Republic of Botswana

National Health Quality Standards

Standards & Guidelines for Hospitals

"Health Care Organizational Management"

Volume 1

Improving Quality & Safety of Health Services

National Health Quality Standards

Standards & Guidelines
For Hospital Standards
Volume 1

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ABBREVIATIONS

ADR	Adverse Drug Reaction
AED	Automated External Defibrillator
BCA	Biological and Chemical Agents
BHPC	Botswana Health Professions Council
BLS	Basic Life Support
BNF	British National Formulary
CAT	Computerized axial tomography
CCTV	Closed-circuit television
CD	Compact Disc
CED	Clinical Engineering Department
COHSASA	Council for Health Service Accreditation of Southern Africa
CSSD	Central Sterilizing and Supply Department
CPR	Cardio-Pulmonary Resuscitation
DAP	Dose Area Product
DNA	Deoxyribonucleic acid
ECG	Electrocardiography
ECT	Electro Convulsive Therapy
EDL	Essential Drug List
EMS	Emergency Medical Services
ESE	Entrance Skin Exposure
ETT	Endotracheal Tube
GCS	Glasgow Coma Scale
HEPA	High-Efficiency Particulate Air
HCW	Healthcare Waste
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IEC	Information Electrotechnical Commission
ISO	International Organization for Standardization
ISQua	International Society for Quality in Healthcare
JCI	Joint Commission International
MEMS	Medical Equipment Management Services
MET	Medical Emergency Team
MI	Myocardial Infarction
MIGB	Metaiodobenzylguanidine
MIMS	Monthly Index of Medical Speciality
MVA	Motor Vehicle Accident
QM&I	Quality Management and Improvement
RRSs	Rapid Response Systems
SANF	South African Nature Foundation
SDU	Sterilizing and Disinfecting Unit
TB	Tuberculosis
UPS	Uninterruptable Power Supply
VIE	Vacuum Insulated Evaporator
VIP	Very Important Person
WHO	World Health Organization

FOREWORD

The Government of Botswana and independent medical institutions have since independence managed to build healthcare facilities of different capacities delivering healthcare services at different levels of care. The adoption of the Primary Healthcare strategy has critically influenced the development of public healthcare facilities to be in areas within reach of every citizen. This has always been a good development pertaining to access to healthcare by the people of this country.

Notwithstanding the above, there have been some major challenges faced by our health system, one which is provision of quality and safe healthcare services. People are no longer complaining of lack of hospitals and clinics but rather of the quality and safety of service they receive. The National Healthcare Service Standards represents a new era in the way we provide healthcare and are aimed at propelling us to greater heights in meeting the needs and expectations of our clients and the public at large. They set out basic requirements that will promote delivery of services based on shared values, and also establish the basis for continuous improvement of the quality and safety of the patient care. The standards will not only provide a framework for self assessment and for external review and investigation, but would also enhance the reputation and credibility of our healthcare system. Their implementation framework provides an execution strategy or road map to realize this.

These National Healthcare Service Standards have been designed in such a way that they can be implemented in all types of healthcare services or settings. They provide the foundation which is applicable to the full spectrum of patient care for the various levels of care in an organization as a whole and to specific areas as appropriate.

I urge all providers to use them to strive to continuously improve the quality and safety of care. May I kindly underscore that successful implementation of the standards requires all healthcare organisations whether in Government and private sector to take account of the quality and safety of all their services. They should conduct self-assessments against the standards and manage their performance. It is envisaged that all healthcare service providers will be subjected to compliance with the standards once the legislation is put in place. I therefore urge all providers to adopt the standards in advance of the proposed legislation. Progress by healthcare organisations to achieve compliance against these standards will be assessed through independent inspections and audits.

I am confident that their implementation will build on the improvements achieved this far and will serve as a catalyst for a change to a culture of continuous improvement that puts the patients at the forefront so that we are able to provide the right care for the right person at the right time, the first time.

Rev. Dr. John G.N. Seakgosing
Minister of Health

Acknowledgements

The National Health Quality Standards are a product of various stakeholders drawn from different disciplines from both Government and private sector and other interested stakeholders. The Ministry of Health acknowledges enormous support from the Council for Health Service Accreditation of Southern Africa (COHSASA) who through their expertise and advice has made the development of the National Health Quality Standards a reality.

Our sincere thanks to the general public and various stakeholders with vested interest in health for their valuable inputs and comments; and management and staff of Athone Hospital for allowing us to use their facility as a pilot test site for the Hospital Standards.

Lastly, let me be mindful of the fact that health is dynamic and assure you that the Government is committed to ensure that these standards remain relevant and the Ministry will be thankful to all stakeholders to be involved in their continuous monitoring and future reviews.

Dr. K. Seipone
Director Health Services

DEFINITION OF TERMS

Acceptability	Acknowledgement that the reasonable expectations of the patient, funders and the community have been satisfied.
Accessibility	Means that access to health services is unrestricted by geographic, economic, social, cultural, organisational or linguistic barriers.
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Accreditation	A determination by an accrediting body that an eligible organisation is in compliance with applicable predetermined standards. (See also *certification, licensure.)*
Adverse event	An adverse event may be defined as any event or circumstance arising during a stay in a clinic/health centre that leads to unintended or unexpected physical or psychological injury, disease, suffering, disability or death not related to the natural cause of the patient's illness, underlying condition or treatment.
Advocacy	Representation of individuals who cannot act on their own behalf and/or promoting individual rights and access to the resources that will allow them to fulfil their responsibilities.
Ambulatory care	Health services that do not require the hospitalisation of a patient, such as those delivered at a physician's office, clinic and casualty or outpatient facility.
Appraisal system	The evaluation of the performance of individuals or groups by colleagues using established criteria.
Appropriateness	The extent to which a particular procedure, treatment, test or service is effective, clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to the client's needs.
Assessment	Process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action.
Audit	1. Systematic inspection of records or accounts by an external party to verify their accuracy and completeness.

2. Periodic in-depth review of key aspects of the organisation's operations. An audit provides management with timely information about specific topics and/or the cost-effectiveness of operations, addressing both quality and resource management issues.

3. In performance measurement, regular systematic, focused inspections by an external party of organisation records and data management processes to ensure the accuracy and completeness of performance data.

4. See also *clinical audit.*

Benchmarking	A method of improving processes by studying the processes of organisations that have achieved outstanding results and adapting these processes to fit the particular needs and capabilities of the health facility concerned.
Biologicals	Medicines made from living organisms and their products including, for example, serums, vaccines, antigens and antitoxins.
Biohazard	Biohazards are infectious agents or hazardous biological materials that present a risk or potential risk to the health of humans, animals or the environment. The risk can be direct (through infection) or indirect (through damage to the environment). Biohazardous materials include certain types of recombinant DNA: organisms and viruses infectious to humans, animals or plants (e.g. parasites, viruses, bacteria, fungi, prions, rickettsias), and biologically active agents (i.e. toxins, allergens, venoms) that may cause disease in other living organisms or cause significant impact to the environment or community. Biological materials not generally considered to be biohazardous may be designated as biohazardous materials by regulations and guidelines.
Business plan	A plan of how to achieve the mission of the facility. The plan includes financial, personnel and other sub-plans, as well as service development and a quality strategy.
Cardiopulmonary resuscitation (CPR)	The administration of artificial heart and/or lung action in the event of cardiac and/or respiratory arrest. The two major components of cardiopulmonary resuscitation are artificial ventilation and closed-chest cardiac massage.
Carer	Anyone who regularly and, in an unpaid capacity, helps a relative or friend with domestic, physical or

	personal care required by virtue of illness or disability.
Certification	The procedure and action by which a duly authorised body evaluates and recognises (certifies) an individual, institution or programme as meeting predetermined requirements, such as standards. Certification differs from accreditation in that certification can be applied to individuals, e.g. a medical specialist, whereas accreditation is applied only to institutions or programmes, e.g. a clinic/health centre or a training programme. Certification programmes may be non-governmental or governmental and do not exclude the uncertified from practice, as do licensure programmes. While licensing is meant to establish the minimum competence required to protect public health, safety and welfare, certification enables the public to identify those practitioners who have met a standard of training and experience that is set above the level required for licensure.
Clinic	1. A defined health session in a health setting. 2. A defined health setting.
Clinical audit	A clinically led initiative that seeks to improve the quality and outcome of patient care through structured peer review, in terms of which clinical personnel examine their practices and results against agreed standards and modify their practice where indicated.
Clinical personnel	All health workers who are registered/enrolled with a professional body, and who are involved in the care of clients/patients in a particular setting. (See also *health professionals.)*
Clinical practice guideline	A generally accepted principle for patient management based on the most current scientific findings, clinical expertise and community standards of practice.
Clinical practice pathway	The optimal sequence and timing of interventions by physicians, nurses and other disciplines for a particular diagnosis or procedure, designed to minimise delays and resource utilisation and to maximise the quality of care. Clinical pathways differ from practice guidelines, protocols and algorithms as they are used by a multidisciplinary team and focus on quality and coordination of care.
Clinician	Refers to a person registered as a medical doctor.
Clinical privileges	Authorisation granted by the governing body to clinical personnel to provide specific patient care services in the organisation within defined limits, based on an individual practitioner's registration,

	education, training, experience, competence, health status and judgement. (See also *privileging*.)
Clinical waste	Clinical waste is waste arising from medical, dental or veterinary practice or research, which has the potential to transmit infection. Other hazardous waste, such as chemical or radioactive, may be included in clinical waste, as well as waste such as human tissues, which requires special disposal for aesthetic reasons.
Community	A collection of individuals, families, groups and organisations that interact with one another, cooperate in common activities and solve mutual concerns, usually in a geographic locality or environment.
Complementary therapist	Any practitioner who offers an alternative therapy to orthodox medical treatment. Complementary medicine does not replace conventional medicine.
Compliance	To act in accordance with predetermined requirements, such as standards.
complaince survey	An external evaluation of an organisation to assess its level of compliance with standards and to make determinations regarding its compliance status. The survey includes evaluation of documentation provided by personnel as evidence of compliance verbal information concerning the implementation of standards, or examples of their implementation that will enable a determination of compliance to be made, and on-site observations by surveyors.
Confidentiality	The assurance of limits on the use and dissemination of information collected from individuals.
Contaminated blood supplies	1. Any blood supply that was issued to a patient after cross matching, but was not used. 2. Any blood that was not transfused and is left in the bag. 3. The empty bags after a blood transfusion.
Continuity	The provision of coordinated services within and across programmes and organisations, and during the transition between levels of services, across the continuum, over time, without interruption, cessation or duplication of diagnosis or treatment.
Continuum	The cycle of treatment and care incorporating access, entry, assessment, care planning, implementation of treatment and care, evaluation and community management.

Continuing education	1. Activities designed to extend knowledge to prepare for specialisation and career advancement and to facilitate personal development. 2. Education beyond initial professional preparation that is relevant to the type of client service delivered by the organisation that provides current knowledge relevant to the individual's field of practice, and that is related to findings from quality improvement activities.
Contract administration	Written agreements and the administration thereof between the purchaser of the service (the health facility) and the provider of the service (the external company).
Contracted service	A service that is obtained by the organisation through a contract with an agency or business. The contracted service is monitored and coordinated by the organisation's staff and complies with national regulations and organisational policies.
Credentialing	The process of obtaining and reviewing the clinical training, experience, certification and registration of a health professional to ensure that competence is maintained and consistent with privileges.
Criterion	A descriptive statement that is measurable and that reflects the intent of a standard in terms of performance, behaviour, circumstances or clinical status. A number of criteria may be developed for each standard.
Data	Unorganised facts from which information can be generated.
(a) Longitudinal data	Implies that it is for a given time span.
(b) Comparative data	When a data set is compared with like data sets or with a given time, usually of the previous month or year.
Data retention	Guidelines on how long an organisation should keep information on various media.
Delegation	Act or function for which the responsibility has been assigned to a particular person or group. The ultimate accountability for the act remains with the original delegating person or group.
Discharge note	The discharge note provides the patient and the patient's carers with written follow-up instructions, including medication, any specific dietary and medical

	orders and when to return for follow-up treatment, or where the patient must go to obtain further treatment.
Discharge summary	Follow-up instructions recorded in writing in the patient's record by the medical practitioner. The discharge summary includes: • the reason for admission • significant findings • final diagnosis • the results of investigations that will influence further management • all procedures performed • medications and treatments administered • the patient's condition at discharge • discharge medications and follow-up instructions.
Effectiveness	Successfully achieving or attaining results (outcomes), goals or objectives.
Efficiency	Refers to how well resources (inputs) are brought together to achieve results (outcomes) with minimal expenditure.
Element, generic	An organisational system within a service element that must achieve and maintain the stated standards and criteria in order for the service element to function optimally.
Element, service	Organisational unit of the clinic/health centre or staff with a director, manager or other designated person in charge. May be a professional service, such as nursing or surgery, a professional support service, e.g. radiology or physiotherapy, a general support system such as administration or health record system, a committee to guide aspects of the service, e.g. health and safety, or a community health service.
Ethics	Standards of conduct that are morally correct.
Evaluation	1. The process of determining the extent to which goals and objectives have been achieved. Actual performance or quality is compared with standards in order to provide a feedback mechanism that will facilitate continuing improvement.
Facility	The health centre, general practice or any other site providing a health service.
Food handler	Persons who in the course of their normal routine work come into contact with uncovered food not intended for their personal use. Food includes water

	and any other liquid intended for human consumption. A food handler is thus any person involved in the processing, production, manufacturing, packaging, preparation, sale or serving of any foodstuff, including water and beverages.
Function	A goal-directed, interrelated series of processes, such as patient assessment, patient care and improving the organisation of care.
Governance	The function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission.
Governing body	Individuals, group or agency with ultimate authority and accountability for the overall strategic directions and modes of operation of the organisation, also known as the council, board, etc.
Guidelines	Principles guiding or directing action.
Health	A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity.
Health worker	A health worker/provider is an individual who provides preventive, curative, promotional or rehabilitative health services in a systematic way to individuals, families or communities. An individual health worker/provider may be a health professional within medicine, nursing, or a field of allied health. Health service providersmay also be a public/community health professional.
Health facility category	The category that indicates the level of care provided by the facility as defined in the accompanying Health Facility Category document.
Health professionals	Medical, nursing or allied health professional personnel who provide clinical treatment and care to clients, having membership of the appropriate professional body and, where required, having completed and maintained registration or certification from a statutory authority. (See also *clinical personnel*.)
Health promotion	Process that enables people to increase control over and to improve their health (World Health Organisation 1986).
Health record	Compilation of pertinent facts of a patient's life and health history, including past and present needs and

	interventions, written by team members contributing to the care and treatment of the patient.
Health summary	A 'health summary' is written by the medical practitioner assisted by the nurse in charge of the medical record. It can be read once the patient has been discharged and revisits the same clinic/health centre. The health summary will quickly and accurately inform the staff at the clinic/health centre of the condition and treatment the patient received at the previous visit.
High-risk	Refers to aspects of service delivery which, if incorrect, will place clients at risk or deprive them of substantial benefit.
High-volume	Refers to aspects of service delivery that occur frequently or affect large numbers of clients.
Human resource planning	Process designed to ensure that the personnel needs of the organisation will be constantly and appropriately met. Such planning is accomplished through the analysis of internal factors such as current and expected skill needs, vacancies, service expansions and reductions, and factors in the external environment such as the labour market.
Implementation	The delivery of planned health.
Integrity of data	Relates to the completeness and accuracy of a set of data required to fulfil a particular information need. This data is protected from unauthorised additions, alterations or deletions.
Incident plan, external	A plan that defines the role of the clinic/health centre in the event of a major national or local disaster that may affect the health of many people. The plan is developed in participation with the relevant local authority, police, civil defence, fire brigade and ambulance teams.
Incident plan, internal	A plan that provides details of preparation for action in the event of a disaster within the clinic/health centre that affects the health or safety of patients and staff, such as fire, bomb threats, explosions or loss of vital services.
Incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on clients, groups, staff or the organisation.
Indicator	1. A measure used to determine, over time, performance of functions, systems or processes.

2. A statistical value that provides an indication of the condition or direction, over time, or performance of a defined process, or achievement of a defined outcome.

3. The measurement of a specific activity that is being carried out in a health setting, e.g. weight for age is a measurement of a child's nutritional status.

Induction programme	Learning activities designed to enable newly appointed staff to function effectively in a new position.
Information	Data that is organised, interpreted and used. Information may be in written, audio, video or photographic form.
Information management	Planning, organising and controlling data. Information management is an organisation-wide function that includes clinical, financial and administrative databases. The management of information applies to computer-based and manual systems.
Informed consent	Informed consent is a process whereby a patient is provided with the necessary information/education to enable him/her to evaluate a procedure with due consideration of all the relevant facts. This will enable the patient to make an appropriate decision when determining whether to consent to or refuse the proposed treatment. The patient or the guardian should be informed about the patient's condition in as much detail as possible and in simple, non-medical language. The proposed service should be described and, if an invasive procedure is envisaged, it should be clearly explained. Facility staff must confirm that the patient or guardian has understood every detail. Should the procedure or treatment have risks or side-effects, these should be described, making sure they are understood. In the same way, the benefits and possible outcomes should be discussed. Alternative treatments should be offered and discussed. If the patient/guardian should refuse the procedure/treatment, the consequences of such a decision should be made clear and, if a second opinion is sought, the patient/guardian should be apprised of the consequences of the delay and be assisted in obtaining a second opinion.
Information system	Network of steps to collect and transform data into information that supports decision making.

In-service training	Organised education designed to enhance the skills of the organisation's staff members or teach them new skills relevant to their responsibilities and disciplines. Usually provided in-house i.e. at the place of employment.
Job description	Details of accountability, responsibility, formal lines of communication, principal duties and entitlements. It is a guide for an individual in a specific position within an organisation.
Leader	A person providing direction, guidance, regulation or control. A person followed by others.
Leadership	The ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people, and motivating and inspiring people to overcome obstacles.
Licensing	The process whereby a governmental authority grants a health organisation permission to operate following an on-site inspection to determine whether minimum health and safety standards have been met.
Manager	An individual who is in charge of a certain group of tasks, or a certain section of an organisation. A manager often has a staff of people who report to him or her. Synonyms: director, executive, head, supervisor, overseer, foreman.
Management	Setting targets or goals for the future through planning and budgeting, establishing processes for achieving targets and allocating resources to accomplish plans. Ensuring that plans are achieved by the organisation, staffing, controlling and problem solving.
Mechanism	The mode of operation of a process or a system of mutually adapted parts working together.
Medical practitioner	Registered medical practitioners are medical doctors with a medical degree registered as medical practitioners in the country they practice in by the statutory registration authority of that country. A general practitioner (GP) is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues and comorbidities. The word physician is largely reserved for certain other types of medical specialists, notably in internal

	medicine. A physician is a health service provider who practices the profession of medicine, which is concerned with promoting, maintaining or restoring human health through the study, diagnosis, and treatment of disease, injury and other physical and mental impairments. They may focus their practice on certain disease categories, types of patients or methods of treatment – known as specialist medical practitioners. Both the role of the physician and the meaning of the word itself vary around the world, including a wide variety of qualifications and degrees.
Mission statement	A statement that captures an organisation's purpose, customer orientation and business philosophy.
Monitoring	A process of recording observations of some form of activity.
Monitoring and evaluation	A process designed to help organisations effectively use their quality assessment and improvement resources by focusing on high-priority, quality-of-care issues. The process includes: identifying the most important aspects of the care that the organisation (or department/service) provides by using indicators to systematically monitor these aspects of care, evaluating the care at least when thresholds are approached or reached to identify opportunities for improvement or problems, taking action(s) to improve care or solve problems, evaluating the effectiveness of those actions and communicating findings through established channels.
Multidisciplinary	The combination of several disciplines working towards a common goal.
Multidisciplinary team	A number of people of several disciplines with complementary skills whose functions are interdependent. They work together for a common purpose or result (outcome) on a short-term or permanent basis. Examples include project, problem-solving, quality improvement and self-managed teams. For instance, the management team and quality improvement steering committees are multidisciplinary teams.
Objective	A target that must be reached if the organisation is to achieve its goals. It is the translation of the goals into specific, concrete terms against which results can be measured.
Organisation	Comprises all sites/locations under the governance of and accountable to the governing body/owners.

Organisational chart	A graphic representation of responsibility, relationships and formal lines of communication within the facility.
Orientation programme	1. Activities designed to introduce new personnel to the work environment. 2. The process by which an individual becomes familiar with all aspects of the work environment and responsibilities, or the process by which individuals, families, and/or communities become familiar with the services and programmes offered by the organisation.
Outcome	Refers to the results of the health service provided, expressed in terms of the patient's health status, or physical or social function.
Peer review	The systematic, critical analysis of care, including the procedures used, treatment provided, the use of resources and the resulting outcome and quality of life for the patient, with a view to improving the quality of patient care by a group of persons of the same professional background.
Performance appraisal	The continuous process by which a manager and a staff member review the staff member's performance, set performance goals and evaluate progress towards these goals.
Performance measure	A quantitative tool or instrument that provides an indication of an organisation's performance regarding a specified process or outcome.
Planning	The determination of priorities, expected outcomes and health interventions.
Planning, operational	Determining ways in which goals and objectives can be achieved.
Planning, project	The art of directing and coordinating human and material resources throughout the life of a project by using modern management techniques in order to achieve predetermined objectives of scope, quality, time and cost, and participant satisfaction.
Planning, strategic	Determining an organisation's mission and determining appropriate goals and objectives to implement the mission.
Policy	Written statements that act as guidelines and reflect the position and values of the organisation on a given subject.

Practice	Partners in a professional practice, employed personnel and their patients/ clients.
Primary Healthcare	The first level of contact of individuals, the family and community with the public health system, bringing health services as close as possible to where people live and work. Primary Healthcare includes health education, promotion of proper nutrition, maternal and child health (including family planning), immunisation against the major infectious diseases, appropriate treatment of common diseases and injuries and the provision of essential drugs.
Privileging	Delineation, for each member of the clinical staff, of the specific surgical or diagnostic procedures that may be performed and the types of illness that may be managed independently or under supervision.
Procedure	A mode of action. A procedure outlines the detailed steps required to implement a policy.
Process	A sequence of steps through which inputs (from health facilities) are converted into outputs (for patients).
Professional registration	Registration in terms of current legislation pertaining to the profession concerned.
Professional staff	Staff who have a college or university level of education, and/or who may require licensure, registration or certification from a provincial or state authority in order to practice, and/or staff who exercise independent judgment in decisions affecting the service delivered to clients.
Professional team	A number of health professionals whose functions are interdependent. They work together for the care and treatment of a specific patient or group of patients.
Protocol	A formal statement. May include written policies, procedures or guidelines.
Quality	Degree of excellence. The extent to which an organisation meets clients' needs and exceeds their expectations.
Quality activities	Activities that measure performance, identify opportunities for improvement in the delivery of services and include action and follow-up.
Quality control	The monitoring of output to check if it conforms to specifications or requirements and action taken to rectify the output. It ensures safety, transfer of accurate information, accuracy of procedures and

	reproducibility.
Quality improvement	The actions undertaken throughout the organisation to increase the effectiveness and efficiency of activities and processes, in order to bring added benefits to both the organisation and its customers.
Quality improvement programme	1. A planned, systematic use of selected evaluation tools designed to measure and assess the structure, process and/or outcome of practice against established standards, and to institute appropriate action to achieve and maintain quality. 2. A systematic process for closing the gap between actual performance and desirable outcomes. 3. Continuous quality improvement is a management method that seeks to develop the organisation in an orderly and planned fashion, using participative management, and has at its core the examination of process.
Recruitment and retention	The process used to attract, hire and retain qualified staff. Retention strategies may include reward and recognition programmes.
Rehabilitation	A dynamic process that allows disabled people to function in their environment at an optimal level. This requires comprehensively planned care and service for the total person.
Reliability	The ability of an indicator to accurately and consistently identify the events it was designed to identify across multiple health settings.
Research	Critical and exhaustive investigation of a theory or contribution to an existing body of knowledge aimed at the discovery and interpretation of facts.
Responsibility	The obligation that an individual assumes when undertaking delegated functions. The individual who authorises the delegated function retains accountability.
Risk	Exposure to any event that may jeopardise the client, staff member, physician, volunteer, reputation, net income, property or liability of the organisation.
Risk management	A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the organisation in accordance with

	relevant legislation.
Safety	The degree to which potential risks and unintended results associated with health are avoided or minimised.
Seamless continuum of care	In the ideal health system, care is delivered in an integrated, uninterrupted or 'seamless' flow. It is defined as an integrated, client oriented system of care composed of both services and integrating mechanisms that guides and tracks clients over time through a comprehensive array of health, mental health and social services spanning all levels of intensity of care.
Setting	The particular health environment that is appropriate for the patient's needs during the continuum of care, i.e. inpatient care, outpatient attendance, rehabilitative and restorative unit~~,~~ or community setting.
Staff	All individuals employed by the facility – this includes full time, part time, casual or contract, clinical and non-clinical personnel.
Staff development	The formal and informal learning activities that contribute to personal and professional growth, encompassing induction, in-service training and continuing education.
Stakeholder	Individual, organisation or group that has an interest or share in services.
Standards	1. The desired and achievable level of performance corresponding with a criterion, or criteria, against which actual performance is measured.
Standard development	Standards for evaluation may be developed in three stages. 1. *Normative development* entails establishing what experts believe should happen. 2. *Empirical standards* reflect what is achievable in practice. 3. A *compromise* between what is professionally optimal and what can reasonably be expected to operate.
Standard, minimum	A predetermined expectation set by a competent authority that describes the minimally acceptable level of *(a)* structures in place *(b)* performance of a process and/or *(c)* measurable outcome that is practically attainable.

