Republic of Rwanda

Ministry of Health

Rwanda Hospital Accreditation Standards

Performance Assessment Toolkit

3rd Edition

August 2022

Contents

Acronyms

ACLS	Advance cardiac life support
ARV	Antiretroviral
BLS	Basic life support
CBHI	Community-based health insurance
COHSASA	The Council for Health Service Accreditation of Southern Africa
CPG	Clinical practice guideline
CPR	Cardiopulmonary resuscitation
DHIS-2	District Health Information System-2
ED	Emergency department
EIDSR	Electronic Integrated Disease Surveillance and Response
HIV	Human immunodeficiency virus
HMIS	Health management information system
ICU	Intensive care unit
HSSPIV	Health Sector Strategic Plan IV
IMCI	Integrated Management of Childhood Illness
IPC	Infection prevention and control
ISQua	International Society for Quality in Healthcare
JCI	Joint Commission International
M&E	Monitoring and evaluation
MNCAH	Maternal Newborn Child and Adolescent Health
MoH	Ministry of Health
MSDS	Material safety data sheets
NICU	Neonatal intensive care unit
NRP	Neonatal resuscitation Program
PALS	Pediatric advanced life support
PBF	Performance-based financing

PCV	Pellet control of vaccine
PDSA	Plan-Do-Study-Act
PHECS	Pre-hospital Emergency Care Service
PMNCH	Partnership for Maternal, Newborn and Child Health
PPE	Personal protective equipment
QI	Quality improvement
RBC	Rwanda Biomedical Center
RMNCH	Reproductive Maternal Newborn and Child Health
SBAR	Situation, Background, Assessment, Recommendation
STI	Sexually transmitted infection
TB	Tuberculosis
TRAC	Treatment Research AIDS Center
USAID	United States Agency for International Development
WHO	World Health Organization

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SECTION 1

Guidance on using the Toolkit

Purpose

The **Rwanda Hospital Accreditation Standards Performance Assessment Tool** has been developed based on the 2nd edition of the hospital standards to assist supervisors, facility managers and staff to assess the quality of their services. The toolkit can be used to guide the set-up of services and to improve current services. It helps to measure progress towards meeting standards and will be used by external surveyors to accredit facilities.

How to use the toolkit

The toolkit is designed to be used in conjunction with the Rwanda Hospital Accreditation Standards document.

Who conducts the assessment?

This toolkit can be used by the quality improvement team in the facility to conduct a self-assessment. A team leader needs to be appointed who is responsible for organizing the group, assigning tasks, and coordinating the effort. This person could be the Quality Improvement Officer or some other individual with the skills to carry out the responsibilities. The best approach is to include assessment team members from all categories of staff, although a subgroup can be designated to carry out most of the work. We recommend that the group include members such as nurses, physicians, pharmacists, allied professionals, customer care and facility management. The effort is to be supported by the central and district level health teams.

Part of the learning process occurs through this participation. If one person tries to complete the assessment alone the process becomes an audit rather than a learning opportunity for the team. Performing the assessment together increases understanding of the services and fosters team spirit and, ultimately, ownership of the findings. When assignments of team members are being made it is important to identify individuals who have knowledge of the specific aspect of service which they will assess. For instance, various members could review the availability of supplies, whereas professional staff would be needed to evaluate the competence of staff in providing care and performing procedures. A customer care officer or public relation officer may be requested to conduct interviews with patients who have used the services.

The toolkit can also be used by a supervisor or other external reviewer to conduct an external assessment. An assessment conducted by someone who is not working in the hospital can add value to the assessment process by offering a fresh view. Regardless of who is designated to carry out the assessment, it is best carried out with the involvement and participation of all staff members.

How is the toolkit organized?

The toolkit is organized into three sections. Section 1 describes the setup of the toolkit and provides guidance on how to use it. Section 2 is the quality assessment tool that is to be used in assessing the quality of services. Section 3 provides other tools including samples of checklists, forms and other tools that support the use of the quality assessment tool.

The quality assessment tool in Section 2 is organized according to **five key risk areas**. **Standards** are listed for each risk area. There is a list of **key documents** that will assist the team to prepare for the assessment, together with suggested **methods** for eliciting the required information. The assessment team needs to be oriented to the data collection tool and the methods that can be used to obtain information.

The assessment tool is outlined as follows:

- The five Risk Areas that are the major domains toward which risk-reduction strategies are directed.
- The Standards that represent the risk-reduction strategies for that domain. Standard numbers highlighted in green are considered “critical”.
- The Levels of Effort that represent progressive achievement in reaching the expectations found in a Standard.
    - At Level 1, the policies, procedures, protocols, and plans have been developed and communicated that describe the expected quality of care/services to be provided.
    - At Level 2, the processes (described in the policies, procedures, protocols, and plans) are implemented in a consistent way.
    - At Level 3, there are data to confirm successful risk-reduction strategies and continued improvement.
- The Performance Findings provide the team concrete elements to determine whether the standard is met. Four levels of findings are listed for each Level of Effort (0, 1, 2, and 3).
- The Overall Score is created by multiplying the weight (Level of Effort) of the element with the progress (Performance Findings) toward meeting the standard. For example, if the Level of Effort is “1” and the Performance Finding is scored “3”, the overall score is 1 x 3 = 3. An Excel spreadsheet is available to assist with these calculations.

It is recommended that the team assess all the Standards and associated Levels of Effort initially to provide a baseline for future progress towards meeting the standards. For easy reference, the five Risk Areas are outlined in Table 1 with the associated standards. The standards highlighted in green have been identified as "critical" to providing safe, quality care. Standards that have been added in the 3rd Edition are indicated (NEW).

Table 1 Overview of Risk Areas and Standards
Standards highlighted in green are "critical"

Risk Area ▶	1	2	3	4	5
Standards	**Leadership Process and Accountability**	**Competent and Capable Workforce**	**Safe Environment for Staff and Patients**	**Clinical Care of Patients**	**Improvement of Quality and Safety**
1	Leadership responsibilities and accountabilities identified	Personnel files available, complete, up to date	Infrastructure, utilities, resources and equipment and furniture (NEW)	Correct patient identification	Quality and safety program
2	Strategic and operational planning	Credentials of healthcare professionals	Regular inspection of environmental safety	Informed consent	Effective customer care program
3	Management of policies, procedures, protocols, and clinical guidelines (documented processes) (NEW)	Privileges for Health Professionals	Management of hazardous materials	Medical, nursing, and allied health professional assessments and reassessment of patients complete and timely	Patient satisfaction monitored
4	Management of health information	Orientation to hospital and jobs	Fire safety and disaster management	Pain assessment, reassessment, and appropriate management (NEW)	Complaint, compliment, and suggestion process
5	Mentorship and oversight of healthcare facilities in catchment area	Trained and competent staff	Biomedical equipment safety	Laboratory services available and reliable	Clinical outcomes are monitored

6	Risk management (NEW)	Sufficient staff to meet patient needs	Stable safe water sources	Diagnostic imaging services available, safe, and reliable	Incident, near miss and sentinel event reporting system
7	Financial management	Oversight of students/trainees	Stable electricity sources	Written plans for care	Staff demonstrate how to improve quality and patient safety
8	Efficient use of resources	Training in resuscitative techniques	Protection from aggression, violence, abuse and loss or damage to property (NEW)	Clinical protocols available and used	Communicating quality and patient safety information to staff
9	Leadership for quality and patient safety	Staff performance management	Coordination of infection prevention and control program	Protocols for managing high-risk patients/procedures	Staff satisfaction monitored
10	Quality requirements in contract management	Staff health and safety program	Reduction of health care-associated infections through hand hygiene	Comprehensive management of reproductive and maternal health care	
11	Integration of quality, safety, and risk management		Effective sterilization processes	Comprehensive management of newborn care (NEW)	
12	Compliance with national laws and regulations		Effective laundry and linen services	Comprehensive management of child and adolescent health care	
13	Commitment to patient and family rights		Reduction of health care-associated infections	Access to safe and adequate nutrition to hospitalized children (NEW)	
14	Patient access to services		Barrier techniques available and used	Comprehensive management of HIV prevention and care	
15	Efficient admission and registration processes		Proper disposal of sharps and needles	Comprehensive management of tuberculosis prevention and care	

16	Effective inventory management		Proper storage and disposal of infectious medical waste	Anesthesia and procedural sedation used appropriately	
17	Effective medical record management		Monitoring, reporting, and preventing the spread of communicable diseases	Surgical services appropriate to patient needs	
18	Oversight of human subject research			Comprehensive management of emergency triage	
19				Essential emergency medications, equipment, and supplies	
20				Ambulance service equipped	
21				Safe medication use	
22				Patients educated to participate in their care	
23				Communication among those caring for the patient	
24				Referral/transfer information communicated	
25				Complete and thorough clinical documentation	

What methods can be used to conduct the assessment?

Several data collection methodologies are necessary for gathering information to complete the assessment. Some are outlined below.

1. **Observation**

   The facility leadership team can use observation to assess attitudes, knowledge, and skills in clinical practice, including patient-provider interaction and patient management. Assessing the competence of staff is a crucial element of the quality of the service. An initial competence assessment is recommended during orientation for all staff members providing direct patient care services, based on the clinical treatment guidelines (protocols). Subsequently, the assessment of competence needs to become a routine part of the performance evaluation process, done on an annual basis. The team needs to determine which aspects of care require on-going competency assessments, for example, family planning counseling or carrying out a high-risk protocol. An assessment tool, usually a checklist, can be developed based on the protocol. A supervisor or qualified peer may then assess the practitioner. The giving and receiving of feedback are important aspects of the process of improving quality. Feedback helps to create an atmosphere in which practitioners welcome the observations made. These observations should be documented and included in personnel files.

   The external assessor typically does not observe clinical practice as described in the previous paragraph. They determine competency by reviewing the process that the facility has put into place for competency assessments and the documentation in the personnel files. The types of observations made by an external assessor include maintenance of equipment, patient privacy, infection control practices and safety of the environment. We recommend that the members of the team make rounds together in order to carry out these observations.

2. **Formal and informal interviews**

   One-on-one interviews may be conducted with managers, staff and patients. The assessment questions seek staff and patient perceptions on important aspects of their experiences in the hospital. The questions need to be linked to the mission and values. For instance, if the mission includes “patient-centered” care, then, some of the questions need to determine how the patients and families feel about their ability to participate in decision-making. The respondents must feel assured that they will not be identified and that the results will remain confidential. When patients are being questioned the approach should to be tailored to the needs of the patient, for example, taking into account literacy, language and the location of the patient. These interactions provide some insights to the care provided and should be considered along with the other observations; however, often the patient tries to accommodate the surveyor and may not be candid about their perceptions.

3. **Inventory**

   Inventory is a process of inspection to determine whether the essential medicines, supplies and equipment are available and to assess the storage and maintenance of supplies and equipment. A variety of tools may be used to assist the surveyor to collect sufficient data to score the standards. Checklists can be useful but are not designed to be used to score standards, as various assessment approaches are used collectively to make this decision.

4. **Review of documents**

   Much of the information to assess whether standards are met is obtained by reviewing documents, for example, the patient register, medical records, personnel files, policies, procedures, protocols, reports and meeting minutes.

What should be done with the Performance Findings?

The Performance Findings should be communicated and acted on.

- **Communicating the findings**
  The results of the assessment need to be shared with all key parties. The team will first determine who needs the information, for example, staff, supervisor and partners, may all be key parties. Each has different needs and therefore different levels of information are required. The team will outline:

  a) who needs the information.
  b) what information is needed.
  c) how the information will be delivered, for example, in a meeting, memorandum or workshop.
  d) who will convey the information/feed it back; and
  e) when the information will be given.

- **Taking action**

  The first place to focus is on the standards that are rated “critical” and use the results to develop a work plan for closing gaps. The team can be motivated by identifying quick fixes, i.e. things that can be implemented easily, and thus, achieving quick results. The quality team can benefit from meeting weekly to implement the actions required to meet the standards. When most of the standards have been met the frequency of the meetings can be reduced.

How often should an assessment be done?

Assessment is best conducted as a systematic process on a regular basis. For new Facilities in program at the initial stages the team will be measuring to establish baseline toward the goals at any time a year. When most of the standards have been met (achieve level 3) the facilities should strive to maintain their achievement.

Major Changes in the Third Edition

- The standards were reviewed and changed where necessary to comply with the ISQua requirements.
- Vague and ambiguous words were removed, and more consistent terminology is used throughout the standards.
- The existing Maternal, Newborn, Child, and Adolescent Health Standards (MNCAH) have been integrated into this set of standards.
- The position and overall responsibilities of each of the hospital's leaders and the process for delegation of authority has been included in Risk Area #1 Standard #1.
- Risk Area #1 Standard #13 has been reviewed to include educating patients about their rights and adding in their responsibilities to the requirements.
- The management of information has been strengthened in Risk Area #1 Standard #4 and the maintenance of information technology will now be measured in the new standard that has been added for infrastructure, utilities, resources and equipment and furniture (Risk Area #3 Standard #1) that requires each service to have input into the what resources they need to perform their functions and for these resources to be maintained.
- Risk area #2 Standard #5 has been extensively reviewed to include the education, skills, competencies, experience, orientation and training and priveleging of independent practitioners along with the requirement of a skills develelopment plan and ongoing education, staff training and competency assessment of all staff.
- Evidence-based staffing requirements has been included in the existing standard of "sufficient staff to meet patient needs" (Risk Area #2 Standard #6) to ensure that staff with appropriate skills are allocated in the department where those skills are required.
- Risk Area #3 Standard #4 has been strenghtened to include disaster management.
- Risk area #4 Standard #3 has been extensively reviewed to include assessment and care planning of patients by all health professionals (not just nurses and doctors) and includes the ongoing reassement of patients.
- Risk Area #5 Standard #6 has been reviewed to include a more robust definition and reporting of near misses and timeframes for communicating with patients about incidents and sentinel events that have affected them.

New Standards

1. Management of policies, procedures, protocols, and clinical guidelines (documented processes)
   Risk Area # 1- Standard #3
2. Risk management
   Risk Area #1 - Standard #6
3. Infrastructure, utilities, resources and equipment and furniture
   Risk Area #3 – Standard #1
4. Protection from aggression, violence, abuse and loss or damage to property
   Risk Area #3 – Standard #8
5. Pain assessment, reassessment, and appropriate management
   Risk Area #4 – Standard #4
6. Comprehensive management of newborn Care
   Risk Area #4 – Standard #11
7. Access to safe and adequate nutrition for hospitalized children
   Risk Area #4 – Standard #13

Merged standards

Risk Area #2 – Standards #2, #3 and #4 (now Standard #2)
Risk Area #4 – Standards #3 and #4 (now Standard #3)

Critical Standards

No new critical standards have been added.

SECTION 2

Rwanda Hospital Accreditation Standards

Date:

Name of facility: _____

Location: (town, district/province) _____

Name(s) of assessor(s): _____

Instructions: Under the title of each Risk Area, you will find a list of required documents and proposed data collection methods. Score each of the standards starting with Level 1. If all the Performance Findings are met for Level 1, you may move on to score Level 2. In contrast, if Level 1 is not fully met, do not move on to Level 2, even if you feel some of the elements are met in Level 2. The reason is that this assessment is intended to move the organization through a systematic process for achieving all of the standards, building from Level 1 to Level 2 and ultimately, Level 3 performance.

After entering all the scores, an overall score can be calculated by multiplying the level of effort by the score of the Performance Findings. For instance, if all the Performance Findings in Level 1 were met, the score would be “3”. The overall score would be Level of Effort 1 times the assessment finding score “3”, thus 1 x 3 = 3.

RISK AREA #1 – LEADERSHIP PROCESS AND ACCOUNTABILITY

Experience around the world has shown that in large and small health care organizations, in general and specialty care facilities, in rural and urban settings, and in public and private settings, the most essential factor in improving quality and patient safety is leadership support at the highest level of the organization. Strong leadership is necessary to create and sustain an organizational culture that supports quality care delivered safely. Leadership for quality can come from many places within the organization such as a governing body, the senior manager, and physician, nursing, and allied health professionals. This leadership can also come from multiple sources outside the organization such as ministries of health, private healthcare organizations and professional associations. Identifying and affirming the leadership for quality and confirming leaders' commitment to champion a quality organization make this the first and most essential risk area.

Required Documents	Data Collection Methods
1. Organization chart and descriptions of positions 2. Leaders job description and performance evaluation 3. Community needs assessment 4. Mission, vision, and values 5. Administrative manual 6. Strategic and operational plans 7. Quality and patient safety plan 8. Risk management plan 9. Financial management policies and procedures, budgets, etc. 10. Patient and family rights document 11. Training records 12. Management and department meeting minutes 13. Admission and registration policies and procedures 14. Contract management policies and procedures 15. Ministerial instructions, laws, and regulations 16. Client flow analyses 17. Inventory management policies and procedures 18. Medical record management policies and procedures 19. Electronic records from central level (print out) 20. Minutes and plans for improving use of resources 21. Quality information for health care centers 22. Data use for improving childbirth quality of care 23. Health communication quarterly plan 24. Mentorship report	A Leadership interviews B Staff interviews C Patient interviews D Document review E Personnel file review F Direct observation

STANDARD #1: Leadership responsibilities and accountabilities identified

The leadership structure of the organization is identified in an organizational chart or other written document that identifies each leader's responsibilities on which he or she will be evaluated.						
RISK LINK: The basis of any quality organization is a clear understanding of which leaders are responsible for setting the mission, plans, and policies of the organization, and how the oversight of daily operations is managed. This level of transparency makes for clear lines of authority and accountability and is fundamental to an organizational culture of quality. Resource decisions needed to advance quality and safety are made at this level.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There are written, current documents that identify accountable leaders by name, position, and responsibilities and details the process for delegation of authority.	0 There are no documents that describe the organization's current leadership structure. 1 A current organizational chart describes the lines of authority and accountability between the governance structure and the healthcare facility and those within the facility. 2 The current names of persons who are in leadership positions are listed on the chart and observed to be posted on office doors. 3 A document in the administrative manual describes the position and overall responsibilities of each of the hospital's leaders and includes the process for delegation of authority and the responsibilities for at least: • Corporate/Head Office/Ministry of Health management (this will differ depending on whether the hospital is a private or government owned facility) • Hospital Management • Human resource management • Financial management					

	• Clinical management • Risk management • Quality management NOTE: In smaller healthcare facilities these functions may all be performed by only one person, but they must still be described.					
Level 2: Leaders are carrying out their responsibilities according to their job descriptions.	0 Job descriptions are not available for leadership positions. 1 A job description outlines the roles and responsibilities of each of the hospital's leaders. 2 Current job descriptions are written for each hospital leader and manager. 3 Management meeting minutes (management and department) show evidence that they are carrying out their roles and responsibilities.					
Level 3: The performance of the leaders is evaluated, and measures have been taken to continuously improve the results of their efforts.	0 Personnel files are not kept for members of the hospital leadership. 1 Personnel files are kept for hospital leaders. 2 The personnel files contain monthly performance-based finance assessments and an annual performance evaluation that was conducted within the past 12 months. 3 The evaluations include objectives, goals or an action plan for improving performance.					

STANDARD #2: Strategic and operational planning

Leadership participates in defining the overall mission, vision, and values of the hospital, setting broad strategic goals, and bearing ultimate responsibility for the hospital's operational policies.

RISK LINK:

Research shows that improved management practices in hospitals are associated with significantly lower mortality rates. Safe, high-quality care cannot be provided by an individual – it takes a team – with all leaders aligned with the mission and goals. The purpose of the mission, vision and goals is to define how the hospital will achieve safety and quality. The leaders need to develop a strategic and operational plan to achieve the mission with specific objectives. The leaders and managers need to review the progress toward meeting these objectives on a regular basis and adjust the strategies as needed to achieve the goals.

Operational plans should be dynamic, open to change if situations change or targets are not being met and remain open to regular revision as circumstances change. Examples of changing circumstances requiring a change of plan would be an unexpected epidemic or a natural disaster, changes in the resources available, or clear signs that goals are not being met.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The leadership has developed a strategic plan that supports long-term goals based on the mission, vision and values of the hospital and accurate data.	0 Information regarding community needs is not available. 1 Community needs are assessed through the collection of service data that describes: a. Geographic catchment area b. Population demographics c. Types of services and patient volumes d. Disease prevalence e. Main occupations and businesses f. Schools g. Other health facilities 2 A strategic plan (long-term goals) is present that has been approved within the past 5 years. 3 The following documents are present in the administrative manual: • Mission, vision, and values specific to the organization • Description of hospital					

	• Organizational chart • Scope and organization of services • Communication and collaboration a. Standing (regular) meetings b. Committees • Master index of hospital policies, procedures, protocols, and clinical guidelines (documented processes)					
Level 2: The mission, vision, values, strategic and operational plans are communicated to staff and implemented.	0 There is no evidence that an operational plan has been developed and that the mission, vision, values strategic and operational plans have been communicated to all staff. 1 Leaders describe how the mission, vision, values, strategic and operational plans are communicated to staff members. 2 An operational plan (short-term goals) is present to implement the strategic goals. 3 The plan includes at least: • Delivering quality evidence-based healthcare (particularly in the clinical areas that have been identified as high priority by the Ministry of Health, for example, maternal, newborn, child and adolescent health, HIV, TB etc.) • Staffing and training • Risk management (financial, physical, environmental, reputational, medicolegal, operational, information technology, etc.) • Quality improvement • Maintenance of equipment and the infrastructure					
Level 3: Progress in achieving the goals and objectives is measured and reviewed in management meetings on at least a quarterly basis.	0 There are no or few minutes that show discussions regarding the measures of progress. 1 Management meeting minutes include discussions of the goals and objectives quarterly. 2 Data is gathered to measure progress in meeting goals/objectives. 3 Management meeting minutes reflect analysis of the data and actions planned to further the achievement of the goals/objectives.					

STANDARD #3: Management of policies, procedures, protocols, and clinical guidelines (documented processes)

The facility's leaders ensure that a system for managing policies, procedures, protocols, and clinical guidelines is implemented.						
RISK LINK: Policies, procedures, protocols, and clinical guidelines are formulated at different levels of authority, for example, national legislation, national health and labor department policies, regional policies and at healthcare facility level. Implementation of the facility's documented processes will be greatly facilitated by the consistent and uniform management and control of each document. A system should therefore be in place to identify both the nature and control of each documented process developed or used in the facility.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure guides the management of all documented processes used by the healthcare facility.	0 There is no policy and procedure on document control. 1 A policy and procedure on document control is available and contains the following: • Each documented process is identified by title and date of issue • Each documented process contains the signature of a person authorized to issue and/or review the document • Associated references (when the content is directly associated with clinical care processes, specific legislation or organizational/corporate directives and processes) • Adherence to a process for review and continued approval of documented processes • Time frames for the review of all documented processes • Controls for ensuring that only current versions of documented processes are available • Retention and archiving of documents that are no longer in use • The management and control of electronic documented processes 2 Documented processes used in the hospital are established and reviewed according to the document control policy and procedures.					

	3	All documentation, including patient-related information, legal, managerial and research documentation, is retained, archived and destroyed in accordance with documented processes.					
Level 2: Leaders ensure that all documented processes which apply to the facility are available to personnel and that a mechanism is in place to ensure that personnel are trained on new, existing, and updated documented processes.	0 1 2 3	A system for ensuring that documented processes which apply to the facility are available to staff and that staff are trained on new, existing and updated documented processes is not implemented. A system for ensuring that all documented processes which apply to the facility are available to staff is implemented. A system for ensuring that staff are trained on existing, new and updated documented processes is implemented. Staff can describe how they are trained and made aware of existing, new and updated documented processes.					
Level 3: The leaders collect and use data to ensure that documented processes are compiled, indexed, circulated, recalled, and reviewed in accordance with the policy and procedure.	0 1 2 3	Data that documented processes are compiled, indexed, circulated, recalled and reviewed in accordance with a document control system is not available. Data are collected on the compilation, indexing, circulation, recall and review of documented processes. The data are aggregated and analyzed to identify deficiencies in the document control system. The data are used to compile and implement a quality improvement plan for document control.					

STANDARD #4: Management of health information

Accurate and complete health information is available for decision-making at all levels.						
RISK LINK: Maintaining, collecting, analyzing, and using health information provides an important connection between doctors, patients, Ministry of Health, insurance providers, and others in the healthcare field. It also assesses the system's effectiveness in detecting health problems, defining priorities, identifying solutions, and allocating resources to improve health outcomes.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures are in place to guide management of health information.	0 There are no policies and procedures for the management of health information. 1 There are policies and procedures for the management of health information that include at least: a. What data should be collected: • Data from high priority clinical areas (for example, maternal, neonatal, adolescent and child health, HIV and TB management, etc.) • Patient record audits • Clinical audits • Essential medicines and supplies inventory (through e-LMIS) • DHIS-2 data • Referral and patient register audits (admission, birth, death, radiology, maternity, child protection, etc.) b. Who is responsible for collecting data c. How and how often data is collected and compiled d. Data quality control e. Data reporting/dissemination, analysis, access, use and confidentiality f. Management, protection, and confidentiality of data 2 Staff involved in the management of health information are trained and have the required skills. 3 Data collection tools are available and data collectors demonstrate that they know how to use them.					

