



SMCW-SUHRC/SOPs/ 115/2025

Date- 24th Aug 2025

OFFICE ORDER No 115

STANDARD OPERATING PROCEDURE

SOP for the Management Review Committee (MRC) of SUHRC

Key Information	
Title	SOP for the Management Review Committee (MRC) of Symbiosis University Hospital and Research Centre (SUHRC)
Policy Owner	Medical Superintendent (MS), Symbiosis University Hospital and Research Centre (SUHRC)
Responsible Department	Head Quality, Quality Department, Symbiosis University Hospital & Research Centre (SUHRC)
Approved by	Medical Superintendent (MS), Symbiosis University Hospital and Research Centre (SUHRC)
Date of Approval	24th Aug 2025
Effective date	24th Aug 2025
Version number	1/2025
Policy Drafter	Head Quality, Quality Department, Symbiosis University Hospital & Research Centre (SUHRC)
Stakeholders consulted	Dean, SMCW & SUHRC; Medical Superintendent (MS), SUHRC; Faculty Members and Administrative Staff
Frequency of review	To be reviewed annually or as required based on feedback or institutional changes

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1. Preamble

1.1 This SOP outlines the structure, roles, responsibilities, and operational procedures of the Management Review Committee (MRC), aimed at ensuring high standards in institutional management, accountability, and continuous improvement at SUHRC as per NABH norms.

2. Purpose

2.1 To provide a structured and systematic approach to management reviews, enabling strategic decision-making, monitoring of institutional performance, and implementation of administrative improvements at SUHRC.

3. Scope and Applicability

3.1 This SOP applies to all stakeholders participating in the weekly Management Review Committee Meetings held at Symbiosis Medical College for Women (SMCW) and Symbiosis University Hospital and Research Centre (SUHRC).

4. Objectives

- 4.1 To review administrative, operational performance.
- 4.2 To identify areas for improvement and monitor corrective actions.
- 4.3 To ensure alignment with institutional goals and compliance requirements.

5. Definitions and Abbreviations

Term	Definition
MRC	Management Review Committee
ATR	Action Taken Report
MoM	Minutes of Meeting
SOP	Standard Operating Procedure

6. Details of the Policy

6.1 **Constitution and Function** - The committee is constituted to oversee institutional performance, coordinate inter-departmental functions, and implement strategic decisions.

6.2 Statutory Composition

- 6.2.1 Dean – Chairman
- 6.2.2 Medical Superintendent (MS) – Member
- 6.2.3 Dy. MS (Head Hospital Admin) – Member Secretary
- 6.2.4 Head of Operations – Member
- 6.2.5 Administrative Heads of various departments – Members

6.3 Current Composition –

Sr. No.	Name and Designation	Current Position in Committee
(a)	Dean	Chairperson
(b)	MS	Member
(c)	Head Hospital Admin	Member Secretary
(d)	Head Operations	Member
(e)	Deputy Chief Admin Aarogya Dham	Member
(f)	Head Finance SUHRC	Member
(g)	Operations and Professor Radiology	Member
(h)	Med. Admin (GW IPD,OPD)	Member
(i)	Med. Admin (GW ER,ICU)	Member
(j)	Deputy Head HR SUHRC	Member
(k)	Deputy Finance SUHRC	Member
(l)	Head IT FoMHS	Member
(m)	Head Quality SUHRC	Member
(n)	Deputy Head Engg Bio Medical	Member
(o)	Deputy Head Engg Maintenance	Member
(p)	Sr. Manager Pharmacy	Member
(q)	Head Insurance SUHRC	Member
(r)	Sr. Manager Purchase SUHRC	Member
(s)	Sr. Manager Govt. Schemes SUHRC	Member

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Sr. No.	Name and Designation	Current Position in Committee
(t)	Manager Dietetics	Member
(u)	Manager MRD	Member
(v)	Deputy Manager Operations IPD	Member
(w)	Deputy Manager Operations OPD	Member
(x)	Deputy Manager Stores	Member
(y)	Manager Statutory compliance	Member
(z)	Office Superintendent	Member

7. Procedures

7.1 Terms of Reference

- 7.1.1 Review previous ATRs and ensure closure
- 7.1.2 Discuss key performance indicators (KPIs) as per NABH norms
- 7.1.3 Evaluate administrative and operational challenges
- 7.1.4 Plan institutional initiatives

