 2023	Implementation Results- from July 1 to (on or before) Aug 31, 2023  <i>(indicate if implementation is</i>  <i>c. simple- within the duration of the project</i>  <i>d. complicated or complex- still subject for discussions and action planning)</i>
<b>Operating Room Pre Operation Process:</b>  Scheduling of Operation	OR1: Enhance the OR Notification slip to include the usual contents plus: the following: <ul style="list-style-type: none"> <li>• “Received by” OR Nurse</li> <li>• Confirmed schedule stamp with signature of the OR nurse</li> <li>• Complete clearance requirements (Pre-operative Risk Evaluation)</li> <li>• Actual Start Time of Operation</li> </ul>	Information indicated on the OR Notification:  <div style="background-color: yellow; padding: 2px;">(see attached <b>old OR Notification</b>)</div>	Additional Information indicated on the OR Notification:  <b>IM/Pedia Clearance Requirements Completed by</b> _____  <b>Date and time</b>  <b>Received and confirmed by_____</b>  <b>OR NOD signature</b>

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**Technology Management Office**  
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			Date and Time
	<p>OR 2A: Ensure copies of the OR Notification slip to the following</p> <ul style="list-style-type: none"> <li>• Doctor</li> <li>• Nurse supervisor</li> <li>• OR Ward</li> <li>• Anesthesiologist</li> </ul> <p>OR2B: Include reminders on the following:</p> <ul style="list-style-type: none"> <li>• Availability of parking</li> <li>• Overlapping schedule (rounds and other doctor duty)</li> <li>• Cancellation and postponement</li> <li>• Coming on time</li> </ul> <ul style="list-style-type: none"> <li>• Actual Start Time of Operation</li> </ul>	<p>Recipients of the OR Notification copy:</p> <p>Duplicate form:</p> <ol style="list-style-type: none"> <li>1. OR Personnel</li> <li>2. ER/OPD Record received by OR Personnel</li> </ol> <p>Relevant reminders to prevent delay in the start of the operation: None</p> <p>% of start time of operation beyond 45 mins:  Jan-Dec 2022: 63.93%  Jan-June 2023: 45.35%</p>	<p>(see attached new OR Notification)</p> <p>Recipients of the OR Notification copy:</p> <p>Quadruplicate form:</p> <ol style="list-style-type: none"> <li>1. OR Personnel</li> <li>2. Ward/OPD/ER Personnel</li> <li>3. Surgeon</li> <li>4. Anesthesiologist</li> </ol> <p>Relevant reminders to prevent delay in the start of the operation:</p> <ol style="list-style-type: none"> <li>1. Parking Space</li> <li>2. Schedule Cardio/Pulmo Clearance</li> </ol> <p>% of start time of operation beyond 45 mins: 0</p>

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**OLD OR NOTIFICATION SLIP (June 2023)**



**DEPARTMENT OF HEALTH  
National Capital Regional Office  
LAS PIÑAS GENERAL HOSPITAL & SATELLITE TRAUMA CENTER  
NOTIFICATION SLIP FOR OPERATION**

Reference Code: HP-HM-C30  
Revision Number: 1  
Date Effective: June 30, 2016

Date: \_\_\_\_\_  
Health Record No. \_\_\_\_\_

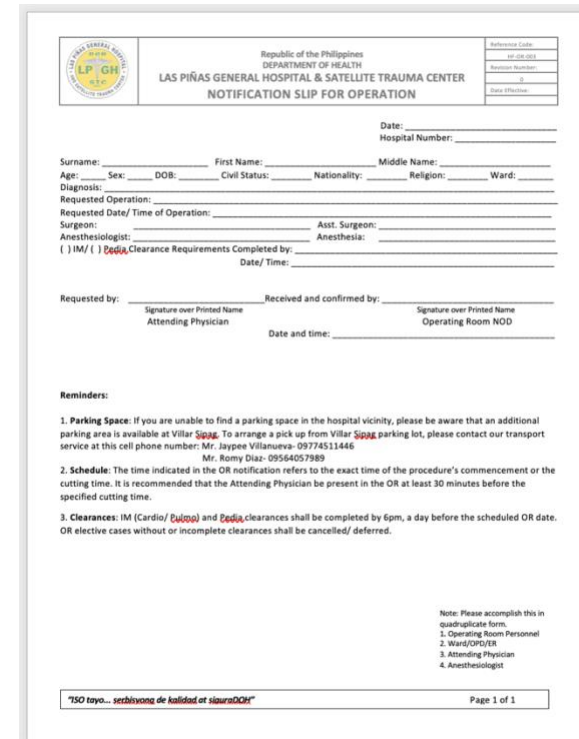
Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Civil Status: \_\_\_\_\_ Nationality: \_\_\_\_\_ Religion: \_\_\_\_\_ Ward: \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. / Cell No.: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Requested Operation: \_\_\_\_\_  
Requested Date / Time of Operation: \_\_\_\_\_  
Surgeon: \_\_\_\_\_ Asst. Surgeon: \_\_\_\_\_  
Anesthesiologist: \_\_\_\_\_ Anesthesia: \_\_\_\_\_  
Requested by: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_