Standard, patient-centred	For the purposes of compliance, standards that address and are organised around what is done directly or indirectly, for or to patients (e.g. creation of patient records, patient assessment).
Standards-based evaluation	An assessment process that determines a health organisation's or practitioner's compliance with pre-established standards.
Step-down facility	The Joint Commission (*Survey Protocol for Sub-acute Programmes,* 1995) defines a step-down unit as follows: **"**At the most complex end (of a range of sub-acute care services) are the short stay, transitional step-down units, which are often, but not always, attached to clinic/health centres. These units provide a substitute for continued clinic/health centre stay. They serve very sick patients, for example, those in cardiac recovery, those in oncology recovery receiving chemotherapy and radiation, or others who need complex wound management or who suffer from complicated medical conditions. These subacute care patients require more than 5 hours of daily nursing, heavy physician involvement and heavy pharmacy and laboratory support. The average stay is 5–30 days." (See also *sub-acute care centre*).
Structure	The physical and human resources of an organisation.
Sub-acute care centre	The Joint Commission *(Survey Protocol for Sub-acute Programmes,* 1995) defines sub-acute care as follows: Sub-acute care is goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalisation to treat one or more specific, active, complex medical conditions or to administer one or more technically complex treatments in the context of a person's underlying long-term conditions and overall situation. Generally, the condition of an individual receiving subacute care is such that the care does not depend heavily on high technology monitoring or complex diagnostic procedures."
Surveyor	A physician, nurse, administrator, or any other health professional who meets health quality surveyor selection criteria, evaluates standard compliance and provides consultation regarding standard compliance to surveyed organisations.

System	The sum total of all the elements (including processes) that interact to produce a common goal or product.
Team	A number of people with complementary skills whose functions are interdependent. They work together for a common purpose or result (outcome) on a short-term or permanent basis. Examples include project, problem-solving, quality improvement and self-managed teams. (See also *multidisciplinary team* and *professional team*.)
Timeliness	The degree to which care is provided to the patient at the most beneficial or necessary time.
User	Someone who uses or could use the services offered by the facility.
Utilisation management	Proactive process by which an organisation works towards maintaining and improving the quality of service through the effective and efficient use of human and material resources.
Utilisation review	A method of controlling utilisation that may be: *Prospective* (pre-admission certification) – The purpose is to assess whether hospitalisation has been justified, and is diagnosis-independent. *Concurrent* – Conducted to assess inpatient care at the time it is provided, the use of resources, the timeliness with which treatment is provided and the adequacy and timeliness of discharge planning. *Retrospective* – Follows a patient's discharge from the clinic/health centre or any patient who has received ambulatory care.
Validation of survey	A process whereby a facilitator assesses the completed self-assessment documents of a facility. The validation ensures that criteria have been correctly interpreted and appropriately answered, and that the technical aspects of the assessment have been correctly addressed. The facilitator uses the opportunity to provide education and consultation on standard interpretation and compliance.
Vision	A short, succinct statement of what the organisation intends to become and to achieve at some point in the future.
Waste management	Collection, treatment, storage, transportation and disposal of waste material including biomedical, household, clinical, confidential and other waste.

Workload measurement	Manual or computerised tool for assessing and monitoring the volume of activity provided by a specific team in relation to the needs for the care, treatment and/or service they are providing.

Introduction

HOSPITAL STANDARDS

This manual contains National Health Quality Standards for hospital services and includes guidelines for their consistent interpretation and accurate assessment.

The purpose of this manual is to serve as a guide to surveyors and facilitators, as well as environmental health staff. It provides information on certain key aspects pertaining to the layout of the standards and their interpretation, as well as core principles to be applied in assessing standard compliance.

These standards are a result of an initiative by the Ministry of Health to develop standards for healthcare facilities at all levels.

In order to plan a system the capabilities of individual organisations need to be catalogued; this information is then used to guide service delivery. The standards provide a tool to achieve this, but also provide a systematic measurement of management, training and equipment shortfalls so that scarce resources can be spent as efficiently as possible.

Although optimisation of the physical environment is an important goal, excellent care can be provided with limited resources; proper training, personnel support and functional administrative structures are the most important priorities.

It is recognised that some institutions in the country start from a deprived base, and that officers may feel that the gap between the actual situation and the standards is so great that it is not worth trying to bridge it. However, standards should not be written to fit current circumstances and in situations where bringing services up to compliance level is a daunting prospect, a graded recognition programme is appropriate, where credit and certification is given for progress towards accreditation.

A: Structure/Format

This set of standards consist of several Service Elements (SE's) for the various services/departments. Each Service Element contains the relevant standards and criteria (measurable elements) to be assessed in order to ascertain the level of compliance with the standards.

The first nine Service Elements, i.e. SE 1 to SE 9, are referred to as the "generic" service elements as their requirements apply across the entire hospital. The same principle applies to Service Elements 28, 29, 30 and 31.

Information on the standards in this document has been set out in the following format and the first section of Service Element 1 - *Management and Leadership* - is used as an example to demonstrate the layout:

1 MANAGEMENT AND LEADERSHIP

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Providing excellent patient care requires effective management and leadership, which occur at various levels in a healthcare organisation. At the governance level there is an entity.

1.1 Governance of the organisation

1.1.1 The responsibilities and accountability of the governance of the organisation are documented and implemented by the organisation's managers.

Intent of 1.1.1
There is a governing body responsible for directing the operation of the organisation, which is accountable for providing quality healthcare services to its community.

1.1.1 Criteria

1.1.1.1 The organisation's governance structure is described in written documents, which are known to the staff in the organisation.

Guideline: This Governance structure refers to the authority(ies) above the level of the Facility Manager and may include National//Regional/District levels in the Public Sector together with the Hospital Board, or Corporate structures in the.

With reference to the example of Service Element 1 above the table below explains the hierarchical layout and purpose of each section:

HEADINGS IN EXAMPLE ABOVE	**EXPLANATION**
1. MANAGEMENT AND LEADERSHIP:	Number and name of the service element
Overview of Management and Leadership	General description of the service element and context of the standards in the service element.
1.1 Governance of the organisation	The first "performance indicator" (or main section) for this service element.
1.1.1 The responsibilities and accountability of the governance of the organisation are documented and implemented by the organisation's managers	The first standard in this service element.
Intent of 1.1.1	A description of the context/scope of the abovementioned standard 1.1.1. Note that the information in this intent statement forms an integral part of aspects to be considered when measuring compliance of criteria.
1.1.1 Criteria	This heading indicates that what follows is the list of criteria (measurable items) that support standard 1.1.1
1.1.1.1 The organisation's	The first criterion in this section for standard

governance structure is described in written documents, which are known to the staff in the organisation	1.1.1
Guideline	*A description/explanation of what is expected and guidance on how to assess compliance with the criterion.*

B: Additional Notes on the "Guidelines" (section in italics below the criteria in the above example)

Purpose/intention of the guideline statements*:*
The purpose of these guidelines is to provide guidance on the scope and interpretation of the criteria statements. The information should also provide facility staff (clients) with a clear indication of the requirements for compliance and some direction on the assessors' expectations.

In some instances the guidelines also state the minimum requirements for compliance and provide direction on how to reach a decision on the compliance score.

Linked criteria/standards:
Where the comment "*Linked to:"* appears in the guideline text box, it refers to other criteria and standards that are linked to the criterion being assessed. For further information on how to deal with these linked criteria, refer to item 7 in section C ("Rules for scoring") of this document.

Root criterion
Where the guideline text box contains the word "root criterion", the following applies:

- A "root" criterion is considered to be the central focus of a process or system, which is supported by several other "sub-criteria" that intend to describe the smaller components of such a system or process.
- The rating of a root criterion is dependent on the compliance rating of its supporting criteria, and should, therefore reflect the aggregated average of the scores of such supporting criteria.
- This implies that a root criterion cannot be scored until such time that all its linked criteria have been assessed.

For more details on the scoring methodology for root criteria and their links, refer to item 7 in section C below.

C: Rules for assessment of compliance with criteria and the scoring system

The standards in this manual are written expectations of structures, processes or performance outcomes and it is assumed that, if these standards are met, better services/care can be delivered The standards in turn are defined by objective, measurable elements referred to as "criteria". Criteria are given weighted values (severity ratings) according to how important the criterion requirement is in relation to various aspects (categories) such as legality, patient and staff safety, physical structure, operational effectiveness and efficiency.

Take note that assessing compliance with the standards and criteria includes various activities such as studying documentation, staff and patient interviews, patient record audits and observation of patient care processes, physical facilities and equipment.

Criteria are scored as follows:
In assessing the level of compliance with a criterion, one should not move beyond what that criterion intends to measure. ***Each criterion should be assessed*** individually according to the following principles:

1. ***Compliant (C)*** means the condition required is met. Evidence of compliance should be present in a tangible and/or observable form, e.g. written material, physical items, etc.

1.1 Should the standards, for example, require a **written** policy and procedure but the facility has only a verbal policy in place, then the criterion should be scored as ***non compliant***

1.2 Should the facility have a written policy but no evidence is found of consistent implementation thereof or if there is evidence of non-adherence, then the criterion should be scored as ***partially compliant***.

The same principle applies in all instances where either the standards or criteria contain words such as ***policies, procedures, programmes, plans, protocols, guidelines, etc.***

2. ***Partially compliant (PC)*** means the condition required is not totally met, but there is definite progress (>50%) towards compliance *and the deficiency does not seriously compromise the standard.* Other considerations for PC ratings are:
   2.1 If the criterion requires a documented system as listed above, but there is no implementation or implementation is partial; or if the policy document is still in draft form.

   2.2 If the criterion contains more than one requirement, e.g.: "There is a policy and procedure on the *safe prescribing, ordering and administration* of medicines," but not all components are compliant.

   2.3 If assessment results can be quantified by means of conducting an audit, e.g.: "less than 80% of staff have received training", or "evidence was found in less than 80% of patient records audited".

   2.4 Since there are degrees of partial compliance (PC), the category PC is further subdivided into four degrees of severity: *mild (1), moderate (2), serious (3) and very serious (4)*. These can be thought of as being 80% towards compliance, 60% towards compliance, 40% towards compliance and 20% towards compliance. Obviously, the further away from compliance, the more severe the deficiency will be.

3. ***Non-compliant (NC)*** means there is no observable progress towards complying with the required condition. The degree of non-compliance is again scored in terms of severity, from mild (1) to very serious (4), as explained above.

4. ***Not applicable (NA)*** means the criterion is not applicable because the facility either does not provide the service at all, or not at the particular level the

criterion is designed to measure. Such criteria are excluded in calculating compliance scores.

5. To quantify the degree of compliance, criteria are awarded points according to their level of compliance and seriousness as follows:

Rating	**Score**
C	80
PC mild	75
PC moderate	65
PC serious	55
PC very serious	45
NC mild	35
NC moderate	25
NC serious	15
NC very serious	5
NA	Not scored

6. **Critical criteria**
A standard may have one or more criteria that are marked "critical". This is where non- or partial compliance will compromise patient or staff safety, or where there are legal transgressions.

The methodology used in scoring critical criteria calls for an exception to the rule of PC ratings as described above:

Where a critical criterion is scored as PC, but it is so serious as to constitute a danger to patient and/or staff safety, is in direct contravention of an act or regulation, severely affects patient care or the efficiency of the facility, then it must be scored as NC. [e.g. there is a fire alarm but it is not working. This must then be scored as NC rather than PC.

Furthermore, non-complaint critical criteria will result in the entire standard being scored as non-or partially compliant.

7. **Scoring "linked" criteria**
Several criteria (either in the same SE or in different SEs) are linked with one another, either because they deal with the same system or process, or because they are duplications, or because one of the criteria may be seen as the "root" with several other criteria focussing on "sub-components" of such a "root" criterion. Should such a linked criterion be scored NC or PC, then this *may have* an impact on the compliance ratings of other linked criteria. The following rules should be applied when scoring linked criteria:

7.1 If a ***critical*** criterion scores NC or PC, then *selected* linked criteria should reflect a similar score.

7.2 Also, if a substantial number of ***non-critical*** criteria linked to a critical criterion score NC or PC, the critical criterion should reflect a similar score.

7.3 The same rule applies to criteria that relate to ***legal*** requirements and patient/staff ***safety*** matters.

The decision to apply the above will depend on the local circumstances and the consideration of the following additional rules.

7.4 If the majority of criteria that focus on the same system or process are scored either NC or PC, then the root criterion should reflect a similar score (because this would constitute a ***high-volume*** deficiency) Example: if ***most*** of the policies and procedures in the organisation have not been reviewed, then the root criterion (1.2.4.5) is scored NC.

7.5 Example of linked criteria:

Criterion 1.2.8.10: The organisation's structure and processes support monitoring of the quality of clinical services.

Criterion 8.1.1.1: There is a relevant and appropriate system/mechanism for the execution/implementation of a quality management and improvement programme.

Criterion 8.2.1.1: Clinical staff identify key measures to monitor clinical areas.

Criterion 10.8.1.1: There is a written quality improvement programme for the service that is developed and agreed upon by the personnel of the service.

Criterion 10.8.1.3: Indicators of performance are identified to evaluate the quality of treatment and patient care.

In the above example, criterion 1.2.8.10 is the ***root criterion*** for the entire organisation, and cannot be scored compliant unless most of the other linked criteria are also compliant. In the same way, criterion 8.1.1.1 is the ***root criterion*** for all quality improvement programmes and cannot be compliant unless there are programmes in operation in the majority of the departments and services (refer to 10.8.1.1 and similar criteria in other Service Elements).

D: The Matrix Model

As explained above, the structure of the standards and criteria is such that many of these are "interlinked", either within the same Service Element or between the different Service Elements. "Interlinked" means that the same standard/criterion is either repeated in more than one location, or that the standard/criterion is similar to, or closely linked to another standard/criterion in terms of its meaning or in terms of the system or process that it measured.

In using the matrix (refer to the separate Matrix document), scoring rules should apply as indicated in subparagraphs 7.1 to 7.5 above.

The matrix document that is supplied has a section for each service element and should be interpreted as follows:

1. The first column (to the left) lists those criteria for the particular Service Element that have associated links in other Service Elements – such links are displayed (in the rows) for the respective Service Elements.

E: Patient Record Audit

There are several criteria in the various clinical Service Elements related to the content of patient records. Such criteria are identified with the words ***patient record audit*** in the guideline statements. In order to assess compliance with these, a structured documentation audit needs to be conducted on a representative sample of patient records from all the clinical services/departments that are being assessed. Relevant criterion numbers are also listed in the guideline for the particular service element - refer to the guideline for 10.8.1.6 as an example.

Documentation audit tools have been designed for each clinical Service Element, which contain all criteria that relate to the content of patient records. See the example below of the extract from an audit tool (for Service Element 10) used by assessors. The average result obtained for each criterion is transferred to the Standard Assessment Manual as the final assessment score. (If the patient record under review is not expected to reflect information as required by the criterion being assessed, such a criterion is scored NA).

Health records/folders of discharged patients are audited for this purpose. Surveyors select patient folder numbers from admission registers in the various clinical departments in the hospital, including outpatient, emergency (casualty) and professional service settings. The reason for admission/diagnosis of the patient forms the basis of this selection and surveyors attempt to include in the selection folders that may also contain information on aspects such as:

1. Internal transfers/admissions
2. External transfers
3. Blood transfusions
4. Nutrition therapy
5. Resuscitation
6. Informed consent
7. Absconding
8. Refusing hospital treatment (RHT)
9. Resuscitation
10. Death

During an audit survey, the assessors conduct this patient record audit before they have a group interview with clinical staff, during which they share these audit results with staff. These audit results can therefore not be changed when surveyors browse through active records during subsequent visits to the clinical wards. Also, these results cannot be changed post survey if the hospital presents progress reports on improvements with regard to remedial actions in this regard.

Assessors are obliged to sign a Declaration of Confidentiality on appointment and they are expected to maintain the highest level of confidentiality in their handling of patient folders and dealing with patient health information.

Extract from Patient Record Audit Tool

4. Whenever the mix contains 2 x or 3 x C's: percentage of C's is either 40 or 60%, therefore score as PC with comment "Evident in less than 80% of files audited.
5.If mix contains either 1x C or **no** C's: if equal distribution of NC's and PC's, record average as PC, with comment as above. If unequal distribution, average score same as most frequent r
6. Any score of NA is ignored and calculations adjusted accordingly.

Patient file number	Patient file number	Patient file number	Patient file number	Patient file number	Average Score	SE 10: Medical/Surgical/Paediatrics/Obstetrics	
						Std.10.1.2: The delivery of services is integrated and co-ordinated amongst care	
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.1.2.3**	The records are up to date to ensure the transfer of the latest information.
						10.1.2.4	Information exchanged includes:
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C			the patient's health status,
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.1.2.5**	summary of the care provided,
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.1.2.6**	the patient's progress.
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.1.2.7**	The author can be identified for each patient record entry
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.1.2.8**	The date of each patient record entry can be identified
						Std. 10.2.1: All patients cared for have their health care needs identified throu	
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.2.1.2**	Only those individuals permitted by applicable laws and regulations or by reg
						Std. 10.2.2: Clinical practice guidelines are used to guide patient assessment	
NA NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C	**NA** NC ***PC*** C		**10.2.2.3**	The maternal and foetal conditions and progress of labour are recorded on a
						Std.10.2.3: Assessments are performed within appropriate time frames.	
						10.2.3.1	Written procedures ensure that assessments are performed within appropriat

F: Patient Interviews

The standards contain several criteria that relate to patient rights, patients' experiences while being attended to in a healthcare facility, the extent to which patients are informed about relevant matters, etc. For some of these criteria, evidence of compliance can only be obtained from the patients' responses and for that reason these criteria have been included in a patient questionnaire which the surveyors will administer in clinical areas of the hospital during the survey.

Below is an extract of the questionnaire. Responses from the patients are scored similarly to those for the patient record audit process described above and the average score of each criterion is transferred to the Standard Assessment Manual as the final compliance score for that particular criterion.

Extract from Patient Questionnaire

Patient Questionnaire to be used during the External Survey

FACILITY: _____

(1st Edition Hospital standards) Survey

Dates:_____

The attached questionnaire should be administered by external surveyors on a random sample of patients to establish the level of compliance with the respective criteria. The clinical condition/diagnosis of the patient interviewed will determine the manner in which the questions are asked in order to obtain appropriate responses. In deciding which patients to interview, surveyors should be guided by either the Unit Managers or the diagnoses. The person in charge of the ward should assist the surveyors to obtain the patients' permission prior to administering the questionnaire.

It is recommended that approximately five patients from each of the major disciplines are interviewed, The survey team decides on the procedure to follow: either one surveyor is tasked to do the full questionnaire or each surveyor interviews the required number of patients in the clinical department that he/she is responsible for.

Std. 4.2.2 During the entry and care processes, patients and their families (as appropriate) receive sufficient information about the following to make informed decisions:							
Crit. No.	**Criterion**	**Pts**	**NA**	**NC**	**PC**	**C**	**AV**
4.2.2.6 38.6.1.5	on alternative sources of care and services when the organisation cannot provide the care and services required, and the doctor assists the patient in seeking alternate care if requested	1					
		2					
		3					
		4					
		5					
Average score							
4.2.2.2 and 3 5.2.1.4, 5.5.1.5 10.3.5.1 10.3.5.3 to 8 38.4.1.1 and 2	their condition, proposed treatment, potential benefits and drawbacks, possible alternatives to the proposed treatment, likelihood of successful treatment, possible problems related to recovery, possible results of non-treatment	1					
		2					
		3					
		4					
		5					
Average score							

G: Additional Comments

1. Several criteria require compliance with laws and regulations. The guideline statements for these criteria indicate that " national" requirements need to be considered for assessing compliance. In instances where national laws/regulations do not exist for such an item, it will be expected that the facility will develop their own internal policy on such topic in accordance with internationally accepted norms and standards.

2. Any reference to "personnel" in the standards and criteria should be interpreted to read all personnel employed by the facility unless otherwise stated. Take note of the exception in standard 2.4 where the requirements also apply to all healthcare professionals who are allowed to render patient care, regardless of their employment status.

SE 1 MANAGEMENT AND LEADERSHIP

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Providing excellent patient care requires effective management and leadership, which occur at various levels in a healthcare organisation. At the governance level there is an entity (for example: a Ministry of Health), an owner(s), or group of identified individuals (for example: a board or governing body) responsible for directing the operation of the organisation and accountable for providing quality healthcare services to its community or to the population that seeks care.

Within the organisation there are individuals assigned the responsibility of ensuring that the policies of governance are implemented, and that there are systems of administration and organisation to provide excellent patient care.
At departmental and service level, heads of departments and services ensure effective management and leadership.

Leadership comes from many sources in a healthcare organisation, including governing leaders, clinical and managerial leaders and others who hold positions of leadership, responsibility and trust. Each organisation must identify these individuals and involve them in ensuring that the organisation is an effective, efficient resource for the community and its patients.

In particular, these leaders must identify the organisation's mission and make sure that the resources needed to fulfil this mission are available. For many organisations, this does not mean adding new resources but using current resources more efficiently - even when they are scarce. Leaders must work well together to coordinate and integrate all the organisation's activities, including those designed to improve patient care and clinical services.

Effective governance, management and leadership begin with understanding the various responsibilities and authority of individuals in the organisation, and how these individuals work together.

Those who provide governance, management, and/or leadership have both authority and responsibility. Collectively and individually they are responsible for complying with laws and regulations and for meeting the organisation's responsibility to the patient population served.

Over time, effective management and leadership helps overcome perceived barriers and communication problems between departments and services in the organisation, and the organisation becomes more efficient and effective. Services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organisation results in improved patient outcomes.

Standards

1.1 Governance of the Organisation

1.1.1 *Governance responsibilities and accountabilities are described in legislation, policies and procedures or similar documents that show how these duties are to be carried out.*

Standard Intent

According to the Oxford Dictionary to govern is "to conduct the policy, actions and affairs of (a state, organisation or people) with authority." The same source defines governance as "the action or manner of governing a state, organisation, etc." It relates to decisions that define expectations, grant power, or verify performance. It consists of either a separate process or part of management or leadership processes.