7.2 The Committee shall review the following

- 7.2.1 Development of Performance Reports
 - 7.2.1.1 The head of the organization (Dean) develops periodic performance reports, typically on a quarterly basis.
 - 7.2.1.2 These reports should also include a detailed analysis of quality and patient safety performance, highlighting areas for improvement.
- 7.2.2 Performance Discussion in Governance Meetings
 - 7.2.2.1 The governance body reviews these performance reports during regular meetings.
- 7.2.3 Action Follow-up
 - 7.2.3.1 Action items arising from the performance discussions are documented and tracked.
- 7.2.4 Identification of Need
 - 7.2.4.1 Governance body assesses the need for leadership appointments based on several key factors that ensure the organization's strategic, clinical, and operational effectiveness
 - 7.2.4.2 Organizational growth or restructuring
 - 7.2.4.3 Regulatory compliance (NABH requirements)
 - 7.2.4.4 Resignation, retirement, or termination of a senior leader
- 7.2.5 Selection Process
 - 7.2.5.1 Define roles & responsibilities for the senior leadership position.
 - 7.2.5.2 Specify required qualifications, skills, and experience based on NABH guidelines.



- 7.2.6 Screening & Evaluation
 - 7.2.6.1 Review candidate applications/CVs.
 - 7.2.6.2 Conduct interviews with governance representatives.
 - 7.2.6.3 Assess competency in leadership, quality management, and regulatory knowledge.
- 7.2.7 Final Approval & Appointment
 - 7.2.7.1 Governance body selects the most suitable candidate.
 - 7.2.7.2 Appointment letter issued with defined roles & performance expectations.
- 7.2.8 On boarding & Orientation
 - 7.2.8.1 Newly appointed leaders undergo orientation on NABH policies, governance structure, and strategic objectives.
- 7.2.9 Performance Monitoring & Review
 - 7.2.9.1 Governance body reviews leadership performance periodically (annually or as required).
 - 7.2.9.2 Performance indicators include operational efficiency, quality & patient safety compliance, and strategic goal achievement.
- 7.2.10 Governance Oversight
 - 7.2.10.1 Governance shall review and support safety and quality initiatives.
 - 7.2.10.2 A structured clinical governance framework shall be implemented to ensure patient safety and continuous quality improvement.
- 7.2.11 Reporting and Risk Management
 - 7.2.11.1 Reports of the Safety and Quality Improvement Committee's minutes shall be shared with governance.
 - 7.2.11.2 The governance team shall review reports on risk management, incident reporting, sentinel events, and quality improvement activities.
- 7.2.12 Patient Safety
 - 7.2.12.1 Implement standardized protocols to reduce clinical risks.
 - 7.2.12.2 Encourage incident reporting and root cause analysis.
 - 7.2.12.3 Establish infection prevention and control measures.
- 7.2.13 Medication Safety
 - 7.2.13.1 Apply medication reconciliation and error reporting systems.
 - 7.2.13.2 Standardize prescribing, dispensing, and administration.
 - 7.2.13.3 Conduct periodic audits and training.
- 7.2.14 Clinical Audits
 - 7.2.14.1 Carry out regular audits to assess compliance with guidelines.
 - 7.2.14.2 Reporting and Risk Management
 - 7.2.14.3 Analyse audit results to improve clinical practices.
 - 7.2.14.4 Implement corrective actions.
- 7.2.15 Clinical Pathways
 - 7.2.15.1 Develop evidence-based pathways for common conditions.
 - 7.2.15.2 Standardize patient care processes.
 - 7.2.15.3 Update pathways as per current evidence.
- 7.2.16 Clinical Indicators
 - 7.2.16.1 Set KPIs for monitoring outcomes.
 - 7.2.16.2 Benchmark performance against national and global standards.
 - 7.2.16.3 Use analytics for quality improvement.
- 7.2.17 Education & Research