Note: Please accomplish in duplicate form  
1. Operating Room Personnel  
2. ER / OPD Record received by OR Personnel

*may oras na / may 2016*

*ISO toyo... serbiyong de kalidad at siguradoH*

**NEW OR NOTIFICATION SLIP (July 2023 for SQI)**



**Republic of the Philippines  
DEPARTMENT OF HEALTH  
LAS PIÑAS GENERAL HOSPITAL & SATELLITE TRAUMA CENTER  
NOTIFICATION SLIP FOR OPERATION**

Reference Code: HP-OR-001  
Revision Number: 3  
Date Effective: \_\_\_\_\_

Date: \_\_\_\_\_  
Hospital Number: \_\_\_\_\_

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Civil Status: \_\_\_\_\_ Nationality: \_\_\_\_\_ Religion: \_\_\_\_\_ Ward: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Requested Operation: \_\_\_\_\_  
Requested Date / Time of Operation: \_\_\_\_\_  
Surgeon: \_\_\_\_\_ Asst. Surgeon: \_\_\_\_\_  
Anesthesiologist: \_\_\_\_\_ Anesthesia: \_\_\_\_\_  
( ) IM / ( ) **Pedia** Clearance Requirements Completed by: \_\_\_\_\_  
Date / Time: \_\_\_\_\_

Requested by: \_\_\_\_\_ Signature over Printed Name: \_\_\_\_\_  
Attending Physician

Received and confirmed by: \_\_\_\_\_ Signature over Printed Name: \_\_\_\_\_  
Operating Room NOD  
Date and time: \_\_\_\_\_

**Reminders:**

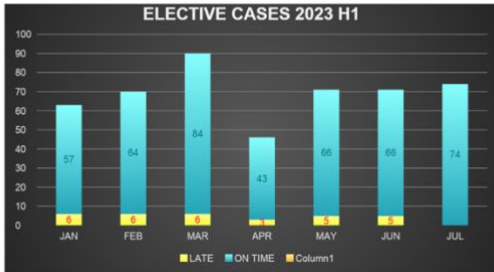
- Parking Space:** If you are unable to find a parking space in the hospital vicinity, please be aware that an additional parking area is available at Villar **Spag**. To arrange a pick up from Villar **Spag** parking lot, please contact our transport service at this cell phone number: Mr. Jaypee Villanueva- 09774511446  
Mr. Romy Diaz- 09564057989
- Schedule:** The time indicated in the OR notification refers to the exact time of the procedure's commencement or the cutting time. It is recommended that the Attending Physician be present in the OR at least 30 minutes before the specified cutting time.
- Clearances:** IM (Cardio/ **Dulopo**) and **Pedia** clearances shall be completed by 6pm, a day before the scheduled OR date. OR elective cases without or incomplete clearances shall be cancelled/ deferred.

Note: Please accomplish this in quadruplicate form.  
1. Operating Room Personnel  
2. Ward/OPD/ER  
3. Attending Physician  
4. Anesthesiologist