A governing body is the group of people given the power and authority to govern an organisation. A governing body can take the form of a board, a council, a steering committee, or an assembly of elders or traditional owners. The role of a governing body is to plan strategic direction, set the organisation's goals, lead the organisation, make the policies and evaluate and support the management and personnel

There is a governing body responsible for directing the operation of the health facility, which is accountable for providing quality healthcare services to its community or to the population that seeks care. The responsibilities and accountability of this entity are described in a document that identifies how they are to be carried out, and are known to those responsible for management within the health facility. The responsibilities of governing bodies lie primarily in approving plans and documents submitted by the managers of the health facility. Those elements of management requiring approval by governance are documented. The process and practices that will apply will vary significantly given the environment in which they are applied. Governance in the public sector, which includes Ministries, Boards and similar entities, takes into account, among others, legal and constitutional accountability and responsibilities.

It is important that the organisation has clear leadership, operates efficiently, and provides quality healthcare services. The lines of communication to achieve this are presented in an organisational chart or other document. The identification of individuals in a single organisational chart does not, by itself, ensure good communication and co-operation between those who govern and those who manage the organisation. This is particularly true when the governance structure is separate from the organisation, such as a distant owner or national or regional health authority. The process for communication and co-operation with the governance structure must therefore be made known to the organisation's managers and be used by them.

The responsibilities of governing bodies lie primarily in approving plans and documents submitted by the managers of the organisation. Those elements of management requiring approval by the governance structure are documented. The hospital board's relationship with the governance structure and the hospital management are described in written documents.

1.1.1 Criteria

1.1.1.1 The organisation's governance structure is described in written documents and is known to the staff of the organisation.

This governance structure refers to the authority(ies) above the level of the Hospital Manager and may include National/Regional/District levels in the public sector together with the Hospital Board, or corporate structures in the private sector including structures such as Head Office, Regional Office, Hospital Board/Board of Directors/ Governance Committees/any other structures that may exist.

Please note that full compliance can only be achieved if there is formal evidence of sharing this information with the staff of the organisation.

A mere organogram does not render this criterion compliant unless there is a concise description/listing of the key functions of the relevant structures as reflected in this criterion.

Also take note that some of this information may be contained in Acts, regulations or directives. In the private sector this information may also be published as a corporate document or on the organisation's website.

Documented evidence is required of a process through which the personnel of the organisation are informed of these responsibilities of the governance structure, e.g. during orientation and induction programmes, staff meetings, information leaflets, memos.

1.1.1.2 There is an organisational chart or document that describes the lines of authority and accountability between the governance structure and the organisation as well as within the organisation.

This criterion requires an organisational chart of both the governance structure and the local organisation. These document(s) should also illustrate the relationship between the Hospital Manager and the next level of Governance above him/her.

The phrase "lines of authority and accountability" requires more than merely a list of available posts or services rendered; it should be formulated in such a manner that it indicates to each member of staff who his/her direct supervisor is as well as his/her span of responsibility. The names of individuals do not need to be shown. As with any other official document, the organogram should be duly authorised (dated and signed).

The titles/post designations of those responsible for governing will automatically be displayed on the organogram provided it is drawn up correctly. This information can also form part of the documentation referred to in 1.1.1.1. Detail about facility managers may also be offered in other documents such as job descriptions, delegations, performance agreements, etc.

Linked criteria:
2.2.1.1
18.4.2.4
19.1.3.1

20.1.3.1
25.1.1.3
26.1.1.3
27.1.1.3
28.1.1.3
32.1.1.3 and SEs 33 to 38

1.1.1.3 Those responsible for governance approve and make public the organisation's mission statement.

This section (1.1.1.3 to 10) requires documented evidence of the involvement of the governance structure in the stated activities;

Please note there is no standardised way in which all the different organisations carry out these functions. Therefore, the official documents in 1.1.1.1, 1.1.1.2 and 1.1.1.4 should guide the assessment of systems and processes in relation to the manner in which these responsibilities are carried out.

1.1.1.4 Those responsible for governance approve the managerial policies and plans to operate the organisation.

Linked criterion:
1.2.1.3

1.1.1.5 Those responsible for governance approve the budget and allocate resources required to meet the organisation's mission.

1.1.1.6 Those responsible for governance appoint the organisation's senior manager(s) or director(s).

Linked criterion:
1.2.1.1

1.1.1.7 Those responsible for governance collaborate with the organisation's managers.

Linked criterion:
1.2.2.1

1.1.1.8 Those responsible for governance receive and act upon reports of the quality programme, at least quarterly.

Linked criteria:
8.1.1.1, 8.1.1.6, 8.2.2.4

1.1.1.9 Those responsible for governance receive and act upon reports on risk management, at least quarterly.

1.1.1.10 Those responsible for governance evaluate the performance of the organisation's senior manager at least annually.

1.2 Management of the Organisation

1.2.1 A senior manager is responsible for operating the organisation within applicable laws and regulations.

Standard Intent

The senior manager is appointed by the governing body to be responsible for the overall, day to day operation of the organisation. These responsibilities are documented and known to the personnel of the organisation. The individual appointed to carry out these functions has the education and experience to do so.

The senior manager is responsible for the implementation of all policies, which have been approved by the governing body.

1.2.1 Criteria

1.2.1.1 The senior manager manages the day to day operation of the organisation, including those responsibilities described in the position description.

This criterion is scored PC in situations where the position is temporarily filled (acting capacity).

Linked criterion:
1.1.1.6

1.2.1.2 The senior manager has the education and experience to match the requirements in the position description.

Compliance is to be assessed against the job profile/post requirements.
Evidence could be found in a copy of the advertisement, interviewing notes or the corporate guideline on the filling of this position.

1.2.1.3 The senior manager carries out approved policies for management functions.

This criterion is not assessed on all the policies in the organisation but only those that apply to the senior management level, which includes corporate/national matters, for example. In other words, this criterion is not scored down for deficiencies that derive from the level of individual departments. However, the final rating of this criterion should be in line withthe overall level of compliance on the "generic" policies and procedures (SEs 2 to 9).

1.2.1.4 The senior manager assures compliance with applicable laws and regulations.

This criterion will be scored compliant by default although a PC rating is given whenever there is actual evidence of non-adherence to any particular legal requirement. In these cases, the transgression needs to be recorded in detail to motivate for the PC rating, and it should be based on accurate facts.
Common examples of non-conformance with legal requirements include the following deficiencies:

- *the required certificates are not available, e.g. fire clearance certificates, electrical installation certificates, commissioning certificates (e.g. Ethylene Oxide sterilisers), pressure test certificates for vessels under pressure*
- *internal/external financial audits are not conducted*
- *nurses transcribe doctors' prescriptions and/or dispense medication*
- *pharmaceutical items are incorrectly labelled and*
- *proof of current registration of professional personnel with the relevant Councils is not available.*

Linked criteria:
1.2.1.5
2.3.3.1, 2.5.1.1
3.2.1.3, 3.3.2.2, 3.4.1.8, 3.4.1.9, 3.4.2.2
5.2.1.3
6.1.2.1, 6.3.2.2
7.3.1.1, 7.5.1.1, 7.7.1.1
18.2.1.4, 18.3.2.1, 18.3.5.3
19.1.1.2
20.2.2.1
21.1.1.3, 21.3.1.1
25.2.2.4
26.2.1.1, 26.5.3.3
29.1.1.5

1.2.1.5 The senior manager responds to any reports from inspecting and regulatory agencies;

Critical criterion

This requires documented evidence for whatever inspections may have been conducted and depends on national requirement requirements.
Examples include inspections by the following authorities:
- *the local Fire Authority for fire clearance purposes*
- *the Department of Radiation Control for radiation safety aspects*
- *the Department of Labour for health and safety compliance*
- *the Auditor General's office (Public Sector) for financial compliance*
- *the Local Authority to test-water supplies and inspect food premises*
- *the relevant professional bodies where student training is provided and*
- *licensing authorities for facilities such as the pharmacy, etc.*

Linked criteria:
1.2.1.4
3.1.1.7
18.3.2.1, 18.3.4.4
20.2.2.1, 20.2.2.3

1.2.2 A senior manager implements processes to manage and control the organisation.

1.2.2 Criteria

1.2.2.1 The senior manager facilitates communication and co-operation between the organisation's governance structure, management and the community.

Linked criteria:
1.1.1.7
1.2.3.3
1.2.4.2

1.2.2.2 The senior manager implements processes to manage and control human, financial and other resources;

*This is assessed against the organisational policy framework and evidence of implementation, and is linked to the next criterion. The criterion score is derived from the final assessment of SE 2, financial management (Section 3.1) and other criteria dealing with adequate supply and effective management of resources (medication, consumables, etc.). The volume and severity of deficiencies in related sections will determine whether both criteria are penalised and to what extent***.**

Linked criteria:
1.3.1.3, 1.3.1.4, 1.3.1.5
2.2.1.1
3.1.1.4
17.2.2.9
22.8.6.4
24.8.5.4
27.2.3.3
32.2.1.1 and SEs 33 to 38

1.2.2.3 The senior manager ensures that the required physical facilities, installations and equipment are available and are used optimally to provide the specified services.

Please note that the term equipment refers to all hospital, as well as medical equipment.

Linked criteria:
1.3.1.5
3.2.1.12, 3.3.2.1
4.1.1.6, 4.2.1.3-5, 4.2.2.6
5.2.2.2
6.2.2.3
7.5.1.1
9.2.2.3
10.2.1.1 and similar criteria in all in-patient services i.e. SEs 11 to 16
17.2.1.1, 17.2.1.4, 17.2.2.9
19.1.4.1
21.5.1 1
22.2.1.1, 22.2.2.3, 22.7.1.1, 22.7.2.1
23.2.1.1, 23.2.2.1
24.2.1.1, 24.2.2.2, 24.7.1.1

25.2.1.1, 25.2.2.1
26.2.1.1, 26.2.2.1, 26.2.2.2
27.2.1.1, 27.2.1.6, 27.2.2.3
28.2.1.1
29.2.1.1, 29.3.1.1, 29.3.1.5
30.2.1.1, 30.2.1.2
31.2.1.1, 31.2.1.11, 31.4.1.1
32.2.1.2 and similar criteria in SEs 33 to 38

1.2.2.4 The senior manager ensures the implementation of risk management processes and activities.

Critical criterion

Linked criteria:
1.2.2.6
7.1.1.1, 7.1.1.7, 7.2.6.4, 7.5.1.1
9.1.2.5
31.2.1.8

1.2.2.5 The senior manager implements processes to monitor patient expectations and satisfaction.

Linked criteria:
1.2.2.6
4.2.3.3
5.5.1.1

1.2.2.6 The senior manager implements processes to monitor staff expectations and satisfaction.

1.2.2.7 The senior manager implements processes for quality management and improvement.

Linked criteria:
1.2.2.4 and 5, 1.2.2.7, 1.2.4.3
7.2.6.4

1.2.2.8 The senior manager implements processes to monitor the quality of clinical and other services.

This criterion's score should be derived from the ratings obtained for standard 8.2.1, in particular criterion 8.2.1.1.

The assessment of the latter is in turn influenced by the aggregated scores obtained from the quality improvement standards in the clinical services that require clinical audits and patient record audits to be conducted.

Linked criteria:
1.2.2.6, 1.2.7.3
8.2.1.1

1.2.3 The organisation's clinical and managerial leaders are identified and are collectively responsible for defining the organisation's mission and creating the plans and policies needed to fulfil the mission.

Standard Intent

An organisation's mission statement usually reflects the needs of its patient population, and patient care services are designed and planned to respond to those needs. Similarly, referral and specialty hospitals derive their mission from the needs of patients within larger geographic or political areas.

While managers are appointed to posts and have a leadership role, leaders of an organisation may arise from many sources. These leaders may represent every service in the organisation, e.g. medical, nursing, maintenance, administration, physiotherapy and radiography. Leaders may also be nominated or elected to certain committees, such as. health and safety committees and infection control. Effective leadership is essential for a healthcare organisation to be able to operate efficiently and fulfil its mission. Leadership is given to the organisation by individuals working together and separately and can be provided by any number of individuals.

Leaders may have formal titles or are recognised for their seniority, stature or contribution to the organisation. It is important that all the leaders of an organisation are recognised and brought into the process of defining the organisation's mission.

Patient care services are planned and designed to respond to the needs of the patient population. The leaders of the various clinical departments and services in the organisation determine what diagnostic, therapeutic, rehabilitative and other services are essential to the community, and their scope and intensity. In private healthcare organisations those persons who have an interest or a share in the service will need to be consulted during the planning processes.

1.2.3 Criteria

1.2.3.1 The leaders of the organisation are formally identified.

This information can be obtained from various sources such as the organogram, job descriptions, performance agreements, letters of appointment to committees, designation of leadership roles for various tasks/responsibilities, etc.

1.2.3.2 The leaders work collaboratively to develop and implement the strategic plan of the organisation.

The term "strategic plan" does not necessarily mean a single document as indicated below. Sometimes organisations refer to "business/operational" plans which may be separate entities or be integrated into the "strategic plans".

In assessing compliance in the public sector, the designated "level" of the hospital and its "service package" as published in national and district documents should be considered.

The major private hospital groups publish this information on their websites, brochures, etc. Although these media may not be part of the document referred to as the "strategic plan", the information does form part of the corporate marketing/public relations strategy, at facility or corporate level.

1.2.3.3 The organisation's leaders meet with the leaders of other provider organisations in their community to develop and revise strategic and operational plans to meet the community needs.

The strategic plan gives rise to the implementation of the mission and the criterion requires not only a documented plan, but also evidence of implementation and this can be assessed by means of progress reports (monthly or quarterly and also annually). Often organisations require each department to compile a departmental "operational plan". These plans are linked to the organisational strategic/business plan, which is regularly reviewed to reflect the progress made with the implementation of strategic/operational objectives in achieving set targets.

Linked criterion:
1.2.2.1

1.2.4 The organisation communicates with its community to facilitate access to information about its patient care services.

Standard Intent

Healthcare organisations define their communities and patient populations and information systems ensure on-going communication with those key groups. The communication may be directly to individuals or through public media, and through agencies within the community or third parties.

1.2.4 Criteria

1.2.4.1 The organisation has identified its target population.

*The term **target population** refers to any clearly definable group of individuals and/or families who may experience a need. In health services this is usually confined to those individuals within a particular geographical location and is linked to the population census for that area. Socio-economic categories and disease profiles are considered when planning for healthcare services to be provided.*

1.2.4.2 The organisation has implemented a communication strategy with these populations.

Linked criteria:
1.2.2.1
4.1.1.1

1.2.4.3 The organisation provides information on the quality of its services.

Linked criterion:
1.2.2.6

1.2.5 The organisation provides patient care within business, financial, ethical and legal norms.

Standard Intent

The organisation has established and implemented a framework for ethical management that includes marketing, admissions, treatment, transfers and discharges, and disclosure of ownership and any business and professional conflicts that may not be in the patients' best interests.

A healthcare organisation has ethical and legal responsibilities to the patients and community it serves. The leaders understand those responsibilities as they apply to the business and clinical activities of the organisation. The leaders create guiding documents, such as the organisation's mission, to provide a consistent framework to carry out those responsibilities. The organisation operates within this framework to:

- disclose ownership and any conflicts of interest
- honestly portray its services to patients
- provide clear guidelines for the levels of care and services offered
- withholding of resuscitation or life sustaining measures
- accurately bill for its services and
- resolve conflicts when financial incentives and payment arrangements could compromise patient care.

When the organisation conducts clinical research, investigations or trials that involve patients, a committee or other mechanism to control all such activities in the organisation is established. The organisation develops a statement of purpose for these activities, which includes the review process for all research protocols, a process to weigh the relative risks and benefits to the patients, and processes related to the confidentiality and security of the research information.

1.2.5 Criteria

1.2.5.1 The organisation's leaders establish ethical and legal norms that protect patients and their rights.

The leaders consider national and international ethical norms when developing the organisation's framework for ethical management. Evidence of compliance exists in the form of documented systems such as a policy framework, guidelines, position statements such as those from professional councils and associations, Acts, regulations, etc. Patient right charters are also relevant to this section. Also note the reference in the intent to the organisation's marketing activities and the processes in relation to the admission, discharge and transfer of patients.

Although this partly refers to formal systems it also requires an organisational system/process/body, e.g. an Ethics Committee or other structure

Final assessment of this criterion is based on evidence of implementation of these principles throughout the organisation and the rating should reflect the aggregated score of relevant standards and criteria.

Linked criteria:

3.2.1.3
5.1.1.1, 5.2.1.1, 5.2.1.3, 5.4.2.1, 5.5.1.1, 5.6.1.1
6.1.2.1
18.1.1.3
20.1.1.4

1.2.5.2 The organisation discloses its ownership.

This is generally evident for hospitals in the public sector as well as in major private hospital groups. In some of the "independent hospitals" this information may not be readily available, but could be found in company documents, list of the Board of Directors, etc.

1.2.5.3 The organisation honestly portrays its services to patients.

There is no single aspect against which compliance is assessed and the criterion is generally rated compliant by default unless there is evidence of a very specific "transgression" such as inadequate/incorrect information to patients (SE 4), complaints about accounts, serious misconduct, financial mismanagement (accounts/billing for services), dishonest/inappropriate marketing of services, etc.

Linked criterion:
4.1.1.10

1.2.5.4 The organisation provides clear admission, treatment, transfer and discharge policies.

The same general rule applies for "policies and procedures" and the score for this criterion should reflect the findings of the relevant/related criteria in the clinical service elements, including the results obtained from patient record audits.

This criterion cannot be marked compliant if there are a large number of non- or partially compliant criteria in the relevant sections in the clinical SEs.

Linked criteria:
1.3.2.1
4.1.1.10, 4.2.2.1 to 3
5.1.1.1
10.9.2.1, 10.9.3.1 and 10.9.4.1 and similar criteria in all in-patient services.
22.11.4.1, 22.11.5.1, 22.11.6.1
23.9.3.1, 23.9.4.1, 23.9.5.1
24.11.4.1, 24.11.5.1, 24.11.6.1
32.4.2.3 and similar criteria in SEs 33 to 38

1.2.5.5 The organisation accurately bills for services.

This refers to a policy framework and the outcome as recorded in either an internal or external financial audit report.

Linked criteria
3.1.1.7
4.2.3.3
10.8.1.4 and similar criteria in all in-patient services.

23.8.1.4

This will be assessed from examination of the complaints register and from the auditors' reports.

1.2.5.6 The organisation has a committee or other mechanism to control all research undertaken within the organisation.

1.2.6 The organisation's leaders ensure that policies and procedures are implemented to support the activities of the organisation and to guide the staff, patients and visitors.

Standard Intent

Policies and procedures are formulated at different levels of authority, e.g. national Acts and regulations, national health and labour departmental policies, and organisational policies.

Leaders must ensure that all policies which apply to the organisation are available to the personnel, and that they are implemented and monitored as they relate to various departments, services and functions.

Leaders should ensure that policies and procedures are available to guide the personnel in such matters as allocation, use and care of resources, financial practices, human resource management and dealing with complaints from patients and visitors.

This section deals with the central control/management of the master filing system(s) of the organisational policy framework, which can be paper-based or electronic.

This section is the "umbrella" for all aspects relating to policies and procedures that are measured in all service elements and therefore the final ratings of these criteria should reflect the aggregated scores obtained from the other service elements.

The general approach is that these criteria are scored NC/PC if the findings in the other services reflect critical/very serious/high volume deficiencies.

1.2.6 Criteria

1.2.6.1 The organisation's leaders ensure that policies and procedures guide and support the activities and management of the organisation.

Root Criterion

In measuring this criterion, the same general rules apply as when measuring "implementation of policies and procedures". This implies that the rating of this criterion should be consistent with the findings on policies and procedures in all the other service elements.

This is a "root" criterion and should be scored compliant only if there are no critical/very serious non- or partially compliant criteria, or not many other non-

/partially compliant "policies and procedures" criteria in any of the other service elements.

Linked criteria:
1.1.1.4, 1.2.1.3, 1.2.5.4, 1.3.2.1
2.1.1.3
3.1.1.2, 3.2.1.2, 3.3.1.2
5.1.1.3
6.1.1.1
7.1.1.1, 7.2.4.2
8.1.1.1
9.1.1.1, 9.2.1.8
17.4.1.1
18.2.1.6, 18.3.2.1
19.1.1.2
20.1.2.2
21.1.1.3, 21.3.1.1
22.6.2.1, 22.9.1.1
23.4.1.1
24.6.2.1, 24.9.1.1
25.1.1.2
26.1.1.2
27.1.1.2
28.1.1.2
29.1.1.5
30.1.1.10
31.1.1.3
32.1.1.2, 32.3.1.1 and similar criteria in SEs 33 to 38

1.2.6.2 A designated manager is responsible for compiling and indexing policies and procedures and for ensuring their circulation, recall and review.

Evidence is obtained from the written designation/delegation of such responsibility to an individual. The criterion is not prescriptive in terms of whether this individual operates independently or acts as a coordinator of a team or as chairperson of a committee.

The criterion should not be scored compliant if there is evidence of non-partial execution of the listed tasks.

1.2.6.3 Policies and procedures are signed by persons authorised to do so.

This is measured against the documented organisational arrangements regarding such authorisation. Often this information is found in the policy document on "management of policies" or a letter of authorisation/delegation to the respective individuals.

1.2.6.4 Policies and procedures are compiled into comprehensive manual(s) or filing system, which is indexed and easily accessible to all personnel.

This should be interpreted to also mean more than one manual –paper-based or electronic.

The effectiveness of the indexing system needs to be tested by random checks on cross references between manuals and policy documents.

Accessibility should be tested at departmental level, especially in the case of electronically-based systems.

1.2.6.5 All policies and procedures are reviewed at appropriate intervals, dated and signed.

The general approach is not to penalise the criterion where there are only a few documents that do not comply. In other words, the general trend should be taken into consideration.

It is expected that policies will be reviewed whenever indicated because of changes, but time frames for the routine review of policies should be defined in organisation policy. It is generally accepted that a period of 2 to 3 years between reviews should not be exceeded.

1.2.6.6 There is a mechanism to ensure that policies are known and implemented.

Compliance can be demonstrated in various ways as organisations have different ways of performing these tasks.

Examples of making policies known may include:
1. *staff members indicate their acknowledgement by signing on the reverse of each document, on the index or on a separate sheet/form, thus undertaking to keep up to date with all relevant policies*
2. *key policies and procedures are discussed at meetings*
3. *memos are circulated to inform the staff of new/changed policy matters, etc.*

The criterion is not prescriptive regarding the method to be used but the system in operation should be tested for effectiveness. Staff members do not necessarily have to receive formal in-service training on policies, but this often happens for important/key aspects.

Linked criteria:
7.2.2.1, 7.2.3.1, 7.2.4.1
10.2.6.3 and similar criteria in all clinical SEs.

1.2.7 The leaders direct the development and monitor the implementation of contracts/agreements for clinical or managerial services.

Standard Intent

Organisations frequently have the option to provide clinical and managerial services directly, or to arrange for such services through referral, consultation, contractual arrangements, or other agreements. Such services may include, for example, radiology services, financial accounting services, equipment management, hotel services etc.

In all cases, the leaders supervise such written contracts/agreements to ensure that the services meet patient needs and are monitored as part of the organisation's quality management and improvement activities.

Where volunteer services are provided, it is managed to provide a safe and effective service and is co-ordinated with other services within the organisation.

Please note the reference to "clinical" in the above intent as the "outsourcing" of clinical services is an integral part of this section and applies especially to the private sector hospitals. There are sometimes written "service level agreements" between private hospitals and private radiology/laboratory services, but one seldom finds such written agreements/contracts with individual healthcare professionals, in which case this section will be scored PC for the relevant criteria. Contractual arrangements with private doctors (session holders) in the public sector should also be considered in this section.

Arrangements with agencies for the provision of professional personnel such as locum doctors and nurses are included here.