- 7.2.17.1 Promote professional development through training
- 7.2.17.2 Encourage participation in evidence-based research.
- 7.2.17.3 Support innovations in care.
- 7.2.18 Ethical Governance
 - 7.2.18.1 Implement a structured process to resolve ethical issues.
 - 7.2.18.2 Form Ethics Committees for research and clinical care.
 - 7.2.18.3 Set up mechanisms for reporting and escalating violations.
 - 7.2.18.4 Provide regular training on ethical practices.
- 7.2.19 Data Collection & Validation
 - 7.2.19.1 Collect performance and safety data.
 - 7.2.19.2 Validate data internally and externally.
- 7.2.20 Feedback Mechanism
 - 7.2.20.1 Gather stakeholder feedback via surveys, suggestions, and reporting.
 - 7.2.20.2 Analyse feedback and act upon it.
- 7.2.21 Third-Party Assessment & Benchmarking
 - 7.2.21.1 Involve independent agencies for assessments.
 - 7.2.21.2 Benchmark data against standards.
- 7.2.22 Public Disclosure
 - 7.2.22.1 Publish performance reports in print and online.
 - 7.2.22.2 Protect confidentiality while disclosing data.
 - 7.2.22.3 Periodically update public information.
- 7.2.23 Continuous Monitoring & Review
 - 7.2.23.1 Periodic audits of public disclosures.
 - 7.2.23.2 Update governance policies to match best practices.
- 7.2.24 Development & Implementation of the Ethical Management Framework
 - 7.2.24.1 Leadership shall define and document the ethical guidelines governing the organization.
 - 7.2.24.2 Codes of conduct for healthcare professionals shall be established, ensuring alignment with the Medical Council of India's Code of Medical Ethics (2002).
 - 7.2.24.3 The ethical framework shall be reviewed periodically to incorporate updates in medical laws and accreditation standards.
- 7.2.25 Handling of Complaints & Grievances
 - 7.2.25.1 A formal complaints and grievance redressal mechanism shall be in place.
 - 7.2.25.2 Complaints related to clinical care, professional misconduct, and patient rights violations shall be addressed within a defined timeframe.
 - 7.2.25.3 Patients and employees shall have confidential channels to report ethical violations.
- 7.2.26 Clinical Care Delivery
 - 7.2.26.1 Ethical principles such as patient autonomy, informed consent, and beneficence shall be upheld.
 - 7.2.26.2 Decision-making in critical care, end-of-life care, and medical interventions shall align with ethical and legal guidelines.
- 7.2.27 Ethical Conduct in Research
 - 7.2.27.1 All research involving human subjects shall adhere to ethical research guidelines and regulatory approvals.
 - 7.2.27.2 An Institutional Ethics Committee (IEC) shall oversee research protocols, ensuring compliance with NABH and ICMR standards.

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7.2.28 Training & Awareness

- 7.2.28.1 Continuous training programs on medical ethics shall be conducted for all healthcare professionals.
- 7.2.28.2 Ethical decision-making workshops and scenario-based training shall be included in professional development programs.

7.2.29 Monitoring & Enforcement

- 7.2.29.1 The Ethics Committee shall monitor adherence to the ethical management framework.
- 7.2.29.2 Non-compliance shall be investigated, and corrective actions shall be taken as per organizational policies.
- 7.2.29.3 Regular ethics audits shall be conducted to assess ethical governance practices.

7.2.30 Environmental Sustainability

- 7.2.30.1 Implementing energy-efficient technologies and renewable energy sources.
- 7.2.30.2 Reducing greenhouse gas (GHG) emissions and managing carbon footprint.
- 7.2.30.3 Adopting sustainable waste management practices, including biomedical waste disposal.
- 7.2.30.4 Conserving water and protecting biodiversity around hospital premises.
- 7.2.30.5 Establishing a climate change strategy with measurable impact reduction goals.

7.2.31 Social Sustainability

- 7.2.31.1 Ensure fair pay, living wages, and equal employment opportunities.
- 7.2.31.2 Adhere to labour laws and promote workplace health and safety.
- 7.2.31.3 Offer employee benefits, wellness programs, and career development opportunities
- 7.2.31.4 Engage in community health programs, outreach services, and CSR initiatives.
- 7.2.31.5 Partner with responsible suppliers who uphold ethical labor and environmental standards.

7.2.32 Governance Sustainability

- 7.2.32.1 Strong corporate governance, ethical decision-making, and accountability.
- 7.2.32.2 Robust risk management frameworks and regulatory compliance.
- 7.2.32.3 Transparency in financial reporting and accounting integrity.
- 7.2.32.4 Avoidance of conflicts of interest and adherence to anti-corruption policies.
- 7.2.32.5 Ethical business practices that uphold patient rights and confidentiality.