*ISO toyo... serbiyong de kalidad at siguradoH*

Page 1 of 1

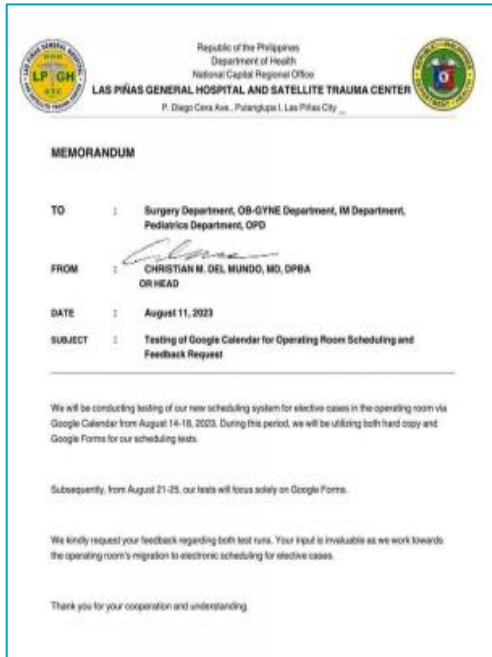

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Technology Management Office  
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	<div><div><div>Delay of start of operation beyond 45 minutes <b>BEFORE</b> implementation of new OR Notification Form: Jan – Dec 2022: 63.93% Jan – June 2023: 45.35%</div><div>➔</div><div>Delay of start of operation beyond 45 minutes <b>AFTER</b> implementation of new OR Notification Form: <b>Zero (0)</b></div></div><div><div>REPORT ON OPERATING ROOM LATE CASES DUE TO LATE SURGEONS</div><div><div>ELECTIVE CASES 2023 H1</div><table><thead><tr><th>Month</th><th>ON TIME</th><th>LATE</th></tr></thead><tbody><tr><td>JAN</td><td>57</td><td>6</td></tr><tr><td>FEB</td><td>64</td><td>6</td></tr><tr><td>MAR</td><td>84</td><td>6</td></tr><tr><td>APR</td><td>43</td><td>6</td></tr><tr><td>MAY</td><td>66</td><td>5</td></tr><tr><td>JUN</td><td>66</td><td>5</td></tr><tr><td>JUL</td><td>74</td><td>5</td></tr></tbody></table></div></div></div>	Month	ON TIME	LATE	JAN	57	6	FEB	64	6	MAR	84	6	APR	43	6	MAY	66	5	JUN	66	5	JUL	74	5
Month	ON TIME	LATE																							
JAN	57	6																							
FEB	64	6																							
MAR	84	6																							
APR	43	6																							
MAY	66	5																							
JUN	66	5																							
JUL	74	5																							
OR 5: Identification of ORMAT members	<div><div>Is the ORMAT functional? <b>No</b></div><div>Is the ORMAT Functional? <b>Yes with monthly meeting (2<sup>nd</sup> Wednesday of the month)</b></div></div>																								

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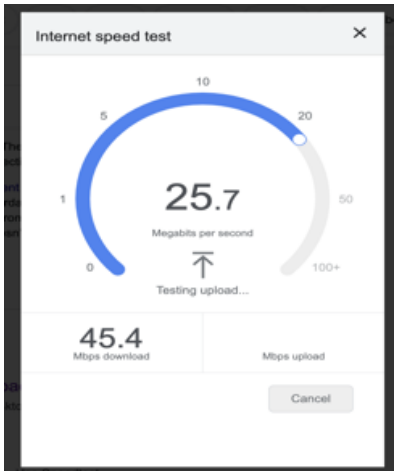

	<div><div>ORMAT: Description and Role</div><div><div>OPERATING ROOM MANAGEMENT TEAM</div><div>The ORMAT is an interdisciplinary Committee composed of medical staff tasked to coordinate and standardize the care of patients undergoing surgical or other invasive procedures.</div><div>The Committee aims:</div><div><div><div>1. To oversee clinical practice related to preoperative, intraoperative, and post operative procedure care.</div><div>2. To collaborate with Documentation and Records Committee and Quality Management Representative to ensure alignment and adherence to quality management standards.</div><div>3. To review and provide recommendations on clinical policies and procedures within and outside the Operating Room Complex.</div><div>4. To oversee and ensure the equitable distribution of resources including OR time within the operative areas to meet the needs of surgical patients, with focus on patient safety quality of care and patient satisfaction.</div></div><div>Team Composition</div><div>Chief Medical Professional Staff – ORMAT Committee Advisor Operating Room Head – ORMAT Committee Head</div><div>Members:</div><div>Consultant representative from the Department of Surgery Consultant Representative from the Department of Anesthesiology Consultant Representative from the Department of Obstetrics and Gynecology Consultant Representative from the Department of Internal Medicine (Gastroenterologist, optional) OR Nurse Supervisor</div></div></div></div>		
OR 6: Review and update of existing OR Guidelines	When was the existing OR guideline updated? Not updated	When was the existing OR guideline updated? July 2023 – GL-or 007	
OR 7: Creation of letter addressed to top management requesting for digitization of OR cases scheduling with coordination with IHOMP	Are the OR Cases digitized? Not yet done	Are the OR Cases digitized? Letter for digitization approved by MCC II and ORMAT Head  On-going dry run	

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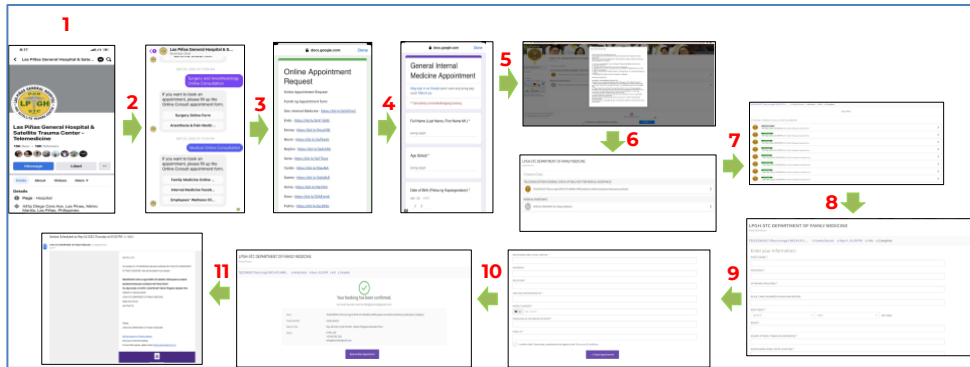