Level 2: The management of the health information system is carried out according to policies and procedures.	0 Management of health information is not done according to policies and procedures. 1 Management of health information is done according to policies and procedures. 2 Complete hospital information (DHIS-2 data) is provided to the Ministry of Health monthly (review past six months). 3 Required hospital information is transmitted before the 15th day of every month to the MOH					
Level 3: The leaders use the health data to make sound decisions.	0 The data is not available or there is no evidence that it is used to make management decisions. 1 Health data is available and there is evidence that it is used to make management decisions (at least the data listed in level 1 and minutes of meetings demonstrating how the data are used to make management decisions is required for compliance). 2 Data are reviewed for data quality control (for example, extreme values, missing data) and documented; the data manager and/or Planning, M&E officer communicates the results to the departments. 3 Monthly reports analyzing hospital data contain: a. Analysis using graphs with trend lines b. Minutes of monthly meetings with heads of departments in which feedback is provided on the results c. Monthly reports of analysis of HMIS data (refer to checklist)					

STANDARD #5: Mentorship and oversight of healthcare facilities in catchment area

Hospital leaders provide ongoing mentorship and oversight of each healthcare facility within their catchment area.

RISK LINK:

Healthcare management that is fragmented poses a risk to the health of a community. Health centers have fewer staff than hospitals and often have less experience and resources to manage patient care. Frequently, the care patients receive in a hospital is not communicated to the health center staff and vice versa; thus, compromising the continuity and quality of care. However, when these facilities function interdependently to provide services, service effectiveness and outcomes are improved.

In the Rwandan model, hospital leaders have a responsibility for mentoring and providing oversight to the health centers that reside within their catchment area. These repeated quality interactions will foster trust, mutual understanding, and shared commitment. In turn, the health center staff has a responsibility to learn through the mentors' experiences and avoid learning by trial and error. The health center staff also needs to take the risks of discussing their own weaknesses and needs with their mentors. The partners can try new ways of working and relating, make mistakes, gain feedback, accept challenges, and learn with each other.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures describe the roles and responsibilities of hospital leadership in mentoring and providing oversight to the associated healthcare facilities and implementation plans exist.	0 There are no policies and procedures that describe the hospital leaderships' roles and responsibilities in mentoring and providing oversight to the healthcare facilities. 1 A current policy and procedure is available that describes the hospital leaderships' roles and responsibilities in mentoring and providing oversight to the health care facilities within the catchment area, including: a. Reproductive, Maternal, neonatal, child health and Malaria b. Technical support provided for managing complicated conditions c. Antiretroviral (ARV) consultations d. Financial overview of use of funds in accordance with stated objectives e. Analysis of community indicators and reports					

	2 There is a quarterly Coordination, Oversight and Mentoring Plan, which includes: a. Identified gaps b. Objectives c. Strategies/activities d. Baseline(s) e. Target(s) f. Timeframe g. Responsibility 3 A transmission letter indicates that the quarterly plan has been received by the concerned health care facility.					
Level 2: The hospital leadership provides monthly mentoring and oversight of each of the associated health care centers.	0 The hospital leadership is not consistently providing mentoring and oversight of the healthcare facilities. 1 The mentorship report demonstrates that the hospital leadership is implementing the mentorship and oversight plan according to the policy and procedure. 2 Patient registers show that the hospital physician has consulted with patients on a monthly basis, which includes a summary report. 3 The patient records reviewed at the health center indicate that the hospital physician consulted with the patients.					
Level 3: The effectiveness of the mentorship/oversight program is evaluated, and measures have been taken to continuously improve the results of their efforts.	0 A quality assessment has not been conducted on a monthly basis and/or is not accurate or complete. 1 The hospital leadership verifies that an accurate and complete monthly quality assessment has been conducted. 2 The hospital leadership conducts an accurate and complete quarterly quality assessment of each associated healthcare facility. 3 The hospital leadership assesses the effectiveness of the program annually in collaboration with the health care centers.					

STANDARD #6: Risk management

Leaders work collaboratively to develop, implement, and maintain effective risk management processes in the hospital.

RISK LINK:

To plan effectively, the hospital must be aware of all relevant clinical and non-clinical risks. The goal is to prevent accidents and injuries, maintain safe and secure conditions for patients, families, personnel, volunteers, and visitors, and reduce and control hazards and risks.

A risk management plan outlines the hospital's risk management processes and approach to managing risk while the risk register contains a list of all identified risks within the hospital, the impact and probability of the risk occurring, the person responsible for monitoring the risk and actions taken to reduce or eliminate the risk. This should be considered a living document which should be updated regularly and reviewed whenever changes in the hospital's risk profile occur, for example, when construction is undertaken, a new service is offered, or new equipment purchased.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A hospital-wide risk management plan and risk register is developed.	0 No risk management plan and risk register is available for the hospital. 1 A current risk management plan has been developed for the hospital that describes at least: • The roles and responsibilities of those identified to implement the risk management plan • The processes for identifying risk • The processes for analyzing risk • The processes for tracking and reporting risk • The processes for reviewing the risk management plan and risk register 2 A risk register is maintained for the hospital that includes at least: • Clinical risk • Operational risk • Financial risk					

	• Physical and environmental risk (including earthquake, floods, fire, radiation, volcanic, chemicals, etc.) • Medicolegal, ethical and reputational risk 3 The risk management plan and risk register are communicated to all staff.					
Level 2: A designated leader implements the hospital-wide risk management plan, and staff are trained on risk management processes.	0 There is no designated leader responsible for risk management and staff are not trained on risk management processes. 1 A designated leader implements risk management processes in the hospital and a job description describes risk management responsibilities. 2 Staff are trained on the hospital's risk management processes and principles. 3 Risk management processes are reviewed, and the risk register updated whenever there are changes in the hospital's systems, processes, or physical facilities.					
Level 3: Analyzed data are used to track and monitor the effectiveness of the risk management system.	0 Risk management data are not aggregated, analyzed and displayed. 1 Risk management data are aggregated, analyzed and displayed. 2 Plans are made to reduce the potential for these events recurring. 3 The results of the interventions are tracked, and actions taken accordingly (PDSA cycle).					

STANDARD #7: Financial management

Hospital leaders use accurate and complete financial data to effectively manage hospital resources to achieve the strategic objectives.

RISK LINK:

Lack of financial resources is a serious risk for the ability of healthcare facilities to achieve the strategic objectives. The primary roles of financial management are to plan for, acquire and use funds to maximize the efficiency of the hospital. Financial management provides the tools necessary to make better decisions. Whereas accounting provides decision makers with a rational means by which to budget for and measure the hospital's financial performance. Both of these functions are crucial for hospital leaders and managers to manage the finances effectively.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures are in place to guide financial management and resources are budgeted to achieve the strategic and operational plans.	0 Policies and procedures regarding financial management are not in place and/or hospital leaders are not involved in financial planning. 1 Policies and procedures for financial management are available and include at least: a. Authorization and approval of expenditures b. Accounting controls in place c. Inventories and assets management d. Financial reporting e. Control of financial documents f. Internal and external audit processes g. Management oversight on financial management 2 The hospital training plan identifies at least: a. The recognized training to be provided b. The leaders identified for training c. The timeframes for receiving training 3 Consolidated budgets are developed and aligned with the hospital annual plan that includes:					

	• A budget line for maintenance of equipment and the infrastructure • Budget plans and established mechanisms to support identified high priority activities for quality improvement (for example, maternal, newborn, child and adolescent health care, HIV and TB)					
Level 2: Financial management policies and procedures are effectively implemented.	0 Cash controls and reconciliation of accounts are not completed as prescribed by financial management policies and procedures. 1 Cash controls and reconciliation of accounts are completed according to financial management policies and procedures. 2 Documentation reveals that invoicing of services is done according to approved tariffs, which are displayed in public areas within the hospital (for example, reception, paying posts). 3 Financial reporting to relevant authorities including community-based health insurance (CBHI) bills is timely and accurate (discrepancy between the amount billed by the hospital and the amount after verification by CBHI must not exceed what is prescribed by the current policy and procedure).					
Level 3: Leaders monitor the management of finances.	0 A monthly process for monitoring finances is not evident. 1 Reports/minutes show that previous financial internal and external audit recommendations are implemented. 2 Interviewed leaders are able to describe how they ensure that proper financial internal and external control procedures are being followed and previous audit recommendations are implemented. 3 Reports/minutes show that leaders review hospital budget implementation and adjust accordingly.					

STANDARD #8: Efficient use of resources

Department leaders and staff are actively involved in resource management.						
RISK LINK: Using resources wisely is crucial in all countries and especially in resource-poor countries. When resources are wasted, the effect is not having the funds to provide for other resources, which ultimately impacts the ability to provide care. Resource management is performed to ensure effective and efficient medical care. It is designed to evaluate the cost and quality of medical services provided. Faced with diminishing resources and escalating costs, the need to use public resources more cost-effectively has never been greater.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Staff members have knowledge and skills regarding resource management.	0 The required in-service training on resource management is not reflected in the hospital's training plan. 1 The required in-service training on resource management is reflected in the hospital's training plan and has been provided to staff as planned on topics such as: • Providing patient services in the most appropriate care setting (use of specialty units, appropriate admissions and discharges, length of stay) • Reducing variations in patient care delivery (use of protocols) • Reducing system inefficiencies and waste 2 Staff training is targeted to resource management issues specific to the department. 3 Staff interviewed are aware of actions taken in their department to improve resource management.					
Level 2: Actions have been taken to improve resource management.	0 No actions have been taken based on the training. 1 Documents indicate that departments have identified opportunities to improve resource management. 2 Plans have been made to improve the use of resources (for example, decrease in rejected lab specimens, decrease in x-ray retakes, decrease in wastage of drugs or supplies, or decrease in inappropriate use of tests and procedures).					

	3 Meeting minutes indicate that the plans have been implemented.					
Level 3: Actions taken to improve effective resource management are measured.	0 Data on improving the use of resources has not been collected or is incomplete or inaccurate. 1 Data have been collected that is complete and accurate for each of the planned improvements. 2 Data have been analyzed and interpreted using charts and graphs. 3 The plans for resource management are updated and implemented based on the results, for example, by using PDSA methodology.					

STANDARD #9: Leadership for quality and patient safety

The leaders accountable for quality and patient safety are clearly identified, trained, and set the priorities for quality improvement.						
RISK LINK: Clear and consistent leadership from the senior leaders of the organization is necessary for a culture of quality and patient safety. Without clear leadership, a culture of quality will not develop, and quality and patient safety will not be viewed as an organizational priority.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The quality and patient safety leaders within and outside the hospital are identified in the quality plan.	0 The quality plan does not include a description of the persons accountable for quality and safety. 1 The quality plan includes a description of the persons accountable for quality and safety and ensures that representatives from high priority areas (for example, maternal, newborn, child and adolescent health, HIV, TB, malaria, etc.) are identified. 2 The responsibility for quality and safety is included in the job descriptions of the identified leaders. 3 The responsibility for quality and patient safety of the central and district health teams is included in the quality plan.					
Level 2: The leadership, including committee chairpersons, are trained in quality management.	0 Evidence of in-service or recognized training in quality management within the past 12 months was not located in leadership and committee chairpersons' personnel files or training records. 1 Training records show that training in quality management has been provided for leaders and committee chairpersons within the past 12 months and includes quality management training specific to the identified high priority areas for leaders representing those areas (for example, maternal, newborn, child and adolescent health, HIV, TB, malaria etc.). 2 Leaders demonstrate use of the knowledge to lead quality improvement (QI) activities within their departments (for example, project description, graphs, dashboards, performance charts).					

	3	Leaders avail resources and ensure implementation of safety policies/procedures and plans.					
Level 3: The leaders set the priorities for quality improvement in the hospital at least annually and monitor progress toward meeting targets.	0 1 2 3	There are no priorities listed in the quality plan and/or evidence of leaders monitoring the progress toward meeting targets. Management meeting minutes show that leaders have identified the priorities for improvement in the quality plan for the current year. Priorities are identified within the past 12 months in the quality plan that includes the criteria for selection (for example, high risk, high priority) and measures of success. Leaders monitor the progress of achieving targets on a monthly basis as evidenced in the management meeting minutes.					

STANDARD #10: Quality requirements in contract management

Quality considerations are a part of all contracts and agreements for clinical or support services from sources outside the health care organization.

RISK LINK:

Health care organizations frequently arrange for clinical or support services from outside sources. These may range from clinical laboratory services to equipment maintenance or food service management. Because these services can often impact the quality and safety of services, there is a clear process to approve all contracts or agreements and to include quality requirements. Processes need to be in place to monitor whether the quality expectations are met, and corrective actions taken when indicated.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure describe the mechanism for management of contracts that includes negotiation and approval of all contracts.	0 A policy and procedure for managing contracts has not been written and/or quality requirements are not included. 1 A policy and procedure for managing contracts includes a definition for the quality requirements during the contract negotiation phase. 2 A policy and procedure for managing contracts describes the process for approving contracts, which includes the role of the hospital in the process. 3 Contracts are approved, signed, and dated according to the policy and procedure.					
Level 2: Contracts include quality requirements.	0 Copies of the contract are not on file. 1 Copies of contracts are kept on file within the facility and the deliverable aspects of the contract are made available to the hospital staff where the contracted services are provided. 2 Contracts describe expectations regarding the quality of the services. 3 A review of contract files shows that the management of the process is carried out according to policies and procedures (for					

	example, garage, cleaning, PBF purchasing contracts, outsourced ambulance services).					
Level 3: Contracts are renewed only when the quality requirements are met.	0 The files do not contain documentation regarding a review of the quality of contract services. 1 Information in the contract file includes communication with the contractor regarding quality. 2 Documentation in the file shows quality audit data, for example, housekeeping checklists, results of patient satisfaction surveys. 3 A review of the quality of the contracted service has been documented within the past 12 months. (If quality requirements are not met, actions are taken, and contracts may be terminated if issues are not resolved).					

STANDARD #11: Integration of quality, safety, and risk management

The organization integrates all quality, safety, and risk-management activities to increase the efficiency and effectiveness of measurement and improvement activities.						
RISK LINK: Quality, safety and risk management goals, indicators and databases may have overlapping priorities. This can fragment and undermine the effectiveness of these programs. It is therefore best to integrate all quality, safety, risk management, and other similar programs to coordinate approaches, use resources wisely, and provide hospital leadership with an overall picture of quality, risk and patient safety in the organization.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The integration and communication between the quality and safety committees and other risk management activities of the organization is described in the quality plan.	0 Coordination and communication between quality and safety committees and other risk management activities are not described in the administrative manual. 1 There is a description of communication/coordination between committees in the administrative manual or quality plan, for example, diagram showing information flow. 2 The committee's terms of reference describes the types of information that are reported between committees and how collaboration occurs. 3 Meeting minutes show communication and collaboration occurred as planned.					
Level 2: Quality and safety committees are integrated and coordinated, and data collection and analysis processes are integrated when appropriate.	0 There is no evidence that committees/departments share data collection and analysis. 1 The committee structure shows that quality and safety committees report data to the same designated senior leader. 2 Quality and safety reports are reviewed and signed by the designated senior leader and there is evidence to demonstrate that the reports are shared with the governance structures of the hospital. 3 Documentation indicates that joint analysis of adverse and sentinel events is done (note: these types of incidents do occur and if none are reported within 12 months, this is not met).					

Level 3: Improvements that are implemented have considered quality and safety implications.	0 Improvement efforts are carried out independently without consideration of the quality and safety implications. 1 Meeting minutes include staff involved with quality improvement and safety. 2 Interviews with committee members indicate collaboration of quality and safety activities. 3 Documentation of improvements demonstrates consideration of quality and safety issues.						

STANDARD #12: Compliance with national laws and regulations

Designated individuals in the hospital are responsible for making the organization aware of applicable ministerial instructions, national laws and regulations and ensuring that the organization complies with them.						
RISK LINK: Patients and their families assume that health care organizations comply with national laws and regulations, such as fire safety, clean water, and infection control. When organizations ignore such laws and regulations or are not in compliance, patients and staff alike are at risk. The organization needs a clear structure to ensure ongoing compliance and reporting to the senior leaders.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Designated individuals are responsible for ensuring compliance with ministerial instructions, national laws, and regulations.	0 A policy and procedure are not present regarding communicating ministerial instructions, laws, and regulations. 1 A policy and procedure describe the process for communicating ministerial instructions, laws, and regulations. 2 There are documents that identify the ministerial instructions, laws and regulations for healthcare facilities, which are filed in an orderly fashion and easy to locate. 3 A designated leader oversees communication and adherence to laws and regulations.					
Level 2: There is a mechanism for staying aware of the ministerial instructions, national laws and regulations that apply to the hospital and for reporting and responding to audit and inspection reports.	0 Leaders are not knowledgeable about the ministerial instructions, laws and regulations that apply to their areas. 1 When interviewed, leaders are knowledgeable about the ministerial instructions, laws and regulations that apply to their areas. 2 An external facility inspection and/or audit reports are present that are dated within the past 12 months. 3 There were no deficiencies, or the facility report noted deficiencies and a corrective action plan is present and implemented.					

	NOTE: These are inspections/audits conducted by external groups, for example, MoH, OAG, Public Service Commission (human resource policies) or fire brigade.					
Level.3: The hospital leaders are informed when the organization does not comply with ministerial instructions, national laws, and regulations and how compliance problems have been resolved.	0 The hospital leaders are unaware of whether the organization is in compliance with ministerial instructions, laws and regulations and/or there are observations that the organization is not in compliance. 1 When interviewed, leaders were able to describe methods used to ensure compliance with ministerial instructions, laws and regulations. 2 Audit data were available demonstrating compliance monitoring. 3 There are no problems identified during the facility tour in which ministerial instructions, laws and regulations were not followed. NOTE: Any problem, such as hazardous waste not managed according to law and regulation or lack of required fire safety equipment, would be scored "0".					

STANDARD #13: Commitment to patient and family rights

The organization's leaders identify patient and family rights and responsibilities and staff respect and protect the rights of patients and their families in the health care process.						
RISK LINK: Patient participation is integral to an organization's culture of safety. International organizations, such as the World Health Organization (WHO), recognize that health care is significantly safer when patients exercise their rights to participate in care decisions, receive information in a language and communication method they can understand, give informed consent for high-risk treatments and procedures, and have an advocate present when appropriate.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The organization has identified patients and family rights and responsibilities and communicated them to staff.	0 No documents are present that describe patient and family rights and responsibilities. 1 A document is present that describes patient and family rights and responsibilities that includes at least: • Dignity and respect • Advocacy (when appropriate for vulnerable patients, for example, newborns, children, adolescents, disabled, elderly, comatose) • Privacy • Confidentiality (including the confidentiality of medical records) • Safety and security • Right to choose • Right to information (including the right to information in a language that the patient and family understand) • Right to complain • Right to refuse treatment • Right to pain management 2 Policies and procedures are in place to identify patient and family cultural and spiritual beliefs that need to be considered when providing care or treatments.					

	3 Staff members are trained on patient and family rights and how to respect them. NOTE: The right to choose may include: • How individuals are addressed (name/title they prefer) • Their personal belongings • Their clothing and self-care routines • Food, drink and meals • Activities, interests, privacy, visitors					
Level 2: Staff respect and protect the rights of patients and their families, including recognizing the cultural and spiritual sensitivities of patients/service users and their communities.	0 Observations indicate that patient and family rights are not routinely respected (for example, lack of privacy or confidentiality). 1 Patient and family rights and responsibilities are posted for public view and patients are made aware of their rights (for example, by drawing their attention to the posted document or by providing them with a copy of the document). 2 Staff members are able to describe how they protect patient and family rights. 3 Patient and family rights are routinely respected (note: this could be measured through observation of patient privacy, interviewing patients, reviewing patient satisfaction and complaint data, etc.).					
Level 3: The hospital asks patients if they were made aware of their rights and responsibilities and if their rights were respected and uses analyzed data for improvement and staff training purposes.	0 The patient satisfaction survey does not include questions about how patients were made aware of their rights and responsibilities and if they feel that their rights were respected. 1 The patient satisfaction survey includes at least questions about: a. Whether the patient was made aware of his/her rights during their stay b. How this was done c. If they feel that their rights were respected 2 Data from the patient satisfaction survey, incident reporting system, complaints and compliments are analyzed to identify trends relating to patient rights. 3 Minutes or an action plan shows the and actions taken (when indicated) to resolve the concerns expressed by patients and families and to train staff on improvement measures.					

STANDARD #14: Patient access to services

Efficient and effective processes are in place to facilitate patient access to health care services.						
RISK LINK: Patients are at risk of not receiving the health care that they need when there are barriers to access. Leaders needs to be aware of the barriers in order to find ways to minimize them. Special attention needs to be given to facilitating access for patients with disabilities.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The scope of services provided by the hospital is described, which is aligned with the service package, and based on the needs of the community.	0 The scope of services provided at the hospital is not described. 1 The scope of services provided at the hospital is described in the administrative manual and are aligned with the required service package. 2 The scope of services are consistent with the community needs identified. 3 The list of services provided at the hospital is observed to be posted for public view.					
Level 2: Barriers to access are investigated and actions taken to make improvements.	0 Barriers to access have not been identified. 1 Barriers to access have been identified and documented, including physical, mental, financial, and special needs patients. • Physical (for example, wheelchairs, ramps, handrails, assistive walking devices and toilets for disabled) • Mental (for example, fears, anxiety, trust) • Financial (for example, transport costs, ability to pay for health care, access to health insurance) • Special needs (for example, cultural and religious needs and the condition-specific needs of special needs patients, illiterate patients) 2 Priorities for reducing barriers have been established. 3 Plans have been developed to address priority issues.					
Level 3: Data is used to inform decisions to improve access to services.	0 Measures have not been taken to make improvements. 1 Meeting minutes show that the plans to reduce barriers are being implemented. 2 Data are used to measure improvement of access to services, for example, reduced wait times. 3 Data shows that access to services has been improved.					

STANDARD #15: Efficient admission and registration processes

Efficient and effective processes are in place to facilitate patients' admission to the hospital.						
RISK LINK: Patients not being aware of the available services or being unable to locate the hospital and service areas are barriers to accessing services as are time-consuming admission processes. Inappropriate use of services, for example, patients placed in ICU or emergency beds that do not require critical care, can limit access to the service by other patients in need of these services.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Services are well marked internally and externally. Policies and procedures for admission and registration processes are written, including admission and discharge criteria to specialty units (for example, ICU, mental health).	0 Services are not well marked. 1 There is clear, visible internal signage that includes the names and directions for main hospital areas and services. 2 External signage provides guidance for the public to locate the hospital from the main roads and Y junctions to hospital. 3 Admission and registration policies and procedures are written: a. Inpatient and emergency admissions b. Outpatient registration c. Admission/discharge criteria for specialty units					
Level 2: An efficient process for admitting patients is in place and admission and discharge criteria are used to make decisions regarding the most appropriate patient placement.	0 Customer care is not consistently available to patients during the admission process. 1 Patients are observed to routinely have access to customer care during admission. 2 Staff interviewed in specialty units describes a daily collaborative process for evaluating patients' conditions and using the information to make patient placement decisions, for example, transfer out of ICU, discharges home. 3 Pre-admission assessments are performed to determine the patient's fitness for procedures and ensure that adequate arrangements are made in preparation for hospitalization.					
Level 3:	1 Client flow analyses have not been conducted and/or not carried out effectively.					

The efficiency of the admission process and the use of admission and discharge criteria for patient placement is monitored and measures taken to improve the process.	1. Client flow analyses are conducted to determine efficiency of admission/registration processes, for example, reduce wait times. 2 Data are collected, such as number of outpatient visits, inpatient length of stays, and length of stay in particular units, for example, ICU or ED, to monitor effectiveness of admission/discharge processes. 3 Plans are implemented and monitored to improve the efficiency of admission/discharge/registration processes.					

STANDARD #16: Effective inventory management

An efficient and effective inventory management system is in place.						
RISK LINK: Adequate medications, equipment and supplies are required to provide care and treatment as well as conduct testing procedures. When these items are not available, the patient is at risk of not receiving timely test results, treatments and perhaps, surgical interventions.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Inventory management policies and procedures to manage medications, equipment and supplies are in place in each department.	0 Inventory management policies and procedures to manage medications, equipment and supplies are not available in each department. 1 Policies and procedures are available for inventory management in each department, including the use of e-LMIS and MEMS in the concerned departments (pharmacy & logistics). 2 Each department has a list of required and existing medications, equipment (including instruments) and supplies. 3 A staff member in each department is assigned to ensure adequate levels of medications, equipment and supplies are available.					
Level 2: Staff members responsible for inventory management are trained to carry out systematic processes to manage inventories.	0 Inventory management is not consistently carried out. 1 Staff interviewed describes a systematic process for reordering medications and supplies and replacing equipment and instruments, for example, first expired-first out rules. 2 Records include maximum/minimum levels and accurate counting of inventory, using e-LMIS, stock control cards or register with stock in and stock out. 3 Medications, equipment, and supplies are observed to be organized and neatly displayed. Note: On the use of e-LMIS check whether the dispensed medicines of the date before the visit are recorded in the system.					
Level 3:	0 Data are not used to measure the effectiveness of inventory management.					

