GANPAT UNIVERSITY

FACULTY OF MANAGEMENT STUDIES

Programme	MBA	Branch/Spec.	Innovation, Entrepreneurship and Venture Development (Minor Specialization - Healthcare Operations Management)
Semester	IV	Version	2.0.0.0
Effective from Academic Year	2026-27	Effective for the Batch admitted in	January 2026
Course Code	IVA16QAP	Course Name	Quality Assurance and Patient Safety in Healthcare

Teaching Scheme						Examination Scheme (Marks)			
(Per week)	Lecture (DT)		Practical (Lab.)		Total		CE	SEE	Total
	L	TU	P	TW					
Credit	4	0	0		4	Theory	60	40	100
Hours	4	0	0		60	Practical			

Pre-requisites

Course Outcomes

On successful completion of the course, the students will be able to:

CO1	The students will be able to explain the core principles of healthcare quality and formulate the strategic business case for investing in patient safety.
CO2	The students will be able to analyze common quality improvement methodologies and risk management tools used to enhance healthcare processes.
CO3	The students will be able to evaluate the components of a high-reliability safety culture and the critical leadership behaviors required to sustain it.
CO4	The students will be able to formulate a strategic governance framework for quality and safety, integrating patient experience, technology, and future healthcare trends.

Theory Syllabus

Unit	Content	Hrs.
1	Foundations of Healthcare Quality, The "To Err is Human" Imperative, Defining Quality: The IOM's Six Domains, The Donabedian Model: Structure, Process, Outcome, The Cost of Poor Quality: Financial & Reputational Impact, The Business Case for Patient Safety, The Role of Accreditation Bodies (JCI, NABH). Continuous Quality Improvement (CQI) and Lean Principles – Tools and methodologies for process optimization in healthcare. Clinical Governance and Accountability Frameworks – Roles, responsibilities, and structures for maintaining high-quality care. Patient-Centered Care and Experience Measurement – Methods to assess satisfaction, engagement, and care quality from the patient perspective. Benchmarking and Performance Indicators in Healthcare – Using KPIs and comparative metrics to drive quality improvements. Root Cause Analysis (RCA) and Failure Mode & Effects Analysis (FMEA) – Tools for investigating errors and preventing future quality lapses.	15
2	Methodologies for Quality Improvement & Risk Management, Process Improvement Models: - Lean Healthcare: Identifying & Eliminating Waste - Six Sigma & DMAIC Framework (Conceptual), Proactive Risk Assessment: - Failure Mode and Effects Analysis (FMEA), Reactive Risk Analysis: - Root Cause Analysis (RCA) & The "5 Whys", The Swiss Cheese Model of System Accidents, Measuring Quality: KPIs & Dashboards for Leaders. Clinical Audit and Peer Review Processes – Systematic evaluation of clinical practices to ensure compliance with standards. Patient Safety Culture and Staff Engagement – Building a	15

	culture of safety and accountability in healthcare teams. Error Reporting Systems and Near-Miss Analysis – Tools and processes for capturing and learning from adverse events. Simulation and Scenario-Based Training for Risk Management – Using mock drills and simulations to improve response to clinical errors. Integration of Digital Tools in Quality & Risk Monitoring – Leveraging dashboards, AI, and predictive analytics for proactive quality management.	
3	Leadership and the Culture of Safety, Creating a "Just Culture": Accountability vs. Blame, The Principles of High-Reliability Organizations (HROs), Fostering Psychological Safety & Speaking Up for Safety, Leadership's Role: Executive Walk-Rounds & Setting the Tone, Effective Teamwork & Communication (TeamSTEPPS Concepts), The Role of Checklists & Standardized Protocols, Patient Engagement in Their Own Safety. Change Management in Safety Initiatives – Strategies for implementing safety improvements and overcoming resistance. Interprofessional Collaboration and Flattening Hierarchies – Encouraging collaboration across clinical and non-clinical teams. Use of Technology for Safety Monitoring – Digital reporting tools, dashboards, and AI-assisted safety alerts. Metrics and Benchmarking for Safety Culture – Measuring safety culture maturity and tracking improvements over time.	15
4	Strategic Governance, Patient Experience, and the Future, The Role of the Board & C-Suite in Quality Oversight, Linking Quality Metrics to Executive & Strategic Goals, The Patient Experience as a Competitive Differentiator, Public Reporting, HCAHPS, and its Financial Implications, Disclosure & Management of Adverse Events, Technology's Role: AI for Risk Prediction, Digital Safety Tools, The Future: Value-Based Care & Population Health Quality. Regulatory Compliance and Accreditation Alignment – Ensuring adherence to NABH, JCI, and other quality standards in governance decisions. Strategic Risk Management at the Executive Level – Board-level oversight of clinical, operational, and reputational risks. Patient Advocacy and Co-Design of Services – Involving patients and families in service design and improvement initiatives. Data-Driven Decision Making for Leadership – Leveraging analytics dashboards and predictive models to inform strategic planning. Innovation in Quality and Safety Programs – Exploring digital twins, AI-based monitoring, and remote quality assessment initiatives.	15
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Practical, assignments and tutorials are based on above syllabus.		
Text Books		
1	Gawande, Atul. The Checklist Manifesto: How to Get Things Right. Metropolitan Books, 2009.	
Reference Books		
1	Institute of Medicine (IOM). To Err Is Human: Building a Safer Health System. National Academies Press, 2000.	
2	Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. National Academies Press, 2001.	
3	Reason, James. Human Error. Cambridge University Press, 1990.	
4	Weick, Karl E., and Sutcliffe, Kathleen M. Managing the Unexpected: Resilient Performance in an Age of Uncertainty. 3rd Edition, Wiley, 2015.	
5	Toussaint, John S., and Berry, Leonard L. Management on the Mend: The Healthcare Executive Guide to System Transformation. McGraw-Hill, 2013.	
6	Lencioni, Patrick M. The Five Dysfunctions of a Team: A Leadership Fable. Jossey-Bass, 2002.	
7	Sinek, Simon. Start with Why: How Great Leaders Inspire Everyone to Take Action. Portfolio, 2009.	
8	Wachter, Robert M. The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age. McGraw-Hill, 2015.	
9	Berwick, Donald M., et al. "The 100,000 Lives Campaign: Setting a Goal and a Deadline for Public Health Improvement." JAMA, 2006.	
ICT/MOOCs Reference		
1	Coursera: Patient Safety and Quality Improvement – Johns Hopkins University	

2	Udemy: Healthcare Quality Management and Patient Safety

	PO 1	PO 2	PO 3	PO 4	PO 5	PO 6	PO 7	PO 8	PO 9	PSO 1	PSO 2	PSO 3	PSO 4
CO1	3	3	2	–	–	3	2	2	2	2	3	3	3
CO2	3	3	2	2	–	3	2	3	2	2	3	3	3
CO3	3	3	3	2	2	3	2	2	2	2	3	3	3
CO4	3	3	3	2	2	3	3	3	3	3	3	3	3