	<p align="center">OR 8: Digitization of OR Notification</p>	<p>Is the OR Notification digitized? <b>No</b></p>	<p>Is the OR Notification digitized? <b>Still for approval of ORMAT Head</b></p>
	<p align="center">Letter Request for Digitization:</p> <div data-bbox="562 582 1052 1241">  <p><b>MEMORANDUM</b></p> <p><b>TO :</b> Surgery Department, OB-GYNE Department, IM Department, Pediatrics Department, OPD</p> <p><b>FROM :</b>  CHRISTIAN M. DEL MUNDO, MD, OPBA OR HEAD</p> <p><b>DATE :</b> August 11, 2023</p> <p><b>SUBJECT :</b> Testing of Google Calendar for Operating Room Scheduling and Feedback Request</p> <p>We will be conducting testing of our new scheduling system for elective cases in the operating room via Google Calendar from August 14-18, 2023. During this period, we will be utilizing both hard copy and Google Forms for our scheduling tests.</p> <p>Subsequently, from August 21-25, our tests will focus solely on Google Forms.</p> <p>We kindly request your feedback regarding both test runs. Your input is invaluable as we work towards the operating room's migration to electronic scheduling for elective cases.</p> <p>Thank you for your cooperation and understanding.</p> </div>	<p align="center">Links to OR Google Form ad Google Calendar as start of Digitization</p> <div data-bbox="1088 632 1812 1043"> <ul style="list-style-type: none"> <li>You can now try to set schedule for Operating Room by accessing the following links</li> <li>Google Forms for scheduling of operating room 1: • <a href="https://forms.gle/AUsA9WaYeibRmbVKA">https://forms.gle/AUsA9WaYeibRmbVKA</a></li> <li>Access code: lpghstcor1</li> <li>Google Calendar of Operating Room Schedule: • <a href="https://calendar.google.com/calendar/u/0?cid=OGNkY2ZhZTBjOWFmODE0M2M3NWVmYzg5MzAyMTJkZGI4ZDY2MjY2N2JjYjUxZDZmZTA5YTUyYjY5ZDU4YmM0MkBNcm91cC5jYWxlbnRhci5nb29nbGUuY29t">https://calendar.google.com/calendar/u/0?cid=OGNkY2ZhZTBjOWFmODE0M2M3NWVmYzg5MzAyMTJkZGI4ZDY2MjY2N2JjYjUxZDZmZTA5YTUyYjY5ZDU4YmM0MkBNcm91cC5jYWxlbnRhci5nb29nbGUuY29t</a></li> </ul> </div>	






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Process in Focus	Service Quality Improvement (SQI) <i>[consider the Strengths of the agency and the Stacey Matrix: Simple, Complicated, Complex, Chaotic]</i>	Baseline Data prior to June 2023	Implementation Results- from July 1 to (on or before) Aug 31, 2023  <i>(indicate if implementation is  e. simple- within the duration of the project  f. complicated or complex- still subject for discussions and action planning)</i>
<b>TeleMedicine Registration Process:</b>  Outpatient Department	TM 1:Improve hospital internet connectivity	Internet bandwidth: <b>100 mbps</b>	Internet bandwidth: <b>200 mbps</b>
	<div>  <div> <p><b>Current speed:</b></p> <p>The total mb/s for the whole hospital is now 200 mbps compared to 100 mpbs in June 2023.</p> <p align="center"></p> <p><b>Latest Update:</b></p> <p>Device used (mb/s per person). Each person was assigned a unique username and passcode to be cable to connect to the hospital's internet.</p> </div> </div>		