Data are collected to determine the effectiveness of inventory management.	1 Staff interviewed describes the use of quality improvement processes (for example, 5-S) to standardize and maintain inventories. 2 Medications and supplies physical inventory and e-LMIS records discrepancy does not exceed 5%. (Note: Surveyors to compare the physical inventory and e-LMIS inventory). 3 Data are used to measure the effectiveness of the inventory management systems, for example, monitoring stock outs.					

STANDARD #17: Effective medical record management

There is a record of medical examination and/or treatment for every patient seen in the hospital, including inpatients, outpatients, and emergency patients.

RISK LINK:

The medical record contains information used by the healthcare professionals to make decisions regarding care and treatment. When the information is not available or kept in different locations, the caregiver does not have complete information to make these decisions. In addition, effective processes are required to ensure the confidentiality of records when they are in use and stored, and to provide security and sufficient storage space for medical records. The archival staff members are responsible for safeguarding the medical records from tampering, loss, and unauthorized use.

Medical records may be both paper-based, electronic or a mixture of both health record systems. Electronic systems vary greatly in their sophistication and can range from a simple spreadsheet which registers all patient admissions/folders to an entire health record.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A current policy and procedure manual describes the management of medical records.	0 A policy and procedure regarding identification of patients for the purpose of medical record management is not present. 1 The unique patient characteristics that are used to ensure patients have only one medical record is described in a policy, including at least: a. Patient's full name b. Date of birth (when known); another option may be the health insurance number c. The process for ensuring that a unique medical record number is allocated to each patient 2 Policies and procedures are written for the management of both paper-based and electronic medical records and includes at least the following: a. Obtaining medical records, particularly during hours when the central medical record department and\or information technology departments are closed b. Completion of medical records prior to filing					

	c. Filing, record retrieval and tracking systems d. Archiving and destruction of medical records e. The confidentiality of both paper-based and electronic medical records (when in use and when stored) f. Verification process of required documents g. Master patient index 3 A central archival system is observed to be in place for paper-based medical records and a secure server is available for electronic medical records.					
Level 2: Each medical record contains sufficient information to identify the patient. Each patient has one medical record, and all admissions are filed in the one folder. A process is carried out to verify that all required documentation is complete after discharge.	0 There is no master patient index, or it is not complete. 1 A master patient index includes all patients' names and medical record numbers. 2 There is only one medical record per patient that is filed in the same folder. (Outpatient visits are documented in the same medical record as inpatient notes). 3 Identifying information is recorded on each medical record form (written, typed, stamped, or on a computer-generated label) in the same location.					
Level 3: There is a central archival system that is well-organized such that medical records are easily located, the records are safe and secure.	0 The records are not well organized, secured or easily retrieved. 1 Records are observed to be stored in an orderly, accessible manner in a safe (for example, from fire, floods, pest infestation, etc.) and secured (for example, protected from theft, tampering and breach of confidentiality) location and electronic records are protected by passwords, firewalls and are routinely backed up. 2 Staff interviewed describes an effective retrieval and tracking process (staff can retrieve patient records within 15 minutes). 3 Archival staff interviewed describes a process for verifying that all required documentation is complete within 15 days of patient discharge.					

STANDARD #18: Oversight of human subject research

Oversight is provided of any human subject research conducted in the organization, which includes a clear mechanism to protect patient rights and safety.						
RISK LINK: Many types of research occur in health care organizations, from formal drug trials to the use of a drug or device for a purpose other than for which it was approved. Because all research poses potential risk to subjects/patients, there needs to be an oversight mechanism that protects subjects/patients and holds the organization to the highest ethical standards of behavior.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is a committee or other mechanism to provide oversight of all research involving human subjects.	0 There is no process for providing oversight of human research subject studies. 1 A committee exists that provides oversight of human research subject studies. 2 The committee has terms of reference. 3 Hospital leaders describe the process for approving human research subject studies. NOTE: All hospitals are to meet at least Level I, even if they do not currently conduct human research. The committee may be ad hoc.					
Level 2: There is verification of authorization and oversight that all research protects the rights and safety of subjects/patients.	0 The human research subject studies conducted at the hospital have not been reviewed. 1 Research studies involving human subjects have been reviewed and approved by the recognized body (for example, National Ethics Committee) according to laws/regulations. 2 For patients participating in a research study, three consent forms are obtained, signed by the patient and two witnesses (one is retained in the medical record, one is given to the patient, and one is retained in the research file). 3 The medical record indicates that the patient received a copy of the signed consent form.					

	NOTE: If humans research subject studies are not conducted in this hospital, score as not applicable.					
Level 3: There is a report to show that the research is carried out according to protocols in respect to patients' rights and to guide enhancements to the program of research oversight.	0 There is no data to show that the process for providing oversight of human research subject studies is effective. 1 Documentation in the patient's medical file indicates that the patient is participating in a research study, for example, a signed consent form. 2 The process for providing human research study oversight is monitored. 3 Data is aggregated and used for improving program oversight.					

RISK AREA #2 – COMPETENT AND CAPABLE WORKFORCE

Patients assume that the health care professionals providing their care and treatment are competent and capable. Furthermore, even though health care professionals may intend to provide quality and safe patient care every day, they are frequently not supported by consistent and low-risk processes and systems, thus placing patients at risk. Many health care professionals, such as physicians, traditional care providers, and others, are permitted by law or regulation to work without supervision and thus without some of the checks and balances that reduce risk. It is essential that all health care professionals have appropriate and valid credentials and are competent to provide care and treatment to patients.

A primary activity related to a competent and capable workforce is an appropriate orientation and ongoing education in patient risk areas. These include a general orientation to the organization such as information on infection control, hazardous materials management, and others. In addition, staff must be oriented to the specific department requirements. It is also critical that staff members know how to communicate essential patient information from one person to another and from one care unit to another. The criteria below address risk points in workforce management.

Required Documents	Data Collection Methods
1. Staffing plan 2. Training and competency assessment plan 3. Staff member job descriptions 4. Personnel file policies and procedures 5. Credentialing policies and procedures 6. Privileging policy and procedure 7. Staff general orientation program agenda 8. Departmental orientation checklists 9. List of trainees and assignments 10. Cardio-pulmonary resuscitation training policy 11. Cardio-pulmonary resuscitation policy and procedure for providing resuscitation services 12. Training and competency assessment records as evidence of meeting various standards 13. Staff health and safety policies and procedures 14. Occupational hazard assessment	A Leader interviews B Staff interviews C Document review D Personnel file review

STANDARD #1: Personnel files available, complete, and up to date

All staff members have a personnel file that is complete, up to date according to the policy and procedure.						
RISK LINK: Patients are at risk when health care professionals provide care and treatments for which they are not qualified. Thus, job descriptions improve safety by clearly identifying what activities and services the professional is qualified to provide. Job descriptions and job assignments are based on evidence such as completion of health profession training programs, in-service education, competence, and other work experience.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies describe the content that is to be included in the personnel file and job descriptions.	0 A policy describing the contents of personnel files is not written and/or does not contain the required elements. 1 A current policy outlines the content of personnel files and includes: a. Current job description b. Curriculum vitae c. Copies of required credentials including degrees/diplomas, evidence of registration certificates and current license (if applicable) d. List of privileges (if applicable) e. Evidence of completion of resuscitation training (if applicable) f. Performance evaluation (PBF) and (MIFOTRA) as prescribed by current policy g. Training certificates h. Evidence of completion of orientation within two months of appointment (new personnel only) i. Required health assessments/vaccinations j. Disciplinary action reports 2 A current policy indicates that the job description contains at least: a. Education, training and experience required b. Reporting relationship (who they report to) c. Roles and responsibilities d. PBF contract (motivation) e. Job contract					

	3 A policy describes the content of volunteer and contracted personnel files. a. Copy of contract b. Qualifications (education, training, and experience) c. Current professional license (if indicated) d. Proof of orientation e. Required health assessments/vaccinations NOTE: • Orientation records are only expected for personnel that have been hired within the past twelve months. • Other forms of documentation would be acceptable, for example, computerized list of staff that participated in an activity with dates of the activity and the providers. This would include training activities and lists of vaccinations.					
Level 2: Personnel files are filed in a standardized order and contain all required elements as described in the policy.	0 A process for ensuring that all healthcare professionals remain registered in accordance with legal requirements is not in place. 1 A process for ensuring that all healthcare professionals remain registered in accordance legal requirements is in place and personnel files reviewed had evidence of a current license (when required). 2 Personnel, volunteer and contractor worker files contained the required items. 3 Personnel, volunteer and contractor workers files were arranged in an organized standard format.					
Level 3: A process is in place to manage personnel files.	0 There is no policy and procedure for the management of personnel files. 1 A policy and procedure is implemented for the management of personnel files that includes at least: • A personnel record audit to ensure that records are up to date • Authority to access personnel records • Secure storage of personnel records 2 Performance-based finance (PBF) reviews, conducted within the past six months, are present in the personnel files. 3 The online Human Resource Information System is available and updated with a current list of quarterly payments of salary and PBF.					

STANDARD #2: Credentials of healthcare professionals

There is a process to gather and verify the credentials of healthcare professionals and to evaluate and authorize them to provide patient services that are appropriate to their licensure, education, training, and competence.

RISK LINK:
Physicians work independently evaluating patients, making decisions regarding patient care, and performing high-risk procedures such as surgery. Patients place high trust in their physicians. Organizations need consistent processes for gathering, verifying, and reviewing the credentials of physicians to ensure that patient trust is not violated, and the services of physicians do not place patients at risk.

Nurses are often the primary patient caregivers. They evaluate patients, provide certain nursing services independently, and carry out physician orders. Nurses often prepare medications and administer most medications to patients - two high-risk procedures. Nurses may have unique training and skills (for example, nurse midwives, intensive care nurses). The assignment of the nurse must be based on a careful review of qualifications to ensure patient safety.

A variety of other health professionals, including laboratory technicians, nutritionists, physical therapists, and respiratory therapists, work in health care organizations, often providing evaluations and services without the direct supervision of physicians or nurses. This can be high risk if the individual is not adequately trained. Also, because training programs for these health professionals vary widely, and many health care organizations provide on-the-job training, it is important that the qualifications of these professionals support their job responsibilities.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure describes a uniform process for gathering and verifying the credentials of healthcare professionals (including independent clinical practitioners and volunteers) and assigning responsibilities accordingly.	0 There is no policy and procedure for gathering and verifying the credentials of healthcare professionals. 1 A current policy and procedure details: a. The required registration and certification with professional councils (including areas of specialization) b. The required licensure, education, training, and competence c. A uniform process for gathering the credentials of healthcare professionals (including independent clinical practitioners and volunteers) d. The process for conducting verification of credentials e. The process for appointing healthcare professionals based on credentials f. How healthcare professionals are assigned job responsibilities based on their credentials and when extending their scope of services (task shifting).					

	2 Appointments are not made, and direct patient care is not provided until at least licensure/registration of healthcare professionals are verified. 3 Healthcare professionals that are extending their scope of services (task-shifting) have associated competency levels defined and assessed, which are documented in the majority of personnel files. NOTE: The primary source verification may be conducted by the professional council, however, the policies and procedures need to indicate that this is the process. For file review, identify the required credentials in the job descriptions of selected healthcare professionals and compare them to the actual credentials in the personnel file.					
Level 2: The credentials are gathered and verified according to the policy and procedure. and healthcare professionals are assigned roles and responsibilities based on the credentials.	0 A complete set of required credentials is not maintained for each healthcare professional. 1 All credentials required are copied by the hospital and maintained for each healthcare professional in their personnel files. 2 When work responsibilities require specialized qualifications for healthcare professionals (for example, surgery, obstetrics, ICU, etc.), verification (by the professional council) of training in that specialty is documented in the personnel file. 3 The credentials of independent clinical practitioners and volunteers providing clinical care are verified before providing direct patient care. NOTE: For file review select healthcare professionals that are working in areas that require specific qualifications, for example, specialized surgery, ICU, ED, dialysis, pathology, radiology, etc.					
Level 3: Evidence shows that the credentialing process is effective.	0 There is no data that show that the verification process is carried out according to the policy and procedure. 1 A dated and signed document indicating that verification of credentials has been done for each healthcare professional is present. 2 A document is present showing that the hospital verifies that the 3rd party (professional council) implements the verification process described in the policy and procedure. 3 Audits are conducted to ensure that healthcare professional appointments are made according to hospital policy.					

STANDARD #3: Privileges for Health Professionals

A standardized objective, evidence-based procedure is used to authorize health professionals to provide clinical services consistent with their qualifications, experience, and competence.						
RISK LINK: The determination of the current clinical competence and making a decision about which clinical services the health professional will be permitted to perform, called "privileging", is the most critical determination an organization will make to protect the safety of patients and advance the quality of its clinical services.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure describe a standardized process to grant clinical privileges to health professionals and assign job responsibilities accordingly.	0 There is no committee that manages the credentialing and privileging of health professionals at the hospital. 1 The committee's members in charge of examining applications for privileging have been appointed and are meeting according to the ministerial instructions establishing it. 2 A policy and procedure describes a standardized process for approving clinical privileges, including the process for approving special and temporary privileges and the training, experience and competence required for new procedures; and how the credentials are used to assign job responsibilities. 3 A core set of privileges is defined for categories of practitioners, for example, internists and general practitioners, including task-shifting for any other health professional.					
Level 2: The organization uses a standardized procedure to approve privileges on initial appointment and when new skills have been acquired to each type of health professional listed in the policy and procedure. The patient services to be provided by each health	0 A process for approving health professional. privileges in not in place or is inconsistently applied. 1 Each health professional has defined core privileges and special privileges (for example, task-shifting, general practitioner may perform hysterectomy), with evidence of training/experience to perform the special procedure, documented in the personnel file, which has been updated within the past 24 months.					

professional are clearly delineated and communicated by hospital leaders across the organization and to the practitioner.	2. Privileges are communicated to relevant departments through a written document. 3.A personnel file is kept for practitioners given temporary privileges (for example, visiting foreign surgeons) that includes: • Licensure status • Written request • Verified information supports a favorable determination regarding the requesting practitioner's qualifications and ability to exercise the requested privileges.					
Level 3: Each privileged practitioner provides only those services that have been specifically permitted by the hospital. The medical staff leaders can demonstrate how the procedure was effective in the appointment process.	0 There is no or inconsistent evidence of monitoring professional practice. 1 All health professionals are included in the monitoring and evaluation of professional practice (These may be included in the performance appraisal process; indicators may include complication rates and compliance with clinical practice guidelines. 2 Areas of achievement and potential improvement related to behaviors and clinical results are documented in the personnel file. 3 Findings are used for determining privileges and are reflected in the list of privileges (for example, if a physician has had surgical complications, their privileges for surgery may be changed.)					

STANDARD #4: Orientation to hospital and jobs

All staff members, volunteers, contract workers and independent practitioners are oriented to the hospital, their job responsibilities, job assignments, and work location.						
RISK LINK: Inadequate job orientation is a major contributor to adverse events in health care organizations. Such events include mistakenly giving patients concentrated electrolyte solutions, not knowing how to operate medical equipment, and injuring patients, administering incorrect medications, and many other situations that can lead to patient harm or even death. A thorough job orientation to the unit on which the individual is to work, or the unit on which the worker is temporarily assigned, is essential for patient safety.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure for general overall hospital and job-specific orientation for new, and reassigned staff, volunteers, contracted workers, and independent practitioners is available.	0 There is no orientation policy and procedure, or it does not address general and job specific orientation expectations and/or all types of staff listed in the standard. 1 A policy and procedure describes orientation expectations for new and reassigned staff, volunteers, contracted workers, and independent practitioners. 2 The general orientation program includes initial orientation on: a. Risk management b. Patient safety c. Infection control d. Incident reporting e. Quality improvement f. Identified policies and procedures 3 A job-specific orientation program is developed for each type of position within a department/service and includes an initial competency assessment.					
Level 2: General and specific job orientation is provided for all new, reassigned staff,	0 The orientation programs are not implemented. 1 Staff members hired within the past six months have attended general orientation and it is documented on a training register or other records					

volunteers, contracted workers, and independent practitioners.	2 Staff members hired or transferred within the past six months have completed a documented, job-specific orientation and competency assessment. 3 General orientation of new contracted workers, volunteers and independent practitioners is conducted within 2 months and the orientation report is retained in their individual files.					
Level 3: The implementation and effectiveness of the orientation program is monitored and improved upon when required.	0 The orientation program is not monitored. 1 A process is in place to verify whether all new and reassigned staff have completed the general and job specific orientation programs as planned. 2 A process is in place to verify whether all contracted workers, volunteers and independent practitioners have received orientation. 3 The data gathered is used to make improvements in the orientation program. NOTE: The orientation may be conducted by the contractor, given that the program content is consistent with the expectations of the hospital, for example, infection prevention and control (IPC) policies/procedures, fire safety plan. In this case, the contractor needs to provide documentation that the orientation was provided, and this document is kept on file.					

STANDARD #5: Trained and competent staff

Ongoing training and competency assessment is provided to maintain and improve the knowledge and skills of staff members to ensure competency to perform their job.

RISK LINK:

Competence includes knowledge and skills. Healthcare providers gain competence through pre-service and ongoing training as well as through on-the-job experience. Measuring competence is essential for determining the ability and readiness of healthcare workers for providing quality care services. Less competent providers are less likely to provide quality services. Therefore, competency measurement can be used to evaluate individuals in terms of their ability to provide services as per the prescribed policies, procedures, and protocols. In order to provide quality services, healthcare providers must have the competencies necessary to perform their jobs according to standards.

To ensure that the hospital is managed by skilled and competent leaders, those who are appointed in leadership roles should be provided with the training required to enable them to perform their functions.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The hospital has developed a training and competency assessment plan to ensure that staff knowledge and skills are consistent with patient needs.	0 There is no staff training and competency assessment plan and/or it is not based on identified training needs. 1 The hospital has an annual written hospital staff training and competency assessment plan based on: • The initial training and competency requirements of new staff • Ongoing competency assessment requirements for all staff • The training requirements of staff who are appointed in leadership positions (for example, management training, financial management training, human resource training, etc.) • Identified ongoing training needs (for example, infection prevention and control, risk management, incident reporting and management, fire and evacuation, resuscitation, person-centered care, etc.) • Training needs in identified high priority services (for example, maternal, newborn, child and adolescent health, HIV, TB, Malaria etc.) • Monitoring data from hospital management processes • The introduction of new equipment and technology					

	• Deficiencies in skills, knowledge and competency identified through the performance evaluation and review process • New clinical processes • Updating or acquiring new skills and knowledge • Plans and development strategies of the facility 2 All levels of staff members are included in the plan. 3 Managers develop annual department/service-specific staff training and competency assessment plans to meet the needs of their patients/departments.					
Level 2: Training and competency assessment is carried out to meet the educational needs of staff.	0 Training and competency assessment activities have not been carried out as planned. 1 Records of training and competency assessment activities and attendance are maintained. 2 Hospital training and competency assessment activities have been conducted as planned. 3 Presentations are held quarterly and documented regarding case management and current medical articles for healthcare professionals.					
Level 3: The effectiveness of staff training and competency assessment is monitored.	0 Staff training and competency assessment effectiveness is not evaluated. 1 Minutes of staff meetings show that staff who received training outside the hospital share the learning with other staff in the hospital (for example, content outline, handouts used). 2 Hospital staff training and competency assessment activities are monitored for effectiveness. 3 The monitoring data is analyzed and used to improve the effectiveness of training and competency assessment. NOTE: Effectiveness can be measured by return demonstration of skills or linked with quality monitoring, for example, improved documentation, hand washing or adherence to policies/procedures or protocols. Staff satisfaction with the training activity is not the intended measure of effectiveness for this standard.					

STANDARD #6: Sufficient staff to meet patient needs

A recognized planning process is used to determine the level of staffing and skill mix required to meet the needs of the patients and services provided.						
RISK LINK: Reports of research on staffing (primarily nursing) over the past decade have documented that in hospitals with high patient-to-nurse ratios, patients experience higher mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction. In addition, when nurses' workloads increase during shifts because of high patient turnover, mortality risk also increases.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Staffing plans are written in each department that identifies the number of staff needed per shift considering the size of the hospital, the scope of services provided and the workload.	0 Staffing plans have not been developed. 1 Each department has a staffing plan, based on the hospital general staffing plan. 2 When staffing levels do not meet the needs, policies and procedures are in place that describe actions to be taken, for example, reassign staff, on-call staff. 3 Staffing plans are based on a recognized and agreed upon staffing model (for example, WHO's Workload Indicators of Staffing Needs or a national staffing model) that includes at least: • Number and types of required staff • Knowledge and skills relevant to the service being provided • Patient acuity (in clinical areas) • The specialized staffing needs of identified priority services (for example, maternal, newborn, child and adolescent health) • Workload (for example, nurse to patient ratio, number of tests performed, or number of rooms to be cleaned)					
Level 2: The work schedule provides an adequate number of staff (according to the plan) on each shift to meet the departmental needs.	0 An interview with department heads indicates that schedules are not developed based on the staffing plan. 1 Staffing schedules in the departments are filled out according to the plans.					

	2 Staffing schedules in the departments are filled out according to the plans; but the number of staff that actually worked is not consistent with the plan. 3 Staffing schedules are filled out according to the plan and the number of staff that actually worked is consistent with the plan.					
Level 3: Staffing plans are evaluated to determine whether adequate staffing is provided; when shortages exist, leaders set priorities and make adjustments to provide safe care.	0 There is no evaluation of the staffing plans. 1 A monthly review of data regarding staffing planned in relation to the staff that worked is done in each department. 2 When interviewed, department leaders are able to describe how they effectively manage situations in which staffing needs are not met, which is consistent with the policy and procedure. 3 Workload studies are done to evaluate the staffing needs.					

STANDARD #7: Oversight of students/trainees

When the organization is a training site for health care professional students, there is adequate oversight of the students and trainees to ensure that they are known to staff, that their current competence matches any patient care responsibilities they may have, that they have the appropriate level of supervision, and that the training program is integrated into the quality and patient safety program.						
RISK LINK: Many hospitals are training sites for medical, nursing, and other health professional students. It is important that the current competence (level of training) of each trainee is known, and the trainees are appropriately assigned and supervised based on their competency. Trainees can introduce a new level of risk to patients unless the training program is well managed with good oversight.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A current policy and procedure is available on student oversight.	0 A current policy and procedure regarding student oversight is not present. 1 A current policy and procedure is available on student oversight. 2 A current list of trainees and their assignments is present for each type of program. 3 A list of trainees and their assignments are observed to be posted within relevant units.					
Level 2: The number of trainees and their assignments are known. The current competence (level of training) of each trainee is known, which is used to make assignments and indicate level of required supervision.	0 Information about the competency levels of trainees is not available. 1 Information about the competency levels of trainees is available. 2 Information about the competence level of trainees is made available to the heads of the departments where trainees are allocated. 3 An interview with department heads demonstrates that trainees are assigned patient care consistent with their competency level and clinical oversight is planned in advance.					
Level 3: Monitoring is performed to determine whether the oversight of students is in compliance with the policy and procedure.	0 There is no evidence that the trainees are supervised according to the policy and procedure. 1 The trainee assignment form indicates that all students are supervised according to policy. 2 Orientation records show that all trainees are oriented to the facility's quality and safety policies and procedures. 3 Department records show that student oversight is routinely performed.					

STANDARD #8: Training in resuscitative techniques

All staff are trained in resuscitative techniques by a certified trainer, have evidence of satisfactory completion of advanced or basic training, and are re-trained every two years. The impact of the training on survival rates following cardiac events is tracked and used to improve the program.

RISK LINK:

Every person employed in the hospital should be trained in basic cardiopulmonary resuscitation to ensure that they can call for help and commence life-saving interventions while waiting for assistance. The training and competency assessment plan should set out the levels of training required for each category of staff.

It is essential that areas where cardiac life support may be needed (for example, emergency areas, intensive care units, operating theaters) have individuals with cardiac life-support training immediately available or have life-support teams available in the organization. Additional risks are that the training is not competency-based, conducted by qualified individuals or retraining does not occur.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure defines the staff that are required to be trained and at which level (for example, basic CPR, BLS, ACLS, PALS or NRP). A resuscitation policy and procedure describes how to respond to a resuscitation emergency.	0 The policies and procedures are not written regarding resuscitation. 1 A policy describes the CPR training requirements and level for each category of staff (basic, advanced, pediatric, neonatal and trauma). 2 A policy and procedure includes: a. Responsibilities for each responder, for example, CPR, obtaining emergency medications/equipment, administering medications, recording the events, and airway management b. How to call the resuscitation team c. Personnel that are to respond d. Documentation required e. Evaluation of the resuscitation response 3 An annual resuscitation training plan is present that includes: a. Identification of staff to be trained b. Priority staff to be trained c. Type of training activity d. Number of personnel to attend (at least 25% of relevant staff in first year and increment of 25% each subsequent year)					

	e. The certified training provider f. Timeframes g. Ongoing competency assessment (for example, by conducting mock resuscitation drills).					
Level 2: Staff members have successfully completed competency-based training by a qualified instructor and have been retrained within the last two years according to the policy.	0 Staff training in resuscitation is not proceeding as planned. 1 Relevant staff have documentation of training for their roles during resuscitation according to the resuscitation policy and procedure. 2 The resuscitation training is being carried out according to the plan. 3 Staff that have attended training have documentation of the required level of competency according to the policy and procedure.					
Level 3: There are data that show the impact of the training program that are used to improve the program.	0 There is no evidence that the impact of the CPR training program is used to improve the program. 1 A tool for evaluating the effectiveness of the resuscitation policy and procedure has been designed and tested. 2 Results of the evaluation of resuscitation have been aggregated and displayed. 3 An analysis of the results of resuscitation and mock drills have been documented and a plan for improvement has been implemented.					