1.2.7 Criteria

1.2.7.1 Copies of contracts are made available to those who ensure their implementation.

1.2.7.2 Services provided under contracts/agreements meet patient needs.

Commonly, this will apply to contracted services for catering, laundry/linen, housekeeping, security, maintenance of buildings, plant and equipment, provisioning services e.g. medication, coal for boilers, etc. It can also apply to providing personnel such as agency nurses, locums, artisans, technicians, etc.

If contracts/agreements exist, this criterion is scored compliant by default, unless non-conformance by other service elements indicates a definite shortfall that can justify a NC/PC rating. Where services are rendered without a formal contract/agreement, this will be scored PC.

Linked criteria:
18.1.1.1, 18.1.1.2, 18.2.1.5, 18.4.2.4
19.1.1.1, 19.2.1.2, 19.3.2.8
20.1.1.1, 20.1.1.3, 20.1.3.1, 20.1.3.6, 20.2.3.2
22.7.1.1, 22.7.2.1
23.5.1.1, 23.5.2.1
24.7.1.1, 24.7.2.1
26.1.1.1
27.1.1.1
28.1.1.1
32.1.1.1 and similar criteria in SEs 33 to 38

1.2.7.3 Contracts and other arrangements are monitored as part of the organisation's quality management and improvement programme.

The reference to "the organisation's quality management and improvement programme" indicates formal monitoring of analysed data.

Assessment of this requirement needs to take into consideration that compliance can be achieved in various ways as different organisations may present information in many different ways, e.g. formal monitoring tools/checklists, satisfaction surveys, minutes of meetings, negotiations of contractual arrangements/specifications, service level agreements with service performance indicators, etc.

This criterion cannot be scored compliant if 1.2.7.1 is non-compliant (i.e. if copies of the contracts are not available at facility level).

Linked criteria:
1.2.2.7
2.5.1.6
6.2.2.5
7.3.1.3, 7.5.1.3
8.2.1.1, 8.2.2.1
18.3.2.13
20.1.1.3
27.2.2.1
28.4.1.4
29.1.2.2, 29.1.2.4
31.2.1.10

1.2.7.4 There is a mechanism to ensure that all volunteers work under the guidance of suitably qualified health professionals in the employ of the care centre.

1.2.7.5 Volunteers sign a memorandum of agreement to abide by the conditions of the centre.

1.2.7.6 There are written policies and procedures for the activities of the volunteer service.

Linked criterion:
2.4.1.4

1.2.8 The organisation's leaders foster communication between individuals and coordinate services among departments.

Standard Intent

To coordinate and integrate patient care, the leaders develop a culture that emphasises co-operation and communication. The leaders develop formal methods (e.g. standing committees, joint teams), and informal methods (e.g newsletter, posters) for promoting communication among services and individual staff members.

Coordination of services comes from an understanding of the mission and services of each department and service and collaboration in the development of common policies and procedures.

Leaders have a special responsibility to patients and to the organisation. These leaders:

- support good communication
- jointly plan and develop policies that guide the delivery of services and
- monitor the quality of service delivery.

The leaders of all services create a suitable, effective organisational structure to carry out those responsibilities. The structure chosen can be highly organised with rules and regulations. In general, the structure(s) chosen is (are):

- inclusive of all relevant personnel
- consistent with the ownership, mission and structure of the organisation
- appropriate for the complexity of the organisation and
- effective in carrying out the responsibilities listed above.

1.2.8 Criteria

1.2.8.1 The organisation's leaders promote communication among departments, services and individual staff members.

Root criterion

Consider formal interdepartmental meetings, written communications in the form of policies, memos, service level agreements, clinical audit committees, drug and therapeutic committees, etc.

Linked criteria:
1.3.2.1
3.1.1.3
7.3.1.1
8.1.1.2
9.1.1.5
17.1.2.1
21.1.2.1
29.1.1.4
30.1.1.1
31.1.1.3

1.2.8.2 Agendas are prepared for meetings, and the personnel are given timely notification in order to prepare for participation.

An assessment of a sample of agendas/minutes of meetings should be undertaken to determine the trend and "general" compliance as the criterion should not be penalised on one or two exceptions.

"Timely notification" should be assessed against the organisational policy framework on meetings and the circulation of agendas. This implies that the dates for circulating the agendas should be indicated.

1.2.8.3 Minutes of meetings are taken and are circulated to all relevant personnel.

An assessment of a sample of minutes of meetings should be undertaken to determine the trend and "general" compliance as the criterion should not be penalised for one or two exceptions.

The manner in which minutes are circulated should be assessed against the organisational policy framework and should consist of documented evidence of the circulation and acknowledgment of receipt.

1.2.8.4 There is a mechanism to ensure that key issues resulting from meetings of the governing body and/or the management of the organisation are communicated to and acted upon by the personnel.

The existing "mechanism" should be assessed for effectiveness in conveying this information to the personnel but please note the importance of searching for evidence of "and acted upon". This generally requires that minutes should reflect the allocation of responsibilities for carrying out tasks and that these are reported on at subsequent meetings.

Often feedback from the governing body meeting is via written internal communication (memo) but if it is stated that it is done at an "open" staff meetings, there should be documented evidence that this does actually happen.

Linked criterion:
1.1.1.2

1.3 Management of Departments and Services

1.3.1 Identified departmental or service managers control clinical and managerial activities in each department or service.

Standard Intent

The clinical care, patient outcomes and overall management of a healthcare organisation are only as good as the clinical and managerial activities of each individual department or service.

Good departmental or service performance requires clear leadership from a qualified individual. The qualifications of departmental managers should be appropriate to the department i.e. suitable paediatric, ICU, operating theatre or information technology qualifications, as applicable. In large departments or services, clinical and administrative leadership may be separate. In such a case, the responsibilities of each role are defined in writing.

Documents prepared by each department define its goals, identify current and planned services, and establish the knowledge, skills and availability of the personnel required to assess and meet patient care needs. The leaders of each department or service make their human resources and other resource requirements known to the organisation's senior managers. This helps ensure that adequate staff, space, equipment and other resources are available to meet patient needs at all times. The organisation's management provides departmental and service managers with data and information needed to manage and improve care and service. Patient care is not provided when special resources are not available.

Clinical services provided are co-ordinated and integrated within each department or service. For example, there is integration of medical and nursing services. Also, each department or service works to coordinate and integrate its services with other departments and services. The management of the organisation's organisational chart guides departmental/service staff in adhering to correct lines of communication. Each department or service documents the lines of communication within that department or service. Unnecessary duplication of services is avoided or eliminated to conserve resources.

1.3.1 Criteria

1.3.1.1 The organisation ensures that a qualified individual manages each department or service in the organisation.

National regulations and guidelines will apply. The qualifications of the incumbent will be assessed against the stated requirements for the position.

The organogram should indicate the departmental arrangements and compliance is to be assessed against job profiles/post requirements. Besides departments, the "generic" services such as patient rights, information management, health and safety, infection control, quality management, resuscitation, medical equipment management, etc. are included.

The final assessment score will be determined by findings from all departments/services. For example, this criterion may be scored PC:

1. *If individual critical posts e.g. nursing manager, medical manager, pharmacy manager etc. are vacant.*
2. *If there is a high volume of departmental/service heads vacancies*
3. *If there is a large number of departmental heads in acting positions*

Linked criteria:
2.2.1.1, 2.3.1.1
18.2.1.5

1.3.1.2 The responsibilities of each departmental manager are defined in writing.

As for 1.3.1.1 with special reference to key performance areas.

The final assessment score will be determined by aggregated findings from all departments/services and relevant criteria in SE 2.
Refer to the comment under 1.3.1.3 with regard to "generic" functions.

Linked criteria:
2.3.1.1

1.3.1.3 The departmental or service manager implements processes to manage and control human, financial and other resources.

The score of this criterion should be based on the aggregated scores from the individual services and should take into consideration any critical/serious/important shortfalls identified with regard to, e.g. physical structure, maintenance installations

such as vacuum, oxygen and water, hand washing facilities, etc. that may have an negative impact on service delivery, patient care, and the safety of patients, staff and visitors.

Linked criteria:
1.2.2.2
9.2.2.1

1.3.1.4 The departmental or service manager ensures that there are sufficient personnel to provide the services.

Critical criterion

The score of this criterion is influenced by the outcome of the assessment of relevant criteria during the departmental surveys. All categories of staff in all departments (clinical and non-clinical) are included.

Take note of links with relevant criteria in SE 2, especially standard 2.1.1.
The score of this criterion should be based on the aggregated scores from the individual services and should take into consideration any critical/serious/important shortfalls identified with regard to staff shortages (both numbers and skills) that impact negatively on patient care and safety. A NC or PC rating for this criterion should be supported by staff numbers (vacancies) as listed in the accompanying "Situational Analysis" document.

Linked criteria:
1.2.2.2
2.1.1.4, 2.2.1.1
17.1.2.3

1.3.1.5 The departmental or service manager ensures that resources are available to provide those services

The score of this criterion should be based on the aggregated scores of relevant criteria in individual services and should take into consideration any critical/serious/important shortfalls identified with regard to consumables, medication etc. that impact negatively on patient care and service delivery.

These items exclude physical resources such as facilities, installations and equipment, which are dealt with in criterion 1.2.2.3

Linked criteria:
1.2.2.2
3.1.1.3, 3.1.1.8, 3.3.1.3, 3.4.1.2
6.2.1.3
7.7.1.7
9.2.2.1
17.2.2.8
19.1.5.2
20.2.3.1
21.2.1.1
26.4.1.3
27.2.3.6

28.4.1.2
29.2.2.1, 29.2.3.2

1.3.1.6 Departmental or service managers provide orientation and training for all personnel of the department or service appropriate to their responsibilities.

Documented evidence if required of orientation/induction/in-service training across the entire organisation, and a NC/PC rating is justified where there are any critical/major/serious shortfalls with regard to training (note any critical deficiencies in relation to resuscitation, health & safety, infection control, pain management), or a general finding/high volume/trend of non-/partially compliant criteria in the service elements.

Linked criteria:
2.4.1.3, 2.4.2.2

1.3.1.7 There is coordination and integration of services with other departments and services.

This criterion's score should be a culmination of the scores obtained at departmental levels throughout the organisation.

The results obtained from patient record audits of aspects pertaining to continuity of care and interdepartmental Coordination will also influence this criterion score.

Linked criteria:
18.1.1.1
19.1.1.1
20.1.1.1
32.4.1.2 and similar criteria in SEs 33 to 38

1.3.1.8 Departmental managers implement quality control and improvement programmes.

This criterion's score should be a culmination of the scores obtained at departmental levels throughout the organisation. Also take note of the relevant links with Service Element 8.

Linked criteria:
8.1.1.1, 8.1.1.2, 8.2.2.1
18.1.1.7
19.3.2.1
20.3.2.1

1.3.2 Policies and procedures and applicable laws and regulations guide the uniform care of all patients.

Standard Intent

As patients move through a healthcare organisation from entry to discharge or transfer, several departments and services as well as many different healthcare providers may be involved in providing care. Throughout all phases of care, patient

needs are matched with the appropriate resources within and, when necessary, outside the organisation. This is commonly accomplished by using established criteria or policies that determine the appropriateness of transfers within the organisation.

For patient care to appear seamless, the organisation needs to design and implement processes for continuity and coordination of care among physicians, nurses and other care providers in:

- emergency services and inpatient admission
- diagnostic and treatment services
- surgical and non-surgical services and
- the organisational and other care settings.

The leaders of the various care settings and services work together to design and implement the processes. The processes may be supported by explicit transfer criteria or by policies, procedures or guidelines. The organisation identifies individuals responsible for coordinating patient care (for example between departments) or for coordinating the care of individual patients (for example the case manager).

Patients with the same health problems and care needs have a right to receive the same quality of care throughout the organisation. To carry out the principle "one level of quality of care" requires that the clinical and managerial leaders plan and coordinate the care provided to patients. In particular, services provided to similar patient populations in multiple departments or care settings are guided by policies and procedures that result in uniform delivery. Those policies and procedures respect applicable laws and regulations that shape the care process and are best developed collaboratively.

Uniform patient care is reflected in the following:

- access to and appropriateness of care and treatment do not depend on the patient's ability to pay or on the source of payment
- the seriousness of the patient's condition determines the resources allocated to meet the patient's needs
- the level of care provided to patients (for example anaesthetic care) is the same throughout the organisation and
- patients with the same nursing care needs receive comparable levels of nursing care throughout the organisation.

Uniform patient care results in the efficient use of resources and permits the evaluation of outcomes of similar care processes throughout the organisation.

1.3.2 Criteria

1.3.2.1 Care planning and delivery is integrated and co-ordinated among care settings, departments and services.

The score of this criterion will be determined by the aggregated ratings of the following criteria that deal with the implementation of clinical policies/procedures/protocols/guidelines i.e. the results of clinical audits:

Linked criteria:
1.2.5.4, 1.2.6.1, 1.2.8.1

10.4.1.1, 10.5.2.1, 10.5.5.2, 10.5.6.1, 10.6.1.1, 10.6.2.3, 10.7.1.5, 10.9.1.1, 10.9.4.1 and similar criteria in all in-patient services.
17.3.1.1, 17.5.3.1
21.3.1.1
22.5.1.1, 22.8.5.2, 22.11.1.1
23.3.1.1, 23.7.1.1, 23.9.1.1
24.5.1.1, 24.1.1.1
32.4.1.1, 32.4.3.1 and similar criteria in SEs 33 to 38

*Also consider the results of **patient record audits/clinical audits** as these reflect the level of implementation of relevant policies on clinical care.*

1.3.2.2 Clinical practice guidelines relevant to the patients and services of the organisation are implemented to guide uniform patient care processes.

Linked criteria:
4.2.2.4
8.2.1.4
10.3.1.1, 10.3.1.3 and similar criteria in all in-patient services.
22.5.1.4
23.6.3.2
24.8.4.1

1.3.2.3 The hospital maintains a clinical record for each patient.

This may be a paper based or electronic record.
Patient held records for outpatients will be scored PC because the record, with its relevant clinical information, is not maintained by the hospital.
Linked criterion:
3.2.1.9

1.3.2.4 The patients' clinical records are completed according to guidelines determined by the organisation.

This refers to the relevant forms/documents that need to be present in the patient folder, as well as the completeness of entries made in the record. For this purpose the results of patient record audits need to be taken into account. Therefore the score of this criterion needs to reflect the aggregated average score of all linked criteria:

Linked criteria:
3.2.1.4
10.1.2.1 and similar criteria in all in-patient services.
17.4.1.1
22.1.2.1
23.1.2.1
24.1.2.1
32.4.1.3 and similar criteria in SEs 33 to 38

SE 2 HUMAN RESOURCE MANAGEMENT

OVERVIEW OF HUMAN RESOURCE MANAGEMENT

A healthcare organisation needs an appropriate number of suitably qualified people to fulfil its mission and meet patient needs. The organisation's clinical and administrative leader's work together to identify the number and types of personnel needed based on the recommendations from departmental managers.

Recruiting, evaluating and appointing staff members are best accomplished through a co-ordinated, efficient and uniform process. It is also essential to document an applicant's skills, knowledge, education and previous work experience. It is particularly important to carefully review the credentials of medical and nursing personnel because they are involved in clinical care processes and work directly with patients.

Healthcare organisations should provide their personnel with opportunities to learn and advance personally and professionally. Thus, in-service education and other learning opportunities should be offered to the personnel.

Standards

2.1 Human Resource Management Support

2.1.1 Administrative support is provided for the organisation's human resource strategy in order for it to meet the need for an adequate number of suitably qualified and trained staff.

Standard Intent

A designated individual ensures that administrative support personnel provide systems to enable the human resource strategy to be implemented. These include the collection, collation and analysis of data to provide and maintain an effective staffing structure.

Policies and procedures guide administrative support personnel in all matters relating to human resource management, e.g.:

- appointments, resignations and termination of service
- granting of leave and maintenance of leave records
- payment of salaries, payment of pension benefits; and
- storage, confidentiality and maintenance of staff records.

2.1.1 Criteria

2.1.1.1 A designated individual is responsible for providing support for the organisation's human resource strategy.

Management has appointed/designated one or more specific individual/s tasked with all human resources activities.

2.1.1.2 The human resource manager is suitably qualified and experienced in human resource management.

This is measured against the individual's job specification.

2.1.1.3 The human resource manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Linked criterion:
1.2.6.1

2.1.1.4 The human resource manager uses information on staffing needs provided by clinical and managerial personnel to ensure adequate staff provision.

Critical criterion

Linked criteria:
1.3.1.4
2.2.1.1

2.1.1.5 Details of the organisation's absenteeism, sickness rates and staff turnover rates are recorded and analysed, to allow for informed decision making by the management of the organisation.

The criterion not only requires the keeping of sickness and absenteeism records of individuals, but more importantly requires analysed data expressed in rates for management decision making purposes.

Linked criteria:
6.1.1.1
7.1.1.1, 7.1.1.7

2.1.1.6 Details of the staff establishment (i.e. available posts, filled and vacant posts) are recorded and analysed to allow for informed decision making by the organisation's management.

Linked criteria:
2.2.1.1
7.1.1.1

2.1.1.7 Receptionists, telephonists, clerical support personnel and porters are allocated to wards and departments in accordance with their needs.

2.1.2 A personnel file is maintained for each member of staff.

Standard Intent

Each staff member in the organisation has a record with information about his or her qualifications, results of evaluations, and work history. These records are standardised and are kept current.

The confidentiality of personnel records is protected.
Personnel records are safely stored, and their contents are monitored to ensure completeness.

2.1.2 Criteria

2.1.2.1 A designated member of staff is responsible for the storage and retrieval of personnel records.

Management has designated one or more individual/s for the maintenance of the personnel records and these individuals are responsible for maintaining confidentiality at all times. Policies prescribe who may have access to individual personnel records and information.

2.1.2.2 There is documented personnel information on each staff member.

Root criterion for all the following criteria

Although it is recommended that there is a single integrated personal record for each staff member, some information may be found in other places in the Human Resource Department, such as separate records (folders, books, forms) for professional registration, leave application, in-service training, performance appraisals, etc.

The following criteria will be assessed during a personnel record audit.

Take note of Standards 2.3.1, 2.3.2 and 2.5.1

2.1.2.3 Personnel files are standardised.

Standardisation refers to the organisation of the content of files or other records, i.e. how easily can information be retrieved?

2.1.2.4 Personnel files are reviewed at least annually.

Linked criterion:
2.5.1.5 and 6

2.1.2.5 Personnel files contain employment contracts/job description

2.1.2.6 Personnel files contain the qualifications of the staff member

2.1.2.7 Personnel files contain details of staff evaluations

2.1.2.8 Personnel files contain the work history of the staff member

This information could be found in the Curriculum Vitae of the individual and in the evidence of post-appointment assignments and experience.

2.1.2.9 Personnel files contain a record of in-service education attended by the staff member.

If records of in-service education are not kept in the personnel files or are not available for examination (e.g. staff held records) this criterion will be scored PC, unless there is a summary of in-service education attendance on the personnel record.

2.1.2.10 Only authorised persons have access to personnel records.

2.2 Staff Planning

2.2.1 The organisation's leaders plan for the provision of adequate numbers of suitably qualified personnel.

Standard Intent

Appropriate and adequate staffing is critical to patient care. The organisation's clinical and managerial leaders carry out staff planning using recognised methods

for determining staffing levels. For example, a patient acuity system is used for determining the number of registered nurses with paediatric intensive care experience required to staff a ten bed paediatric intensive care unit.

The organisation's mission, mix of patients, services provided and technology used are considered in the planning. Applicable laws and regulations are incorporated into the planning.

Staff retention, rather than recruitment, provides greater long-term benefit. Retention is increased when leaders support staff development. Thus, the leaders collaborate to plan and implement uniform programmes and processes related to the recruitment, retention and development of all personnel.

There is a written plan, which identifies the numbers and types of required personnel, and the skills, knowledge and other requirements needed in each department and service. The plan is designed to address:

- the reassignment of personnel from one department or service to another in response to changing patient needs or staff shortages
- the consideration of staff requests for reassignment, based on cultural values or religious beliefs and
- the policies and procedures for transferring responsibility from one individual to another (for example, from a physician to a nurse) when the responsibility would fall outside such an individual's normal area of responsibility.

Planned and actual staffing levels are monitored on an ongoing basis and the plan is updated as necessary. When monitored on a departmental or service level, there is a collaborative process for the clinical and managerial leaders of the organisation to update the overall plan.

2.2.1 Criteria

2.2.1.1 There are documented processes for staffing the organisation.

Root criterion

It is preferable that all these aspects be summarised in an executive-type summary for ease of access to relevant information. However, this does not preclude the presentation of separate documents related to various structured processes that are guided by policies, procedures, protocols or narratives and should be needs based.

The plan should be available either as part of the strategic planning process or as an operational plan. The plan should include the current staff establishment, i.e. posts available, posts filled and posts vacant.

The staff establishment should be based on scientific findings, e.g. analysed work-study findings, catchment area population, patient loads, bed occupancy and patient acuity levels, conducted either in-house or by an independent agent.

Minimum staffing levels for professional personnel should be based on accepted national or international norms/standards.
This applies to all the criteria in this standard.

Linked criteria:
1.3.1.1, 1.3.1.4
2.1.1.1, 2.1.1.4. 2.5.1.1
3.1.1.1, 3.2.1.1, 3.3.1.1, 3.4.1.1, 3.4.2.4
6.2.2.1
7.1.1.6
10.1.1.1 and 10.1.1.2 and similar criteria in the in-patient services i.e. SEs 11 to 16
17.1.1.1-2, 17.1.2.2-3
18.2.1.1, 18.2.1.5, 18.4.2.4
19.1.2.1
20.1.2.1, 201.3.1
21.1.1.1-2
25.1.1.1
26.1.1.1
27.1.1.1
28.1.1.1
29.1.1.1, 29.1.2.1
31.1.1.1
32.1.1.1 and similar criteria in SEs 33 to 38

2.2.1.2 The processes include personnel recruitment.

2.2.1.3 The processes include numbers and categories personnel required.

2.2.1.4 The processes include desired education, qualifications, skills and knowledge of required personnel.

Linked criteria:
17.1.1.2
30.1.1.5
32.1.1.3 and similar criteria in SEs 33 to 38

2.2.1.5 The processes include assignment and reassignment of personnel.

This generally involves nursing personnel, but applies to all members of staff.

For example, it could include the temporary or permanent re-deployment of personnel to meet organisational requirements.

Linked criteria:
19.1.1.3
20.1.1.2
22.1.1.4
23.1.1.4
24.1.1.4
29.1.2.4

2.2.1.6 The processes include personal development of the personnel.

2.2.1.7 The processes include staff retention.

2.3 Personnel Management

2.3.1 Each staff member's responsibilities are defined in a current description and performance agreement.

Standard Intent

The job description and performance agreement provides details of accountability, responsibility, formal lines of communication, principal duties and entitlements. It is a guide for an individual in a specific position within an organisation. Key performance areas should be included in order to evaluate the staff member's performance.

2.3.1 Criteria

2.3.1.1 Personnel employed by the organisation have written job description and performance agreements, which define their responsibilities.

Critical criterion

Compliance will be verified during the ***staff record audit.***

Linked criteria:
1.3.1.1, 1.3.1.2.
21.1.1.3
25.1.1.4
26.1.1.4
27.1.1.4
28.1.1.4
29.1.1.4
30.1.1.2
31.1.1.2
32.1.1.4 and similar criteria in SEs 33 to 38

2.3.1.2 Job descriptions and performance agreements are reviewed according to organisational policy.

2.3.1.3 Each staff member accepts their job description and performance agreement by signing it.

2.3.2 The organisation uses a defined process to evaluate personnel knowledge and skills to ensure that these are consistent with patient needs.

Standard Intent

The organisation complies with laws and regulations that define the desired educational level, skill or other requirements of individual staff members, or define staffing numbers or the mix of personnel for the organisation. The organisation considers the mission of the organisation, and the needs of patients in addition to the requirements of laws and regulations. The organisation defines the process for; and the frequency of, and the ongoing evaluation of personnel abilities. Ongoing

evaluation ensures that training occurs when needed and that the staff member is able to assume new or changed responsibilities. While such evaluation is best carried out in an ongoing manner, there is a least one documented evaluation each year for each staff member.