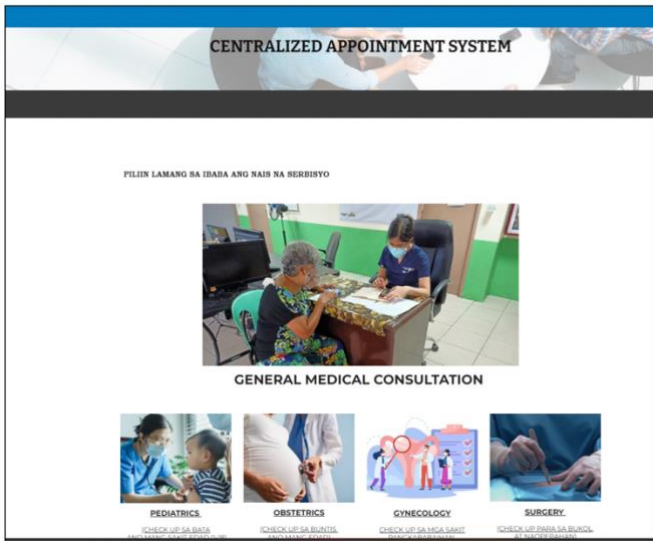
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	<p>TM 2A: Enhance the registration to a minimum/optimum number of clicks</p>	<p>Number of <b>digital clicks</b> to register (for outpatient): <b>Eleven (11)</b></p>	<p>Number of <b>digital clicks</b> to register (for outpatient): <b>Five (5)</b></p>
	<p><b>Prior to SQL: Eleven (11) clicks to register (June 2023)</b></p>  <p><b>After SQL Implementation: 5 clicks:</b></p> <div style="display: flex; flex-direction: column; align-items: center;"> <div style="display: flex; justify-content: space-between; width: 100%;"> <div style="width: 45%;"> <p><b>Click 1.</b> The new FB page of LPCH Telemedicine. Upon opening the FB page, a cover photo with instructions will be seen.</p>  </div> <div style="width: 45%;"> <p><b>Click 2.</b> Upon clicking the SIGN-UP Button, another window will open. The central link for all the registration of the different departments. The patient will click the service they need as described.</p>  </div> </div> <div style="display: flex; justify-content: space-between; width: 100%; margin-top: 20px;"> <div style="width: 45%;"> <p><b>Click 4 &amp; 5.</b> They need to click the "I AGREE" button at the end for the disclaimer before clicking the SUBMIT button.</p>  </div> <div style="width: 45%;"> <p><b>Click 3.</b> After clicking their preferred service, another prompt will open. They just need to provide the details needed.</p>  </div> </div> </div>		

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	<div> <div> <p>After clicking the SUBMIT button, another prompt will open for instructions. The link below will be for those who did not receive their appointment after 5 days for them to be able to follow-up their previous request.</p> </div> <div> <p><b>PEDIATRICS Appointment Request Form</b></p> <p>Natanggap na po namin ang inyong request for Appointment.</p> <p>Kung walang natanggap ng confirmation ng appointment galing sa department na inyong nirequest sa loob ng limang (5) araw.</p> <p>Maaring sagutan po ang form na ito upang mafollow up ang inyong appointment request.</p> <p><a href="https://forms.gle/vZoaabxth7UfMYGA">https://forms.gle/vZoaabxth7UfMYGA</a></p> <p><small>This content is neither created nor endorsed by Google. Report Abuse - Terms of Service - Privacy Policy</small></p> <p align="center">Google Forms</p> </div> </div>		
	<div> <div> <p><b>Before:</b> The patient needs to click the MESSAGE BUTTON to have their appointment. There's also no instructions given.</p>  </div> <div> <p><b>Current:</b> Now, there's a big sign in the cover photo for the instructions. They also need to click the SIGN-UP button. (we weren't able to make it BOOK NOW button since the app linked to BOOK NOW button have certain fees)</p>  </div> <div> <p><b>Simplifying the disclaimer button by changing from TYPE Box to CHECK button "I AGREE" button</b></p>  </div> </div>		
	<p><b>Prior to SQI Implementation:</b> Multiple portal/links are used for registration.</p> <ul style="list-style-type: none"> <li>To reduce the number of portal or links for registration to 1 link for all the departments by June 2023.</li> </ul> <p><b>After to SQI Implementation:</b> Only one (1) portal/link for all the departments</p> <ul style="list-style-type: none"> <li><a href="https://sites.google.com/view/lpghtelemed/home?fbclid=IwAR2MG3i4TVn7ysmXJPuIvKq3LnvqvdmzPxDGMYAJRCwIJyMbHPYUKwOI6w4">https://sites.google.com/view/lpghtelemed/home?fbclid=IwAR2MG3i4TVn7ysmXJPuIvKq3LnvqvdmzPxDGMYAJRCwIJyMbHPYUKwOI6w4</a></li> </ul>		
	<p>TM 2B: Centralize all the registration to Family Med for filtering (change the name of Family Med for telemedicine purposes); then filtered into 8 departments:</p>	<p>% of mistriaged registration: <b>No data available</b></p> <p>** no data of mistriaging but it happens</p>	<p>% of mistriaged registration: <b>On-going monitoring and data gathering</b></p>

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2023 Project Accomplishment Report**

	<ul style="list-style-type: none"> <li>• IM, OB, Pedia</li> <li>• Post surgery (with type of surgery)</li> <li>• Family Med</li> <li>• Pain Management</li> <li>• Rehab</li> <li>• Dental</li> </ul>		
	<p align="center"><b>Latest Update:</b></p> <p>Centralize all the registration to Family Med for filtering (change the name of Family Med for telemedicine purposes); then filtered into 8 departments:</p> <ul style="list-style-type: none"> <li>• Creation of Online Google Form for registration which will be linked to the BOOK NOW Button.</li> <li>• One link for all the departments:  <a href="https://sites.google.com/view/lpghteledmed/home?fbclid=IwAR2MG3i4TVn7ysmXJPulvKq3LnvqvdmzPxDGMYAIRCwIJyMbHPYUKwOI6w4">https://sites.google.com/view/lpghteledmed/home?fbclid=IwAR2MG3i4TVn7ysmXJPulvKq3LnvqvdmzPxDGMYAIRCwIJyMbHPYUKwOI6w4</a> </li> </ul>		<p><b>To lessen the mistreated in the registration process of tele-appointment from 20% to 5%by June 2023:</b>  <b>Not yet assessed, changes are still for implementation.</b></p>