STANDARD #9: Staff performance management

Staff performance is evaluated on a regular basis and feedback provided to the employee to improve work performance.						
RISK LINK: Conducting performance appraisals provides the employees with feedback about their work performance based on standards expectations described in the job description. When staff are not aware of their performance, they may continue on a path that leads to poor patient care, service delivery or making errors. Therefore, it is important to provide each employee ongoing feedback regarding their job performance to provide an opportunity for them to make improvements.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure describes the performance management process.	0 There is no policy and procedure for performance management. 1 A current policy and procedure is in place that describes the performance management process. 2 Each category of employee has a job-specific evaluation related to the assigned tasks described in the job description. 3 Staff interviewed are aware of the process.					
Level 2: The performance management process is implemented according to the policy and procedure.	0 Annual evaluations are not done and/or not consistently performed according to the policy and procedure. 1 Personnel files contain individual annual performance evaluations conducted within the past 12 months. 2 Performance goals/objectives are set with each employee with a plan to achieve these goals/objectives, which are linked to goals of the organization (for example, achieving targets). 3 Feedback is provided to each staff member and progress toward the goals/objectives is documented.					
Level 3: The effectiveness of the performance management process is evaluated.	0 The effectiveness of the performance management system has not been evaluated within the past 15 months. 1 A performance program evaluation tool is developed and tested, which measures whether the program functions according to the policy and procedure. At least the following questions are addressed:					

	• Were evaluations done on time? • Did everyone who was supposed to receive an evaluation get one? • Were employee performance goals written and progress noted? 2 An evaluation of the program has been conducted within the past 15 months. 3 The results of the evaluation were analyzed, and actions taken to make improvements.					

STANDARD #10: Staff health and safety program

A program to promote staff health, reduce health hazards for staff and provide safe working conditions is in place.						
RISK LINK: A healthy workforce is essential to provide quality and safe patient care. Staff may bring infectious diseases into the hospital from the community, or they may spread infections between patients, and may even be absent or ineffective in their work if they are injured or ill. Processes need to be in place to assess potential occupational risks of all categories of staff and implement ways to minimize those risks. Where risk resides, there needs to be proactive steps to protect workers. (Common risks include control of hazardous materials, prevention of injuries from poorly maintained equipment, immunizations, or other measures to protect workers from infectious diseases, screening for tuberculosis and other diseases, and proper care for needle and sharps exposure and other work-related injuries.) Research shows that by actively promoting staff health an organization can improve productivity and reduce absenteeism, build and sustain employee morale, retain staff and improve staff's health behaviors which in turn will reduce health care costs.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure identifies how staff health is promoted and the management of work-related injuries and incidents. Staff injuries and health issues are attended to in a reactive manner as incidents occur.	0 There is no policy and procedure regarding promoting staff health and attending to staff illnesses and injuries. 1 A policy and procedure describes procedures for promoting staff health and attending to staff illnesses and injuries. 2 Department heads describe the process for completing incident reports when staff injuries and illnesses occur. 3 Required follow up for incident reports includes staff referral for treatment for illnesses and injuries and the outcomes.					
Level 2: The hospital has a proactive program to promote staff health and to identify and implement processes to reduce staff safety risks.	0 There is no proactive approach to staff health and safety. 1 An employee occupational hazard risk assessment has been done. 2 Plans are in place to promote staff health and reduce the potential risks to staff; plans include providing the following: a. Measures to promote staff health (for example, periodic health screening, promotion of a healthy lifestyle, emotional wellbeing)					

	b. Measures to prevent manual handling and needlestick injuries c. Education, evaluation, counseling, and follow-up for staff who are second victims of adverse or sentinel events d. Hepatitis B vaccine e. Annual TB tests for staff working in high-risk areas: OPD, emergency department, TB unit, laboratory, and HIV unit. 3 Documentation in minutes or reports shows that the plans have been implemented. NOTE: Several of the occupational hazards are related to IPC and are included in the IPC policies and procedures. Other issues may include such things as back injuries or falls.					
Level 3: The hospital collects and analyzes data on staff health, risks and injuries and can demonstrate increased safety and reduced health incidents.	0 There is no documentation of employee risks and injuries. 1 The incident report data is aggregated and reported in graphs/charts. 2 An action plan has been developed to reduce employee's risk of injuries. 3 Data analysis shows progress in reducing staff injuries and illnesses.					

RISK AREA #3 – SAFE AND FUNCTIONAL ENVIRONMENT FOR STAFF AND PATIENTS

Health care organizations are very complex places which house a significant amount of equipment, hazardous materials, and many types of patient supplies. Health care practitioners may be proficient in using equipment but may often lack the expertise to inspect and maintain the equipment. Those inspecting and maintaining equipment may not have the required skills and knowledge to ensure that equipment is functional and safe. Health care facilities typically undergo frequent remodeling or expansion, resulting in varying types and levels of fire safety conditions. These are a few examples of why heath care organizations are high-risk places for patients, staff, and visitors. Reducing environmental risks requires leadership commitment to safety, staff training, and regular inspection, maintenance, and monitoring.

Patients and visitors usually do not understand the risks in the health care environment and assume conditions are safe. Because they are not prepared to be cautious on their own behalf, the organization must take appropriate actions to ensure that patients and staff are safe and to provide a protective and supportive environment.

To provide safe patient care, service-specific resources are required. The physical facilities must be clean, functional, well ventilated, and well-lit. Sluice rooms, treatment rooms, dressing rooms and storage space (for example, for clean linen, cleaning equipment, medications, equipment, and supplies) should be available and secure to prevent unauthorized access. Sanitary and bathing facilities must accommodate the number of patients in the service and patient accommodation must provide for privacy and safety. The design of facility should provide for a logical flow of patient care, services, and tasks (for example, in theatre, CSSD, laundry and in specialized services such operating theatre, ICU and maternity).

Required Documents	Data Collection Methods
1. Planned preventative maintenance plan 2. List of environmental risks 3. Facility inspection report (See RA#1, St #11) 4. Facility improvement plan 5. Facility management plans: a. Fire safety b. Water management c. Power management 6. Hazardous materials inventory, policies, and procedures 7. Material Safety Data Sheets (MSDS) 8. Environmental safety plans, policies, and procedures	A Leader interviews B Staff interviews C Document review D Personnel file review E Inspection F Observation

9. Biomedical equipment inventory, policies, procedures, and replacement plans 10. Biomedical and non-medical equipment maintenance records 11. Reports of fire drills 12. Reports of staff attendance for required training 13. Reports for monthly safety rounds 14. Site plan for electrical service distribution 15. Minutes of Facility Safety Committee 16. Infection prevention and control focal person job description 17. Infection prevention and control policies and procedures and plan a. Hand hygiene b. Sterilization c. Laundry and linen services policies and procedures d. Proper storage and disposal of medical waste e. Communicable disease reporting 18. Infection prevention and control surveillance data	

STANDARD #1: Infrastructure, utilities, resources and equipment and furniture

The infrastructure, utilities, resources, equipment, and furniture of the facility meet patient and service-specific needs.						
RISK LINK: The availability of safe and effective infrastructure, utilities, medications, supplies, equipment, and furniture provide the enabling environment for a hospital and health providers to function effectively.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The leaders plan the space, utilities, equipment, resources, and furniture needed to safely and effectively support the services provided and the plan is reviewed when the strategic and operational plans of the facility are reviewed.	0 There is no plan to ensure the provision of service-specific infrastructure, utilities, resources, equipment, and furniture. 1 There is a plan to ensure the provision of service-specific infrastructure, utilities, resources, equipment, and furniture that is reviewed when the strategic and operational plans of the facility are reviewed and addresses at least the following: • Patient accommodation and ablution facilities (including space to accommodate newborn caregivers) • All mothers of small and sick newborns have a dedicated area for supportive adequate space for KMC, family centered care, privacy for mothers to express breast milk and facilities for hygiene. • Administrative and clinical work areas • Patient and workflow (for clinical and non-clinical areas) • Infection prevention and control measures • Risk prevention measures • Essential furniture, equipment, medications, and supplies (checklists) • Planned preventative maintenance for infrastructure, utilities, furniture, and equipment					

	2 There is evidence that each service was consulted and provided input into the plan. 3 There is evidence that professional recommendations and national guidelines were used guide the provisions of the plan (for example, for maternal, newborn, child and adolescent health, mental health, operating theatre, laundry, CSSD, etc.).					
Level 2: The space, utilities, equipment, resources, and furniture needed to support the services safely and effectively are provided and well maintained.	0 The space, equipment, utilities, resources, and furniture needed to support the services safely and effectively are not provided according to the plan or they are not well maintained. 1 Documented evidence that the space, utilities, equipment, resources, and furniture are provided according to the plan (for example, routine inspections, checklists, etc.) 2 Evidence that the infrastructure, utilities, equipment, and furniture in each service are reflected on the planned preventative maintenance schedule. 3 Documented evidence that the space, equipment, resources, and furniture are maintained according to the plan (maintenance records should be referenced, for example, requests for maintenance, completion of requests and planned preventative maintenance records).					
Level 3: Implementation of the plan to provide functional space, utilities, equipment, resources, and furniture is monitored and improvements made when required.	0 Implementation of the plan is not being monitored. 1 Evidence that the plan is being monitored is available in at least the following documents: a. Inventory lists b. Environmental checklists c. Planned preventative maintenance records d. Completion of maintenance requests 2 Data is aggregated and analyzed to identify trends and the information shared with a designated leader. 3 Action plans are developed and implemented.					

STANDARD #2: Regular inspection of environmental safety

All the health care organization's buildings and grounds are thoroughly and regularly inspected to identify and reduce safety risks to patients, staff, and visitors.						
RISK LINK: The first step to protect patients, staff, and visitors from risks in the health care environment is for the organization to know the location, nature, and severity of the risks. This inspection covers a full range of risks, from broken furniture and locked or blocked fire exits to faulty biomedical equipment, terrain, road conditions and missing signs. The effort then is to systematically reduce or eliminate those risks.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is an inspection process to identify and list health care environment risks of all types.	0 There is no list of environmental risks, or it does not include all areas or types of risks. 1 There is a list of environmental risks which includes input from all areas and includes issues identified in facility inspection reports from external agencies. 2 A safety team (designated by the Health and Safety Committee) uses a checklist to identify risks when visiting areas on a monthly basis. 3 There is a comprehensive list of all types of environmental risks in all areas that includes at least those relating to: a. Safety b. Security c. Hazardous materials d. Fire safety e. Biomedical equipment f. Utilities (power and water) g. Infection control (for example, laundry, sterilization, and waste management) NOTE: If during survey, the survey team identifies risks not included in the hospital's list, then a score of 3 cannot be awarded.					
Level 2:	0 The environmental risks have not been prioritized. 1 The environmental risks have been prioritized.					

The risks identified during the inspection process are prioritized according to severity and likelihood of occurrence and a plan is developed to reduce priority risks.	2 An interview with the biomedical maintenance officer reveals that all risks have been prioritized by the hospital's leadership. 3 The risks have been prioritized by the hospital's leadership using a set of criteria. NOTE: The risk criteria would include at least: a. potential severity of an event, injury, or failure and b. likelihood of the event, injury, or failure occurring.					
Level 3: The risks identified are systematically reduced or eliminated, and the list is updated through periodic, routine re-inspections.	0 There is no plan for reducing the risks or it does not include specific responsible parties and target dates for completion. 1 The facility improvement plans include actions to reduce the priority risks. 2 Minutes or reports indicate that the facility improvement plan has been implemented. 3 The implementation of the facility improvement plan is monitored at least quarterly as evidenced in meeting minutes.					

STANDARD #3: Management of hazardous materials

There is a list of hazardous materials in the organization and a plan for their safe handling, storage, disposal, and use.						
RISK LINK: Hazardous materials include examples such as radioactive diagnostic and treatment materials, chemicals in the clinical laboratory, and caustic cleaning supplies. The first level of risk reduction is identifying the location of hazardous materials and the second level of risk reduction is proper labeling, storage, and handling of the materials. Spilled hazardous materials need to be reported, investigated, and cleared in a manner that does not expose patients, staff, and visitors to undue risk.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is an inventory of the all the locations, types, and volume of hazardous materials and a plan for management.	0 There is no list of hazardous materials. 1 There is a list of hazardous materials that is available at departmental level. 2 There is a comprehensive list of all types of hazardous materials in all areas. 3 The list is updated on an annual basis.					
Level 2: Based on the plan, hazardous materials are safely and properly handled, labeled, stored, used, and disposed.	0 There are no policies and procedures for safe and proper handling, labeling, storage, use and disposal of hazardous materials. 1 There are policies and procedures for safe and proper handling, labeling, storage and use of hazardous materials, including material safety data sheets (MSDS) available for staff reference for each of the hazardous materials. 2 Staff is observed to be using appropriate PPE when handling hazardous materials. 3 Monthly safety rounds are documented to ensure that hazardous materials are labeled, stored, and used properly, and that staff are using the appropriate PPE when handling hazardous materials.					
Level 3: Policies and procedures describe the required equipment, PPE, staff training,	0 There are no policies/procedures for managing spills or accidents with hazardous material.					

management and investigation of spills or accidents with hazardous materials.	1 Policies and procedures are in place on managing spills or accidents with hazardous materials that includes at least: a. Equipment and personal protective equipment required for each category of spill or accident b. Placement and accessibility to the equipment and personal protective equipment c. The method of managing each category of spill or accident d. Staff identified for training and competency assessment for each category of spill or accident (for example, clinical staff may need to be trained on chemotherapy and body fluid spills while technical staff may need to be trained on diesel spills) 2 Staff have been trained and found competent on how to manage spills or accidents in their work environment (refer to the hospital's training plan) and the equipment and personal protective equipment required is readily available in the service areas. 3 Spills and accidents involving hazardous materials are investigated and measures taken to prevent future spills and accidents and/or improve the response to such spills and accidents.					

STANDARD #4: Fire safety and disaster management

There is a program to ensure that all occupants of the healthcare facility are safe from fire and smoke.

RISK LINK:

Although fires are not common in healthcare facilities, when they occur, they can have devastating outcomes. An effective approach to fire safety includes fire risk reduction, appropriate reaction when a fire occurs, and staff knowledge and training to ensure patients and staff can exit safely or move to safety in another part of the building. An effective fire program includes prevention, early detection, suppression, abatement, and safe exit from the facility. All staff is regularly trained on the fire safety program. The fire plan is tested, including any related equipment, as well as staff knowledge on how to move patients to safe areas.

Community emergencies, epidemics, and disasters, for example, damage to patient care areas because of an earthquake, or infections that affect large numbers of personnel, may directly involve the hospital. The hospital should also be prepared for bomb threats, flooding, natural disasters, failure of water and electrical supplies, hostage taking, explosions and the consequent loss of vital services. As with fire, there may be a time when it is necessary to evacuate patients. This can only be done quickly and effectively if personnel are trained in evacuation procedures. To respond effectively, those responsible for risk management must develop a plan and test it. The plan must include processes to access alternative care sites when necessary and alternative sources of medical supplies, communications equipment, food, and water.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is a program for fire safety and disaster management that is specific to the hospital and includes training, prevention, early detection, and safe exit of staff and patients.	0 There is no fire safety and disaster management plan. 1 The fire safety plan and disaster management plan are present but not specific to this hospital. 2 The fire safety and disaster management plan has been developed that is specific to the hospital and the specific requirement of each department and includes: a. Training b. Allocation of staff roles and responsibilities in each department in the event of a fire or disaster c. The identification of department-specific risks d. Prevention e. Early detection (for example, by smoke detectors or regular patrols)					

	f. Communication (for example, by electronic or manual alarm or use of whistles) g. Abatement (for example, by extinguishers or functional fire hose) h. Safe exit of staff and patients 3 Documentation shows that the fire safety plan was developed in collaboration with the fire brigade/police and that the disaster management plan was developed in collaboration with local authorities.					
Level 2: The fire safety and disaster management program has been implemented throughout the organization and sufficient equipment is available and functioning.	0 Annual staff training on the fire safety and disaster management plan is not reflected on the hospital's training plan or staff have not been trained according to the training plan. 1 Annual staff training on the fire safety and disaster management plan is reflected on the hospital's training plan and staff have been trained within the past 12 months on both the hospital-wide plan and department-specific plans. 2 The staff are able to describe their allocated roles and responsibilities in responding to a fire or disaster (including for example, bomb threats, hostage taking, etc.) and how to evacuate patients. 3 Sufficient fire equipment (extinguishers, water hoses and water supply, and exit signage) is available and functioning through routine maintenance. NOTE: The training should not be limited to the use of fire extinguishers staff need to be trained in all aspects of the fire safety and disaster management plan. Staff need to practice their specific roles/responsibilities and communication skills as well as department specific requirements (for example, what is the plan if a fire breaks out in theatre and a patient's abdomen is open? How are ventilated patients, children and newborns being evacuated?)					
Level 3:	0 There are no monthly fire safety rounds.					

The fire safety and disaster management program is continually monitored and tested annually, and the results are used to continually improve fire safety.	1 Fire safety rounds are conducted monthly, and actions taken to correct issues, for example, locked fire exits or blocked fire extinguishers. 2 Annual rehearsals of the fire safety and disaster management plan have been carried out and include: a. A hospital-wide fire drill that has been conducted and evaluated in collaboration with the fire brigade b. A rehearsal of the disaster plan that has been conducted and evaluated in collaboration with local authorities c. A department-specific rehearsal in each department of the hospital (this can be conducted by the department managers) 3 A plan for improvement is developed and implemented based on findings of safety rounds and the evaluations of the fire and disaster management drills.					

STANDARD #5 Biomedical equipment safety

There is an inventory of all biomedical equipment, and qualified individuals provide appropriate inspection, testing, and preventive maintenance of the equipment; a replacement plan for all biomedical equipment is in place.						
RISK LINK: Poorly maintained biomedical equipment can injure patients and staff. Broken, unusable equipment can potentially compromise the diagnostic and treatment process for patients. Poorly maintained equipment may not give accurate results, further compromising patient care.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is an inventory of all biomedical equipment and a replacement plan and comprehensive program for inspecting, testing, and maintaining biomedical equipment by qualified individuals is carried out.	0 There are no policies and procedures and/or replacement plan for biomedical equipment. 1 Policies and procedures and a replacement plan for biomedical equipment are in place. 2 Each piece of biomedical equipment has an inventory number attached to it and a complete inventory of biomedical equipment is present. 3 All staff that maintain the equipment are trained.					
Level 2: All biomedical equipment is appropriately inspected, tested, and maintained. Only trained and competent people handle specialized equipment.	0 Biomedical equipment has not been inspected and tested. 1 All equipment is tagged with date of inspection/maintenance and next due date. 2 Equipment management records show that all biomedical equipment is inspected, tested, and maintained on a scheduled basis by trained individuals. 3 All staff that handles specialized equipment is trained and this is documented in their personnel file. NOTE: Identify staff members who handle specialized equipment, for example, ventilators, anesthesia machines, sterilizers and review their personnel files to determine that they have been trained.					
Level 3:	0 The biomedical maintenance report does not reflect the biomedical equipment maintenance plan.					

Data related to the program are used to reduce equipment breakdown and reduce risk to patients and staff.	1 The biomedical maintenance report reflects the facility maintenance plan (may be evidenced through the biomedical maintenance software). 2 The types of equipment and breakdowns are analyzed and reported to the safety committee at least quarterly. 3 Actions are taken to reduce risks identified through data analysis.					

STANDARD #6: Stable safe water sources

Safe water is available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.						
RISK LINK: Clean water is needed for many activities in a healthcare organization, including sterilization and infection control. Without a plan for alternate sources of water, patients and staff are at risk for infection and potentially, death.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A plan describes the processes for maintaining a safe water supply.	0 There is no plan and budget line for water management. 1 There is a plan for water management that includes: a. Current water sources and suppliers b. Storage of water c. Sources for obtaining emergency water supplies d. Consideration of previous water shortages e. The availability of supplies for water testing f. A budget for water management g. How many days the hospital can rely on stored water should the main water supply be interrupted 2 The plan outlines methods to conserve water use. 3 Agreements are in place for obtaining emergency water supplies for drinking, cooking, cleaning, sterilization, and handwashing in all clinical areas.					
Level 2: A stable source of safe water and alternate sources are available; uninterrupted sources of clean water are available to support essential processes for patient care.	0 The plan for providing safe water is not implemented. 1 Safe water is available according to the plan. 2 All water containers are observed to be clean (surveyors to check on the main water tanks, out/in). 3 Supplies are routinely available to test water.					
Level 3: The hospital ensures that the water is treated regularly and tested; the results	0 There are no or inconsistent testing and treatment of water sources.					

are used to ensure patients have an uninterrupted supply of safe water.	1 Records show that the water sources are tested on a weekly basis by the Environmental Health Officer, including pH, biological and chemical testing. 2 Records show that water treatment is performed every five weeks or as needed by the hospital Environmental Health Officer. 3 An evaluation of the management of water shortages is conducted and the results of the evaluation are used to make improvements in maintaining a safe water supply.					

STANDARD #7: Stable electricity sources

Electrical power is available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.						
RISK LINK: Electricity is needed to refrigerate medicines and blood and blood products and to operate all types of equipment, including respirators and other life-maintaining equipment. Without a plan for alternate sources of electricity, many patients are at high risk for injury and death.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Essential equipment and processes requiring electricity that support patient care have been identified.	0 There is no plan for power management. 1 There is a plan for power management that describes the processes for maintaining electrical power to meet emergency needs that is supported by an adequate budget. 2 A site plan showing electrical service entrance, distribution system, service transformer, and emergency generator location is posted in the power plant. 3 Critical areas and equipment requiring back up have been identified in the plan, including NICU, ventilators, newborn resuscitation table, operating theater, maternity and pediatric services.					
Level 2: A process is in place to ensure an uninterrupted source of electrical power to essential equipment and processes.	0 Alternate sources of electrical power are not available, not included in the planned preventive maintenance schedule or are not well maintained. 1 Alternate sources of power are available (for example, solar, generator or grid), included in the planned preventive maintenance schedule and maintained by trained staff who are competent. 2 Maintenance staff interviewed can describe how to carry out the power management plan. 3 Maintenance practices for emergency power systems are carried out according to policy and procedure and documented.					
Level 3:	0 There are no or inconsistent testing of backup electric power.					

The organization tests the utilities program and uses the information to ensure patients are safe if electrical power is interrupted.	1 The backup generator(s) is tested and documented on a weekly basis, including that there is sufficient oil/gasoline to run them. 2 Emergency equipment that uses back up batteries (for example, defibrillators) and UPS systems (for example, for neonatal incubators or other critical equipment) are routinely tested at least quarterly. 3 Actions are taken and documented to ensure reliability of the sources.					

STANDARD #8: Protection from aggression, violence, abuse and loss or damage to property

Patients, staff, and visitors are protected from aggression, violence, abuse and loss or damage to property.						
RISK LINK: Leaders have a responsibility to ensure that the facility as well as patients, staff and visitors are safe from aggression, violence, and abuse (physical, sexual, verbal, psychological and financial). Those responsible for risk management should ensure that systems are developed and implemented to provide protection from such incidents, including the identification of specific areas of the facility and patient groups that are particularly vulnerable, for example, remote areas of the grounds with poor lighting and vulnerable patients (newborns, children, the elderly and disabled, comatose, and mentally ill patients, etc.). Additional security measures should be provided for these areas and groups. Security services must include both the external and internal monitoring of the facility's security to ensure that everyone in the hospital is protected from personal harm and from loss or damage to property.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: As part of the risk management strategy, the hospital has developed policies and procedures to protect patients, staff and visitors from aggression, violence, abuse and loss or damage to property.	0 Policies and procedures to protect patients, staff, volunteers and visitors from aggression, violence, abuse and loss or damage to property have not been developed. 1 Policies and procedures to protect patients, staff, volunteers and visitors from aggression, violence, abuse and loss or damage to property have been developed and include at least: • The identification of vulnerable patient groups • The use of restraints • The identification of vulnerable areas in the hospital • The identification and management of restricted areas • The management of aggression, violence, and abuse (physical, sexual, verbal, psychological and financial) • The management of loss or damage to property • Internal security • External security • Measures to ensure that all staff, volunteers, contract workers and independent practitioners are identified					

	• How to summon the assistance of hospital security and the local security/police/protection service in the case of an emergency 2 The resources required for the protection of patients, staff, and visitors from aggression, violence, abuse and loss or damage to property is included in the hospital's financial planning and reflected in the budget. 3 Training for all staff, volunteers, contract workers and independent practitioners on protection from aggression, violence, abuse and loss or damage to property is included in the hospital's training plan.					
Level 2: Staff are trained and patients, staff, and visitors are protected from aggression, violence, abuse and loss or damage to property.	0 Evidence of staff training, and implementation of the policies and procedures is not available and observed. 1 There is evidence that staff training on protecting patients, staff, and visitors from aggression, violence, abuse and loss or damage to property has been given as planned. 2 Staff can describe how to summon the assistance of hospital security and the local security/police/protection service in the case of an emergency. 3 Internal and external security measures are in place and access to restricted areas are controlled.					
Level 3: The processes for protecting patients, staff, and visitors from aggression, violence, abuse and loss or damage to property are evaluated for effectiveness.	0 No data or incomplete data is collected. 1 Data is collected that includes at least: • Incident and near-miss data • Patient and staff complaints • Staff training • Staff identification • Monitoring data for access to restricted areas 2 Data are aggregated, analyzed, and shared with a designated leader. 3 The data are used to identify trends and develop improvement plans.					