2.3.2 Criteria

*The following criteria will be assessed during a **personnel record audit**.*

2.3.2.1 Key performance areas for each personnel member are identified in their job descriptions and performance agreements.

2.3.2.2 There is at least one documented evaluation of each personnel member each year or more frequently as defined by organisational policy.

Linked criteria:
2.6.1.4, 2.6.1.5

2.3.2.3 New personnel members are evaluated as defined by organisational policy.

There is a documented process for the evaluation of new personnel during their probation period to establish their suitability for the post, prior to permanent appointment to the organisation.

2.3.3 Sound industrial relations, which are based on current labour legislation, are implemented and maintained in the organisation.

Standard Intent

Consistent application of fair labour practice; grievance and disciplinary procedures, dismissal, demotion and retrenchment policies and procedures are essential to prevent labour dispute, with its consequent negative effects on patient care. Membership of trade unions and/or health professional organisations must be encouraged. There must be negotiation and consultation between these bodies, the management of the organisation and the personnel to promote harmonious working relationships. Current employment policies need to be known and applied. The organisation's leaders thus have a responsibility to:

- be conversant with all current labour laws and regulations (national requirements will apply)
- educate personnel managers in relevant aspects of labour law
- ensure that policies and procedures are developed and
- ensure that these policies and procedures are effectively implemented.

2.3.3 Criteria

2.3.3.1 Designated personnel are educated/trained in labour law legislation and related processes.

2.3.3.2 There are mutually agreed processes for the satisfactory conduct of industrial relations activities, which meet the requirements of current legislation.

Root criterion

There is need for an agreement between management and the personnel regarding the industrial relations processes to be followed. At the same time, these processes must meet National legal requirements.

Linked criteria:
1.2.1.4

2.3.3.3 Disciplinary procedures are implemented.

2.3.3.4 Grievance procedures are implemented.

2.3.3.5 Dispute and appeal procedures are implemented.

2.3.3.6 There are recognition agreements with trade unions and/or health professional organisations, where applicable.

Where recognition agreements are in place, these may have been agreed upon through a wider consultative process. These recognition agreements must be available in the organisation.

2.4 Staff Orientation and Education

2.4.1 All staff members are orientated to the organisation and to their specific job responsibilities at the time of appointment.

Standard Intent

The decision to appoint an individual to the staff of an organisation sets several processes in motion. To perform well, a new staff member needs to understand the workings of the entire organisation and how his or her specific responsibilities contribute to the organisation's mission. This is accomplished through a general orientation to the organisation and his or her role in the organisation, and a specific orientation to the job responsibilities of his or her position. The organisation includes, as appropriate, the reporting of medical errors, infection control practices, the organisation's policies on telephonic medication orders, and so on. Contract workers and volunteers are also orientated to the organisation and their specific assignment or responsibilities, such as patient safety and infection control.

2.4.1 Criteria

2.4.1.1 There are documented programmes for staff orientation to the organisation.

Root criterion

The organisation has a generic/macro orientation programme, as well as department-specific programmes as required in criterion 2.4.1.3, for all employees, contract workers and volunteers.

2.4.1.2 New staff members are orientated to the organisation within a time frame determined by organisational policy.

2.4.1.3 Departmental and service managers implement orientation programmes for departmental and service personnel.

Linked criterion:
1.3.1.6

2.4.1.4 Contract workers and/or volunteers are orientated to the organisation, their job responsibilities and their specific assignments.

Linked criteria:
1.2.7.6

2.4.2 Each staff member receives on-going in-service training and development to maintain or advance his or her skills and knowledge, based on identified needs.

Standard Intent

The organisation has a responsibility to ensure that staff members are educated in matters which affect their performance in the organisation. In particular, the personnel are trained in health and safety matters, infection control and cardio-pulmonary resuscitation. The organisation collects and integrates data from several sources to understand the ongoing educational needs of the personnel. Such sources include monitoring data from the facility management programme, the introduction of new technology, skills and knowledge areas identified through the review of job performance, new clinical procedures, and future plans and strategies of the organisation.

Education is relevant to each staff member as well as to the continuing advancement of the organisation in meeting patient needs and maintaining acceptable staff performance, teaching new skills and providing training on new equipment and procedures. There is documented evidence that each staff member who has attended training has gained the required competencies.

Each department or service manager ensures that in-service training is provided to the personnel of the particular department or service, e.g. , medical staff members may receive education on infection control, advances in medical practice or new technology. Information management personnel may be provided with in-service training on computer software and technicians may receive on-the-job training relating to equipment repair.

The leaders of the organisation support the commitment to ongoing in-service education for the staff by making available space, equipment and time for education and training programmes. The education and training can take place in a centralised location or in several smaller learning and skill development locations throughout the facility. The education can be offered once to all or repeated for all personnel on a shift by shift basis so as to minimise the impact on patient care activities.

2.4.2 Criteria

2.4.2.1 The organisation has a coordinated plan for in-service training and development.

Root criterion

A summarised plan is provided for ease of access to information about the relevant programmes.

Linked criteria:
5.1.1.4
7.3.1.5, 7.5.1.7

2.4.2.2 Department and service managers have established in-service training and development programmes relevant to departmental and service personnel.

This refers to the departmental/unit-based services and the generic services.
The following aspects should at least be included:

- *patients' rights (criterion 5.1.1.4)*
- *risk management (criterion 7.1.1.5, 7.5.1.7)*
- *quality management and improvement (criterion 8.1.2.3)*
- *infection prevention and control (9.5.1.1)*
- *pain management (criterion 10.5.5.4 and all clinical services)*
- *cardio-pulmonary resuscitation (30.3.1.1)*
- *medical equipment management (standard 31.3.1).*

Linked criteria:
1.3.1.6
2.4.2.4
5.1.1.4
7.1.1.5, 7.5.1.7
8.1.2.3
9.5.1.1
22.8.54
23.6.3.4
24.8.4.3
31.3.1.1-3, 31.3.1.4-5

2.4.2.3 The organisation uses various sources of data and information to identify the in-service training and development needs of the personnel.

These needs can be identified through a formalised skills audit process.
Examples of sources which can be used for establishing training needs are:

- *job observations*
- *performance reviews*
- *annual training 'wish-lists*
- *changes in patient profile; and/or*
- *results of clinical and document audits.*

2.4.2.4 The organisation provides on-going in-service training and development for it's personnel.

Evidence of training session attendance must be provided.
Analysed attendance data should be available, e.g. what percentage of which category of staff attended which training session.

Linked criteria:
2.4.2.2
10.5.5.4 and similar criteria in all clinical services.

2.4.2.5 Staff competencies, where relevant, are assessed and recorded after in-service training and development.

The organisation identifies where competencies must be tested after training. These could include the use of complex medical, technical and electronic equipment, resuscitation techniques, fire safety, etc.

Evidence must be provided of the tests conducted to determine the individual staff member's competence.

Linked criteria:
30.3.1.6
31.3.1.2

2.4.3 Staff members participate in continuing education, research, and other educational experiences to acquire new skills and knowledge and to support job advancement.

Standard Intent

The organisation has a process for informing the personnel of opportunities for development and training, participation in research and investigational studies and acquiring advanced or new skills. These opportunities may be offered by the organisation, by a staff member's professional or trade association or through educational programmes in the community. The organisation supports such opportunities as appropriate to its mission and resources. Such support may be given through tuition support, scheduled time away from work, recognition of achievement and in other ways.

2.4.3 Criteria

2.4.3.1 There is a continuing educational strategy developed by the management of the organisation for all professional personnel in the organisation to fulfil the requirements for continued registration with the relevant professional bodies.

In the public sector this includes doctors, nurses and other healthcare professionals.

This refers specifically to professional personnel and the requirements for continued registration with the relevant professional bodies, where applicable. Management must have a clear strategy for assisting professional personnel to maintain their continued registration.

Linked criterion:
30.3.1.1

2.4.3.2 There is a development strategy for the organisation to ensure that managers receive the training required to fulfil their responsibilities.

This criterion refers to managers of all departments and services. Training could include formal management training or those specific skills required by the individual as identified by means of skills audits or performance reviews.

2.4.3.3 The personnel are informed of opportunities to participate in advanced education, training, research and other experiences.

Linked criterion:
31.3.1.6

2.4.3.4 The organisation supports staff participation in such opportunities.

Compliance with criteria 2.4.3.3 and 2.4.4.4 will be verified during an audit of the personnel records of various categories of professional personnel or other training records.

Staff members may also be an interviewed.

Linked criterion:
31.3.1.6

2.4.3.5 The organisation supports the need for relevant postgraduate qualifications.

2.5 Credentialing of Staff Members

2.5.1 The organisation has an effective process for gathering, verifying and evaluating the credentials (registration, development, training and experience) of those healthcare professionals who are permitted to provide patient care without supervision.

Standard Intent

Healthcare professionals who are registered to provide patient care without clinical supervision are primarily responsible for patient care and care outcomes. These professionals usually include doctors, dentists, professional nurses, radiographers and members of other professions allied to medicine. The organisation identifies those permitted to work independently in compliance with applicable laws and regulations. The organisation is responsible for ensuring that these individuals are qualified to provide patient care without clinical supervision and for specifying the types of care they are permitted to provide within the organisation. The organisation needs to ensure that the staff of qualified health professionals appropriately matches its mission, resources and patient needs.

To ensure such a match, the organisation evaluates staff members' credentials at the time of their appointment. An individual's credentials consist of an appropriate current registration, completion of professional education and any additional training and experience. The organisation develops a process to gather this information, verify it's accuracy, and evaluate it in relation to the needs of the organisation and it's patients. This process can be carried out by the organisation or by an external agency such as a Ministry of Health in the case of public organisations**.** The process applies to all types and levels of employed persons (employed, honorary, contract and private practitioners).

Evaluating an individual's credentials is the basis for two decisions: whether this individual can contribute to fulfilling the organisation's mission and meeting patient needs, and, if so, what clinical services this individual is qualified to perform.

These two decisions are documented, and the latter decision is the basis for evaluating the individual's ongoing performance.

Take note of the bold section in the intent statement: this standard applies not only to employed personnel, but to all healthcare professionals who render patient care in the organisation.

2.5.1 Criteria

2.5.1.1 Those permitted by law, regulation and the organisation to provide patient care without supervision, are identified.

Root criterion

See the intent statement.
This applies to all healthcare professionals, who are registered as independent practitioners with their individual registration bodies.
Employed personnel are identified from the organogram, staff establishment, staff allocation lists, consultant practice indicator boards, etc.

Linked criteria:
1.2.1.4
2.2.1.1. 2.5.1.4
17.1.1.1-2, 17.1.2.4
18.2.1.5
19.1.2.1
20.1.2.1
21.1.1.1-2
22.1.1.1-2, 22.1.1.4
23.1.1.1-2
24.1.1.1-2
31.1.1.1
32.1.1.1, 32.4.2.1 and similar criteria in SEs 33 to 38

2.5.1.2 The registration, education, training and experience of these individuals are documented.

Compliance will be verified during an audit of the personnel records of various categories of professional personnel.

Copies of all the relevant original degrees/diplomas/certificates must be available, as well as evidence of registration with the relevant registration bodies (refer to criterion 2.5.1.4).

2.5.1.3 Such information is verified from the original sources.

2.5.1.4 The personnel record contains copies of any required registration certificate(s).

Critical criterion
This will be verified during the ***personnel record audit****.*

Linked criteria:
1.2.1.4
2.2.1.1

2.5.1.5 There is a process to review the personnel records annually.

Linked criterion:
2.1.2.4

2.5.1.6 The organisation has a process to ensure that nurses and other professionals who are not employees of the organisation, but provide services to the organisation's patients, have valid credentials.

A system is in place to verify the credentials of private/consultant health professionals that are not employed by the organisation.

In the private sector, this could include medical practitioners, physiotherapists, dieticians, occupational health service providers.

Their contractual agreements with the organisation should include providing proof of registration with the relevant professional body(ies).

Linked criterion:
1.2.7.3

2.5.1.7 The services to be provided are made known to appropriate individuals and units of the organisation.

This criterion relates to the criterion above. The personnel need to be informed of individuals who are privileged by the organisation, e.g. the theatre manager should be informed of general practitioners who are privileged to administer anaesthesia.

Linked criterion:
17.1.1.3

2.6 Quality Improvement

2.6.1 A formalised proactive quality improvement approach is maintained in the service.

Standard Intent

This refers to the implementation of organisational quality improvement process (Service Element 8).

It is the responsibility of the management of the organisation to ensure that standards are set throughout the organisation. Within each department or service, it is the responsibility of managers to ensure that standards are set for the particular department. This requires coordination with the organisation's central/management/coordinating quality improvement structures or systems. Departmental managers use available data and information to identify priority areas, which urgently require quality monitoring and improvement.

The following will be evaluated:

- problems identified in this service for which quality improvement activities were initiated;
- the processes put in place to resolve the problems
- the identification of indicators to measure improvement
- the tool(s) used to evaluate these indicators
- the monitoring of these indicators and corrective steps taken when goals were not achieved
- graphed and/or tabled results, as appropriate

The medical staff's essential clinical roles require them to actively participate in the organisation's efforts to evaluate their performances and clinical care outcomes. At any point during a staff member's monitoring and evaluation, if his/her performance is in question, the organisation has a process to evaluate that individual's performance.

A once off project such as acquiring a specific item of equipment will be scored NC.

2.6.1 Criteria

2.6.1.1 There are formalised quality improvement processes for the service that have been developed and agreed upon by the personnel of the service.

2.6.1.2 Indicators of performance are identified to evaluate the quality of the service.

An indicator, in this context, is a measure used to determine improvements in human resource practices over time.
Refer to the intent for 2.6.1.

2.6.1.3 The quality improvement cycle includes the monitoring and evaluation of the standards set and the remedial action implemented.

2.6.1.4 The performance of individual staff members is reviewed when indicated by the findings of quality improvement activities.

There must be evidence that the outcomes of these audit findings (as stated above) are considered part of individual performance, i.e. during performance appraisals.

Linked criteria:
2.3.2.2, 2.3.3.2
8.2.1.8

2.6.1.5 The performance of individual staff members is reviewed periodically, as established by the organisation.

Linked criteria:
2.3.2.2

SE 3 ADMINISTRATIVE SUPPORT

OVERVIEW OF ADMINISTRATIVE SUPPORT

The administrative support service provides the organisation with effective structures to support patient care. The organisation's leaders need to be able to rely on an effective and efficient administrative support system for the planning, organisation and Coordination of managerial processes. Persons responsible for providing administrative support services must be suitably trained and experienced in, e.g. financial management, human resource management, and in providing equipment and supplies.

The administrative service is frequently the window to the public, i.e. admission and discharge systems and sending and collecting accounts.

The administrative support system ensures an effective filing and storage system for all records, including financial, staff and patient records.

Administrative personnel use quality improvement methods to improve the administrative support structures.

Standards

3.1 Financial Management Support

3.1.1 Budgeting, reporting and auditing processes are consistent with statutory requirements and accepted standards.

Standard Intent

Financial planning and management needs to be conducted by a person who is suitably qualified and experienced in all matters relating to the organisation's finances. Clinical and other leaders need to be included in planning their financial requirements. They also require information relating to the funds available to them for the management of their departments and up-to-date statements of current expenditure. Sound accounting and auditing practices are implemented to ensure transparency.

Financial managers improve their services through quality improvement methods.

3.1.1 Criteria

3.1.1.1 A designated financial manager is responsible for the implementation and maintenance of the financial strategy.

This requires an individual in the organisation who will have the officially assigned duties of overseeing and taking responsibility for all aspects of financial management. In some instances, this may be a shared responsibility between the facility manager and a "financial officer", in which case the latter may not necessarily have the "appropriate" qualifications but one should always be guided by the organisation's specific post requirements in making a final assessment.

There are often documented delegations from the governance structure for this post against which one can measure compliance.

Compliance should not necessarily be compromised in cases of shared responsibility as mentioned above. A judgement call needs to be made, based on the individual arrangements.

A NC rating is allocated when this position is vacant and a PC rating if it is filled temporarily (acting capacity).

Linked criteria:
2.2.1.1

3.1.1.2 The financial manager ensures that policies and procedures are available to guide the staff and that they are implemented.

***Root criterion**

In instances where financial management is guided/regulated by governmental and corporate directives/regulations/policies/procedures, the hospital personnel are not expected to rewrite all of these for compliance purposes, except in those instances where such documentation does not specify the organisation-specific arrangements.

In these instances, hospital personnel must adjust/customise/complement these documents as required.

Linked criteria:
1.2.6.1

3.1.1.3 There is a mechanism for allowing the personnel to participate in the development and management of budgets (e.g. cost centres).

Documented evidence is required of the participation of departmental personnel in the budgetary and financial management processes of the organisation. This can vary widely between different organisations, from minutes of meetings to structured "cost centre based" financial statements.

This criterion will be scored PC where no official cost centres exist and the personnel do not have the opportunity to participate in financial management decisions, e.g. how funds should be allocated and spent, but merely participate in the submission of "wish lists".

Linked criteria:
1.2.8.1, 1.3.1.5
29.1.1.3

3.1.1.4 A monthly report is produced for the organisation's management, setting out the financial position to date.

Evidence should exist in the form of financial statements that are discussed at relevant meetings/committee meetings on a monthly basis.

Linked criteria:
1.2.2.2
6.1.1.1

3.1.1.5 There is a mechanism for establishing the reason for budget variation in either income or expenditure.

Evidence should exist in the format in which financial statements are produced. Generally, these statements contain a column/section indicating the variance, i.e. under or over expenditure. Evidence showing what is done about this variance (especially over-expenditure), should be available, e.g. in the minutes of relevant financial management meetings.

3.1.1.6 Annual financial statements are produced at the end of the financial year.

National arrangements will apply, but hospitals should have documented evidence of such submissions. Also, financial audit reports may reflect findings of such compliance.

3.1.1.7 Internal/external audit reports and responses thereto are available.

Critical criterion

Linked criteria:
1.2.1.5, 1.2.5.1, 1.2.5.5
7.1.1.1

3.1.1.8 There is a capital asset register, which is routinely maintained.

An inventory is not synonymous with a capital asset register, but is one component of the register. In order to be compliant, the capital asset register must be based on/include a complete inventory of all capital items, each item properly identified with model and serial numbers (as applicable) or bar code, with the listing of the purchase price, replacement value, and depreciation value.

The following can be regarded as a minimum data set for a capital (fixed) asset register:

- *a description and identification of each asset*
- *location in the organisation*
- *date of acquisition*
- *projected life span e.g. equipment, vehicles;*
- *purchase price*
- *depreciation cost*
- *replacement cost.*

Organisational policy will determine what is regarded as a capital item. This may differ between organisations.

Linked criteria:
1.3.1.5
19.1.4.3
31.2.1.1

3.1.1.9 There is a capital asset replacement programme.

A documented system is required to show how the organisation plans for the replacement of capital asset items. The capital asset register (3.1.1.8 above) is meant to form the basis on which such planning is done. The term "programme" implies that this process is linked to the budget and incorporates a multi-year approach based on information included in the capital asset register such as life span and replacement values.

3.1.1.10 There is a mechanism to ensure that the level of debtors is kept to a minimum.

Evidence of the implementation of relevant processes must be found in documented analysis of the outstanding debts.
Normally, this means that there will be documented evidence of the regular age analysis of outstanding debts/accounts, i.e. what amount is outstanding for 30, 60, 90, 120 day, and recorded evidence of actions taken to recover the money.

3.2 Health Record Management

3.2.1 There is a system for the management of health records, which meets the needs of confidentiality and safety.

Standard Intent

Health record management must be implemented by a person with suitable training and experience. The manager controls the safe storage and retrieval of health records. Health records must be readily available each time the patient visits a healthcare professional, and therefore must be filed in such a way that they are easily identified. Policies and procedures, as well as managerial supervision, ensure the safety and confidentiality of health records. Loss of information may be through electronic failure, fire, flood, or natural or man made disasters. The organisation develops and implements a policy that guides the retention of health records and other data and information. Health records and other data and information are retained for sufficient periods to comply with law and regulation and support patient care, the management of the organisation, legal documentation, research and education. The retention policy is consistent with the confidentially and security of such information. When the retention period is complete, health records and other data and information are destroyed appropriately.

Facilities make more use of electronic systems, requiring these standards and criteria to be assessed appropriately in such instances. These electronic systems vary greatly in their application and can range from a simple spreadsheet, which registers all patient admissions/folders, to very sophisticated systems, where the entire health record is kept electronically.

Often organisations do not have a single central location from where records are managed and it is important to apply the standards and criteria to all areas where health records are being handled, stored or archived. All these areas (that are under the control/management of the organisation) need to be assessed, even if located off-site, e.g. across the street, on an adjacent plot (within reasonable travelling distance). This assessment does not include warehouses of private companies to whom the archiving of records has been contracted as the service agreement/contract will have to make provision for the monitoring of compliance with specifications (refer to standard 1.2.7).

3.2.1. Criteria

3.2.1.1 A designated individual is responsible for the storage, maintenance and retrieval of health records.

This evidence should be available in the individual's job description, performance agreement and work profile.

Linked criterion:
2.2.1.1

3.2.1.2 The health record manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

Root criterion *for all criteria below.*

Linked criterion:
1.2.6.1

3.2.1.3 There is a written policy for addressing the privacy and confidentiality of information that is based on and consistent with law and regulation.

Critical criterion

Linked criteria:
1.2.1.4, 1.2.5.1
3.2.1.12
4.1.1.6
5.2.1.3
6.1.2.1

3.2.1.4 Originals of all reports by medical, nursing and other health professionals are filed in the records.

This criterion refers to the "availability" and thus the completeness of the records. Its score should therefore be consistent with other linked (root) criteria that focus on the patient records, e.g. 1.3.2.4 and 10.1.2.3 and similar criteria in other in-patient services.

Note that this does not refer to an "administrative" check only, but should link up with the record audit process.

The reference to "medical" records includes reports by doctors, laboratories, radiology and any other "clinical investigation" reports.

Linked criteria:
1.3.2.4
8.2.1.5

3.2.1.5 A documented policy regarding records that are kept separately (e.g. psychiatric, social work, motor vehicle accidents) is implemented.

This criterion does ***not*** *require that records* ***should*** *be kept separately, but rather states the need for a policy in those instances where certain records are stored separately. Records kept outside of the central department and archives must also be taken into account, e.g. in other clinical departments such as outpatients, the dental clinic, social work, physiotherapy and the HIV/AIDS clinic.*

3.2.1.6 There is a system that allows for the rapid retrieval and distribution of health records.

This refers to the manner in which the records are filed and organised in order to allow for easy retrieval of records and making them available for the required

intervention. It therefore considers not only the function within the health record room or archive, but also the activities that involve the movement of health records to the end-point of use.

3.2.1.7 There is a communication system for the request of health records.

This refers to the process that is followed by the personnel in the rest of the organisation, and others, when requesting patient folders from the health record management section.

The guideline must clearly state who may request patient records and under what circumstances. This should include both internal and external (such as requests from the police or lawyers) requests. At all times, the possibility of a breach of confidentiality must be reduced, if not eliminated entirely.

3.2.1.8 The organisation implements a policy regarding patients having access to their health information and the process for gaining access when permitted.

3.2.1.9 There is an effective monitoring system (e.g. by using tracer cards) whereby records can be traced within the facility at all times.

Different applications of this principle may be in use, e.g. actual tracer cards that are filed in the positions where the health records are removed from the shelf/drawer with entries on the cards showing the records' destinations. This information can be entered into a register or electronic health record instead, as long as the system in use allows the health record to be traced at any given time.

In some instances, the paper-based tracer card is used only for health records that are retrieved for purposes other than patient consultations. In this case, most of the health records are not traceable, unless there is another system that can indicate that a patient is attending on that day or has been admitted.

Merely recording health record numbers as the records leave the department renders this criterion PC, as one has to search through all the entries for a specific health record.