**Productivity and Development Center**  
**Technology Management Office**  
**2022 Project Accomplishment Report**

*What went well:*

1. An overview of the project was discussed to the top management and the SQI Core Team the criteria for choosing the critical processes during the project briefing. Thus, they had ample time in deliberating the top three (3) processes prior to presenting to DAP and while waiting for the official start of the project;
2. Dr. June De Vera, SQI Core Team member, who also directly coordinates with DAP, was very dedicated. Support of the Medical Chief was also very evident.
3. Validation interviews and hospital visit were done onsite which helped the DAP Project Team understand the flow of the critical processes clearly.
4. All of the activities were done onsite: Introduction and Workshop on SQI, Action Planning Workshop for the SQI Core team and Orientation (2 batches for general employees)
5. Based on the results of the Action Planning, the DAP Project Team recommended to have an Organizational Transition and Change Workshop (3 batches for general employees) that would help the implementation of simple quick win solutions.
6. Consistent follow-up and reminders from the Project Manager and SQI Secretariat helped the agency finish the project on time; and,
7. Commitment of LPGen to finish the project on time with implemented improvement on their chosen process.

*Points for Improvement:*

1. More time implementing the improvements for evaluation.

**Lessons Learned:**

Observing and knowing the needs of your client are very important to be able to recommend activities that will help them implement the quick win solutions. Constant communication and update with the SQI Core Team will help them appreciate and understand the whole process of the technical assistance, as well the roles and responsibilities of each member of the SQI Core Team, Secretariat and Process Owners. Activities were done smoothly because of their commitment.

**Productivity and Development Center**  
**Technology Management Office**  
**2022 Project Accomplishment Report**

#### **IV. Attachments**

Annex A – Certificate of Project Deliverables


Annex B – Certificate of Project Closure

Annex C – Evaluation from the Professional Education, Training, and Research Unit (PETRU)

*Prepared by:*

  
**MARIA VERONICA P. ANGELES**  
Project Manager

*Approved by:*

  
**SAMUEL C. ROSAL**  
Director, PDC - TMO

*Noted by:*

  
**ARNEL D. ABANTO**  
Vice President, PDC

**Notes:**

1. Project details on Section I-III can be generated thru PMIS based on PMs Inputs
2. Project Managers are required to accomplish Section IV & provide Section V to reflect results of project implementation
3. Project Managers can update/adjust the pre-filled sections(I-III) based on actual data.



**CERTIFICATE OF PROJECT DELIVERABLE ACCEPTED**

Date : 2-May-23

Center : PDC-TMO Project Code : QEGXD  
Project Title : Technical Assistance on Service Quality Improvement  
Client : Las Piñas General Hospital and Satellite Trauma Center (LPGen)  
Project Manager : Maria Veronica P. Angeles

**Deliverable Information/ Report**

Project Phase : Process Selection Meeting (25 PM and 26 PM April 2023)  
Deliverable : Critical Process/es for Assessment

**Acceptance Information/Report**



Approved



Deferred

INSTRUCTIONS: On a scale of 1 to 5, rate the project in each of the relevant indices below.  
The ends of the scale are 1 - Poor and 5 - Excellent. Encircle the number which best indicates your rating of the project deliverable in that item.

- |                                                                   |   |   |   |   |   |
|-------------------------------------------------------------------|---|---|---|---|---|
| 1. Overall Satisfaction                                           | 1 | 2 | 3 | 4 | 5 |
| 2. Project deliverable was submitted within agreed timeframe      | 1 | 2 | 3 | 4 | 5 |
| 3. Project deliverable was acceptable as agreed upon.             | 1 | 2 | 3 | 4 | 5 |
| 4. Project deliverable was made within the standards agreed upon. | 1 | 2 | 3 | 4 | 5 |

Comments:  
(if any)

Authorized Representative/s:

DR. IGNACIA G. FAJARDO

Signature over printed name

MEDICAL CENTER CHIEF II

Position / Designation



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## CERTIFICATE OF PROJECT DELIVERABLE ACCEPTED

Date : 9-May-23

Center : PDC-TMO Project Code : QEGXD  
Project Title : Technical Assistance on Service Quality Improvement  
Client : Las Piñas General Hospital and Satellite Trauma Center (LPGen)  
Project Manager : Maria Veronica P. Angeles

### Deliverable Information/ Report

Project Phase : SQA: Introduction and Workshop (4 and 5 May 2023)  
Deliverable : Process Map of the 3 processes, Gap Analysis and Solutions

### Acceptance Information/Report



Approved



Deferred

INSTRUCTIONS: On a scale of 1 to 5, rate the project in each of the relevant indices below.  
The ends of the scale are 1 - Poor and 5 - Excellent. Encircle the number which best indicates your rating of the project deliverable in that item.