STANDARD #9: Coordination of infection prevention and control program

One or more individuals oversee and coordinate all infection prevention and control activities that is qualified in infection prevention and control practices through education, training, experience, or certification.						
RISK LINK: Effective infection prevention and control requires consistent oversight and coordination by one or more qualified individuals. This is essential for caring for infectious disease patients as well as preventing patient and staff infections from drug-resistant and other hospital-endemic organisms. When individuals accountable for the infection prevention and control program are unqualified or do not have time to carry out their responsibilities, patients and staff are at high risk for acquiring hospital-associated infections, and even patient deaths.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A position description exists for an infection prevention and control (IPC) focal person, which is included in the personnel file.	0 There is no IPC focal person or no current job description. 1 The IPC focal person's job description has been reviewed/updated within the past 24 months. 2 The job description of an IPC focal person includes roles and responsibilities regarding: a. Program management b. Infection prevention and control activities c. Quality improvement and risk management d. Infection control committee e. Patient and staff education 3 The IPC focal person has sufficient time allotted to carry out the roles and responsibilities, for example, routine surveillance of infections, data management. (Note: this will be a judgment based on observations that the program is being carried out as planned).					
Level 2: The focal person has received sufficient training in infection prevention and control to fulfill the job responsibilities.	0 The IPC focal person has not received training in infection prevention and control. 1 The IPC focal person has attended a general training program (for example, at least a 2-day workshop conducted by qualified individuals) in infection prevention and control. 2 The focal person attends annual training activities to maintain and build capacity in current infection prevention and control practices.					

	3	The focal person successfully completes a competency-based infection prevention and control certification course provided by qualified trainers.					
Level 3: A qualified IPC focal person carries out surveillance, data gathering, aggregation and analysis of infection prevention and control data, quality improvement activities and staff training.	0 1 2 3	The IPC focal person does not carry out routine surveillance activities. Data shows that the IPC focal person conducts routine surveillance for infection risks according to current practice guidelines (for example, CDC). Meeting minutes reflect that the IPC focal person guides IPC data analysis, action planning and quality improvement activities. The IPC focal person guides the development and staff training of the IPC policies and procedures and quality improvement activities.					

STANDARD #10: Reduction of health care associated infections through hand hygiene

A hand hygiene program based on accepted guidelines is effective in increasing compliance with hand hygiene guidelines.						
RISK LINK: Transmission of infections most commonly occurs due to lack of proper hand hygiene. Infections contribute to increased length of stay, cost, morbidity, and mortality. The adoption and consistent use of hand hygiene guidelines from WHO or another authoritative source can dramatically decrease infections.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Hand hygiene is emphasized and guided by evidence-based guidelines.	0 There are no hand hygiene policies/procedures. 1 There are hand hygiene policies/procedures based on current practices (for example, WHO). 2 Departments have trained and communicated the policies/procedures to staff (for example, at orientation, in-service training, posters above sinks). 3 Staff interviewed are aware of hand hygiene policies and procedures.					
Level 2: A consistent and effective hand hygiene program is in place with adequate equipment and supplies.	0 Adequate handwashing/hygiene facilities and supplies (including water, soap, disposable towels, and/or alcohol hand gel) are not consistently available. 1 Adequate handwashing/hygiene facilities and supplies for staff, patient and visitor use are observed to be located in the areas that have been identified in the hand hygiene policy and procedure as ideal placement areas (for example, at entrances to the hospital and departments, at patient's bedsides, in sluice rooms, ablution facilities, waste storage area, etc.). 2 The in-charge describes that a systematic process for ensuring availability of adequate supplies is evident, (for example, use of a daily checklist). 3 Staff are observed to be performing hand hygiene according to the policies/procedures.					
Level 3: Infection prevention and control data and hand hygiene surveillance data are used to improve the program.	0 No data or incomplete data is collected regarding hand hygiene practices. 1 A standardized hygiene observation tool and method is used to collect data. 2 Data are collected in all clinical areas on a scheduled basis. 3 The data are aggregated and used to identify gaps and develop and implement improvement plans.					

STANDARD #11: Effective sterilization processes

Effective sterilization processes are consistently carried out according to current evidence-based guidelines.						
RISK LINK: Each procedure that involves contact by a medical device or surgical instrument with a patient's sterile tissue or mucous membranes creates a major risk for the introduction of pathogens that lead to an infection. Disinfection and sterilization are essential for ensuring that medical and surgical instruments do not transmit infectious pathogens to patients. Failure to properly disinfect or sterilize equipment carries not only risk associated with breach of host barriers but also risk of person-to-person transmission (hepatitis B virus) and transmission of environmental pathogens (pseudomonas aeruginosa).						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Decontamination and Sterilization processes are guided by evidence-based policies and procedures carried out by competent staff with adequate equipment and supplies.	0 The required decontamination and sterilization policies or procedures are not present and/or complete. 1 Current evidence-based policies and procedures are written for: a. Cleaning, Decontamination, and disinfection processes for surgery, CSSD, and patient care units. b. Cleaning, Decontamination and disinfection processes for laundry, kitchen, and mortuary (housekeeping) c. Sterilization techniques (for example, sterilization times, temperatures, and humidity) d. Reuse of single use devices. e. General cleaning for critical areas (examples: Theater, neonatal units, isolation rooms, etc.) 2 Each person who reprocesses instruments receives initial and annual competency testing. 3 Equipment and supplies necessary to implement decontamination and sterilization policies and procedures are present and in good working order.					
Level 2: Consistent and effective decontamination and	0 Decontamination and sterilization processes are not functioning or are observed to create a potential for cross-contamination. 1 Cross-contamination is observed to be prevented in the CSSD cleaning area, laundry, kitchen and by housekeeping staff.					

sterilization process are in place.	2 Staff interviewed indicates that before use on each patient, non-critical (stethoscope, thermometers, Blood pressure cuffs), critical medical and surgical devices and instruments are Cleaned, decontaminated, sterilized, including dental instruments (for example, extraction forceps, scalpel handles). 3 Staff interviewed indicates that at a minimum, high-level disinfection is provided for semi-critical patient care equipment (for example, gastrointestinal endoscopes, endotracheal tubes, anesthesia breathing circuits, and respiratory therapy equipment).					
Level 3: There is documented evidence that complete sterilization has been accomplished.	0 Processes (for example, indicators) to verify complete sterilization are not present or inconsistent. 1 Policies and procedures are in place for each type of monitoring technique including: a. How to perform the testing b. How often testing should be done c. How the results are documented d. Timeframe for maintaining sterilization records 2 Mechanical, biological, and chemical monitors are used to ensure the effectiveness of the sterilization process and results are documented. 3 Documentation indicates that each load is monitored with mechanical (for example, time, temperature, pressure) and chemical (internal and external) indicators (If the internal chemical indicator is visible, an external indicator is not needed).					

STANDARD #12: Effective laundry and linen services

Effective laundry and linen processes are consistently carried out according to current evidence-based guidelines.						
RISK LINK: Linen may become a contaminated surface with the possibility of transferring pathogens. When textiles are contaminated with potentially infective body substances, they can transmit bacteria. Therefore, use of current control measures should be used to minimize the contribution of contaminated laundry to the incidence of healthcare associated infections.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Current evidence-based policies and procedures guide the operation and maintenance of laundry and linen services.	0 Laundry and linen policies and procedures are not present, incomplete, or out of date. 1 Current policies and procedures are present based on evidence-based guidelines and include at least: a. Separation of personnel working in clean and soiled areas b. Transportation of used or soiled linen from service units c. Marking of linen to identify ownership d. Handling of damaged and/or stained linen e. Delivery of clean linen f. How to obtain clean linen in an emergency g. Handling of infected linen including high risk infections such as viral hemorrhagic fevers h. Handling of linen infested with parasites i. Wearing of protective clothing j. Searching of used linen for sharps k. Sorting of linen l. Labelling of high-risk linen within the facility (for example, biohazard, radioisotopes, chemotherapy, etc.) m. Time/temperature combinations of different types of soiled and infected linen n. Classification of work for processing, for example, colors, fabrics, degree of soiling					

	o. Maximum capacity loading of machines (weight of dry fabric to cubic capacity of the machine) p. Maximum capacity loading of dryers (weight of wet fabric to cubic capacity of the machine) q. Use of, for example, chemicals, soaps, sodium hypochlorite solutions and softeners (including the availability of MSDS for each chemical) r. Finishing processes and folding of clean linen 2 Laundry equipment is included in the planned preventive maintenance plan. 3 Staff members interviewed are aware of the policies and procedures.					
Level 2: Consistent and effective laundry and linen processes are in place with adequate equipment and supplies.	0 The washing machines are not functional, or the capacity is not sufficient to meet the demands. 1 There is an adequate supply of functioning automated washing machines, and water. 2 Adequate, acceptable cleaning supplies and detergents are available to meet workload demands. 3 Operation of laundry and linen services is observed to be carried out according to the policies and procedures including good separation of clean and dirty processes					
Level 3: There is a quality control program for laundry and linen services.	0 There is no quality control plan for laundry and linen services, or it is inconsistently carried out. 1 The quality control plan includes: a. Process to monitoring implementation of policies and procedures b. Implementation of the planned preventive maintenance, cleaning, disinfection, and decontamination schedule based on the operation performed c. Analyzing reported incidents, near misses and patient complaints (for example, sharps found in the linen, shortage of linen, damaged linen etc.) 2 Records indicate that the plan is being followed. 3 Action plans are developed and implemented to address quality control issues.					

[1] Health Care Laundry Accreditation Council. Accreditation Standards for Processing Usable Textiles for Use in Healthcare Facilities. 2006: Health Care Laundry Accreditation Council, Frankfort, Il

STANDARD# 13: Reduction of health care associated infections

The hospital has an active program to reduce the risks of health care associated infections.						
RISK LINK: Infections contribute to increased length of stay, cost, morbidity, and mortality. Patients with vascular and urinary catheters, intubated patients, and post-surgical patients are at particular risk of developing an infection.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: An infection prevention and control plan with measurable quality goals is in place that guides the implementation of the program.	0 There is no IPC program. 1 There is an IPC program based on current practices including an IPC focal person, a functional committee, policies and procedures and a plan with measurable goals. 2 There is annual training of all staff regarding IPC based on identified needs. 3 Staff interviewed are aware of the IPC policies and procedures.					
Level 2: Risks of health care associated infections are identified for patients, staff, and visitors and measures taken to reduce the risks.	0 Risks of infection have not been identified for patients, staff, and visitors. 1 Risks of infection have been identified for patients, staff, and visitors. 2 Policies and procedures are developed to manage risks that are identified. 3 The staff is observed to be carrying out the IPC policies and procedures.					
Level 3: The infection prevention and control program is evaluated for effectiveness in reducing the incidence of health care associated infections, through monitoring infection rates.	0 The infection prevention and control program has not been evaluated. 1 The surveillance data are aggregated, analyzed, and displayed in relevant departments by type of infection, (for example, neonatal infections, urinary tract, blood stream, ventilator associated and post op infections surgical site infections). 2 The data are used to develop and implement plans for reducing infection rates. 3 The overall infection prevention and control program is evaluated every 12 months and improvements made based on findings.					

STANDARD # 14: Barrier techniques available and used

Gloves, masks, eye protection, and other protective equipment are available and used correctly when required.						
RISK LINK: Along with hand hygiene, barrier techniques are essential to any program to reduce the risk of infections in patients and staff. To be effective, the supplies must be available, readily accessible, used, and disposed of correctly.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The situations in which personal protective equipment and isolation techniques are to be used have been identified; policies and procedures developed and made known to staff.	0 Policies and procedures regarding the use of personal protective equipment (PPEs) and isolation techniques have not been developed. 1 Policies and procedures regarding use of PPEs and isolation techniques have been developed and are based on current practice and available in all non-clinical/clinical areas. 2 The staff has been trained regarding the use of PPEs and isolation techniques. 3 The staff interviewed are aware of the proper use of PPEs and isolation techniques.					
Level 2: Barrier techniques are used for those identified situations, supplies are available and accessible, and the techniques are used correctly.	0 PPEs are not available in all departments as required. 1 PPE supplies and equipment are available and convenient to staff in all locations. 2 Staff are observed using the PPEs according to recommended practice. 3 Isolation rooms are available and equipped and used according to recommended practice.					
Level 3: There are data on the use of personal protective equipment and isolation techniques that contributes to the continuous improvement in correct use.	0 Data are not collected regarding the use of PPEs and isolation techniques. 1 Data are collected regarding the use of PPEs and isolation techniques. 2 The data are aggregated, analyzed, and displayed. 3 The data are used to develop and implement plans for improving use of PPEs and isolation techniques.					

STANDARD # 15: Proper disposal of sharps and needles

Sharps and needles are properly disposed of by staff throughout the organization.						
RISK LINK: Sharps and needles pose a risk for infection and injury to staff and patients and their families. Proper disposal requires an organized, uniform process that guides staff and not at the discretion of the worker. The regular collection and disposal of collection containers is essential to overall safety in the workplace and proper disposal is essential for the health and safety of the community.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure provides guidance on proper disposal of sharps and needles, which is made known to staff.	0 There are no policies and procedures regarding disposal of sharps and needles. 1 Policies and procedures regarding disposal of sharps and needles are based on current practice. 2 Staff interviewed are aware of the proper disposal of sharps and needles. 3 Sufficient supplies of sharps containers are observed to be available in all relevant locations.					
Level 2: The disposal of sharps and needles is well organized and uniform, with disposable containers collected regularly and disposed of properly.	0 The disposal of sharps and needles is not well organized and uniform. 1 Puncture-proof sharps containers are properly located and secured in all areas as described in the policies and procedures. 2 Containers are observed to be no more than 3/4 full, sealed and disposed of according to policy/procedure. 3 The sealed sharps containers are picked up on a routine schedule and stored in a separate, secured storage area.					
Level 3: There are data available on injuries and accidents related to sharps and needles; these data are then used to continually improve the program.	0 No data are collected related to needle sticks or sharps injuries. 1 Data are collected related to needle stick and sharps injuries and near-misses (for example, needles found in the laundry, patient's beds, on the floor, etc.). 2 Results of data are communicated to the Infection Prevention and Control Committee at least quarterly. 3 Data are used to develop and implement plans to reduce the potential for injury.					

STANDARD # 16: Proper storage and disposal of infectious medical waste

Staff properly store and dispose of all types of infectious medical waste safely and legally.						
RISK LINK: Healthcare organizations generate great quantities of infectious medical waste every day. Because health care staff may not be aware of what waste is or could be infectious, all such waste must be stored and disposed of in a uniform and safe way that protects the health care worker and the community. Such waste includes body fluids, materials contaminated with body fluids, blood and blood product components, including waste from operating theaters, clinical laboratories, mortuaries or patient rooms.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures describe proper storage and disposal of medical waste.	0 There are no policies and procedures regarding storage and disposal of infectious medical waste. 1 There are current evidence-based policies and procedures regarding storage and disposal of infectious medical waste by segregation and labeling of waste bins including noninfectious waste (food), anatomical waste (placenta) and wound dressings, and this has been budgeted on an annual budget plan. 2 Staff is oriented on proper storage and disposal of infectious medical waste. 3 Staff interviewed in all areas is able to describe proper storage and disposal of infectious medical waste.					
Level 2: A uniform storage and disposal process is used that includes all types of infectious waste collection, storage, and proper disposal. Equipment and supplies necessary to manage medical waste are routinely available.	0 The equipment and supplies for storing and disposing of infectious waste is inconsistently available. 1 The equipment and supplies are available for storing and disposing of infectious waste, including PPEs. 2 Infectious waste is observed to be segregated, bagged, and labeled according to policy and procedure. 3 The storage and disposal sites, including incinerators and placenta pits, are observed to be well maintained and secure.					
Level 3: The infectious medical waste storage and disposal process is part of the organization's infection prevention and control process and is regularly evaluated and improved when indicated.	0 The proper storage and disposal of medical waste is not evaluated on a regular basis. 1 There is a scheduled (at least monthly) and implemented system for the inspection of waste storage and disposal. 2 The results of the inspection are documented and reported to the Infection Prevention and Control Committee. 3 Actions are taken to correct issues identified.					

STANDARD # 17: Monitoring, reporting, and preventing the spread of communicable diseases

Communicable diseases are reported, monitored and measures are taken to prevent and control transmission.

RISK LINK:

Communicable disease reporting is the cornerstone of public health surveillance and disease control. Prompt reporting gives the local health agency time to interrupt disease transmission, locate and treat exposed contacts, identify, and contain outbreaks, ensure effective treatment and follow-up of cases, and alert the health community. The information obtained through disease reporting is used to monitor disease trends over time, identify high risk groups, allocate resources, develop policy, design prevention programs, and support grant applications.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies, procedures, and protocols are in place for the monitoring, reporting, and preventing the spread of communicable diseases.	0 Current policies, procedures and protocols are not in place regarding monitoring, reporting, and preventing the spread of communicable diseases. 1 Current policies, procedures and protocols are in place regarding monitoring, reporting, and preventing the spread of communicable diseases. 2 Prevention programs are established based on identified community needs. 3 A communicable disease outbreak management policy and procedure is in place which includes the management of epidemics and pandemics.					
Level 2: Monitoring, reporting, prevention and control policies, procedures and protocols are carried out.	0 Programs to monitor, report, prevent and control communicable diseases are not effectively managed. 1 Effective promotional and education programs are provided to staff and community regarding prevention of communicable diseases. 2 The childhood vaccination program and supply chain is implemented according to the guidelines and vaccination plan. 3 Screening programs are in place to identify communicable diseases (for example, sexually transmitted infections and HIV).					
Level 3: Communicable diseases are reported, and data are used to plan promotional and service delivery.	0 Communicable diseases are not reported according to MOH requirements. 1 Communicable diseases are reported according to MOH requirements. 2 The success of control and prevention efforts is evaluated on an annual basis. 3 Communicable disease data is monitored, and the data is used to plan promotional and service delivery.					

RISK AREA #4 – CLINICAL CARE OF PATIENTS

The clinical care of patients includes medications, laboratory and diagnostic imaging services, surgery, anesthesia, and many types of treatments that place patients at risk. These risks may result in the mix-up of test results between patients, delays in diagnosis and treatment, wrong side or wrong patient surgical procedures, incorrect medications or doses, and many other harmful outcomes that for the most part are preventable. While health care providers intend to do the right thing, the lack of consistent systems and checks and balances in health care processes may mean that a minor incorrect act or decision may cause harm or even death to the patient.

Clinical care is usually fast paced; many decisions are often made in rapid succession. Physicians and others who are authorized to provide care without supervision may have incomplete information that leads to incorrect conclusions and treatment.

In the clinical care of patients, all the systems of care (for example, human resource management, information management, diagnostic imaging, clinical laboratory, and patient rights) and other systems come together. Planning, accurate and timely documentation, and sound patient assessment and re-assessment must come together completely and correctly. This is not an easy task in most organizations but an essential one that requires constant attention to risk, risk intervention, and risk reduction.

Reducing variation among how physicians and nurses care for patients and reducing differences in care from one day of the week to another and from one patient care unit to another, is a challenge. The standards in this Risk Area address the key strategies needed to get started in this effort.

Required Documents	Data Collection Methods
1. Patient identification policy and procedure 2. Informed consent policy and procedure 3. Patient assessment policy and procedure 4. Laboratory policies and procedures, quality control and safety manual 5. Radiology policies and procedures, quality control and radiation safety 6. Policies and procedures regarding patient care planning 7. High risk patients and procedures 8. Maternal and child health policies, procedures, and protocols 9. Anesthesia and surgical services policies and procedures 10. Triage process	A Leader interviews B Staff interviews C Document review D Medical record review E Personnel file review

11. Emergency equipment and supplies lists, policies, and procedures 12. Ambulance services policies and procedures 13. Ambulance service job descriptions 14. Medication use policies and procedures and medication errors 15. Patient education policies and procedures 16. Referral and transfer policies and procedures 17. Staff training records	

STANDARD #1: Correct patient identification

Patients are identified correctly, using two patient identifiers, before administering medications, blood, or blood products, before taking blood and other specimens for clinical testing, and before performing procedures and treatments.

RISK LINK:

Clinical errors are frequently not reversible; thus, the risk of such errors must be reduced. Administering a medication to the wrong patient may have no consequences or may cause morbidity or mortality. Similarly, surgery on the wrong patient can result in loss of function, disability, or death. Thus, having a method to positively identify each patient at high-risk times is essential.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure describes when and how patients are to be properly identified, which includes two patient identifiers when providing care, treatment, or services.	0 There is no policy and procedure regarding identifying patients. 1 A policy and procedure identifies at least: • When patient identification is required o before administering medication, blood, or blood products o before taking blood and other specimens for clinical testing o before providing treatments and procedures and when required by the time out process • The use of two patient identifiers unique to the patient, not including the use of the patient's room number or location • The methods used for identifying patients for in-patient and outpatient settings (for example, wrist bands, verbal identification) • The involvement of conscious patients in the identification process					

	• The correct identification of patients in special circumstances, such as the comatose patients, non-verbal patients or newborns who are not immediately named 2 The policy and procedure has been approved and is dated within the past 24 months. 3 Training for all staff, volunteers, contract workers and independent practitioners on patient identification is included in the hospital's training plan.					
Level 2: The identification process is fully implemented and followed.	0 None of the staff members are able to state the two identifiers that are in the policy and procedure. 1 All staff members interviewed are able to describe when patient identification is required. 2 All staff members interviewed are able to state how to correctly identify patients. 3 A time out process is in place to ensure that patients undergoing procedures are identified, which is documented (links with use of surgical checklist – see Risk Area #4, Standard 17).					
Level 3: Monitoring data are used to continually improve the identification process.	0 No data was found regarding monitoring of patient identification. 1 Accurate and complete data is collected to determine if the staff is following the procedure. 2 Data regarding patient identification is aggregated, analyzed, and communicated to staff. 3 Minutes or other documents show that actions were taken to improve patient identification.					

STANDARD #2: Informed consent

Informed consent is obtained before surgery, anesthesia, use of blood and blood products, and other high-risk treatments and procedures.						
RISK LINK: Patients' active participation in their care process often reduces risk. One of the most important ways patients participate is through granting consent for treatments and procedures that pose risk to them. Patients remain at risk if they grant consent without understanding the risks, benefits, and alternatives to the proposed treatment or procedure.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure describes expectations for providing information to patients regarding their treatment and procedures, taking of photographs and granting informed consent.	0 There is no policy and procedure regarding obtaining informed consent. 1 An informed consent policy and procedure is written and approved within the past 24 months. 2 The policy and procedure indicates at least: • The situations under which informed consent is required • Who may give informed consent • The information that patients must be given to enable them to give informed consent ○ Discussion of the patient's diagnosis and why the procedure is advised ○ The expected benefits of the procedure ○ The likelihood of success of the procedure ○ A thorough explanation of the proposed procedure ○ The potential risks and complications of the procedure ○ A discussion of viable alternative options including risks and benefits ○ The potential risks of refusing the proposed procedure • The identity of the physician or other practitioners responsible for their care • Who should obtain informed consent from the patient (consent should only be obtained by suitably trained professional personnel who are familiar with the procedure and its risks, complications, and alternatives. Ideally, the person who will perform the procedure should be the one to					

	obtain consent for the procedure. Where this is not the case, the patient should be informed of which healthcare professional will be performing the procedure) • The type of consent required, for example, written or verbal consent • A uniform process for recording written and verbal consent • How to obtain consent if the patient is unable to give consent due to age, diminished mental capacity (for example, delirium, learning difficulties, etc.) or because of physical illness (for example, comatose) • Where permissible, according to legislation, the identification of facility personnel who can consent on behalf of patients unable to give consent • Consent for photographs that will be taken including the time and purpose 3 The consent form contains the same elements as above and is available in languages common to the patient populations served.					
Level 2: Informed consent is obtained before surgery, anesthesia, use of blood and blood products, Family Planning methods and other high-risk treatments and procedures identified by the hospital.	0 Consent is not documented in the medical records. 1 Written and verbal consent is documented in the medical records as required by the policy and procedure. 2 The medical progress notes indicate that the patient was informed of all of the elements required for informed consent (see Level 1). 3 All patients interviewed indicate that they have been well informed prior to signing the consent.					
Level 3: The consent process is evaluated and improved based on patient and staff data and on its effectiveness in supporting patient rights to participate in the care process.	0 No data exists regarding monitoring of informed consent. 1 Accurate and complete data is collected to determine if the staff is following the procedure. 2 Data regarding informed consent are aggregated, displayed, and analyzed. 3 Minutes or other documents show that actions were taken to improve informed consent.					