Linked criterion:
1.3.2.3

3.2.1.10 The filing system allows for incorrectly filed records to be easily identified (e.g. by using colour coding).

*Please note that a colour coding system is merely an option and **not** a requirement. Organisations may apply different methods as long as the system allows for the identification of such misfiling. Assessors need to use their own judgement as some of the colour-coding systems in use are ineffective in providing such control, e.g. when the different types of patients (maternity, paediatrics, HIV, Road Traffic Accidents are allocated a specific colour, which is intended for the easy identification of files and has no bearing on the "misfiling" aspect.*

3.2.1.11 There is provision for authorised access to health records at all times.

The organisational policy framework needs to indicate who these "authorised" individuals are and the arrangements should be such that there are "authorised" individuals available 24 hours a day.

There may be no "health record personnel" on duty after hours; nurses will then manage the administrative admission process and this allows them access to the health record section without their necessarily being "authorised" in writing to have such access.

Linked criterion:
7.1.1.1

3.2.1.12 Where electronic health records are used, there is a system to protect the integrity of the records.

Access control systems to ensure that only authorised individuals have access to and may make entries into health records must be implemented. Back-up process to prevent loss of information must be in place.

3.2.1.13 All storage areas for health records are secure against unauthorised entry.

This applies to areas where current as well as archived records are stored. Where departments or services keep separate records e.g. psychiatric and social work records, the processes for storage will be assessed on site.

The criterion is not specific in terms of what type of access control should be in place but it is expected that some form of access control is exercised, such as locked doors or security gates, the provision of electronic access control codes, etc. Burglar bars should be fitted to windows in the absence of intruder alarm systems. The latter is particularly important for the security of archives that are not manned 24 hours a day.

Linked criteria:
1.2.2.3
3.2.1.3

3.2.1.14 The organisation's policy on the retention of health records and other data and information is implemented.

Compliance will be assessed against the individual organisation's policies, but it is of value to study the national legal requirements.
Note that the criterion refers to "other data and information" that does not form part of the actual patient record. Assessing this aspect will depend on the content of the organisation's policy.

3.2.1.15 Policies and procedures for health record destruction, specifying the criteria for selection and the method of destruction of records, are implemented.

This criterion can never be scored NA because even if the organisation does not destroy patient information, the alternative arrangements must be clearly stated in a policy framework.
It is important to assess the implementation of the policy e.g. where the records earmarked for destruction are stored.

3.3 Procurement and Provisioning of Supplies

3.3.1 There is a system to ensure that equipment and supplies are ordered, available, stored and distributed from a central point.

Take note of the reference to a "central point", i.e. the operating of central stores. This refers to a fully-fledged "Provisioning and Supply" or "Supply Chain Management" system as is often found in the Public Sector. This is generally not the case in the private sector where supplies are delivered directly to the end user after having been signed in at a central "administrative" point – purely for payment purposes. Therefore, standard 3.3.2 should be regarded as NA in instances where there are no "main" or "central supply stores". The process standard (3.3.1) is applicable in all instances.

Standard Intent

A competent and qualified person ensures the effective administration of the provisioning department. This includes the timely ordering of equipment and supplies, safe storage, prevention and notification of losses, effective distribution to departments on request, and maintenance of information relating to ordering, receipt, storage and distribution of equipment and supplies. Managers need to be assured that all equipment and supplies needed by departments will be immediately available on request.

Policies and procedures guide the processes of provisioning management. Such policies could include the ordering of and the payment for supplies and equipment, the safe storage of supplies, condemning procedures and the security of order books, prescription pads and other face-value documents.

The organisation's leaders need to ensure that finances are made available for the purchase of those items of equipment and supplies which have been identified as needed by clinical and managerial leaders. The provisioning managers therefore need to work closely with the financial manager.

The high costs of hospital supplies and equipment make it essential that sound auditing practices are in place to ensure control of the financial aspects of provisioning. A management information system must track all inventory. Expenditure on equipment and supplies is transparent, and all records must be monitored and available to managers and auditors for accounting.

3.3.1 Criteria

3.3.1.1 An individual is designated to control the ordering, storage, distribution and control of equipment and supplies used in the organisation.

Depending on the specific organisational arrangements, one may tend to regard 3.3.1.1, 2 and 3 as NA. However, these functions need to be assessed in all instances as there should be somebody who performs them, even though the person may not necessarily be a designated/appointed "provisioning and supply manager"

Linked criteria:
2.2.1.1

3.3.1.2 The provisioning manager ensures that policies and procedures are available to guide the personnel and that they are implemented.

***Root criterion** for the criteria that follow*

Linked criteria:
1.2.6.1
31.2.1.11

3.3.1.3 A record is kept of goods received and goods issued.

Such a record can be either paper-based or electronic. The use of "BIN cards" is included here. All records should be up to date.

Linked criteria:
1.3.1.5

3.3.1.4 Records are audited.

3.3.1.5 All losses are investigated, reported and recorded.

This forms part of the policy framework required in criterion 3.3.1.2 and should be assessed accordingly. In many instances this will also form part of the internal audit process.
Organisations in the public sector are required to keep a "loss control register" that should contain this information, which is supplemented with a range of other forms to be completed for the reporting and investigation processes.
A stock-taking report must be available.

Linked criteria:
1.2.2.2
7.1.1.1, 7.1.1.7
27.2.3.8

3.3.1.6 There is an inventory of all goods stored.

Either paper-based or electronic systems can be used.

Linked criterion:
6.1.1.1

3.3.2 All equipment and supplies are safely stored.

Standard Intent

The storage of equipment and supplies must allow for security, ease of access, and effective inventory taking. Acts and regulations, as well as policies and procedures, guide the storage of equipment and supplies.

The administrative support service ensures that supplies and provisions are ordered, received and provided to departments in time to meet their needs.

This standard is scored NA if the physical facility (central main store) does not exist, e.g. in small hospitals or private hospitals where ordered items go straight to ward/department on delivery.

Please note that 3.3.2.2 (storage of hazardous and flammable materials) applies to this central store ONLY. Criteria in other SEs should be used to assess such storage in other areas of the facility.

3.3.2 Criteria

3.3.2.1 Secure storage facilities are available.

Root criterion

Linked criteria:
1.2.2.3
7.1.1.1

3.3.2.2 Hazardous and flammable materials are stored in accordance with relevant regulations.

Critical criterion

National regulations apply. Where applicable, inspection by the local fire authority should include these storage areas.

Hazardous and flammable materials are defined by local law or organisational policy.
Note that this criterion deals only with the storage areas under the management of the provisioning and supplies section.

Linked criteria:
1.2.1.4
7.5.1.1

3.3.2.3 Separate designated storage areas for a) receiving and b) unpacking incoming goods are provided.

This criterion measures the availability of space for the two functions mentioned. The ideal situation would be the availability of separate enclosures, but "functionally" separate areas would be acceptable.

3.3.2.4 Arrangements, including alarm systems and door access controls, are used to provide security.

The store must be lockable and exclude any unauthorised entry.

Linked criterion:
7.4.1.1

3.3.2.5 There is adequate storage space to enable the retrieval and removal of equipment and supplies, when needed.

Equipment is stored in an organised manner in a secure facility (adequate shelving, goods are stored above floor level, different types of supplies are separated, etc).
This criterion will be scored PC if the store is overcrowded, untidy or it is difficult to get to equipment and stock.

3.4 Use of Motor Vehicles

3.4.1 *The use of organisational motor vehicles by personnel is planned and monitored to ensure safety and legality*.

Standard Intent

The use of vehicles needs to be controlled because of the cost of acquiring and maintaining vehicles and the legal aspects of driving motor vehicles and transporting passengers.

3.4.1. Criteria

3.4.1.1 A specific manager is identified for the control, use and maintenance of vehicles.

This can be assessed by means of the organisational chart and the "responsible" person's job description.

Linked criterion:
2.2.1.1

3.4.1.2 The need to use transport is established by the management of the organisation in consultation with the users of vehicles and is reviewed annually.

This criterion implies that the organisation assesses its transport requirements at least once a year. There should be documented evidence that the "users/different departments" have had input into the process by making management aware of their needs.

In assessing the level of compliance, adequate provisioning of transport should be assessed during the evaluation of relevant individual departments, e.g. social work, maintenance.

Linked criterion:
1.2.2.2

3.4.1.3 There is a system for monitoring the use of vehicles (e.g. permission, records).

Evidence of this is normally in the form of "trip authorisation forms" in the case of the public sector and other types of written communication (email, electronic requests) in the private sector. Some organisations do "utilisation reviews" which can include records of the frequency of use of vehicles, by whom and for what purposes.

Satellite tracking systems also come into play here.

3.4.1.4 There is a system for booking vehicles in advance.

Various systems are in use in different organisations and the assessment of compliance with this requirement should focus on the existence of documented evidence of such arrangements.

3.4.1.5 There is a control system for mileage travelled.

This generally refers to keeping "log books" for each vehicle that should reflect mileage travelled for each trip as authorised. It is important that there should be recorded/documented evidence that these log books/sheets are checked and audited; this constitutes the required "control system". The criterion does not require evidence of "distance tables" for most commonly travelled trips but such tables do assist in the monitoring/control process.

3.4.1.6 There is a vehicle maintenance plan.

This criterion requires some form of documented system to ensure that vehicle maintenance is planned. The score of this criterion will be determined by the compliance rating of the next criterion, which refers to the implementation of this plan.

Linked criterion:
3.4.2.5

3.4.1.7 There is proof of vehicle maintenance.

Linked criterion:
3.4.2.5

3.4.1.8 There is proof of current licensing of vehicles.

Critical criterion

Motor vehicle licensing in accordance with national requirements should be included in the assessment.

Linked criteria:
1.2.1.4
7.1.1.1

3.4.1.9 Drivers of vehicles are suitably licensed.

Critical criterion

Although various systems are in use, the principle is that there should be a documented control process to ensure that all authorised drivers of the vehicles do have current, valid driver's licences, in accordance with national requirements.

Where required, ambulance drivers should also have additional training in defensive driving and conditions that warrant the violation of existing traffic laws.

Linked criteria:
1.2.1.4
7.1.1.1

3.4.2 The organisation provides a medical transport/ambulance service in line with relevant laws and regulations.

Standard Intent

A comprehensive response and deployment plan addresses the location of facilities and distribution of vehicles, personnel and other resources. These should be deployed in a way that optimises their use and provides uniform care across the area served.

This section will only apply where the organisation provides its own ambulance service.

3.4.2 Criteria

3.4.2.1 The organisation has a written response and deployment plan including the identification of response areas and availability of response units.

The organisation's documented plan should include at least the following:
- *identification of the service's catchment area*
- *identification of vehicle and staffing requirements*
- *provision of communication systems*
- *a prioritisation process for medical transport/ambulance requests*
- *coverage of peak periods*
- *response to multiple victim incidents*
- *response to disasters.*

3.4.2.2 Response time standards are monitored against national laws, regulations, policies or guidelines.

Critical criterion

National specific requirements apply.
Analysed data of response times must be available.

Linked criteria:

1.2.1.4
7.1.1.7

3.4.2.3 The organisation designs and implements processes to provide coordination of services among other organisations and agencies in the community.

3.4.2.4 The individuals who provide patient care in the ambulance services have the required training and experience.

Critical criterion

The personnel receive appropriate patient management training, depending on the level of service provided.
The personnel should also be trained to:

- *operate and maintain medical equipment;*
- *operate and maintain communication equipment;*
- *operate vehicles safely, including under conditions that warrant the violation of existing traffic laws.*

Linked criteria:
1.2.2.2
2.5.1.2
22.11.5.5
24.11.5.5

3.4.2.5 The organisation plans and implements processes for inspecting, testing and maintaining equipment and supplies.

There is an inventory of all equipment.

There is documented evidence that equipment and supplies are checked daily and after use, in accordance with organisational policy.
There is a process for retrieving equipment from facilities to which patients have been transported.

Linked criteria:
3.4.1.6

3.4.2.6 The organisation maintains its medical transport/ambulance vehicles to reduce risk and promote safety.

There is evidence of medical transport/ambulance maintenance, which *includes tracking vehicle failures.The organisation has a documented, current, accurate vehicle inspection record.*

Linked criteria:
3.4.1.7
7.1.1.1

3.4.2.7 Medical transport/ ambulance vehicles are clean.

The organisation's policy framework should include at least the following:

- *the sites at which vehicles may be cleaned;*
- *the cleaning methods and chemicals to be used for cleaning vehicles;*
- *healthcare waste management;*
- *preventing pollution of the environment by cleaning chemicals and clinical/healthcare waste;*
- *training personnel in proper cleaning methods.*

SE 4 ACCESS TO CARE

OVERVIEW OF ACCESS TO CARE

A healthcare organisation should consider the care it provides as part of an integrated system of services, healthcare professionals, and levels of care, which make up a continuum of care. The goal is to correctly match the patient's healthcare needs to the services available, coordinate the services provided to the patient in the organisation, and then plan for discharge and follow up. The result is improved patient care outcomes and more efficient use of available resources.

Information is essential for making correct decisions about:

- which patient needs can be met by the healthcare organisation
- the efficient flow of services to the patient; and
- the appropriate transfer or discharge of the patient to his or her home or another care setting.

In order to meet the community's needs for services, the organisation needs to clearly define the boundaries of the community, and the boundaries of the services provided by the organisation, and to involve the community in the planning for care. The community needs to be provided with information relating to the services offered by the organisation, the hours at which services are offered, and how to obtain access to care.

Standards

4.1 Access to Care

4.1.1 Patients are admitted to receive inpatient care or registered for outpatient services, based on their identified healthcare needs and the organisation's mission and resources.

Standard Intent

To improve access to its services, the healthcare organisation provides information to the community on its services and hours of operation and how to obtain care.

Only those patients for whom the organisation can be expected to provide care enter the organisation.

Matching patient needs to the healthcare organisation's mission and resources depends on obtaining information on the patient's needs and condition through screening at the first point of contact. The screening can occur at the referral setting, during emergency transport, or when the patient arrives at the organisation.

The screening assessment leads to an understanding of the type of preventive, palliative, curative and rehabilitative services needed by the patient. This information is used to determine the most appropriate setting(s) required to meet the patient's most urgent needs. Thus, admission to the organisation and/or referral to another setting may be required to meet the patient's needs.

The patient's needs may have been determined before entering the organisation by a physician or other organisation. If the patient's needs had not been determined prior to entry, those needs are identified through a triage process, screening assessment, or medical history and physical examination of the patient. Diagnostic testing may also be required to:

- determine the patient's needs
- determine if the organisation has the appropriate resources to treat the patient, or
- establish if the patient should be referred or transferred to another setting for care.

For emergency or critical patients, the needs are clear and diagnostic testing follows admission. Diagnostic test results are made available to those who must decide on further management in the facility, transfer or referral of the patient.

Patients are informed when there are known long waiting periods for diagnostic and/or treatment services or when obtaining the planned care may require placement on a waiting list. Patients are informed of the associated reasons for the delay or wait and are informed of available alternatives. This requirement applies to inpatient and outpatient care and/or diagnostic services, not to minor waits in providing outpatient care or inpatient care as when a physician is behind schedule.

4.1.1 Criteria

4.1.1.1 Information on services, hours of operation and processes to obtain care are provided to agencies and referral sources in the community, and to the population served.

This indicates some form of publicity and advertising by means of the notice-boards, media, brochures, open days, websites, helpdesk etc.

Linked criteria:
1.2.4.2

4.1.1.2 Directional signage to the organisation is clearly visible from all main access roads.

4.1.1.3 The name of the organisation and the services provided is clearly indicated on the site.

This could include the level of service according to local classifications and the types of specialities that are provided.

4.1.1.4 Adequate parking is made available for patients and visitors.

4.1.1.5 Directional signage within the organisation includes the most commonly used local languages and relevant symbols.

To accommodate individuals, who may be illiterate, appropriate signage should be provided. This could take the form of different colours for the various departments. There would be arrows in the different colours on the walls or painted footprints on the floor.

4.1.1.6 There are areas for staff to obtain and give confidential information in privacy.

Linked criteria:
1.2.2.3
3.2.1.3
5.2.1.2
19.4.1.2
20.4.1.2
22.2.1.2, 22.13.1.2
23.2.1.2, 23.13.1.2
24.2.1.2, 24.13.1.2

4.1.1.7 Screening is initiated at the point of first contact with the organisation.

***Root criterion** for those that follow.*

Screening of the patient should take place, on arrival at the facility, for the type of care being sought, to ensure prompt direction and management.
This includes the triage of patients in the emergency unit.

The screening assessment should be fully documented (patient registers, patient records or patient held cards).

Linked criteria
4.2.2.4
22.6.1.1
23.1.3.1
24.1.3.1
24.6.1.2

4.1.1.8 The screening assessment leads to an understanding of the type of preventive, palliative, curative and rehabilitative services needed by the patient.

4.1.1.9 The suitability of the patient for admission is based on the results of the screening, in accordance with the mission and resources of the organisation.

In the private sector, admission is generally restricted to those patients who belong to a medical aid scheme or who are able to pay for treatment. However, all hospitals are obliged to provide initial resuscitation in an emergency and transfer the patient to a suitable facility only when their condition has stabilised.

4.1.1.10 Patients are accepted only if the organisation has the ability to provide the necessary services and settings for care.

The necessary guidelines/protocols for transfer of patients, who do not meet the admission criteria, are documented.
Linked criteria:
1.2.5.3, 1.2.5.4
4.2.2.3
22.2.2.10, 22.11.5.1
23.2.2.8
24.2.2.9, 24.11.5.1

4.2 Admission Processes

4.2.1 The organisation seeks to reduce physical, language, cultural and other barriers to access and delivery of services.

Standard Intent

Organisations frequently serve communities with a diverse population. Patients may be aged, have disabilities, speak multiple languages or dialects, be culturally diverse, or present other barriers that make the process of entering the organisation and receiving care very difficult. The organisation is familiar with these barriers and has implemented processes to eliminate or reduce these barriers during the entry process. For instance, wheelchairs will be available for the physically disabled, the staff will be trained to communicate with the hard of hearing, and translation services will be available for those who speak foreign languages. Mechanisms for meeting these needs will be documented and known to the staff.

4.2.1 Criteria

4.2.1.1 The organisation has identified the barriers in its patient population.

4.2.1.2 There is a process to limit the impact of barriers on the delivery of services.

An example could be the availability of telephonic access to the hospital by the public. How long does it take for the hospital telephone to be answered?

4.2.1.3 Parking is made available close to the building entrance for physically challenged people.

4.2.1.4 There is wheelchair access to and within the building.

Linked criteria:
22.2.1.6
23.2.1.6
24.2.1.6

4.2.1.5 Ramps and stairs include safety features such as rails.

Linked criterion:
7.2.5.3

4.2.2 The organisation has an established process for admitting inpatients and for registering outpatients.

Standard Intent

The process for admitting patients to the organisation for care is standardised through the use of policies and procedures. Staff responsible for the admission process, are familiar with and follow the standardised procedures. The policies and procedures address the admission of patients directly from the emergency service and the process for holding patients for observation. The policies also address how patients are managed when inpatient facilities are limited or no space is available to admit patients.

Patients with emergency or immediate needs are assessed and receive the necessary care as quickly as possible. Such patients may be assessed by the physician before other patients, receive diagnostic services and have treatment initiated to meet their needs as rapidly as possible. The organisation establishes criteria and trains the staff to recognise those patients with immediate needs and prioritise their care process.

4.2.2 Criteria

4.2.2.1 Policies and procedures are used to standardise the outpatient registration process.

There is a documented process for the registration of out-patients by both administrative and clinical personnel. The process must include documentation requirements, clinical observations and investigations, patient identification requirements, record keeping, etc.

Linked criteria:
1.2.5.4
7.2.1.1

4.2.2.2 Policies and procedures are used to standardise the inpatient admitting process.

There is a documented process for the admission of in-patients by both administrative and clinical personnel. The process must include documentation requirements, clinical observations and investigations, patient identification requirements, record keeping, etc.

Linked criteria:
1.2.5.4
7.2.1.1

4.2.2.3 The policies and procedures address the admission of emergency patients to inpatient units.

The policies on admission of emergency patients should include the identification of medical emergencies and trauma as well as the criteria for patients, who require priority treatment.

Linked criteria:
1.2.5.4
4.1.1.10

4.2.2.4 Patients with emergency or immediate needs are prioritised, according to established criteria, for assessment and intervention.

Critical criterion

All personnel who interact with patients during the initial contact phase should be trained to recognise emergencies and apply the criteria for prioritisation of patients.

Linked criteria:
1.2.5.4, 1.3.2.2
4.1.1.7
22.6.1.2
23.1.3.1, 23.1.3.5
24.1.3.1, 24.1.3.6

4.2.2.5 Policies and procedures that address the holding of patients for observation are implemented.

If patients are held in the casualty/emergency unit/day ward or OPD areas for observation without going through the formal admission procedure, policies should direct staff on patient safety, clinical observations and record keeping as well as the maximum length of stay in the holding area.

Linked criteria:
22.11.2.1
23.9.2.4
24.11.2.1

4.2.2.6 Policies and procedures that address the management of patients when bed space is not available in the desired service or unit or elsewhere in the facility are implemented.

Where there is evidence of overcrowding, this criterion will be scored PC or NC depending on the extent of the problem.

Linked criteria:
1.2.2.3
10.2.1.1 and similar criteria in all in-patient services.
22.2.1.1, 22.11.3.4
23.2.1.1
24.2.1.1, 24.11.3.4

4.2.2.7 Policies and procedures for the management of patients deceased prior to arrival are implemented.

4.2.3 At admission as an inpatient, patients and their families receive sufficient information to make informed decisions.

Standard Intent

During the admission process, patients and their families receive sufficient information to make an informed decision about seeking care. Information is provided on what care is proposed, the expected results, and any expected cost to the patient or family for that care, when this is not paid for by a public or private source. Patients and families need complete information on the care and services offered by the organisation, as well as on how to access those services. Providing this information is essential to the building of an open and trusting communication between patients, families and the organisation. This information helps to match the patient's expectations to the ability of the organisation to meet those expectations. Information on alternative sources of care and services is provided, when the needed care is beyond the organisation's mission and capabilities.

For patients and families to participate in care decisions, they need basic information regarding the medical conditions, found during assessment and on the care and treatment proposed. Patients and families understand when they will be given this information and who is responsible for telling them. Patients and families understand the type of decisions that must be made about care and how to participate in those decisions. In addition, patients and families need to understand the organisation's process to obtain consent and which care processes, tests, procedures and treatments require their consent.

While some patients may not wish to personally participate in the decisions regarding their care, they are, nevertheless, given the opportunity, and can choose to participate through a family member, friend or a surrogate decision-maker.

4.2.3 Criteria

4.2.3.1 There is a process to provide patient/family with information at admission.

Refer to intent statement.

***Root criterion** for those below.*
This section refers to the process following admission i.e. the initial management of the patient by the relevant clinical service.

*All the criteria in this standard will be assessed from information received from **patient record audits** and **patient interviews**.*

Linked criteria:
5.6.1.4

4.2.3.2 The process includes information on the proposed care and the expected results of care.

Linked criteria:
10.8.1.2 and related criteria in all the clinical SEs.

4.2.3.3 The process includes information on any expected costs to the patient or family.

Linked criteria:
1.2.5.5
10.8.1.4 and similar criteria in in-patient services.

4.2.3.4 Patients receive sufficient information to make knowledgeable decisions.

Linked criteria:
5.6.1.5

4.2.4 Admission or transfer to units providing intensive or specialised services is determined by established criteria.

Standard Intent

Units or services that provide intensive care (for example a post-surgical intensive care unit) or that provide specialised services (for example the care of patients with burns, or organ transplant units), are costly and usually have limited space and staff. Each organisation must establish criteria for identifying those patients who require the level of care provided in such units. Appropriate individuals from the intensive or specialised services participate in developing those criteria. The criteria are used to determine direct entry to the unit, for example directly from the emergency service.