- |                                                                   |   |   |   |   |   |
|-------------------------------------------------------------------|---|---|---|---|---|
| 1. Overall Satisfaction                                           | 1 | 2 | 3 | 4 | 5 |
| 2. Project deliverable was submitted within agreed timeframe      | 1 | 2 | 3 | 4 | 5 |
| 3. Project deliverable was acceptable as agreed upon.             | 1 | 2 | 3 | 4 | 5 |
| 4. Project deliverable was made within the standards agreed upon. | 1 | 2 | 3 | 4 | 5 |

Comments:  
(if any)

Authorized Representative/s:

  
DR. IGNACIA G. FAJARDO

Signature over printed name

MEDICAL CENTER CHIEF II

Position / Designation





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## CERTIFICATE OF PROJECT DELIVERABLE ACCEPTED

Date : 2-Jun-23

Center : PDC-TMO Project Code : QEGXD  
Project Title : Technical Assistance on Service Quality Improvement  
Client : Las Piñas General Hospital and Satellite Trauma Center (LPGen)  
Project Manager : Maria Veronica P. Angeles

### Deliverable Information/ Report

Project Phase : TG on SQI Implementation (Action Planning Workshop 30, 31 May and 1 June 2023)  
Deliverable : Priority Improvement Plans for the SQA Recommendations  
Communication Plan for the SQA Recommendations

### Acceptance Information/Report



Approved



Deferred

INSTRUCTIONS: On a scale of 1 to 5, rate the project in each of the relevant indices below. The ends of the scale are 1 - Poor and 5 - Excellent. Encircle the number which best indicates your rating of the project deliverable in that item.

1. Overall Satisfaction
2. Project deliverable was submitted within agreed timeframe
3. Project deliverable was acceptable as agreed upon.
4. Project deliverable was made within the standards agreed upon.

1 2 3 4 5  
1 2 3 4 5  
1 2 3 4 5  
1 2 3 4 5

Comments:  
(if any)

The project activities are able to engage the participants with great interest and enthusiasm. The targeting & action plans made them realize that there have to be taken seriously & monitored.

Authorized Representative/s:

DR. IGNACIA G. BAJARDO

Signature over printed name

MEDICAL CENTER CHIEF II

Position / Designation

Thank you for your  
effort and  
motivation.



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## CERTIFICATE OF PROJECT DELIVERABLE ACCEPTED

Date : 18-May-23

Center : PDC-TMO Project Code : QEGXD  
Project Title : Technical Assistance on Service Quality Improvement  
Client : Las Piñas General Hospital and Satellite Trauma Center (LPGen)  
Project Manager : Maria Veronica P. Angeles

### Deliverable Information/ Report

Project Phase : Service Quality Assessment  
Deliverable : Final Presentation of SQA Results and Recommendations

### Acceptance Information/Report



Approved



Deferred

INSTRUCTIONS: On a scale of 1 to 5, rate the project in each of the relevant indices below. The ends of the scale are 1 - Poor and 5 - Excellent. Encircle the number which best indicates your rating of the project deliverable in that item.

- |                                                                   |   |   |   |   |   |
|-------------------------------------------------------------------|---|---|---|---|---|
| 1. Overall Satisfaction                                           | 1 | 2 | 3 | 4 | 5 |
| 2. Project deliverable was submitted within agreed timeframe      | 1 | 2 | 3 | 4 | 5 |
| 3. Project deliverable was acceptable as agreed upon.             | 1 | 2 | 3 | 4 | 5 |
| 4. Project deliverable was made within the standards agreed upon. | 1 | 2 | 3 | 4 | 5 |

Comments:  
(if any)

Authorized Representative/s:

  
DR. IGNACIA G. FAJARDO

Signature over printed name

MEDICAL CENTER CHIEF II

Position / Designation



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## CERTIFICATE OF PROJECT DELIVERABLE ACCEPTED

Date : 14-Jul-23

Center : PDC-TMO Project Code : QEGXD  
Project Title : Technical Assistance on Service Quality Improvement  
Client : Las Piñas General Hospital and Satellite Trauma Center  
Project Manager : Maria Veronica P. Angeles

### Deliverable Information/ Report

Project Phase : TG on SQI Implementation  
Deliverable : Orientation on SQI with Top Management and Employees (13 July 2023)

### Acceptance Information/Report



Approved



Deferred

INSTRUCTIONS: On a scale of 1 to 5, rate the project in each of the relevant indices below.  
The ends of the scale are 1 - Poor and 5 - Excellent. Encircle the number which best indicates your rating of the project deliverable in that item.