STANDARD #3: Medical, nursing, and allied health professional assessments and reassessment of patients complete and timely

There are documented medical, nursing, and allied health professional assessments and reassessment of all patients admitted for care and treatment in the organization.

RISK LINK:

Patients are at risk if they are not promptly and appropriately assessed and their condition evaluation by the healthcare professionals responsible for their care when they are admitted to a hospital. The scope of the initial assessment must be appropriate to their needs and the assessment process must be as prompt on weekends and evenings as at other times.

Patients are at further risk if a deterioration in their condition is not detected and acted upon. Patient needs must be reassessed throughout the course of care, treatment, and services. Reassessment is key to understanding the patient's response to the care, treatment, and services provided and is essential in identifying whether care decisions are appropriate and effective.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The content and timeframes for conducting medical assessments (including initial and reassessments) are defined and standardized for specific patient populations, for example, maternity, pediatric, mental health, emergency, and outpatients.	0 There are no policies and procedures regarding performing patient assessments and reassessments. 1 A policy and procedure describes the content and time frames for assessments and reassessments that are to be conducted by healthcare professionals and should include the following: • The scope of practice for each discipline, together with specific information required, procedures to be carried out and all documentation to be completed during the initial and ongoing assessment of patients • Only those individuals licensed by professional councils or permitted by legislation perform assessments • All healthcare professionals dealing with the patient document their assessment and reassessment of the patient • An initial history and physical examination performed by a medical practitioner is conducted for every patient admitted to the hospital within specified time frames which includes: o Health history o Physical examination					

	○ Pain assessment ○ Functional and nutritional examination ○ Social and economic assessment ○ Psychological assessment ○ Cultural assessment ○ Discharge planning • Established time frames for the assessment and reassessment of patients for each discipline (this does not refer to the length of time that it takes to perform the assessment, but the time within which the initial assessment should be commenced and/or completed and when reassessment is required taking into account the urgency and priority of each situation) • Verification on admission of assessments completed outside the hospital • Assessment and reassessment of patients waiting for admission (admitted but no bed) • Pre-procedural assessments and post-procedural assessment and reassessment • Risk assessments where required (for example, risk for falls, pressure ulcers, venous thromboembolism) 2 Policies and procedures outlines different expectations for each type of patient, for example, pediatric, emergency, outpatient and maternity and the time frames for which the assessments and reassessments are to be done, for example, an Emergency Department (ED) assessment would be expected to be done more rapidly than elective admissions. 3 The assessment forms are designed to collect the information required. NOTE: Assessments of patients in specialty areas are to be located in the department policies and procedures.					
Level 2: Assessments and reassessment are standardized and timely to meet patient needs.	0 Assessments and reassessments are not done based on the type of patient and the policy and procedure requirements. 1 Assessments and reassessment are done based on the type of patient, for example, ICU, medical, pediatric, maternity and the policy and procedure requirements.					

	2 Medical records reviewed demonstrate that the medical assessments are complete. 3 Medical records reviewed demonstrate that the medical assessments are completed within the expected time frame (note: this is determined according to the time of patient arrival to the area/department compared with the time that the assessment was done).					
Level 3: The content and timeliness of assessments and reassessments are monitored to improve the process and meet patient needs.	0 No data was found regarding monitoring of documentation of assessments and reassessments. 1 Accurate and complete data is collected to determine if the staff is following the policy. 2 Data regarding assessments and reassessments are aggregated, displayed, and analyzed. 3 Minutes or other documents show that actions were taken to improve documentation.					

STANDARD #4: Pain assessment, reassessment, and appropriate management

Pain is assessed, reassessed, and appropriately managed.						
RISK LINK: Whatever the origin of pain, unrelieved pain has adverse physical and psychological effects. Patients in pain have the right to appropriate assessment, reassessment, and management of pain.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The hospital has a policy, procedure, guidelines, and tools (including assessment or pain score cards) used by healthcare professional staff in assessing, reassessing, and managing pain.	0 There are no or incomplete policies, procedures, guidelines, and tools for pain management. 1 Current, evidence-based, policies, procedures, guidelines are developed for the assessment, reassessment and management of pain that include: • Standardized pain management scoring tools for all categories of patients including pregnant women in labor/childbirth, newborns, children, and non-verbal patients • Scoring tools assess: ○ Provocation/palliative pain management ○ Quality/quantity of pain ○ Region/radiation of pain ○ Severity of pain (pain scale) ○ Timing of pain ○ Pain management guidance prior any specific procedure application such, Lumber puncture, NG tube insertion, Intubation, etc. • Standardized documentation • Pharmacological and non-pharmacological pain management • Psychological preparation and support of patients when pain is anticipated during the care process • Assessment, reassessment, and management of pain in palliative care 2 Standardized pain management scoring tools are available in all departments that are appropriate to the category of patient admitted to that department. 3 Training for all healthcare professionals on the assessment, reassessment and management of pain is included in the hospital's training plan.					

Level 2: There is documentation in medical records by clinical staff of the assessment, reassessment, and management of pain.	0 Assessment, reassessment, and management of pain is not documented in the patient records. 1 Assessment, reassessment, and management of pain is documented in the patient records as prescribed by the policy, procedure, and guidelines. 2 Staff interviewed can describe how to assess, reassess, and manage pain according to the policy, procedure, and guidelines. 3 Patients interviewed clearly explain how pain was alleviated by clinical staff using pharmacological and non-pharmacological means and if staff returned to ensure that their pain had been alleviated following their interventions.					
Level 3: The patient pain management process is evaluated for effectiveness and improvements are made when required.	0 There is no data collected or reports regarding the assessment, reassessment, and management of pain. 1 Data regarding assessment, reassessment and management of pain is collected. 2 Pain management data is aggregated and analyzed, and the results shared with clinical staff. 3 Improvements in pain management and assessment are made based on the results of data.					

STANDARD #5: Laboratory services available and reliable

Laboratory services are consistently available to meet patient needs that are provided by qualified individuals, using standardized ranges to report results in a reliable and timely manner.						
RISK LINK: Patients are at risk for inappropriate or delayed treatment when clinical laboratory services are not available during certain times or are performed by individuals without appropriate qualifications. Patients are also at risk when results are not reported in a standardized format and in a timely manner. The result can be incorrect, missed, or delayed diagnosis and treatment.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Current laboratory policies, procedures and safety manual are available to staff.	0 There are no policies and procedures regarding performing lab tests. 1 Laboratory policies, procedures and safety manual are present, which have been approved within the past 24 months. 2 A list of normal ranges, turnaround times and critical values are defined and made available to all clinical staff. 3 The hospital scope of services indicates that the expected facility-level package of investigations is delivered by qualified staff.					
Level 2: Clinical laboratory services are consistently available to meet patient needs, and results are reliably reported, including critical lab results, in a timely manner by qualified individuals in a standardized format using established ranges.	0 Effective processes are not in place to collect and transport specimens. 1 Effective and timely processes are used to collect and transport specimens to the laboratory; rejected specimens and turnaround time are monitored. 2 Stock record review/inventory indicate that reagents and required materials are routinely available to perform the required lab tests. 3 Laboratory results are documented and located in the same location of the medical records reviewed; critical lab results reported by telephone require a "write down" and "read back" process.					
Level 3: Clinical laboratory quality control is performed for lab tests and oversight is provided for tests performed/collected outside the laboratory; data are used to improve accuracy of results.	0 There is no current laboratory quality control manual. 1 A current laboratory quality control manual is present. 2 Laboratory quality control is run and documented at the beginning of each shift. Data that exceeds quality control tolerance limits is acted upon immediately. 3 External quality control results are at least 95% in concordance with the national reference laboratory.					

STANDARD #6: Diagnostic imaging services available, safe, and reliable

Diagnostic imaging services are consistently available to meet patient needs and are safely provided by qualified individuals, with reliable results reported in a timely manner.						
RISK LINK: Patients are at risk when their assessment requires diagnostic imaging services and the services are not available within or outside the organization, or are not provided safely (for example, lead aprons used) or if the services are not conducted and reported by qualified individuals and in a timely manner. The result can be incorrect, missed, or delayed diagnosis and treatment.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Current radiology policies, procedures and safety manual are available.	0 There are no current radiology policies and procedures. 1 Radiology policies and procedures are present, which have been approved within the past 24 months. 2 A radiation safety manual is available based on current evidence-based practices inclusive of caretakers/parents. 3 Staff interviewed are aware of the policies, procedures and safety practices.					
Level 2: Diagnostic imaging services are consistently available to meet patient needs, the radiation safety program meets all legal requirements, and the tests are conducted and reported by qualified individuals in a timely manner.	0 Radiology results are not reported in a timely manner. 1 All radiology results are documented and located in the same location within the medical records. 2 The hospital scope of services indicates that the expected service-level package of investigations is delivered and the master staffing schedule for radiology shows that qualified staff members are scheduled 24 hours per day (or there is someone on call). 3 Staff is observed to be in compliance with using the required PPEs including radiation monitors, lead apron, lead gloves, and lead goggles.					
Level 3: Diagnostic imaging quality control is performed for	0 There is no radiology register.					

imaging tests and oversight is provided for tests performed outside the radiology department; data are used to improve accuracy of results.	1 A radiology register is kept that contains number, date, given name and family name, sex, age, address (sector, cell and district), type of x-ray requested, requesting doctor and number of retakes. 2 A current radiology quality control manual is present; quality is monitored, and actions taken to make improvements (includes analyzing and acting upon retake data). 3 Radiation monitors are tested regularly for the exposure limits by certified authorities. NOTE: Check to see if there is a portable x-ray machine used and if so, it must also meet the quality control expectations.					

STANDARD #7: Written plans for care

The care planned and provided for the patient is written in the patient's record. Whenever patients are reassessed, care plans are updated as needed.						
RISK LINK: Patients are at risk for less-than-optimal outcomes if their care is not planned or if the planned care is provided but not written in the patient's record to ensure communication of essential information among care providers. Effective communication of patient information depends on complete and accurate record entries that are timely and available to all the patient's care providers.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure is written to provide guidance on documentation for care planning and provision.	0 Policies and procedures regarding planning patient care and discharge are incomplete. 1 A current policy and procedure describe the process for developing patient plans of care to include: Individual treatment or care plans are prepared and documented based on: a) The assessment of patient/service user needs, including the results of diagnostic tests where relevant b) The involvement of the patient and their families when appropriate c) The goals or desired results of the treatment or care d) Physician's plans of care contain a notation of the subjective and objective findings, assessment, and plan with goals e) Nursing/midwifery care plans consist of a nursing/ midwifery diagnosis, nursing/ midwifery interventions and expected outcomes f) Allied health care plans are written and expected outcomes 2 Forms are readily available to staff for writing the plan of care. 3 Clinical staff receives training/mentoring in writing and implementing effective plans of care. NOTE: Initiating a standard protocol is a plan of care.					
Level 2: Planning patient care is collaborative (for example,	0 Medical records do not have medical and nursing plans of care. 1 Medical, nursing, and allied health care plans are written according to the policy and procedure.					

physicians, nurses, and allied healthcare professionals) with written care plans, including discharge planning, that are relevant to the patient's current condition.	2 Plans of care are consistent with current treatment guidelines. 3 Discharge planning needs are identified in the plan of care.					
Level 3: Care plans are revised, when necessary, in response to the findings of reassessments.	0 Patient care plans are not updated based on changing needs. 1 Treatment or care plan are revised, when necessary, in response to the findings of reassessments. 2 Patients' progress in achieving the goals or desired results of treatment, care or service is monitored and documented. 3 A collaborative team meeting (including physicians, nurses, patient/family and other care givers as indicated) is conducted for patients that are hospitalized for more than 10 days to discuss and revise the plan of care.					

STANDARD #8 Clinical protocols available and used

There is a process to identify the clinical practice guidelines (CPGs) that relate to the priority patient populations and clinical services and to develop protocols based on the guideline recommendations and make them available to health care providers.						
RISK LINK: Reducing variation in practice reduces risk. Clinical practice guidelines provide recommendations based on research that can be adopted to develop protocols that guide daily management of patient care, thereby reducing the variation among care providers.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Clinical protocols are adopted for the most common diagnoses/conditions and procedures to guide clinical practice.	0 A policy and procedure for adopting clinical protocols is not available. 1 A policy and procedure for adopting clinical protocols is available. 2 Treatment guidelines, protocols, algorithms and/or clinical pathways have been adopted for at least five common diagnoses/conditions, including at least: a. Diabetes mellitus b. Malaria c. Hypertension d. Congestive heart failure 3 The protocols are based on current evidence, are referenced and approved by the medical staff.					
Level 2: Treatment guidelines and protocols are used to guide the management of priority patients and procedures.	0 The treatment guidelines and protocols are not consistently used to guide practice. 1 Treatment guidelines and protocols are observed to be readily available to staff in the units. 2 All relevant staff interviewed are familiar with the treatment guidelines and protocols. 3 Reviewed medical records indicates that the treatment guidelines and protocols are implemented.					
Level 3: Compliance by individual healthcare providers (nurses, physicians, or others) is monitored.	0 There is no monitoring of compliance with treatment guidelines and/or protocols. 1 Data are collected, aggregated, and analyzed regarding use of the treatment guidelines and/or protocols. 2 The data are tracked for individual healthcare workers (nurses, physicians, or others). 3 The results are included as part of the healthcare workers' performance improvement evaluation.					

STANDARD #9: Protocols for managing high-risk patients and procedures

The organization identifies high-risk clinical procedures and patients and develops protocols to guide the care of these patients or those undergoing clinical procedures.						
RISK LINK: Many patients are high risk (for example, newborns and infants below 2 months, elderly patients, and immune-compromised patients) and many procedures can be high risk. Risk is reduced when protocols guide consistent care in these situations and staff follows them.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is a list of types of patients and clinical procedures provided by the hospital that are considered high risk and protocols have been developed based on current evidence.	0 There is no list of high-risk patients and procedures. 1 The high-risk patients (for example, pregnant women with previous uterine scar, nutritional deficits, potential for falls, long term conditions, comatose, mental health and those requiring palliative care) and high-risk clinical procedures (for example, mother receiving anticonvulsant drugs, patients receiving sedation, dialysis, chemotherapy, blood transfusions or are on ventilators) are identified. 2 Protocols are available for all of the high-risk patients and procedures on the list. 3 The protocols are developed by a multidisciplinary team (physicians, nurses, physiotherapists when indicated).					
Level 2: Relevant staff has implemented protocols to guide care for all patients and procedures on the list, and staff are educated on the protocols.	0 There is no evidence that the protocols have been effectively implemented. 1 Protocols are observed to be readily available to staff in the units. 2 All relevant staff interviewed are familiar with the protocols. 3 Documentation of reviewed medical records indicates that the protocols are implemented.					
Level 3: Use of the protocols is monitored, and the data is used to enhance staff training and improve use.	0 There is no documentation that shows that the implementation of these protocols has been monitored. 1 A checklist or other tool is being used to monitor at least one of the high-risk procedures and one of the high-risk patient protocols. 2 There are analyses of the findings of each and action plans that show that results of the monitoring were acted upon during the past 12 months. 3 Feedback is given to staff regarding the results to improve patient care.					

STANDARD #10: Comprehensive management of reproductive and maternal health care

Interventions and strategies for improving reproductive and maternal health and survival are provided through the use of current evidence-based clinical practices.						
RISK LINK: Maternal mortality remains a leading cause of death for women of reproductive age in developing countries. The majority of maternal deaths occur during or immediately after childbirth. The common medical causes for maternal death include bleeding, high blood pressure, prolonged and obstructed labor, infections, and unsafe abortions. The majority of maternal deaths could be prevented with timely and appropriate emergency obstetric care. A well-functioning health system can ensure the equitable and efficient delivery of safe motherhood information and services.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Key registers of pregnant women and family planning clients are kept. Essential guidelines for reproductive and maternal health[2] are adopted or adapted according to current evidence.	0 A register of maternal health referrals and family planning clients is not kept. 1 Admission, Normal delivery, operations, PNC, Abortion, registers, of all maternal health conditions and family planning clients are kept and updated. 2 Current evidence-based (with references) protocols, approved within the past 24 months, are available for prioritized maternal health conditions. Required protocols include: a. Normal labor and delivery b. Management of obstructed labor a. Management of pregnant women with previous uterine scar b. Management of cord prolapse c. Cesarean Delivery d. Post-partum hemorrhage e. Post-partum sepsis f. Pre-eclampsia with severe features and eclampsia g. Respectful maternity care (including Companion of choice, prevention of harmful practices during labor, childbirth, and postnatal period). h. Postnatal care i. Family planning (Medical eligibility criteria, Side effects management protocols)					

	3 The protocols are observed to be readily available to staff members in the clinical area.					
Level 2: Protocols are implemented and essential medications, equipment, and supplies to meet patient needs for reproductive (including family planning) and maternal health are available.	0 Staff are not aware of the clinical protocols. 1 Relevant staff members interviewed are aware of the clinical protocols. 2 Medications, Supplies, and equipment are available for providing reproductive and maternal health services according to the protocols (refer to Reproductive and Maternal Health checklist). 3 A review of medical records reveals that documentation of patient care indicates that the protocols are implemented. NOTE: - Select a protocol for maternal and reproductive health to determine whether the documentation reflects that the protocol was followed. - maternal death audit and verbal autopsy must be available for any recorded death at the facility.					
Level 3: Monitoring data include measurement of implementation and outcomes of priority protocols and adequacy of medication, supplies and equipment.	0 There is no documentation that shows that the implementation of these protocols has been monitored. 1 Availability of medications, supplies and equipment are monitored. 2 Data are collected and analyzed regarding compliance with priority protocols and death audits. 3 Action plans show that results of the monitoring were acted upon during the past 12 months.					

[2]The Partnership for Maternal, Newborn and Child Health. 2011. *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH).* Geneva, Switzerland: PMNCH.

STANDARD #11: Comprehensive management of newborn care

Interventions and strategies for improving newborn care and survival are provided through the use of current evidence-based clinical practices.						
RISK LINK: Poor newborn care remains a significant problem in developing countries. Globally, the main causes of neonatal death are preterm birth, severe infections, and asphyxia.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Newborns are assessed immediately after birth and taken care of according to the current national neonatal protocols.	0 Policies, procedures, and protocols are not in place to guide newborn care. 1 Policies, procedures, and protocols are in place to guide newborn care immediately after birth. 2 The policies, procedures and protocols are observed to be readily available to staff members in the clinical area (both maternity and neonatal units) and include: • Newborn care immediately after birth • Management of newborns who are not spontaneously breathing • Neonatal resuscitation • Postnatal care • Management of newborns with neonatal infections inclusive of isolation of infected babies • Preterm care and management (including thermoregulation, kangaroo mother care for low-birth-weight infants, infant safe feeding including fortification and hydration) • Safe medication and positive interaction with newborn • Prevention of harmful practices in the early newborn period • Effective communication and meaningful participation with mothers/caregivers • Health education on prevention of harmful practices, danger signs, exclusive breastfeeding in the early newborn period • Emotional, psychosocial and development support (minimal separation with caregivers; mothers/caregivers recognized and supported.					

	• Available SOPs for cleaning neonatal units as well as their equipment and supplies 3 The newborn assessment forms are designed to collect the information required (partograph, PNC file and neonatal file).					
Level 2: Relevant staff are aware of the MOH newborn care protocols. Essential medications, supplies and equipment for detection and management of sick newborns are readily available and in sufficient quantities at neonatal and maternity services.	0 The national updated protocols are not consistently used to guide practice. 1 The national updated protocols are observed to be readily available to relevant staff in maternity and neonatal(delivery) services. 2 All relevant staff interviewed are familiar with the protocols and able to clearly describe newborn care immediately after birth. 3 Medications, supplies, and equipment are observed to be readily available for providing routine care and in sufficient quantities as set out in the updated national protocols. Notes: child or neonatal death audit and verbal autopsy must be available for any recorded death in the facility.					
Level 3: Midwives or nurses in labor and childbirth service receive in-service training regularly regarding routine newborn care and handling of emergency newborns.	0 Clinical staff are not regularly trained and evaluated in routine newborn care, assessment, emergency identification and management. 1 The knowledge of trained staff members regarding routine care of newborns, identification, assessment, and management of emergencies is evaluated. 2 Documentation in majority of reviewed medical records indicates that protocols are implemented. 3 The application of skills to practice is evaluated at least once a year (or drills once in 6 months).					

STANDARD #12 Comprehensive management of child and adolescent health care

Interventions and strategies for improving child and adolescent health and survival are provided through the use of current evidence-based clinical practices.

RISK LINK:

Poor child health remains a significant problem in developing countries. Integrated Management of Childhood Illness (IMCI) and Emergency Triage, Assessment and Treatment plus admission (ETAT+) aims to reduce child mortality and morbidity and promote children's healthy growth and development in children under 5 years of age. Case fatality rates can be substantially reduced in hospitals that have introduced guidelines, accompanied by training, and quality improvement measures.

Despite being thought of as a healthy stage of life, there is significant death, illness, and injury in the adolescent years. Much of this is preventable or treatable. During this phase, adolescents establish patterns of behavior – for instance, related to diet, physical activity, substance use, and sexual activity – that can protect their health and the health of others around them, or put their health at risk now and in the future.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Protocols for child and adolescent health are adopted or adapted according to current evidence,	0 Protocols are not available for child and adolescent health care. 1 Protocols are available for child and adolescent health care (including ETAT+). 2 Current evidence-based (with references) protocols, approved within the past 36 months, are available. Required protocols include: a. Access to safe and adequate nutrition for hospitalized children b. Management of common childhood conditions c. Management of self-limiting viral infections or life-threatening infections such as malaria, pneumonia, septicemia, urinary tract infection d. Management of children with diarrhea e. Correct assessment and appropriate management of children with cough or difficulty in breathing due to respiratory infections 3 The protocols are observed to be readily available to staff members in the clinical area.					
Level 2:	0 Staff are not aware of the child and adolescent health protocols. 1 Relevant staff members interviewed are aware of the protocols.					

The protocols are implemented and essential medications, supplies and equipment to meet patient needs for child health care are available.	2 Medications, supplies, and equipment are available for providing services according to the protocols. 3 Reviewed medical records reveal that documentation of patient care (including malnutrition cases) indicates that the protocols are implemented. NOTE: Select protocol for malnutrition cases and adolescent care to determine whether the documentation in the record reflects that the protocol was followed.					
Level 3: Monitoring data include measurement of implementation and outcomes of priority protocols and adequacy of supplies.	0 There is no documentation that shows that the availability of medications, supplies and equipment is monitored. 1 Availability of medications, supplies and equipment are monitored. 2 Data are collected and analyzed regarding compliance with priority protocols. 3 Action plans show that results of the monitoring were acted upon during the past 12 months.					

[3]The Partnership for Maternal, Newborn and Child Health. 2011. *A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH).* Geneva, Switzerland: PMNCH.

STANDARD #13: Access to safe and adequate nutrition to hospitalized children

The nutritional needs of hospitalized children are assessed and provided through the use of current evidence-based clinical practices.						
RISK LINK: Providing high-quality nutritional care and interventions for hospitalized children is critical for recovery from surgery, illness, or prolonged hospitalization.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Nutrition policies and guidelines are available for children to meet their needs including special needs consistent with dietary requirements. A dedicated staff (or nutrition specialist) is responsible for preparing children`s menus.	0 The required nutritional guidelines are not available. 1 Current evidence-based nutrition policies and guidelines are available for all children and children with special categories of menus which include at least: • HIV • TB • Chronic diseases including diabetes, hypertension • Children with different categories of malnutrition • Breastfeeding, preparation, storage and hygiene practices for breastmilk. 2 The hospital has a clear written policy for breast feeding that adheres to international code of marketing breastmilk substitutes and there is evidence that it is routinely communicated to clinical staff. 3 There is a dedicated staff or nutritionist responsible for overseeing preparation of children`s menus.					
Level 2: The hospital has an adequately equipped, designated kitchen (area or room) with facilities for food preparation.	0 The hospital has no kitchen for patients which is functioning. 1 The hospital has an adequately equipped, designated kitchen (area or room) with facilities for food preparation. 2 There are mechanisms put in place of providing food on a regular basis which is high quality and meets needs for pediatric patients. Or the hospital allows caregivers to prepare special food for admitted children which is sufficient. 3 All patients and their families are able to admit how they are satisfied with the meals (or services to allow them to prepare their own meals) they receive at the hospital.					

Level 3: The hospital provides regular, safe, nutritious, appetizing, high-quality meals of sufficient variety to meet the needs of pediatric patients (where possible). A monitoring mechanism is in place to ensure appropriate dietary requirements are met by parents or caregivers to the sick children who are hospitalized.	0 There is no mechanism to monitor whether children are provided with adequate food according to their needs. 1 A mechanism is in place to monitor adequate food is provided to admitted children, breastfeeding mothers, and their families. 2 Data are collected and analyzed regarding providing regular, safe, nutritious food. 3 Action plans are in place to monitor and improve nutrition program for admitted children and breastfeeding mothers during the past 12 months.					