The criteria are also used to authorise transfer into the unit from within or outside the organisation, and in deciding when a patient no longer requires the services of the unit and can be transferred to another level of care.

4.2.4 Criteria

4.2.4.1 The organisation has established entry and/or transfer criteria for its intensive and specialised units, including research and other programmes to meet special patient needs.

Documented criteria for admission or transfer to all specialised units or services are available e.g. ICU's, High Care, Neonatal, Burns, Renal Dialysis, Oncology, Psychiatric and Rehabilitation Units etc.

4.2.4.2 The criteria are physiologic-based where possible and appropriate.

4.2.4.3 Appropriate individuals are involved in developing the criteria.

4.2.4.4 Personnel are trained to apply the criteria.

Evidence of training could take the form of policies/procedures/guidelines, which are used to ensure that correct methods are implemented in prioritising emergency patients.

This criterion will be scored PC/NC if 4.2.4.1, 4.2.4.5 and 4.2.4.6 are not compliant.

4.2.4.5 Patients transferred or admitted to intensive and specialised units/services meet the criteria, as documented in the patient's record.

*The score of this criterion will be derived from the **patient record audits** in the relevant departments/units.*

4.2.4.6 Patients who no longer meet the criteria to remain in the unit are transferred or discharged.

*The score of this criterion will be derived from the **patient record audits** in the relevant departments/units.*

SE 5 PATIENT AND FAMILY RIGHTS

OVERVIEW OF PATIENT AND FAMILY RIGHTS

Each patient is unique, with his or her own needs, strengths, values and beliefs. Healthcare organisations work to establish trust and open communication with patients and to understand and protect each patient's cultural, psychosocial and spiritual values.

Patient care outcomes are improved when patients, and, as appropriate, their families or those who make decisions on their behalf, are involved in care decisions and processes in a way that matches cultural expectations.

To promote patient rights in a healthcare organisation, one starts by defining those rights, followed by educating patients and the staff about those rights. Patients are informed of their rights and how to act on them. The personnel are taught to understand and respect patients' beliefs and values and to provide considerate and respectful care, thus protecting the patients' dignity.

This chapter addresses processes to:

- identify, protect and promote patient rights
- inform patients of their rights
- include the patient's family, when appropriate, in decisions about the patient's care
- obtain informed consent
- educate the staff about patient rights and
- guide the organisation's ethical framework.

How these processes are carried out in an organisation depends on its national laws, regulations, charters, and any international conventions, treaties or agreements on human rights endorsed.

The implementation of patient rights is dependent on the healthcare organisation providing equitable services.

Standards

5.1 Implementation of Patient Rights

5.1.1 The organisation is responsible for providing processes that support patient and family rights during care.

Standard Intent

An organisation's leaders are primarily responsible for the way in which that organisation treats its patients. The leaders need to know and understand patient and family rights and their organisation's responsibilities as specified in laws, charters and regulations. The leaders provide direction to ensure that personnel throughout the organisation assume responsibility for protecting these rights. To effectively protect and advance patient rights, the leaders work collaboratively, and seek to understand their responsibilities in relation to the community served by the organisation.

Patient and family rights are a fundamental element of all contacts between the personnel of an organisation and patients and families. Thus, policies and procedures are developed and implemented to ensure that all staff are aware of and respond to patient and family rights issues, including their role in supporting patients' and families' rights to participate in the care process.

Admission to a healthcare organisation can be a frightening and confusing experience for patients, making it difficult for them to understand and act on their rights. Thus, the organisation prepares a written statement of patient and family rights, and this is given to patients when they enter the organisation for care, and is available throughout their stay for e.g., the statement may be posted in the facility.

The statement is appropriate to the patient's age, understanding and language. When written communication is not effective or appropriate, the patient and family are informed of their rights in a manner they can understand.

Each patient brings his or her own set of values and beliefs to the care process. Some values and beliefs are commonly held by all patients and are frequently cultural and religious in origin. Other values and beliefs are those of the patient alone. All patients are encouraged to express their beliefs in ways that respect the beliefs of others.

Strongly held values and beliefs can shape the care process and how patients respond to care. Thus, each care provider seeks to understand the care and services they provide within the context of the patient's values and beliefs. The organisation educates all personnel about the rights of patients and families. The educational process recognises that personnel members may hold values and beliefs that are different from the patients under their care. The educational process includes training each staff member how to identify patient values and beliefs, and how to respect those values and beliefs in the care process.

5.1.1 Criteria

5.1.1.1 The leaders of the organisation work collaboratively to protect and advance patient and family rights through an established framework.

Root criterion

This refers to multi-disciplinary participation and responsibility to ensure the implementation of all aspects pertaining to patient and family rights. Evidence of such collaboration can exist in the form of meetings, policies and procedures, information sharing sessions, in-service training, relevant entries in patient records, etc.

Linked criteria:
1.2.5.1
7.1.1.1

5.1.1.2 Patient and family rights are identified and documented in accordance with relevant and current laws, charters and regulations.

This refers to national requirements on human and patients' rights, e.g. the National Patient Rights Charter applies.

5.1.1.3 Policies and procedures that guide and support patient and family rights in the organisation are implemented.

These are the operational documents that will guide staff on the implementation of whatever rights are stated in 5.1.1.2.

Policies should include the rights of children, the elderly and other vulnerable individuals, who may be unable to insist on their rights. Healthcare professionals must be guided by the policies and procedures e.g. what to do when parents or relatives make decisions on behalf of patient, which may not be in the best interest of the patient.

Linked criteria:
1.2.6.1
10.11.1.1 and equivalent criteria in all clinical services

5.1.1.4 Personnel are trained on the policies and procedures and their participative role in the implementation of patients' rights.

Evidence of such training can exist in various forms such as formal in-service training sessions, meetings where policies and procedures are discussed, staff acknowledging in writing that they have studied policies and procedures, etc.

Linked criterion:
2.4.2.1

5.1.1.5 Each patient is given information about his/her rights in a language that he or she can understand.

The organisational policy framework will determine how this is done but it basically requires that patients have access to written material on their rights, e.g. posters, pamphlets, handouts, insertions in patient folders, video material, etc.

Interpreters are available if required.
Compliance will also be assessed during patient interviews.

5.1.1.6 Processes ensure that care is considerate and respectful of the patient's personal values and beliefs.

Refer to criterion 5.1.1.3.
Compliance will be assessed during patient interviews.

Linked criterion:
26.7.1.2

5.2 Protection of Privacy, Person and Possessions

5.2.1 The organisation takes measures to protect patient privacy.

Standard Intent

The organisation ensures that the patient's needs for privacy are respected, especially when the patient is providing personal information and undergoing clinical examination. Patients may desire privacy from other staff, other patients, and even from family members.

Medical and other health information, when documented and collected in a patient record or other form, is important for understanding the patient, his or her needs, and for providing care and services over time. The organisation respects such information as confidential, and has implemented policies and procedures that protect such information from loss or misuse. The staff respects the confidentiality of patient information by not posting information on the patient's door or at the nursing station and by not holding patient-related discussions in public places. The misuse of patient information can result in the patient's loss of dignity, employment, and damage to personal or family relationships. Misuse can be by the staff of the organisation, family members, or others not authorised to have access to the information.

When the organisation takes responsibility for any or all of the patient's personal possessions brought into the organisation, there is a process to account for those possessions and ensure that they will not be lost or stolen. This process considers the possessions of emergency patients, those patients unable to make alternative safekeeping arrangements and those incapable of making decisions regarding their possessions. The organisation communicates its responsibility, if any, for the patient's possessions to patients and families.

5.2.1 Criteria

5.2.1.1 The patient's need for privacy is protected during all examinations, procedures and treatments.

Linked criteria:
1.2.5.1
10.11.1.2 and similar criteria in in-patient services.
32.2.1.4 and similar criteria in SEs 33 to 38

5.2.1.2 The patient's need for privacy is protected when providing personal information.

As above, but also includes areas such as the main reception desk or pharmacy.

Linked criterion:
4.1.1.6

5.2.1.3 The organisation respects patient health information as confidential.

Critical criterion

Note that this applies to all settings where patient information is handled, from admission to discharge.

Linked criteria:
1.2.1.4, 1.2.5.1
3.2.1.3
6.1.2.1
10.11.1.2 and similar criteria in in-patient services.
32.7.1.2 and similar criteria in SEs 33 to 38

5.2.1.4 Patients receive information on the organisation's level of responsibility for patients' possessions.

Policies and procedures should include the "kitting" process, care of valuables, fire-arm, etc.

Special attention should be given to situations where the patient is unable to participate in the process e.g. emergency unit, unconscious or confused patients, etc.

Evidence could be obtained from printed material provided to patients and patient interviews.

5.2.2 Patients are protected from assault.

Standard Intent

The organisation takes responsibility for protecting patients from physical assault by outsiders, other patients and the staff. This responsibility is particularly relevant to infants and vulnerable children, the elderly, and others unable to protect themselves or signal for help. Each organisation identifies its vulnerable patient groups and establishes a process to protect the rights of individuals in those groups. Vulnerable patient groups and the organisation's responsibility may be identified in laws, charters or regulations. Comatose patients, and patients with mental or emotional disabilities, are also included. Such protection extends beyond physical assault to other areas of safety such as protection from abuse, negligent

care, withholding of services, or assistance in the event of a fire.

The organisation seeks to prevent assault through processes such as investigating individuals in the facility without identification, monitoring remote or isolated areas of the facility, and quickly responding to those thought to be in danger of assault.

The staff understands their responsibilities in these processes.

5.2.2 Criteria

5.2.2.1 The organisation has a process to protect patients from assault.

This is defined as part of the processes and policy framework as required for criteria 5.1.1.1 and 5.1.1.3 and the score of this criterion is derived from assessing implementation in all areas of the hospital where patients are interviewed, examined and treated.

Please note that this aspect does not deal with physical safety only as explained in the above mentioned intent.

Linked criterion:
7.4.1.4

5.2.2.2 Remote or isolated areas of the hospital are monitored.

The "monitoring" may take the form of security cameras or patrolling by security guards or both.

Linked criterion:
7.4.1.4

5.2.2.3 The organisation implements processes to ensure that patients are not subjected to abuse from healthcare professionals.

5.3 Right to Health Education

5.3.1 Health education supports patient and family participation in care decisions and care processes.

Standard Intent

Every patient is offered the information and education he or she requires. Organisations may choose to appoint an education co-ordinator, an education committee, or service, or simply work with all staff to provide education in a co-ordinated manner.

5.3.1 Criteria

5.3.1.1 The organisation plans education consistent with its mission, services and patient population.

5.3.1.2 There is an appropriate structure or mechanism for education throughout the organisation.

The score for this criterion will be influenced by the findings for those criteria relating to patient and family education in the clinical documents.

Linked criteria:
Standard 10.8.1 and similar standards in in-patient services.

5.4 Right to Treatment and to Refuse Treatment

5.4.1 The organisation respects the rights of patients and families to refuse or discontinue treatment.

Standard Intent

Patients, or those making decisions on their behalf, may decide not to proceed with the planned care or treatment or to continue care or treatment after it has been initiated. The organisation informs patients and families about their right to make these decisions, about the potential outcomes that could result from these decisions, and about their responsibilities related to such decisions. The patient/family's right to refuse treatment may not apply where infectious and/or communicable diseases are involved. Also where such decisions compromise care for minors or other vulnerable individuals. Patients and families are given information on any care and treatment alternatives. Personnel are informed of their responsibility to implement and respect the choices of patients.

5.4.1 Criteria

5.4.1.1 Patients and families are informed about their rights to refuse or discontinue treatment.

The score for this criterion will be influenced by the findings for those criteria relating to patients' rights in the clinical documents. Evidence of compliance will be verified from ***patient interviews*** *and* ***patient record audits****.*

Linked criteria:
5.4.2.1
10.11.1.3 and similar criteria in in-patient services.
32.7.1.3 and similar criteria in SEs 33 to 38

5.4.1.2 Patients are informed about the consequences of such decisions.

5.4.2 The organisation respects patients' wishes and preferences to withhold resuscitative services and forgo or withdraw life sustaining treatment.

Standard Intent

Decisions about withholding resuscitative services or forgoing or withdrawing life-sustaining treatment are among the most difficult choices facing patients, families, healthcare professionals and organisations. No single process can anticipate all

the situations in which such decisions must be made. For this reason, it is important for the organisation to develop a framework for making these difficult decisions.

Such a framework:

- helps the organisation identify its position on these issues
- ensures that the organisation's position conforms to its community's religious and cultural norms and to any legal or regulatory requirements
- addresses situations in which these decisions are modified during care; and
- guides health professionals through the ethical and legal issues in carrying out such patient wishes.

To ensure that the decision making process related to carrying out the patient's wishes is applied consistently, policies and procedures are developed through a process that includes many professionals and various viewpoints. The policies and procedures identify lines of accountability and responsibility and how the process is documented in the patient's record.

5.4.2 Criteria

5.4.2.1 The organisation has identified its position on withholding resuscitative services and forgoing or withdrawing life-sustaining treatments.

Root criterion

This requires the formulation of a documented strategy, which will clearly state the organisation's position. Refer to the intent as well as the criteria below for further guidance on the content of such documentation.

Linked criteria:
1.2.5.1, 1.3.2.1
5.4.1.1
10.5.6.1 *and similar criteria in in-patient services.*

5.4.2.2 The organisation's position conforms to its community's religious and cultural norms and to any legal or regulatory requirements.

5.4.2.3 Policies and procedures that guide the processes for patients to make their decisions known to the organisation and for modifying decisions during the course of care are implemented.

5.4.2.4 Policies and procedures that guide the organisation's response to patient decisions are implemented.

5.4.2.5 The organisation guides health professionals on the ethical and legal issues in carrying out such patient wishes.

Evidence of such guidance can exist in various forms such as the existing policy framework, meetings during which these matters are discussed, in-service education, etc.

5.5 Right to Voice Complaints

5.5.1 The organisation informs patients and families about its process to receive and act on complaints, conflicts and differences of opinion about patient care, and the patient's right to participate in these processes.

Standard Intent

Patients have a right to voice complaints about their care, and to have those complaints reviewed and, where possible, resolved. Also, decisions regarding care sometimes present questions, conflicts or other dilemmas for the organisation and the patient, family or other decision makers. These dilemmas may arise around issues of access, treatment or discharge. They can be especially difficult to resolve when the issue involves, for example, withholding resuscitative services or forgoing or withdrawing life-sustaining treatment.

The organisation has established processes for seeking resolutions to such dilemmas and complaints. The organisation identifies in policies and procedures those who need to be involved in the processes and how the patient and family participate.

5.5.1 Criteria

5.5.1.1 There is a mechanism to allow for the hearing of complaints and to act upon them.

Root criterion

Documented evidence is required of such a mechanism (such as suggestion boxes, patient opinion surveys, formal complaint systems) and its implementation.

Linked criteria:
1.2.2.5, 1.2.5.1

5.5.1.2 Patients are aware of their right to voice complaints and the processes by which to do so.

Results obtained from patient interviews will determine the level of compliance.

5.5.1.3 Complaints are reviewed according to the organisation's mechanism.

Linked criterion:
7.1.1.7

5.6 Informed Consent

5.6.1 The organisation has a clearly defined process for obtaining informed consent.

Standard Intent

One of the main ways that patients are involved in their care decisions is by granting informed consent. The patient must be provided with all information relating to the planned care to enable him or her to make decisions. The consent process is clearly defined by the organisation in policies and procedures. Relevant laws and regulations are incorporated into the policies and procedures.

Informed consent for care sometimes requires that people other than (or in addition to) the patient be involved in decisions about the patient's care. This is especially true when the patient does not have the mental or physical capacity to make care decisions, when culture or custom designate that others make care decisions, or when the patient is a child. When the patient cannot make decisions regarding his or her care, a surrogate decision maker is identified. When someone other than the patient gives the consent, that individual is noted in the patient's record.

5.6.1 Criteria

5.6.1.1 Policies and procedures that guide the staff in the process of gaining informed consent are implemented.

Critical criterion

Criteria below list some of the details that need to be included in the policy framework. Compliance will be verified during the ***patient record audits.***

Linked criteria:
1.2.5.4
7.1.1.1
10.5.3.1 and similar criteria in in-patient services.

5.6.1.2 High risk and problem-prone procedures are identified and listed as requiring special consent.

The organisation must identify those procedures for which consent is required e.g. HIV testing

Compliance will be verified during the ***patient record audits.***

5.6.1.3 A note is made in the patient's record when any individual, other than the patient, grants consent.

Compliance will be verified during the ***patient record audits.***

5.6.1.4 General consent/acknowledgement of admission requirements is obtained when patients enter the organisation.

This refers to the type of written consent that patients grant, during the admission process, to receive general medical and nursing care, and may also include permission to share personal health information with third parties such as medical aids.

Compliance will be verified during the ***patient record audits.***

Linked criterion:
4.2.3.1

5.6.1.5 Patients and families acknowledge the scope of such general consent / admission requirements.

Linked criterion:
4.2.3.4

SE 6 MANAGEMENT OF INFORMATION

OVERVIEW OF MANAGEMENT OF INFORMATION

Providing patient care is a complex endeavour that is highly dependent on information. To provide, co-ordinate, and integrate services, healthcare organisations rely on information about the science of care, individual patients, care provided, results of care, and their own performance. Just like human, material and financial resources, information is a resource that must be managed effectively by the organisation's leaders. Every organisation seeks to obtain, manage and use information to improve patient outcomes and individual and overall organisational performances.

Over time, organisations become more effective in:

- identifying information needs
- designing an information management system
- defining and capturing data and information
- analysing data and transforming them into useful information
- transmitting and reporting data and information and
- integrating and using information.

Although computerisation and other technologies improve efficiency, the principles of good information management apply to all methods, whether paper-based or electronic.

Standards

6.1 Planning

6.1.1 *The organisation plans and implements processes to meet the information needs of clinical and managerial services, and those outside the organisation that require data and information from the organisation.*

Standard Intent

Information is generated and used during patient care and for safely and effectively managing an organisation. The ability to capture and provide information requires effective planning. Planning incorporates input from a variety of sources:

- the care providers
- the organisation's managers and leaders and
- those outside the organisation who need or require data or information about the organisation's operational and care processes.

The most urgent information needs of those sources influence the organisation's information management strategies and its ability to implement those strategies. The strategies are appropriate for the organisation's size, complexity of services, availability of trained personnel and other human and technical resources. The plan is comprehensive and includes all the departments and services of the organisation**.**

6.1.1 Criteria

6.1.1.1 Information systems are developed and implemented in the organisation.

Root criterion

Refer to the standard intent above for guidance on the content and purpose of this system. It is desirable that there is an integrated plan incorporating all the required components. However, it may exist in different formats e.g. separate information management manuals, or various electronic modules.

Whatever format exists, an executive summary, which reflects all data management components in the organisation should be available. This should include finances, human resource, equipment, patient care, medication, supplies, quality management, infection control, etc.

In many instances such information management systems are corporately driven systems, but it is important to note that the compliance standards may require certain additions/adaptations to such systems at facility level in order to comply with all the standards and criteria. The "plan" should therefore include all the requirements stated in this service element document.

Linked criteria:
1.2.6.1
2.1.1.5
3.1.1.4, 3.3.1.6

7.1.1.7
8.3.1.1, 8.3.1.2
9.1.1.8
21.5.1.6

6.1.1.2 Those who provide clinical and managerial services identify their information needs.

The type of data that is gathered for analysis should be based on the information needs of the relevant stakeholders in the organisation i.e. the resultant information should serve the purpose of assisting personnel in, e.g. operational decision making processes and the evaluation of services.

6.1.1.3 Clinical and managerial personnel participate in information technology decisions.

It is expected that relevant personnel will be consulted on information, communication and technology (ICT) decisions with regard to, e.g. format of data capture forms, report formats, type of software, computer requirements, etc., and such evidence may be found in minutes of meetings or other forms of communication.

6.1.2 Confidentiality, security and integrity of data and information is maintained.

Standard Intent

The organisation determines the level of security and confidentiality to be maintained for different categories of information. Access to each category of information is based on need and defined by job title and function. An effective process defines:

- who has access to information
- the information to which an individual has access
- the user's obligation to keep information confidential and
- the process followed when confidentiality and security are violated.

One aspect of maintaining security of patient information is to determine who is authorised to obtain a patient record and who makes entries into the patient record. The organisation develops a policy to authorise such individuals and identifies the contents and format for entries into patient records. There is a process to ensure that only authorised individuals make entries in patient records.

The organisation maintains the security and confidentiality of data and information, and is especially careful about preserving the confidentially of sensitive data and information. The balance between data sharing and data confidentiality is addressed.

Adequate and appropriate back-up systems are in place.

6.1.2 Criteria

6.1.2.1 Confidentiality of data and information is maintained.

Critical criterion

These aspects need to be documented as part of the information management processes for the various types of information, whether it be financial data, personal information on personnel, patient information, etc. Where applicable, national legal requirements need to be considered.

Linked criteria:
1.2.1.4, 1.2.5.1
3.2.1.3
5.2.1.3
10.11.1.2 and equivalent criteria in all clinical services
32.2.1.4 and equivalent criteria in SEs 33 to 38.

6.1.2.2 Security and integrity of data and information is maintained.

Security relates to access control in terms of passwords, back up processes as well as archiving of paper based records.

Up to date anti-virus/anti-malware software is in place.
The integrity of data refers to the validation of raw data to ensure accuracy of information.

6.2 Information Management Support

6.2.1 The information systems are implemented and supported by sufficient personnel and other resources.

Standard Intent

The organisation's information management systems, once completed and approved as necessary, are implemented. The organisation provides the personnel, technology and other resources necessary to implement the information systems and meet the identified information needs of the healthcare providers, managers and others.

Individuals in the organisation who generate, collect, analyse and use data and information are educated and trained to effectively participate in managing information. Such education and training enables these individuals to:

- understand the security and confidentiality of data and information
- use measurement instruments, statistical tools, and data analysis methods
- assist in interpreting data
- use data and information to help in decision making
- educate and support the participation of patients and families in care processes and
- use indicators to assess and improve care and work processes.

Individuals are appropriately educated and trained in regard to their responsibilities, job descriptions, and data and information needs.

Information management technology represents a major investment of resources for a healthcare organisation. For this reason, technology is carefully matched to the current and future needs of the organisation, and the organisation's resources.

Available technology needs to be integrated with existing information management processes, and serves to integrate the activities of all the departments and services of the organisation. This level of coordination requires that key clinical and managerial personnel participate in the selection process. The management of the organisation ensures that the personnel have the required supplies, registers, check lists, forms etc required for data management.

6.2.1 Criteria

6.2.1.1 Sufficient personnel support the implementation.

6.2.1.2 Decision makers and others are provided with appropriate training in the principles of information management.

6.2.1.3 Required technology and other resources support the implementation.

Resource requirements may differ vastly between paper-based and computerised systems and the assessment of compliance needs to take these factors into account. In many instances such technological support may be provided from a corporate level.

Linked criteria:
1.3.1.5

6.2.2 Where information, communication and technology (ICT) equipment is available, it is properly maintained to meet the needs of the services.

Standard Intent

Organisations have a responsibility to ensure that appropriate ICT equipment is available and ready for use at all times. There is an accountable, systematic approach to ensuring that cost-effective, safe and appropriate information technology equipment is available to meet organisational demands.

Managers take responsibility for ensuring that ICT equipment is available, appropriately maintained, calibrated and that personnel are competent in the use thereof. Policies and procedures are available to guide personnel in the back-up of data.

6.2.2 Criteria

6.2.2.1 A designated individual supervises the management of ICT equipment in the organisation.

6.2.2.2 Policies and procedures that guide the management of ICT equipment are implemented.

6.2.2.3 All desktop and server computers are attached to an uninterrupted power supply (UPS) with surge protection.

Linked criteria:
1.2.2.3

6.2.2.4 Records are kept of the maintenance of ICT equipment.

6.2.2.5 Where technical ICT support is not available at facility level, an arrangement is in place to obtain such support from outside.