- |                                                                   |   |   |   |   |   |
|-------------------------------------------------------------------|---|---|---|---|---|
| 1. Overall Satisfaction                                           | 1 | 2 | 3 | 4 | 5 |
| 2. Project deliverable was submitted within agreed timeframe      | 1 | 2 | 3 | 4 | 5 |
| 3. Project deliverable was acceptable as agreed upon.             | 1 | 2 | 3 | 4 | 5 |
| 4. Project deliverable was made within the standards agreed upon. | 1 | 2 | 3 | 4 | 5 |

Comments:  
(if any)

Authorized Representative/s:

DR. IGNACIA S. FAJARDO

Signature over printed name

MEDICAL CENTER CHIEF II

Position / Designation



CERTIFICATE OF PROJECT DELIVERABLE ACCEPTED

Date : 14-Aug-23

Center : PDC-TMO Project Code : QEGXD  
Project Title : Technical Assistance on Service Quality Improvement  
Client : Las Piñas General Hospital and Satellite Trauma Center  
Project Manager : Maria Veronica P. Angeles

Deliverable Information/ Report

Project Phase : TG on SQI Implementation  
Deliverable : Workshop on Organization Care and Change (14 July, 10 and 11 August)

Acceptance Information/Report



Approved



Deferred

INSTRUCTIONS: On a scale of 1 to 5, rate the project in each of the relevant indices below. The ends of the scale are 1 - Poor and 5 - Excellent. Encircle the number which best indicates your rating of the project deliverable in that item.

- |                                                                   |   |   |   |   |   |
|-------------------------------------------------------------------|---|---|---|---|---|
| 1. Overall Satisfaction                                           | 1 | 2 | 3 | 4 | 5 |
| 2. Project deliverable was submitted within agreed timeframe      | 1 | 2 | 3 | 4 | 5 |
| 3. Project deliverable was acceptable as agreed upon.             | 1 | 2 | 3 | 4 | 5 |
| 4. Project deliverable was made within the standards agreed upon. | 1 | 2 | 3 | 4 | 5 |

Comments:  
(if any)

Authorized Representative/s:

DR. IGNACIA G. FAJARDO

Signature over printed name

MEDICAL CENTER CHIEF II

Position / Designation



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## CERTIFICATE OF PROJECT CLOSURE

Date: 28 Sept 2023

Project Title : Technical Assistance on Service Quality Improvement  
Project Manager : Maria Veronica P. Angeles  
Center : Productivity and Development Center  
Project Duration : March to August 2023  
Project Code : QEGXD  
Client : Las Piñas General Hospital and Satellite Trauma Center

This is to certify that the above-cited project is declared officially closed. It further certifies that all project outputs have been delivered and satisfactorily conform to our agreements and our office's standards.

Overall Satisfaction

Not Satisfied 1 2 3 4 5 Very Satisfied

FEEDBACK (please indicate here your comments and/or suggestions for further improving our services.)

*We are grateful to the facilitator. Their good nature and expertise not limiting to technical assistance are all valuable in making us fully understand that this undertaking would enhance the good things we have started and to cultivate among us the shared responsibility in moving forward to quality improvement in our clinic delivery.*

Authorized Representative of Client Agency:

*Ignacia G. Fajardo*  
DR. IGNACIA G. FAJARDO  
Signature over printed name

Medical Center Chief II  
Position/Designation

DAP-WI-04 F13, Rev. 3



Republic of the Philippines  
Department of Health  
METRO MANILA CENTER FOR HEALTH DEVELOPMENT  
**LAS PIÑAS GENERAL HOSPITAL and SATELLITE TRAUMA CENTER**



**Summary of Level 1 Evaluation**

Date	Title of LDI	Over-All Rating of Evaluation	Breakdown of Rating		Number of Participants	Number of Accomplished Evaluation Forms
			CATEGORY	AVERAGE		
July 13, 2023	Orientation for Service Quality Improvement Projects and Implementation with DAP (2 Batches)	<b>4.88</b> (Very Good)	Job Relevance	4.84	53	50
			Course Design	4.87		
			Venue & Food	4.87		
			Trainers/Facilitators	4.94		
July 14, 2023	Change Management Workshop	<b>4.92</b> (Very Good)	CATEGORY	AVERAGE	39	29
			Job Relevance	4.93		
			Course Design	4.90		
			Venue & Food	4.92		
			Trainers/Facilitators	4.92		
August 10 & 11, 2023	Change Management Workshop (2 batches)	<b>4.92</b> (Very Good)	CATEGORY	AVERAGE	100	84
			Job Relevance	4.94		
			Course Design	4.91		
			Venue & Food	4.90		
			Trainers/Facilitators	4.92		

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