STANDARD #14: Comprehensive management of HIV prevention and care

Interventions and strategies for preventing the spread of HIV and caring for people with HIV/AIDS are provided through the use of current evidence-based clinical practices.						
RISK LINK: Failure to provide adequate HIV services for key groups (for example, those having unprotected sex, drug addiction and victims of sexual assault) threatens global progress on the HIV response. Treatment by itself will not solve the global HIV epidemic. Controlling and ultimately ending the epidemic requires a combination of scientifically proven HIV prevention approaches. Providing treatment to people living with HIV infection to improve their health must always be the first priority. Getting an HIV test is the first step to identifying persons with HIV infection and the pivotal entry point into the medical care system for both treatment and prevention. By lowering the level of virus in the body, early treatment helps people with HIV live longer, healthier lives and also lowers their chances of transmitting HIV to others.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A comprehensive HIV prevention and care program is established.	0 A policy on HIV testing based on national testing guidelines is not available. 1 There is a policy on HIV testing based on national testing guidelines that includes testing, prevention and care for infants, children, adolescents, and pregnant women. 2 Current evidence-based (with references) protocols, approved within the past 24 months, are available for: • Provider-initiated testing (PIT) • Confidentiality of test results • Assessing for opportunistic infections (for example, TB) • Prevention of mother-to-child transmission • Treatment of children • Antiretroviral therapy and ongoing monitoring • People living with HIV • Caregiver education • Referral for treatment and social needs • Pain management • Palliative care 3 The protocols are readily available to staff members in the clinical area.					

Level 2: The protocols are implemented and essential medications, supplies and equipment to meet patient needs for comprehensive HIV prevention and care are available.	0 1 2 3	Medications supplies and equipment for HIV prevention and care are not consistently available. Medications, supplies, and equipment are available for providing services according to the protocols (refer to HIV checklist). Staff interviewed are knowledgeable of the current protocols. Reviewed medical records reveal that documentation of patient care indicates that the protocols are followed (refer to tool).					
Level 3: Monitoring data for adherence to HIV treatment protocols, outcomes and the availability of medications, equipment and supplies is evaluated.	0 1 2 3	There is no documentation that shows that the HIV program or the availability of medications, supplies and equipment is evaluated. Adherence to HIV treatment protocols, outcomes and the availability of medications, equipment and supplies is monitored and evaluated (refer to checklist). A quarterly analysis of HIV data is performed, and a report written according to the guidelines. Quarterly reports are submitted five days after the end of each quarter to HMIS.					

STANDARD #15: Comprehensive management of tuberculosis prevention and care

Interventions and strategies for preventing the spread of tuberculosis and caring for people with tuberculosis are provided through the use of current evidence-based clinical practices.						
RISK LINK: TB remains an important cause of death from an infectious agent, second only to HIV. The importance among infectious diseases is not so much the number of cases but the high case fatality rate of untreated or improperly treated patients. TB can be controlled by preventing infection, by stopping progression from infection to active disease and by treating active disease.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Comprehensive tuberculosis prevention and treatment is available including a specialized unit, necessary laboratory services and treatment guidelines.[4],[5]	0 A specialized unit for managing tuberculosis is not available and/or it does not meet the established criteria. 1 A specialized unit and structure for managing tuberculosis is in place that meets established criteria (see TB checklist). 2 A laboratory and supplies are available to carry out reliable microscopic sputum tests and GeneXpert and to send specimens for cultures and drug resistance to the reference laboratory. 3 Current policies, procedures and evidence-based (with references) protocols, approved within the past 24 months, are available for: a. Screening and diagnostic guidelines b. Triage guidelines for emergency and outpatient departments c. Test results reporting d. Maintaining a TB registry e. Retreatment regimen f. Infection prevention and control g. Directly observed therapy (DOT) h. Contact tracing i. Patient/family education (instructions on therapy and transmission prevention) j. Community education (early symptoms and treatment availability) k. TB prevention in HIV-infected patients l. Medical follow up and referral					

	m. Referral to specialized facilities for treatment of multidrug resistant organisms (MDRO)					
Level 2: The policies, procedures and protocols are implemented and essential supplies to meet patient needs for comprehensive TB prevention and care are available.	0 Drug supplies are not consistently available for TB care/treatment. 1 Supplies of drugs are available for providing treatment according to the protocols (refer to checklist). 2 Specialized staff is assigned to the unit that is knowledgeable of the current protocols. 3 Reviewed medical records reveal that documentation of patient care indicates that the protocols are followed (refer to tool).					
Level 3: Monitoring data for adherence to TB treatment protocols, outcomes and the availability of medications, equipment and supplies is evaluated.	0 There is no documentation that shows that the TB program or the availability of medication, equipment and supplies is evaluated. 1 Adherence to TB treatment protocols, outcomes and the availability of medications, equipment and supplies is monitored and evaluated (refer to checklist). 2 A quarterly analysis of TB data is performed, and a report written according to the guidelines. 3 Quarterly reports are submitted five days after the end of each quarter to HMIS.					

[4]WHO. Guidelines for the Programmatic Management of Drug-Resistant Tuberculosis 2011 Update. Available at: http://whqlibdoc.who.int/publications/2011/9789241501583_eng.pdf

[5]CDC. Plan to Combat Extensively Drug-Resistant Tuberculosis Recommendations of the Federal Tuberculosis Taskforce 2009 Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5803a1.htm?s_cid=rr5803a1_e

STANDARD #16: Anesthesia and procedural sedation used appropriately

Anesthesia and procedural sedation services are based on a pre-anesthesia/procedural sedation assessment of the patient by a qualified provider and include the physiological monitoring of the patient during anesthesia/procedural sedation and recovery.						
RISK LINK: The selection of the appropriate (lowest risk) anesthesia/procedural sedation is based on the patient's medical history and physical examination, the medications used by the patient, and other health issues or co- morbidities. Risk is further lowered by appropriately monitoring the patient during anesthesia/procedural sedation and anesthesia/procedural sedation recovery. All of these risk-reduction activities are overseen or performed by an individual(s) who is qualified as an anesthesiologist or anesthetist.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures guide the pre-anesthesia and pre-procedural sedation processes and the monitoring of the patient during the administration of general, regional, and local anesthesia and procedural sedation as well as during recovery.	0 There are no or incomplete policies, procedures and protocols for anesthesia and procedural sedation. 1 Current evidence-based policies, procedures and protocols are developed for anesthesia/procedural sedation that include: a. Definitions of the different types of procedural sedation provided b. Procedures and areas in which procedural sedation is provided c. Screening for risk factors that may increase likelihood of adverse effects for the administration of anesthesia or procedural sedation d. Pre anesthesia or procedural sedation assessment (which includes ASA classification and focused airway assessment) e. Management during anesthesia and procedural sedation (for example, vital signs) f. Monitoring during recovery g. Criteria to return to unit 2 A multidisciplinary team from departments that provide anesthesia and procedural sedation develop the policies and procedures collaboratively. 3 All Staff participating in anesthesia and procedural sedation are trained to implement the policies, procedures, and protocols.					
Level 2:	0 Anesthesia/procedural sedation care is not consistently provided throughout the organization.					

The policies, procedures, or protocols are consistently used for general, regional, and local anesthesia and procedural sedation as applicable.	1 Staff interviewed are aware of the policies, procedures, and protocols. 2 Anesthesia/procedural sedation care is consistent wherever it is provided, for example, endoscopy and surgery. 3 Documentation of anesthesia and procedural sedation care is consistent and complete.					
Level 3: Data are collected on complications and incidents of anesthesia and procedural sedation, and the data are used to improve practices.	0 There are no data collected or reports regarding anesthesia and procedural sedation complications or incidents. 1 Data regarding anesthesia and procedural sedation complications and incidents are collected. 2 Anesthesia and procedural data is aggregated and analyzed, and the results shared with clinical staff. 3 Improvements in anesthesia and procedural sedation care are made based on the results of data.					

STANDARD #17: Surgical services appropriate to patient needs

Surgical services are planned based on the assessment of the patient and a pre-operative diagnosis is recorded.						
RISK LINK: Surgery patients are at risk if the intended surgical procedure is not based on the patient's assessment data, when the patient is inadequately monitored during the procedure, and when post- surgical planning is absent or weak.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies, procedures, or protocols are available for pre-operative patient assessments, monitoring patients during surgery, and the content of the surgical report.	0 The required surgical policies, procedures or protocols are not present and/or complete. 1 Policies, procedures, or protocols are in place (that include the management of specific patient populations, for example, pregnant women, neonates, children, adolescents) regarding: a. Conducting pre-op assessments b. Surgical site marking c. Surgical safety checklist d. Recording a pre-op diagnosis and prophylactic medications e. Monitoring patients during surgery f. Operative report content and timely completion 2 Policies, procedures, and protocols are readily available to all relevant staff. 3 Relevant staff interviewed are aware of the policies, procedures, and protocols.					
Level 2: The policies and procedures or protocols are consistently used for all types of surgical procedures and operative equipment is available and functioning.	0 Operative reports are not consistently completed according to policy and procedure. 1 The surgical safety checklist is implemented and documented in the medical record. 2 Functioning equipment is available for performing operative procedures. 3 Records reviewed demonstrate that the operative report includes at least the following: a. Start and end time of surgery b. The procedure performed c. Findings during surgery (intra-operative) d. Post-operative diagnosis					

	e. Surgical specimens removed (pathology) a. Procedure outcome(s)Name of surgeon and any assistant b. Signature of the surgeon					
Level 3: Data are collected on surgical complications and incidents, and the data are used to improve surgery safety.	0 There are no data collected or reports regarding surgical documentation. 1 Data regarding surgical complications are collected, including returns to surgery. 2 Surgical data are aggregated, analyzed and the results shared with clinical staff. 3 Improvements in surgical care are made based the data analysis and interpretation.					

STANDARD #18: Comprehensive management of emergency triage

An effective emergency triage process is consistently used to determine patient priority for treatment.						
RISK LINK: Initial triage and treatment constitute one of the weakest links in the system. In many hospitals patients are not managed properly or have to wait a long time before being treated; as a result, their medical condition deteriorates dramatically even when they succeeded to reach the hospital in a reasonable time.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Triage processes are described in policies and procedures.	0 No emergency triage policies and procedures are written. 1 Emergency triage policies and procedures are written for adult, pediatric neonatal and maternity patients. 2 The triage processes are based upon physiologic criteria. 3 Current evidence-based triage processes have been approved within the past 24 months.					
Level 2: Staff has been trained on use of the triage processes. The triage processes are implemented and documented within the medical record consistently and essential equipment and supplies for conducting triage are available.	0 Emergency triage is inconsistently implemented. 1 Relevant staff members are trained on how to perform triage of patients. 2 Staff members describe effective implementation of the emergency triage processes essential equipment and supplies for conducting triage are available and there is a reserved space for clients found in critical/urgent need of care for stabilization 3 Documentation on the medical record shows that patients are prioritized according to relevant triage process.					
Level 3: Data are collected on the effectiveness of the triage processes.	0 No data are collected regarding the effectiveness of emergency triage. 1 Data are collected regarding the effectiveness of emergency triage, for example, correct assignment of category based on criteria. 2 Data regarding emergency triage are aggregated, analyzed and results shared with clinical staff. 3 Improvements in emergency triage are made based on the data analysis and interpretation.					

STANDARD #19: Essential emergency medications, equipment, and supplies

Emergency personnel, medications, equipment, and supplies are available that match the patients' needs.						
RISK LINK: When emergency medications, equipment and supplies are not available or serviceable, the practitioners will not have the resources needed to effectively treat the patient. However, the patient is also put at risk when hospitals are equipped with emergency medications, equipment and supplies that are beyond the limit of the care setting. The space allocated for providing emergency care can affect rapid treatment.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A list of essential emergency medications, equipment and supplies is developed based on the level of care and resuscitation provided by the hospital and populations served.	0 There is no list of essential emergency medications, equipment and supplies and/or some items on the list are not appropriate to the level of care provided. 1 A list of essential emergency equipment is developed that is based on the level of care and resuscitation provided by the hospital and populations served. 2 A list of essential emergency medications, and supplies is developed that is based on the level of care and resuscitation provided by the hospital and populations served. 3 The lists are reviewed/updated on an annual basis or when service levels change.					
Level 2: The appropriate essential medications, equipment and supplies are available and well organized; equipment is in good working order and medications are within expiry date.	0 The emergency supplies and equipment are not well organized. 1 The emergency supplies medications and equipment are observed to be organized, labeled and within expiry date. 2 The essential equipment is available and in good working order. 3 The process for managing (monitoring) emergency medications, equipment and supplies is standardized throughout the organization.					

Level 3: The essential medications, equipment, and supplies, are monitored for availability and functioning.	0 The policy and procedure for ensuring the availability of medication, equipment and supplies and the functioning of equipment is not present and/or complete. 1 A policy and procedure that outlines the process for ensuring the availability of medication, equipment and supplies and the functioning of equipment is available. 2 An inventory process is implemented to ensure that emergency medications, equipment and supplies are available, and stock is observed to be well secured. 3 Emergency equipment is included in the equipment maintenance program and evidence is available to demonstrate that it is being maintained. NOTE: Check the emergency trolleys to determine whether they are organized in 1st line and 2nd line emergency drugs; and that the quantity is determined based on use.					

STANDARD #20: Ambulance services equipped

Ambulance services, which are well equipped and manned by qualified staff, are available to transport emergency patients.						
RISK LINK: Lack of transportation is often a major barrier to accessing emergency care. In developing countries where ambulances are available, often the ambulance crew is composed of drivers without skills in the basic management of emergency patients. Even when professional staff attends the patient, they may not have emergency management skills. The lack of resuscitation equipment and essential drugs as well as compromised mechanical integrity of the vehicle can place a patient at risk. As a result, many patients' condition dramatically deteriorates during the transfer.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures guide ambulance service delivery.	0 The required policies and procedures regarding ambulance services are not present. 1 Current policies and procedures are present and available to relevant staff that define: a. Who can use the service b. Dispatcher and driver training c. Equipment needed as per technical domain a. Medications and supplies needed based on served clients b. Emergency procedures that can be performed and by whom c. Maintenance of the vehicle and equipment d. Mechanical and safety inspections e. Process for receiving calls and dispatching ambulances f. Cleaning and disinfecting of ambulances 2 Interviews with relevant staff indicate that they are aware of the policies and procedures. 3 Ambulance register (book) is correctly and completely filled out according to the policy and procedure: a. The time the call was received, the ambulance dispatched when the ambulance arrived at the patient, . a. Full name and the correct address of patients transported b. The name of the clinical staff accompanying the ambulance					

	c. Name and signature of the person responsible for authorizing the departure d. Name of the person who has called					
Level 2: A check list is used to ensure that the contents of the ambulance are present, clean, functioning and within expiry date; staff operating within the ambulance are qualified.	0 The qualifications of ambulance staff is not included in their job descriptions. 1 Qualifications of the driver and staff members who assist in transport are described in their job description. 2 check list is used at each shift to ensure that the contents of the ambulance including medicine (Oxygen, supplies, consumables and drugs) are present, functioning and within expiry date. 3 Supplies and equipment are observed to be sufficient to carry out the emergency protocols. NOTE: If the ambulance is not owned by the hospital, ask about the arrangement for transport and how the hospital ensures collaboration to transport patients and the quality of the service and measure the service as part of the standard on contract management (Risk Area #1, Standard #.10)					
Level 3: The maintenance of the ambulance and effectiveness of the services is monitored.	0 The ambulance service mechanical inspection records are not reviewed by management at least quarterly. 1 The safety and mechanical inspection records are reviewed by management at least quarterly. 2 Data are collected regarding the effectiveness of the ambulance service (for example, response time) and the monthly report of maintenance of ambulances of the hospital respecting PHECS format is submitted no later than 10th day of the month following the month reported. 3 The results of the data are used to develop action plans to improve the service.					

STANDARD #21: Safe Medication use

Medication use complies with applicable law and regulation and is overseen by an individual who is qualified by licensure, training, and experience.						
RISK LINK: Medication use is a complex system of processes (selection, storage, prescribing, dispensing, administration, and patient monitoring) that has many risk points. There must be a qualified individual familiar with and responsible for all parts of the medication use system. There also needs to be check points to ensure that the right medication, in the right dose, reaches the right patient at the right time. Policies and procedures are implemented for safe storage and handling of medications.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Medication use complies with national laws and regulations, for example, narcotics management, and is overseen by qualified individuals.	0 The pharmacy is not supervised by a qualified pharmacist. 1 The personnel file includes documentation that the pharmacist in-charge is qualified according to local regulations. 2 There are policies and procedures that describe medication management processes within the hospital, which are consistent with laws/regulations, ministerial instructions and WHO guidelines, which include at least: a. Look-alike sound-alike drugs b. Medication accuracy at transitions of care c. Avoiding IV tubing disconnections d. Who can prescribe medications e. Who can dispense medications f. Who can administer medications g. How medications are verified before administration h. Storage of medications i. How to manage high-alert medications, including concentrated electrolytes j. Narcotics and psychotropic drugs k. Cold chain management l. Antibiotic stewardship 3 Relevant staff interviewed are aware of the policies and procedures.					
Level 2:	0 Medications are not consistently stored and dispensed in the pharmacy according to the policies and procedures.					

The medication use policies and procedures are followed.	1 Observation in the pharmacy demonstrates that medications are stored and dispensed according to policies and procedures. 2 Observation in the clinical areas demonstrates adherence to the management of medications and especially, high alert medications and narcotics management. a. Labeling and separation of high alert medications b. Secured narcotics with records of management c. Refrigerator and freezer temperatures maintained between the official limits d. Absence of stock-out of essential drugs (based on the list adopted by the department) e. Availability of pediatric formulations 3 Interviews with staff indicate that the cold chain is managed effectively. a. No interrupted cold chain during the past three months b. Cold chain guaranteed in case of power failure (kerosene fridge with a kerosene stock of at least 5 liters, or a functioning generator • Temperature of the fridge in the limits (between 2 degrees C and 8 degrees) • Pellet control of vaccine (PCV) in good condition					
Level 3: Monitoring data include adverse events, medication errors, near misses and stock control (for example, insufficient/missing stock, expired medications, etc.) are used to continually improve medication use.	0 There are no data regarding medication management. 1 Adverse events, medication errors and near misses are identified and reported. 2 Data are collected, aggregated, analyzed, and used for quality improvement purposes regarding adverse events, medication errors, near misses and stock control. 3 Progress is evident toward implementing the Pharmacy & Therapeutic Committee's pharmaco-vigilance action plan, which contains interventions for reducing medication errors.					

STANDARD #22 Patients educated to participate in their care

Patients and their families receive education that they can understand to support their participation in their care (for example, regarding their diagnosis and treatment) during their hospitalization and after discharge.						
RISK LINK: Patients are at risk for readmission, poor outcomes, and complications if they and their families are not educated about home management at discharge. Also, the education needs to include reasons to return for emergency or routine follow-up care.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Policies and procedures describe the importance of patient education and the types of education that is given to all patients.	0 There are no policies and procedures regarding patient education. 1 The patient and family education policy and procedure includes: a. Assessment of patient and family educational needs b. Providing education that meets patient and families ongoing health needs c. Ways to evaluate the effectiveness of the education d. Providing child and adolescent-friendly, age-appropriate health information, in a language relevant to children, adolescents and their careers or the use of health information materials (for example, audiovisual, diagrams and illustrations) e. Measured for providing general health education (for example, the prevention of lifestyle diseases, HIV, Malaria, etc.) 2 The policy and procedure describe the use of effective educational approaches, for example, group, 1:1, use of verbal and written instructions and return demonstration. 3 Staff interviewed are aware of the policies and procedures.					
Level 2: Individualized patient education relevant to their condition is consistently provided and documented including medications, home management and follow-up care.	0 There is no evidence that physicians, nurses and other care providers participate in patient and family education. 1 Physicians, nurses, and other health care providers participate in patient and family education. 2 Documentation indicates that patients and families participate in discharge planning. 3 Individualized education provided during hospitalization and at discharge that includes at least (as needed):					

	a. Safe use of medications b. Safe use of medical equipment c. Infection prevention measures d. Potential interactions between medications and food e. Nutritional guidance f. Pain management g. Diagnostic test and rehabilitation techniques h. Home self-management, for example, wound care					
Level 3: There is a process to evaluate the degree to which patients understood the education.	0 There is no evidence that patient and family education was effective. 1 Staff members interviewed describes their approaches to evaluating the effectiveness of patient and family education. 2 Medical records have documentation that the patient and family understood the instructions. 3 The effectiveness of patient and family education approaches are evaluated and documented.					

STANDARD #23: Communication among those caring for the patient

Essential patient information is communicated among those caring for the patient through information exchange between shifts of care providers, when a patient is transferred to another unit within the hospital and when contacting a physician regarding a patient's condition.						
RISK LINK: Ineffective communication is the most frequently cited category of root causes of sentinel events. Patients often move between areas of diagnosis, treatment, and care on a regular basis and may encounter three shifts of staff each day - introducing a safety risk to the patient at each interval. The hand-over communication between units and between and amongst care teams might not include all the essential information, or information may be misunderstood. These gaps in communication can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm to the patient. Effective communication, which is clear, timely, accurate, complete, and understood by the recipient, reduces error and results in improved patient safety.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A current policy and procedure is in place that describes a standardized approach to providing information between caregivers that supports patient-centered care.	0 There are no policies and procedures regarding communication among caregivers. 1 A policy and procedure describes a standardized approach to hand-over clients and materials/equipment, communication between staff, change of shift and between different patient care units in the course of a patient transfer, for example, SBAR (situation, background, assessment, recommendation) technique 2 Write down and read back steps are included in the policy and procedure. 3 Staff interviewed indicates that all nurses are involved in change of shift reporting.					
Level 2: A standardized approach to hand-over communication is used between staff, change of shift and between different patient care units in the course of a patient transfer.	0 Staff are unaware of the hand-over technique. 1 Staff interviewed are knowledgeable about the techniques. 2 Pre-prepared hand-over report templates are provided to staff coming for the next shift, for example, summary of recommendations relevant to the department from daily staff meetings, critical patients that need close monitoring (refer to the reporting template) and for patients that are being transferred between departments (for example, from the ward to theatre,					

	from ICU to the ward or from the emergency service to an in-patient department). 3 The prepared reports are consistently completed based on the policy and procedure.					
Level 3: There is a process to assess the effectiveness of hand-over communications.	0 There is no process for assessing the effectiveness of hand-over communications. 1 Data are collected regarding the effectiveness of the hand-over process. 2 Data are aggregated and analyzed. 3 The results are used to improve the hand-over communication process.					

STANDARD #24: Referral/transfer information communicated

Health practitioners ensure timely, justifiable referrals and that patients are referred to the appropriate health specialist and facility with sufficient patient information to provide effective continuity of care.						
RISK LINK: When patients are transferred to another facility, information about their condition, care and treatment is needed by the receiving medical team to provide ongoing care. When this information is not provided, the patient is at risk of misdiagnosis or treatment.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A policy and procedure is in place for transfer and referral of patients.	0 There is no policy and procedure for transfer and referral of patients. 1 A policy and procedure describe the transfer and referral processes and includes: • The requirements of the integrated national referral guidelines • Specialized transfer and referral processes for pregnant women, newborn babies, infants, children and adolescents • What category of staff should accompany the patient (with particular reference to children and high-risk patients) • The type of transportation and required monitoring during transport (with particular reference to high-risk patients) • Clear communication with family members about the condition of their family member and why and where they will be referred • Communication with the referral hospitals before transfer so that the appropriate arrangements can be made to receive patients • How to manage challenges such as patient financial barriers • Organization of well-equipped transport services available and operating 24 hours a day, seven days a week 2 The referral/transfer sheet includes: a. The reason for referral/transfer b. Significant findings c. Procedures and treatments given d. A list of current medications and administration e. The patient's immediate condition					

	f. Where the patient is being transferred g. The type of transportation and required monitoring during transport 3 Staff interviewed are aware of how to implement the policy and procedure. NOTE: Refer to the national integrated referral guidelines.					
Level 2: Referrals/transfers are timely and justifiable. The patient is referred to the appropriate healthcare specialist and facility to ensure continuity of care. Patients are transferred safely using the type of transportation and monitoring required.	0 The transfers/referrals are not justified in the medical record. 1 The transfers/referrals are justified in the medical record. 2 Documentation indicates that a copy of the referral/transfer sheet is sent with the patient when transferred to another facility. 3 A majority (80%) of copies of the referrals/transfers sheets are retained in the patient's medical record.					
Level 3: Data on referrals/transfers are collected and used to continuously improve patient care and strengthen the referral system.	0 Medical records reviewed do not include the type of transportation and monitoring required for patients being transferred or demonstrate adherence to the national integrated referral guidelines. 1 Medical records reviewed indicate that patients are transferred using the type of transportation and monitoring required and demonstrate adherence to the national integrated referral guidelines. 2 Data are collected regarding the numbers and types of transfers/referrals made and whether the referrals and transfers meet the national referral guidelines. 3 Data are aggregated, analyzed and used to improve the referral system.					