7.2.33 Contingency plans

7.3 Meeting Schedule and Frequency

- 7.3.1 **Day:** Every Wednesday
- 7.3.2 **Time:** 3 PM – 4:30 PM
- 7.3.3 **Frequency:** Weekly
- 7.3.4 **Venue:** 5th Floor Conference Room
- 7.3.5 **Invitation to Provost, FoMHS, SIU** to attend meeting once a month shall be sent to Office of Provost by Member secretary.

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7.4 Quorum

7.4.1 Minimum 50% of listed members must be present for the meeting to proceed.

7.5 Minutes of Meeting (MoM)

7.5.1 The Member Secretary is responsible for maintaining, uploading in the link of SMCW & SUHRC Minutes of Meetings (MoM), and circulating the MoM in the approved format.

7.6 Action Taken Report (ATR)

7.6.1 The member secretary will update, upload in the link of SMCW & SUHRC Minutes of Meetings (MoM) and circulate the ATR before the commencement of the next meeting.

7.7 Transaction Policy

7.7.1 Agenda Points only shall be discussed.

8. Roles & Responsibilities

Role	Responsibility
Chairperson	Oversees execution and Final Approval
Member Secretary	Coordinates meeting logistics, documentation, and follow-up.
Member	Active Participation

9. Equipment

- 9.1 Projector
- 9.2 Computer with internet
- 9.3 Stationery and printed templates

10. Approvals / Guidelines / Rules / Manuals / Compliance

- 10.1 Institutional Code of Conduct
- 10.2 NMC and NABH Guidelines
- 10.3 SIU Notifications

11. Notification of Policy / Guidelines / Rules / Manual

11.1 This SOP is to be formally communicated via institutional email and uploaded to the internal Quality Management System (QMS) portal.

12. Dissemination of the SOP

12.1 Disseminated through internal training and orientation sessions.

13. Review or Revision

13.1 To be reviewed annually or as required based on feedback or institutional changes.

14. Repeals and Savings

14.1 Any prior conflicting SOPs are hereby repealed; actions already taken under previous SOPs remain valid.

15. Annulment of Policy

15.1 Subject to approval from the Dean or relevant authority.

16. Retention / Archiving of Records

Document	Retention Period
MoM	3 years
ATR	3 years
Reports	3 years

17. Quality Assurance & Control

17.1 **Internal Audit** - Annual audit of committee operations.

17.2 **Feedback** - Feedback from stakeholders after select meetings to improve functioning.

18. Documentation and Record Keeping

18.1 Record Types

Form Name	Purpose
MRC/01	Agenda
MRC/02	MoMs
MRC/03	ATRs
MRC/04	Decision Reports

18.2 **Storage** -Digitally on institutional servers.

18.3 **Indexing** -By Meeting number and year.

19. Training and Competency

19.1 **Workshops** -Annual training (upskilling, reskilling, communication workshops) for committee members and department heads as per HR norms.

19.2 **IEC Coordination** -Member Secretary to coordinate Information, Education & Communication (IEC) programs.

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20. Forms / Templates

Form Name	Purpose
MRC/01	Agenda Registration
MRC/02	MoMs Template
MRC/03	ATRs Template
MRC/04	Final Decision Reports

21. Safety Measures

21.1 Confidentiality -All agenda points shall be handled confidentially.

22. Infection Control Measures

22.1 Protocol Adherence -Follow institutional infection control SOPs.

22.2 Virtual Meetings -Use virtual platforms as needed for safety or convenience.

23. References

23.1 SIU Notification No. SIU/U/28/858 dated 30/09/2019

23.2 NABH and NMC Guidelines

23.3 Institutional Code of Conduct

24. Appendix

24.1 Copy of SIU Notification

24.2 List of Useful Plagiarism Detection Tools

24.3 Example Redacted Reports

25. Change Log

Version	Date	Change Description	Approved By
2.0			
3.0			

26. Conclusion

26.1 The Management Review Committee (MRC) serves as a cornerstone of institutional governance, ensuring that strategic decisions are informed, accountable, and aligned with the mission of compassionate care, academic excellence, and ethical leadership. Through