STANDARD #25: Complete and thorough clinical documentation

Essential patient information is communicated among those caring for the patient through the use of standardized patient records. Periodic review of patient records contributes to improved completeness, legibility, and accuracy.

RISK LINK:

Many patient safety incidents occur when essential information is not recorded, recorded incorrectly or is not available. The key to reducing these risks is to have a standardized patient record available to all those providing care to the patient. This includes standardized entries, such as for medication dosages and for the use of abbreviations, signs, or symbols. When verbal or telephone orders are given, there is a risk of misunderstanding the order and thereby, providing incorrect treatment. This applies to both paper-based and electronic patient records.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: A current policy and procedure is in place that describes clinical documentation and patient record audit expectations.	0 There is no policy and procedure for clinical documentation. 1 A policy and procedure describes clinical documentation and patient record audit expectations for both paper-based and electronic patient records. 2 The policy defines: a. Who is authorized to make entries in the medical record (for electronic patient records this would include password protected permission to access defined areas of the patient record). b. How to make corrections in the record (for electronic patient records this would include who authored the corrections and how they are tracked, dated and timed). c. Legibility d. Dating and timing entries e. Signatures and use of stamps (for electronic patient records this would include ensuring that passwords are kept secure and confidential and only used by the authorized person). f. Use of approved abbreviations g. Selection, sample size, disciplines, and timeframes for patient record audits 3 The policy includes expectations regarding the discharge summary contents.					

Level 2: The patient record is available to all those caring for a patient and the content is standardized and completed according to the policy and procedure.	0 The patient record is not available to all those caring for a patient and the content of the medical record is not standardized or completed according to the policy and procedure. 1 The patient record is available to those caring for the patient and the content of the medical record is standardized and completed according to the policy and procedure. 2 All patient medical record entries are legible, complete, dated, and timed. 3 The discharge summary includes at least the following: a. The reason for admission b. Significant findings, including investigations c. Procedures performed d. Diagnoses made e. Medications or other treatments f. Patient's condition at discharge g. Follow-up instructions and all discharge medications that the patient is to take following discharge					
Level 3: There is a process to review documentation quarterly, and this information is used to improve documentation in patient records.	0 Medical record reviews are not performed quarterly. 1 Staff interviewed describes the medical record review process. The process includes the following: a. Review of the completeness (content) and legibility of entries b. A representative sample size from key services as defined in the policy and procedures c. Representative samples of all disciplines that make entries in the medical record 2 Data are aggregated and analyzed. 3 Documentation shows that relevant staff members are provided feedback regarding the results.					

RISK AREA #5 – IMPROVEMENT OF QUALITY AND SAFETY

Health care organizations, and their patients, remain at risk from poor quality and unsafe practices if organizations do not learn from their good and bad experiences and take actions to continually improve. Data are at the core of this learning. Organizations need to understand and value data collection and analysis in process improvement. Organizations must gain experience in setting improvement priorities, collecting data, displaying data for better analysis, and finally, planning and implementing improvement strategies. When leaders are committed to quality improvement and value the data that form the basis of evidence-based learning, the organization's culture is focused on quality and safety. This helps create a non-punitive environment and encourages an incident-reporting system. It embraces teamwork on all levels and includes patients as important members of their treatment teams and quality efforts.

Required Documents	Data Collection Methods
1. Quality and safety plan 2. Customer care program 3. Incident reporting policy and procedure 4. Patient satisfaction policies, procedures, data, and actions for improvement. 5. Staff satisfaction policies, procedures, data, and actions for improvement. 6. Patient/family complaint policy and procedure, data, and actions for improvement 7. Staff quality training plan and records 8. Clinical outcomes monitoring data and actions for improvement	A Leader interviews B Staff interviews C Document review D Medical record review E Personnel file review

STANDARD #1: Quality and safety program

A quality and safety program provides the structure for carrying out systematic activities to improve quality and patient safety.

RISK LINK:

Continuous improvement and constant concern over reducing the risks to patients and staff members identify hospitals that are committed to the welfare of their patients. To improve quality and reduce risks, the hospital must constantly evaluate (measure) its performance and use that information to identify ways in which it can improve. This self-evaluation must be planned and ongoing and should focus on systems and processes, not solely on individual performance.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The roles and functions of the appointed Quality Improvement Officer are described in a job description and a quality and patient safety plan with terms of reference for the quality committee is written and guides the quality and patient safety program.	0 There is no Quality Improvement Officer job description. 1 A current Quality Improvement Officer job description is present. 2 There is a hospital wide plan for quality improvement and patient safety, which includes at least the following: a. A definition of quality b. The description of quality improvement methods used in the hospital c. The membership of the quality improvement and patient safety committee and defines the leadership and responsibilities of the committee d. The coordination among all components of the organization's quality improvement and safety activities e. Hospital wide specific quality goals are identified f. Quality and safety indicators that are currently being measured 3 Each quality indicator has a clear definition, formula, data collection method, who is responsible for data collection, frequency of data collection, and target.					
Level 2: A quality focal person is coordinating the quality and patient safety activities. The quality plan has been implemented and progress toward meeting goals/objectives is tracked	0 There is no Quality Improvement Officer has not attended a formal QI course. 1 The Quality Improvement Officer has attended a formal course in QI and patient safety approaches. 2 An interview with the QI committee indicates that the team is functioning. 3 Meeting minutes show that the goals/objectives of the quality plan are being tracked on a quarterly basis and indicators are reported and acted upon according to the plan.					

through the quality and patient safety committee.	NOTE: A formal course would consist of at least a 3-day workshop conducted by a qualified instructor.					
Level 3: The quality and patient safety plan is evaluated annually, and new goals/objectives and indicators set for the upcoming year.	0 The quality and patient safety plan is not evaluated annually. 1 Minutes of the QI Committee indicate that the quality and safety plan has been evaluated within the last 15 months. 2 Goals, objectives, and indicators for improving quality and safety have been established for the current year. 3 The plan has been approved within the past 12 months.					

STANDARD #2: Effective customer care program

Customer care is identified as a priority with well-defined workplace expectations and performance guidelines for customer service.						
RISK LINK: One of the simplest, least complicated, yet often overlooked aspects of delivering health care is practicing good customer service skills. Patient satisfaction surveys repeatedly show that health care worker attitudes, manners and amenities encountered during patients' experiences at healthcare facilities weigh with similar importance to treatment processes. Providers and administrators are learning how good service, not just good outcomes, relates to patient satisfaction.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is an effective customer care program.	0 There is no customer care program. 1 A customer care program defines the workplace expectations and performance guidelines for customer service for all staff. 2 A dress code is developed for all staff to present a professional image to the public that includes: a. Identification b. Clothing c. Shoes d. Nail care e. Jewelry f. Hair 3 A job description is written for the Customer Care Officer and customer service expectations are included in all staff job descriptions.					
Level 2: The patient and family are treated with respect and dignity and individual needs are met.	0 Staff have not been trained in customer care. 1 Staff have received general training regarding providing customer service and comply with dress code requirements. 2 Patients and their families are oriented to their environment upon outpatient visit and admission. 3 The Customer Care Officer provides individualized assistance to address patient and family needs.					

	NOTE: Patient orientation includes such things as how to find their way, how to call for assistance, visiting hours, meals, storing personal belongings and where the fire exits are located.					
Level 3: The effectiveness of the customer care program is monitored, and actions taken to make improvements.	0 There is no monitoring of the effectiveness of the customer care program. 1 The customer care program is monitored through patient feedback (this may be done through the patient satisfaction survey, incident reports, complaints, or other means). 2 Action plans are developed and implemented to improve the program. 3 Leadership demonstrates how they provide recognition for good customer service behaviors.					

STANDARD #3: Patient satisfaction monitored

There is a process to monitor the patient satisfaction with the care process, the care environment, and the organization's staff.

RISK LINK:

Patient satisfaction with the care process, the care environment, and the staff involved in their care is important information that will help identify quality and patient safety issues. This information is useful in identifying priorities for improvement and for understanding if improvements increase patient satisfaction.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is a policy, procedure, and a tool to monitor patient satisfaction.	0 There is no policy, procedure, or tool to monitor patient satisfaction. 1 A policy and procedure for monitoring patient satisfaction has been developed. 2 A tool has been developed and tested. 3 The required sample size is detailed in the policy and procedure and has been obtained for the targeted populations.					
Level 2: Patient satisfaction is monitored, and the data analyzed according to the policy and procedure.	0 The leaders do not describe an effective patient satisfaction process. 1 Leaders describe an effective patient satisfaction survey process. 2 Data have been collected accurately. 3 Data have been aggregated, analyzed, and displayed according to specific services/departments.					
Level 3:	0 The data have not been used to make improvements. 1 An action plan has been developed to address priority issues identified.					

Trends in patient satisfaction are used to set priorities for improvement or for further evaluation.	2 Staff interviewed are aware of the patient satisfaction results and the actions being taken. 3 Minutes of meetings show that improvement is being tracked.					

STANDARD #4: Complaint, compliment, and suggestion process

There is a process to receive and act on complaints, compliments and suggestions from patients, families, and others.

RISK LINK:

A complaint is often the first indication that a process has failed and that other patients may be at risk for the same or a similar event. Thus, complaints and suggestions are received through an established process so they can be tracked, and actions taken.

A compliment is any expression of praise, commendation or admiration given by any person on health services being rendered and care being provided. The importance of analyzing compliments cannot be understated. Not only do they identify the healthcare practices that are desired and valued by the patient population but by acknowledging, rewarding, and promoting these practices, compliments can contribute to improving healthcare services through promoting these behaviors.

		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is a policy and procedure for receiving complaints, compliments, and suggestions.	0 There is no policy and procedure for receiving oral or written complaints, compliments or suggestions or the process is not systematic. 1 There is a policy and procedure for receiving oral or written complaints, compliments or suggestions that includes at least: • How the hospital informs patients and families about its process to receive and to act on complaints, compliments, and suggestions (this should be publicly available as, for example, posters in the hospital, brochures/handouts, information on the website, etc.) • The process to be followed when reporting, recording, investigating, and responding to complaints, compliments, and suggestions • Those who need to be involved in the processes • Patient and family participation in the processes • The process to report back to the patient and/or the family within an established time frame					

	• The process to be followed to address any identified deficiencies in care • The review of complaints, compliments, and suggestions to identify any common or emerging themes • The identification of adverse events which should then be managed as an adverse event as well as a complaint • The acknowledgement of staff who have been complimented 2 Training for all staff, volunteers, contract workers and independent practitioners on the policy and procedure for receiving complaints, compliments and suggestions is included in the hospital's training plan. 3 The process is easily accessible to the public (for example, pencils and paper are available, the email address of the customer service manager is posted in public view or on the website, etc.).					
Level 2: An effective process for reviewing and resolving complaints, compliments and suggestions is operational. Feedback is given to affected individuals regarding the process for managing complaints within the specified timeframes.	0 Staff members are unable to describe how they advise patients regarding the complaint, compliment, and suggestion process. 1 Staff members are able to advise the patient and the family about the complaint, compliment, and suggestion process. 2 Staff members describe steps that they take to resolve patient complaints. 3 Staff members refer patients/families according to the policy when they are unable to resolve the patient/family issues.					
Level 3: Complaints and suggestions are categorized by type and tracked. This information is used to prioritize patient issues and implement solutions. The results of the solutions are monitored for effectiveness.	0 Complaint, compliment, and suggestion data are not categorized and trended. 1 Complaint, compliment and suggestion data are aggregated, analyzed and trends identified. 2 Minutes show that complaints, compliments, and suggestions are systematically reviewed within a committee within the specified timeframes. 3 Action plans are developed and implemented to correct recurring problems.					

STANDARD #5: Clinical outcomes are monitored

The hospital monitors the outcomes of care for patients with the most prevalent diagnoses and the outcomes of the most common operations and acts to improve them over time.						
RISK LINK: The purposes of caring for patients are to mitigate disease, eliminate or palliate symptoms, and to prolong high-quality life. The outcome of any one single episode of care does not reliably indicate to what extent the hospital is meeting its goals in these areas, nor does it tell how clinical performance compares to prior performance, that of similar organizations, or published benchmarks. The risk is that in the absence of monitoring clinical outcomes, less-than-optimal outcomes will be accepted, and patient risk will not be reduced over time.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Leadership identifies and defines priority clinical outcome indicators.	0 Indicators have not been established for key clinical outcomes. 1 Indicators have been established by the hospital's leaders for key clinical outcomes that are selected from: • Clinical guidelines applicable to the patient services provided (mandatory national guidelines are included in this process where available) • High-volume, high-risk, and high-cost conditions treated at the hospital (including EIDSR, maternal, neonatal and child death, malaria death indicators) 2 Each indicator has a clear definition, formula, data collection method, who is responsible for data collection, frequency of data collection, and target. 3 Data are collected accurately and completely for each of the key clinical outcome indicators.					
Level 2: Outcome data are compared to those of previous time periods and published benchmarks (if they exist) and to those of similar organizations (when data is available). Data is used by	0 Data for clinical outcome indicators are not aggregated and analyzed. 1 Clinical outcome data are aggregated and analyzed for each of the indicators 2 Death surveillance and audits (especially for maternal, perinatal and neonatal) are regularly conducted and contributing factors of deaths are communicated to relevant staff (both at the hospital level and referring health centers) 3 The data are compared to established targets and trends over time.					

the facility staff to make improvements in care.						
Level 3: The hospital systematically and proactively seeks outcome data from similar organizations and published benchmarks and compares its own performance.	0 The outcome data are not compared across hospital departments. 1 The data are compared across hospital departments. 2 The data are compared with other hospitals within the country. 3 Some indicator data are compared to published benchmarks, for example, infection rates and a clear implementation plan of recommendations from deaths audit committee established.					

STANDARD #6: Incident, near miss and sentinel event reporting system

There is a system for reporting and analyzing incidents, near misses and sentinel events that is fair and non-punitive, based on a clear definition of what is to be reported.						
RISK LINK: The frequency, magnitude, and impact/potential impact of incidents, near misses and sentinel events can only be known if data are collected and analyzed. Frequently, the review of data convinces organizations that risk is indeed present and of significant magnitude and impact/potential impact so that action must be taken to understand and reduce the risk. A difficult challenge is to develop a reporting process that is free of punitive overtones and/or actions and encourages reporting.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: Leaders are committed to an incident, near miss and sentinel event reporting process. There is a policy and procedure for the reporting process that clearly defines the incidents, near misses and sentinel events to be reported.	0 There is no incident, near miss (including maternal near miss) and sentinel event reporting policy and procedure. 1 An incident, near miss (including maternal near miss) and sentinel event reporting policy and procedure identifies at least: • Definitions (for example, incident, near miss, sentinel event, just culture, second victim, root cause analysis, ethical dilemma) • The events to be reported (clinical, administrative, environmental, ethical, etc.) • The manner in which reporting takes place • Timeframes for managing incidents, near misses and sentinel events • The process for conducting root cause analysis/ review of incidents, near misses and sentinel events • • The timeframes and processes for informing individuals affected by incidents and sentinel events of the situation and the outcome of the investigation • The management of staff involved and affected by an incident (just culture, second victims, retraining, and, where required, disciplinary processes) 2 The resources required for implementing the incident, near miss and sentinel event reporting system is included in the hospital's financial planning and reflected in the budget.					

	3 Training for all staff, volunteers, contract workers and independent practitioners on the incident, near miss and sentinel event reporting system is included in the hospital's training plan.					
Level 2: The incident, near miss and sentinel event reporting process is implemented, and data are collected.	0 Few or no incidents or near misses (including maternal near miss) have been reported. 1 Incident, near miss (including maternal death) and sentinel event reports are submitted from each clinical department within the organization and are categorized into types and severity of events, persons involved, and locations. 2 Incidents, near misses and sentinel events are managed according to the processes and timeframes required by the policy and procedure and maternal near misses are reviewed using national tools 3 Individuals affected by the incident and sentinel events are informed of the situation and of the outcome of the investigation within the specified timeframes.					
Level 3: The data are analyzed and used to educate staff and to improve processes to avoid similar incidents from occurring.	0 The data are not aggregated, analyzed, and displayed 1 Data related to incident, near misses and sentinel event reporting are aggregated, analyzed, and displayed. 2 Plans are made to reduce the potential for these events recurring, lessons learnt are well documented and accessible to health care providers including maternal services. 3 The results of the interventions are tracked, and actions taken accordingly (PDSA cycle) and lessons learnt from different services including maternal near miss review shared with other hospitals					

STANDARD #7: Staff demonstrate how to improve quality and patient safety

Staff is educated on the principles of quality improvement and patient safety appropriate to their participation in quality improvement activities.						
RISK LINK: When staff is aware of quality and patient safety issues but does not have the knowledge or tools to improve, the risks will remain and potentially multiply. It is important that when an opportunity or a priority for improvement is established, the staff involved in the improvement process receive basic training in quality improvement.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There are written priorities for staff quality and patient safety training.	0 No priorities have been set for quality and patient safety training. 1 A quality and patient safety training plan lists the priorities. 2 Priorities include training of hospital leaders and different levels of staff. 3 Priorities are based on current need to know information that supports implementation of the quality and patient safety program.					
Level 2: There is an organized training program for staff who participates in quality improvement and patient safety activities. Department QI teams are carrying out systematic quality improvement activities based on the PDSA model.	0 There is no quality and patient safety training program. 1 The quality and patient safety training program includes awareness and quality improvement methods. 2 The training activities are practical and interactive. 3 Training records indicate that the targeted groups attend the training activities.					
Level 3: The impact and effectiveness of the training program are documented and used to improve program content and scope over time.	0 The knowledge of trained staff members regarding quality and patient safety is not evaluated. 1 The knowledge of staff members attending quality training is evaluated. 2 The skills of staff attending quality training are evaluated. 3 The application of the skills to practice is evaluated.					

STANDARD #8: Communicating quality and patient safety information to staff

Staff is aware of the organization's quality and patient safety activities through periodic reports, newsletters, posters, or other means.						
RISK LINK: An organization's quality and patient safety efforts are at risk if its staff believes the program is one or two events and not an ongoing activity or if program activities are perceived as not related to their jobs but carried out by others. Regular communication of quality and patient safety information will keep the program visible and more relevant to the work activities of all staff.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: The means of communicating quality and patient safety information to staff is described in the quality plan.	0 The quality plan does not include expectations regarding when quality reports are to be submitted. 1 The quality plan identifies when the various departments/committees are to submit quality reports to the Quality Improvement Committee. 2 The plan identifies when and how information flows between the leadership, departments, and staff. 3 The plan identifies how training for all staff, volunteers, contract workers and independent practitioners on quality and patient safety is included in the hospital's training plan.					
Level 2: Quality and patient safety information are regularly communicated to staff.	0 Quality and patient safety information is not consistently communicated to staff during departmental staff meetings. 1 Staff meeting minutes show that quality and patient safety information is communicated monthly in the departments. 2 Training registers show that staff, volunteers, contract workers and independent practitioners were trained on quality and patient safety as set out in the hospital's training plan 3 Staff interviewed are able to describe quality and safety activities performed within the department in the last 3 months.					
Level 3: Staff use of quality and patient safety information is evaluated to improve the effectiveness of the communication effort.	0 Meeting effectiveness is not evaluated quarterly in the departments. 1 An evaluation of meeting effectiveness is conducted at least quarterly for all departmental staff meetings. 2 The results of the feedback are shared with each group. 3 An action plan is developed for each department to improve information sharing and use of quality information.					

STANDARD #9: Staff satisfaction monitored

There is a process to monitor staff satisfaction with the care process, the environment of care, and the education and technical support available to them to support their patient care or other responsibilities.						
RISK LINK: Knowing staff satisfaction with the care process, care environment, education, and technical support will help identify quality and patient safety issues. This information is useful in identifying priorities for improvement and for understanding if improvements already made contribute to staff satisfaction. Satisfied staff members are more likely to provide safe and caring services to patients.						
		Score				
Levels of Effort	**Performance Findings**	**0**	**1**	**2**	**3**	**Overall**
Level 1: There is a policy, procedure, and tool to monitor staff satisfaction.	0 There is no policy, procedure, or tool to monitor staff satisfaction. 1 A policy and procedure for monitoring staff satisfaction has been developed. 2 A tool has been developed and tested. 3 A sufficient sample size has been obtained (at least 50% of all staff members).					
Level 2: Staff satisfaction is monitored according to the policy and procedure, and the data analyzed and reported to staff. An improvement plan is developed and implemented.	0 Staff satisfaction data have not been collected. 1 An annual hospital staff satisfaction survey is conducted. 2 Data have been collected accurately. 3 Data have been aggregated, analyzed, and displayed according to specific services/departments.					
Level 3: Trends in staff satisfaction are used to set priorities for improvement or for further evaluation.	0 The results of the staff satisfaction have not been shared with the staff. 1 Staff meeting minutes show that the outcomes of the survey are made known to staff. 2 An action plan has been developed to address priority issues identified. 3 The action plan has been implemented, progress is being tracked and the impact is measured.					

GLOSSARY

Term	Definition
Adverse Event	An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care.
Algorithm	Algorithms are written in the format of a flowchart or decision tree. This format provides a quick visual reference for responding to a situation. For instance, algorithms are effective in emergency departments and critical care units. When staff is faced with an emergency, such as a patient hemorrhaging, they can treat the patient rapidly by following the algorithm.
Clinical Practice Guideline	A systematically developed set of recommendations that are written to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Their purpose is to influence physicians to practice according to current evidence.
Clinical Privileges	A process to ensure that the medical and surgical care in the facility is provided by practitioners who possess the current qualifications (for example, license, certification) and demonstrated competency for each category of practice
Competency	Competence is defined in the context of particular knowledge, skills, abilities and attitudes.
Contracted services	Services provided through a written agreement with another organization, agency, or individual. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.
Credentials	Evidence of competence, current and relevant licensure, education, training, and experience. Other criteria may be added by a health care organization.
Credentialing	The process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization. The process of periodically checking staff qualifications is called “re-credentialing.”
Critical Standards	Critical standards are those standards that are required by national laws and regulations or, if not met, may cause death or serious harm to patients, visitors, or staff.
Core Standards	Core standards are the standards addressing systems, processes, policies and procedures that are important for patient care or providing quality services.
Effectiveness	The degree to which a services, interventions or actions are provided in accordance with current best practice in order to meet goals and achieve optimal results
Efficiency	The degree to which resources are brought together to achieve desired results most cost effectively, with minimal waste, re-work and effort.
Essentials	Risk areas identified by Joint Commission International on which to focus initial quality and safety improvement efforts
Hazard	Any threat to safety, for example, unsafe practices, conduct, equipment, labels, names.

Hazardous materials	Hazardous materials are chemical substances which, if released or misused, can pose a threat to the environment, life, or health. Industry, agriculture, medicine, research, and consumer goods use these chemicals. Hazardous materials come in the form of explosives, flammable and combustible substances, poisons, and radioactive materials.
Healthcare-associated infections	Infection originating in a health care facility
High risk	An uncertain event or condition, that if it occurs, potentially results in harm or death.
Identifiers	Names or labels associated to a person. The use of two patient identifiers improves the reliability of the patient identification process. Examples of acceptable patient identifiers include name, assigned identification number, telephone number, date of birth, social security number, or address.
Incident	Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm, which includes errors, preventable adverse events, and hazards.
Leaders	In Rwandan hospitals, the use of this term refers to the Hospital Director General, Director of Medical, and Allied Health Professional, Director of Nursing, Hospital Director of Administration and Finance or Human Resources Officer
Leadership	In Rwandan hospitals, the use of this term refers to the leaders and managers.
Managers	In Rwandan hospitals, the use of this term refers to department heads and midwives/nurse in-charges
Majority	In this assessment toolkit, a simple majority is anything greater than 80%.
Nutritional care	Interventions and counseling to promote appropriate nutrition intake. This activity is based on nutrition assessment and information about food, other sources of nutrients, and meal preparation. It considers the patient's cultural background and socioeconomic status.
Patient safety	Prevention of errors and adverse effects to patients associated with health care.
Plan of care	A detailed method, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies and procedures, protocols, treatment guidelines, clinical paths (or care maps), or a combination of these.
Policy	A policy is a principle or rule to guide decisions and achieve rational outcomes. A policy is a statement of intent and is implemented as a procedure.
Procedures	Procedures are step-by-step instructions on how to perform a technical skill. This format often involves the use of equipment, medication, or treatment.
Protocol	Care management plans that set out specifically what should be done, when and by whom in providing patient care. They are developed based on recommendations outlined in clinical practice guidelines.
Qualifications	The education, training, experience, competence, registration, certification or applicable license, law or regulation of a healthcare worker.
Sentinel events	A sentinel event is an unanticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.

Standards	A statement of expected quality, which can be presented in various formats (policies, procedures, protocols, standing orders, standard operating procedures, etc.)
Triage	A process of sorting patients in a healthcare facility to determine their priority for treatment.
Maternal near- miss	When a woman nearly dies but survives a complication during pregnancy, childbirth or within 42 days of termination of pregnancy