Linked criteria:
1.2.7.3

6.2.2.6 There is a documented procedure known to personnel for reporting defects in ICT equipment during and after normal working hours.

6.3 Data Processing and Information Management

6.3.1 The organisation has a process to aggregate data for user needs.

Standard Intent

The organisation collects and analyses aggregated data to support patient care and management of the organisation. Aggregated data provide a profile of the organisation over time and allow for comparison between the organisation's various performance improvement activities. In particular, aggregated data from risk management, utility system management, infection control and utilisation review can help the organisation to understand its current performance and identify opportunities for improvement.

6.3.1 Criteria

6.3.1.1 The organisation has a process to aggregate data.

In order to have aggregated data available, the information management plan/ system needs to make provision for effective processes for the collection of data and data-flow processes between departments and individuals – from the point of collection to the end-user

6.3.1.2 Clinical and managerial data and information are integrated as needed to support decision-making.

Root criterion

Assessment of compliance is based on the availability of reports on the various types of data as well as documented evidence (e.g. minutes of meetings or other form of communication) of discussions on the information and how this is taken into consideration to assist with decision making processes. This needs to happen at all levels of the organisation and not just at top management as information also needs to be available on departmental operations such as personnel matters, financial aspects, supply management, outcomes of quality improvement programmes, results from both clinical as well as patient record audits, negative incidents, etc.

Information forms an integral part of the communication processes/activities referred to in standard 1.2.8.

Linked criteria:
7.1.1.1, 7.1.1.7
8.3.1.1, 8.3.1.2

6.3.1.3 Aggregated data and information are used to support patient care.

As above.

Linked criterion:
8.2.1.4

6.3.1.4 Aggregated data and information are used to support management of the organisation.

As 6.3.1.2

6.3.1.5 Aggregated data and information are used to support the quality management programmes.

Important to note that this criterion requires results of quality improvement programmes to be handled in the same manner as any other organisation-based information, i.e. formal reporting processes to central (management) level for sharing of information and to assist in managerial decision making processes.

Linked to standards 8.2.2 and 8.3.1 in SE 8 Quality management and improvement

6.3.2 The organisation contributes to external databases when required by laws or regulations.

Standard Intent

By participating in external performance databases, an organisation can compare its performance with that of other similar organisations locally, nationally or internationally. Performance comparison is an effective tool for identifying opportunities for improvement and documenting the organisation's performance level. Healthcare networks and those purchasing or paying for healthcare often ask for such information.

6.3.2 Criteria

6.3.2.1 The organisation has a process to participate in or use information from external databases.

Documented evidence is required of the active sharing or use of information.
Where national requirements apply, note the link with 1.2.1.4.

6.3.2.2 Data or information is contributed to external databases as required by law or regulation, where applicable.

This requirement is included in the processes for 6.1.1.1. and as defined by various levels of government.

Linked criteria:
1.2.1.4
9.4.1.6

6.3.2.3 The organisation compares its performance with that of other, similar organisations, using external reference databases.

Particular attention needs to be paid to the comparing of performance indicators as they relate to organisation-based quality improvement programmes.

Linked criteria:
8.3.1.4.
9.4.1.4

SE 7 RISK MANAGEMENT

OVERVIEW OF RISK MANAGEMENT

Healthcare organisations work to provide a safe, functional and supportive facility for patients, families, staff, volunteers and visitors. To reach this goal, facilities, equipment and medication must be effectively managed. In particular, management must strive to:

- identify, evaluate, reduce and control hazards and risks
- prevent accidents and injuries and
- maintain a safe environment.

Effective risk management includes the planning, education and monitoring of resources needed to safely and effectively support the clinical services provided in the in-patient, day care and home care settings. All staff are educated on how to reduce risks, monitor and report situations that pose risk. Criteria are used to monitor important systems and identify needed improvements.

Planning should consider the following areas in all settings, when appropriate to the activities of the organisation.

- Patient safety taking into account the International Patient Safety Goals, which highlight problematic areas in healthcare and describe evidence- and expert-based consensus solutions to these problems
- Occupational health and safety programmes – the organisation complies with legislation relating to health and safety and risk management
- Fire safety – property and occupants are protected from fire and smoke.
- Emergencies – responses to disasters and emergencies are planned and effective
- Hazardous materials – control of the handling, storage and use of flammable and other materials, and safe disposal of hazardous waste and
- Security – property and occupants are protected from harm and loss.

The provision of health and safety services, emergency planning and other aspects of providing a safe environment all require staff and volunteers to have the necessary knowledge and skills for their implementation.

Standards

7.1 Risk Management

7.1.1 Managers and leaders work collaboratively to develop, implement and maintain effective risk management systems in the organisation.

Standard Intent

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

Risk management includes:

- Comprehensive risk identification within the organisation;
- Planning all aspects of the risk management (financial, physical, environmental, medico-legal, operational etc.)
- Ensuring that there is adequate insurance
- Implementation of the risk management system
- Education of staff
- Monitoring processes to manage risk and
- Periodic review and revision of the programme.

Monitoring of all aspects provides valuable data to make improvements in the programme and further reduce risks within the organisation**.**

7.1.1 Criteria

7.1.1.1 There are documented risk management processes for the identification of all risks (physical, environmental, medico-legal, operational, etc) relating to organisational processes and systems, staff, patients, visitors and physical facilities.

Root criterion

A formal process should be followed to identify and analyse risks in the organisation.

This will be used to develop the action plan required in 7.1.1.2

The intent of standard 7.1.1 and criterion 7.1.1.1 attempts to indicate the scope of what is meant by risk management in the context of this Service Element. The risk management process should include all relevant risks, financial, corporate and legal risks, physical facility, security and environmental risks, etc. This does not necessarily require a single integrated document, provided all components are dealt with in documented systems for the relevant operational processes/functions/sections.

Take note that there are several linked criteria in each service element.

(*NOTE: doing only monthly workplace inspections does not qualify for a compliance rating).*

Linked criteria:
1.2.2.4;
2.1.1.5; 2.1.1.6;
3.1.1.7; 3.2.1.11; 3.3.1.5; 3.4.1.8-9; 3.4.2.6;
5.1.1.1;
6.3.1.2
7.2.1.1; 7.2.2.1; 7.2.3.1; 7.2.4.1; 7.2.5.1; 7.2.6.1; 7.2.6.4, 7.3.1.2; 7,3.1.5; 7.4.1.1-5;
7.5.1.1; 7.6.1.1; 7.7.1.1;
9.1.1.1, 9.2.1.1
10.13.1.1; 11.13.1.1; 12.13.1.1; 13.13.1.1; 14.13.1.1; 15.14.1.1; 16.13.1.1
17.9.1.1, 17.2.3.4, 17.4.1.5
18.6.1.1
19.6.1.1
20.6.1.1
21.9.1.1
22.15.1.1
23.14.1.1
24.14.1.1
25.5.1.1
26.9.1.1; 27.7.1.1; 28.7.1.1;
29.6.1.1; 31.7.1.1;
32.9.1.1; 33.9.1.1; 34.9.1.1; 35.9.1.1; 36.9.1.1; 37.9.1.1.38.9.1.1

7.1.1.2 Risk management processes include documented plans and actions to eliminate or reduce the identified risks.

7.1.1.3 Risk management processes include on-going documented monitoring of risks.

7.1.1.4 Management and leaders ensure the development and implementation of documented policies and procedures for risk management processes and activities.

7.1.1.5 On-going in-service training of all staff in these policies, procedures and risk management principles, including reporting of adverse events is documented.

7.1.1.6 One or more qualified and/or skilled and/or experienced individuals supervise the implementation of the risk management system.

7.1.1.7 Analysed data, including adverse events and near misses, are used to monitor the effectiveness of the risk management system.

Critical criterion

See the glossary for the terms near misses, sentinel and adverse events

Linked criteria:
1.2.2.4
2.1.1.5
3.3.1.5, 3.4.2.2

6,1,1,1, 6.3.1.2
7.2.6.4
8.3.1.1-2
9.1.1.1, 9,2,1,1, 9.4.1.3
10.13.1.2 and similar criteria in in-patient services
31.7.1.2
32.9.1.2 and similar criteria in SEs 33 - 38

7.1.1.8 Risk management systems are reviewed whenever there are changes in organisational systems and processes, or physical facilities.

7.2 Patient Safety

7.2.1 The organisation develops an approach to improve accuracy of patient identifications.

Standard Intent

These standards are based on the Joint Commission International (JCI) Patient Safety Goals.

Wrong patient identification virtually in all aspects of diagnosis and treatment. Patients may be sedated, disoriented or not fully alert; may change beds, rooms or locations within the hospital.; may have sensory disabilities; or may be subject to other situations that may lead to incorrect identification. The intent of this standard is twofold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual and should be in place until final discharge from the organisation.

Policies and/or procedures are collaboratively developed to improve identification processes, in particular, the processes used to identify a patient when giving medications, blood, or blood products; taking blood and other specimens for clinical testing; or providing any other treatments or procedures. The policies and/or procedures require at least two ways to identify a patient, such as the patient's name, identification number, birth date, bar-coded wristband or other ways. The policies and/or procedures clarify the use to two different identifiers in different locations within the organisation, such as in outpatient services, the emergency department or operating theatre

The identification process commences at the entry of the patient into the hospital system.

7.2.1 Criteria

7.2.1.1 Policies and/or procedures that address the accuracy of patient identification are implemented.

Root criterion

Linked criteria:
1.2.6.1
4.2.2.1 - 2

7.1.1.1
17.4.2.2
19.2.1.1
20.2.1.1
22.4.1.2
23.1.3.3
24.1.3.4

7.2.1.2 The policies and/or procedures require the use of two patient identifiers, not including the use of the patient's room number or locations.

It is advisable not to use the patient's room number or locations as patients may move from one place to another within the organisation. Identity bands attached to the patient's wrist, for example, is a good choice; also unique patient identification numbers.

7.2.1.3 Patients are identified before administering medications, blood or blood products.

Linked criteria:
10.6.2.2 and similar criteria in all in-patient services.

7.2.1.4 Patients are identified before taking blood and other specimens for clinical testing.

7.2.1.5 Patients are identified before providing treatments and procedures.

7.2.2 The organisation develops an approach to improve the effectiveness of communication among caregivers.

Standard Intent

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient reduces errors, and results in improved patient safety. Communications can be electronic, verbal or written. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws or regulations. Another error-prone communication is the report back of critical test results, such as the clinical laboratory telephoning the patient care unit to report the results of a STAT test.

The organisation collaboratively develops a policy and/or procedure for verbal and telephone orders that includes: the writing down (or entering into a computer) of the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the confirmation that what has been written down and read back is accurate. The policy and/or procedure identify permissible alternatives when the read back process may not always be possible such as in the operating theatre and in emergency situations in the emergency department or intensive care unit.

7.2.2 Criteria

7.2.2.1 Policies and/or procedures that address the accuracy of verbal and telephone orders are implemented.

Critical criterion

Linked criteria:
1.2.6.1 (availability), 1.2.6.6 (implementation)
7.1.1.1
10.6.1.2 and similar criteria in in-patient services
19.2.1.8
21.3.1.1

7.2.2.2 The complete verbal and telephone order or test result is written down by the receiver of the order or test result, who signs as having done so.

Compliance will be verified during the patient record audit.

7.2.2.3 The complete verbal and telephone order or test result is read back by a second person, who signs as having done so.

7.2.2.4 The order or test result is confirmed by the individual who gave the order or test result by signing the relevant document as per organisation policy.

This refers to, for example:
a) *The signing of the verbal medication order on the prescription sheet by the doctor within the specified time.*
b) *The official test results, e.g. laboratory, radiology, validated by the relevant person.*

7.2.3 The organisation develops an approach to improve the safety of high-alert medications.

Standard Intent

When medications are part of the patient treatment plan, appropriate management is critical to ensure patient safety. A frequently cited medication safety issue is the unintentional administration of concentrated electrolytes (for example, potassium chloride (2mEq/ml or more concentrated), potassium phosphate, sodium chloride more concentrated than 0.9% and magnesium sulphate (50% or more concentrated).

This error can occur when a staff member has not been properly oriented to the patient care unit, when contract nurses are used and not properly oriented, or during emergencies. The most effective means to reduce or eliminate this occurrence is to remove the concentrated electrolytes from the patient care unit to the pharmacy.

The organisation collaboratively develops a policy and/or procedure that prevents the location of concentrated electrolytes in patient care areas where misadministration can occur. The policy and/or procedure identifies any areas where concentrated electrolytes are clinically necessary, such as the emergency department, intensive care unit or operating theatre and identifies how they are clearly labelled and how they are stored in those areas in a manner that restricts access to prevent inadvertent administration.

7.2.3 Criteria

7.2.3.1 Policies and/or procedures that address the location, labelling and storage of concentrated electrolytes are implemented.

Critical criterion

Linked criteria:
1.2.6.1 (availability) 1.2.6.6 (implementation)
7.1.1.1
21.2.1.3, 21.3.1.1, 21.4.1.4

7.2.3.2 Concentrated electrolytes are not present in patient care units, unless clinically necessary and actions are taken to prevent inadvertent administration in those areas where permitted by policy.

7.2.4 The organisation develops an approach to ensure correct-site, correct-procedure and correct-patient surgery.

Standard Intent

Wrong-site, wrong-procedure, wrong-patient surgery is a disturbingly common occurrence in healthcare organisation. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative sites. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not support open communication among surgical team members, problems related to illegible handwriting and the use of abbreviations are frequent contributing factors.

Organisations need to collaboratively develop a policies and/or procedures that are effective in eliminating these problems.

Marking the operative site involves the patient and is done with an unambiguous mark. The mark should be consistent throughout the organisation, should be made by the person performing the procedure, should take place with the patient awake and aware, if possible, and must be visible after the patient is prepped, and draped. The operative site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions) or multiple levels (spine).

7.2.4 Criteria

7.2.4.1 Policies and/or procedures that establish uniform processes to ensure the identification of the correct site, correct procedure and correct patient are implemented.

Root criterion

Linked criteria:
1.2.6.1 (availability) 1.2.6.6 (implementation)
7.1.1.1

7.2.4.2 The organisation uses a clearly understood mark for surgical site identification and involves the patient in the marking process.

Critical criterion

Linked criterion:
17.4.2.3

7.2.4.3 The organisation uses a process to verify that all documents and equipment needed to perform the marking are on hand, correct and functional.

This refers to the equipment needed for marking the surgical site.

7.2.5 *The organisation develops an approach to reduce the risk of patient harm resulting from falls.*

Standard Intent

Falls account for a significant portion of injuries in hospitalised patients. In the context of the population it serves, services it provides, and its facilities, the organisation should evaluate its patients' risk of falls and injuries and take action to reduce the risks. and injury.. The evaluation could include assessing environmental factors (wet floors, unprotected ramps, etc.) and patient factors (fall history, medications and alcohol consumption review, gait and balance screening, use of walking aids, etc.). The organisation establishes and implement a fall-risk reduction programme based on appropriate policies and/or procedures.

7.2.5 Criteria

7.2.5.1 Policies and procedures that address reducing the risk of patient harm resulting from falls in the organisation are implemented.

**Root criterion*

Linked criteria:
1.2.6.1
7.1.1.1
10.5.2.1 and similar criteria in all in-patient services.

7.2.5.2 The organisation implements a process for the initial assessment of patients for fall risk and reassessment of patients when indicated by a change in condition, medications, etc.

Linked criteria: *10.4.2.9 and similar criteria in all in-patient services.*

7.2.5.3 Measures are implemented to reduce fall risk for those assessed to be at risk.

Critical criterion *Linked criteria:* *1.2.2.4* *4.2.1.5*

7.2.6 The organisation uses a defined process for identifying and managing sentinel events.

Standard Intent

Each organisation establishes an operational definition of a sentinel event that includes at least:

a) unanticipated death unrelated to the natural course of the patient's illness or underlying condition
b) major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition and
c) wrong-site, wrong-procedure, wrong-patient surgery.

The organisation's definition of a sentinel event includes a) to c) above and may include other as may be required by law or regulation or viewed by the organisation as appropriate to add to its list of sentinel events. All events that meet the definition are assessed by performing a credible root cause analysis. When the root cause analysis reveals that systems improvement or other actions can prevent or reduce the risk of such sentinel events recurring, the organisation redesigns the processes and takes whatever other actions are appropriate to do so.

It is important to note that the term "sentinel event" does not always refer to an error or mistake, or suggest any particular legal liability.

Certain events related to specific processes always result in intense analysis to understand the cause and prevent recurrence. When appropriate to the organisation's services, these events include:

- confirmed transfusion reactions
- significant adverse drug reactions
- significant medication errors
- significant discrepancy between preoperative and postoperative diagnoses and
- significant adverse anaesthetic events.

7.2.6 Criteria

7.2.6.1 The organisation's leaders have established a definition of a sentinel event that at least includes a) to c) found in the intent statement.

Linked criterion:
7.1.1.1

7.2.6.2 The organisation conducts a root cause analysis on all sentinel events in a time period specified by the organisation's leaders.

7.2.6.3 Events are analysed when they occur.

7.2.6.4 The organisation's leaders take action on the results of the root cause analysis.

Critical criterion

Linked criteria:
1.2.2.4, 1.2.2.6
7,1,1,7
8.3.1.1
10.13.1.2 and similar criteria in all in-patient services
32.9.1.2 and similar criteria in SEs 33 to 38

7.2.6.5 Intense analysis of data and implementation of corrective measures takes place when adverse levels, patterns or trends occur.

7.3 Occupational Health and Safety

7.3.1 As part of risk management an occupational health and safety system is implemented in accordance with current legislation.

Standard Intent

Legislation may describe the health and safety measures to be implemented by organisations. In terms of such legislation, where it exists, the organisation must ensure the safety of staff, patients and visitors.

The provision of health and safety services, emergency planning and other aspects of providing a safe environment all require staff to have the necessary knowledge and skills for their implementation.

To plan effectively, the organisation must be aware of all the risks present in the facility and to develop a proactive plan to reduce those risks e.g. TB screening, manual handling, needle stick injuries, etc. Personnel who are exposed to high risk should receive appropriate protective measures, such as Hepatitis B immunisation. The legal requirements, where they exist regarding the reporting of incidents and occupational diseases such as TB, HIV, Hepatitis B and C, injury on duty, etc., must be met.

It is expected that every organisation will provide an occupational health service. However, it is not expected that the organisation provide all components of the service itself, but it may be provided by another service provider. In the latter case, only relevant criteria will be scored. The occupational health service here refers to the service rendered to the employees of the organisation and not, as is the practice in some organisations, pre-employment examinations and surveillance for commerce or industry in the catchment area of the health service.

7.3.1 Criteria

7.3.1.1 A health and safety committee, where applicable, is constituted in terms of current legislation.

National requirements will apply. Where such legislation does not exist, this criterion will be scored NA.

Linked criterion:
1.2.1.4

7.3.1.2 Policies and procedures on all aspects of health and safety that guide staff in maintaining a safe work environment are implemented.

A formal process of job observation and analysis is used to establish work-specific related risks and steps are taken to minimise or eliminate these risks.

Staff are made aware of all aspects of risk identification and prevention, early detection and reporting and their role in taking corrective action. Relevant aspects for each department are highlighted by means of posters, information pamphlets, department specific training programmes, etc.

Safe work procedures must be documented and staff adherence monitored. Regular monitoring can be by means of workplace inspections, formal and informal observations, rounds/visits, formal competency tests, etc, as defined by organisational policy.

Linked criteria:
1.2.6.1
7.1.1.1
9.2.2.1

7.3.1.3 Management makes provision for occupational health services according to a documented policy framework.

This criterion will be assessed according to national legislation.

This service can either be provided in-house by the organisation or as a contracted service by an outside provider, e.g. a local industrial company, private occupational health practitioners, etc.

Linked criteria:
1.2.6.1
1.2.7.3

7.1.1.1

7.3.1.4 The organisation has access to the services of a knowledgeable and experienced person in the field of occupational health.

The availability of a qualified doctor can be at corporate, districts, or as a contracted service by a private occupational health practitioner.
This refers to qualified occupational health practitioners in either the medical or the nursing field. The person need not be on-site at the clinic, but must be known to be available at a referral facility.

7.3.1.5 The organisation provides information and training on risks specific to the healthcare workers.

Linked criteria:
2.4.2.1
7.1.1.1
Standard 31.3.1

7.4 Security

7.4.1 A security system is maintained for the routine monitoring and safeguarding of the premises, equipment, property, patients, staff, volunteers and visitors.

Standard Intent

The organisation has a responsibility to ensure that staff, volunteers, patients and visitors are safe from attacks or theft by intruders. The organisation identifies areas and groups that are vulnerable and require added security.

Systems are developed and implemented to provide protection. The loss of organisational property must be prevented.

This can be an in-house or a contracted service but it must include both the external and internal security monitoring of the organisation.

The powers and duties of the security personnel must be documented, either as part of the health and safety systems or in the agreement with a contracted service provider. This is particularly important in emergency planning, where the role of the security service in, for example, crowd control, must be clearly defined.

There should be evidence of the monitoring of the activities of the security personnel, where available.

7.4.1 Criteria

7.4.1.1 Internal security is provided 24 hours per day, seven days per week.

Linked criteria:
3.3.2.4

7.4.1.2 External security is provided 24 hours per day, seven days per week.

7.4.1.3 Policies on the management of weapons are implemented.

Policies on the management of weapons include:
a) Control of access points
b) Identification of high risk areas and the implementation of protective measures
c) Denial of access to armed persons
d) Arrangements for the safe-keeping of handguns and other weapons
e) Training of staff regarding security measures.
f) This includes the management of weapons brought onto the premises by patients or visitors.

Linked criteria:
1.2.6.1
7.1.1.1

7.4.1.4 Where vulnerable patients are cared for, special safety and security measures are implemented.

Critical criterion

Alarm systems would include both intruder detection systems as well as panic alarms. Alarm systems may be replaced by CCTV.

Linked criteria:
1.2.2.3, 1.2.6.1
5.2.2.1
7.1.1.1
10.13.1.3 and similar criteria in in-patient services
32.9.1.3 and similar criteria in SEs 33 to 38

7.4.1.5 There is a mechanism known to staff for summoning the assistance of the local security/police/protection service in case of an emergency.

7.5 Fire Safety

7.5.1 As part of risk management, the organisation implements structured systems to ensure fire safety.

Standard Intent

Fire is an ever-present risk in a healthcare organisation. An organisation needs to plan for:

- The prevention of fires through the reduction of risks, such as the safe storage and handling of potentially flammable materials
- Safe and unobstructed means of exit in the event of fire
- Clearly depicted fire escape routes
- Demarcated assembly points, known to all personnel
- Inspection reports from the local fire departments and

- Suppression mechanisms such as water hoses, chemical suppressants or sprinkler systems. These actions, when combined, give patients, families, staff and visitors adequate time to safely exit the facility in the event of a fire or smoke. These actions are effective no matter what the age, size or construction of the facility.

The organisation's fire safety plan identifies the:

- Frequency of inspection, testing and maintenance of fire protection and safety systems, consistent with requirements
- Process for testing, at least annually, the plan for the safe evacuation of the facility in the event of a fire or smoke
- Necessary education of staff to effectively protect and evacuate patients when an emergency occurs and
- Participation of each staff member in at least one emergency preparedness test per year.

All inspections, testing and maintenance are documented.
The organisation develops and implements a policy and plan to eliminate smoking in the organisation's facilities, or to limit smoking to designated non-patient care areas.

As the application of fire safety regulations differ vastly between countries and different authorities within the same country, it is essential that some form of fire safety certification is made by relevant authorities, either in a letter or a formal certificate. This certification documentation should state the norms/standards/regulations against which such certification of compliance was issued.

In most instances, this certification remains valid until building alterations or additions take place. However, where this is not the case, the organisation must ensure that the certificate remains current.

7.5.1 Criteria

7.5.1.1 There are structured systems and processes in place to ensure that all occupants of the organisation's facilities are safe from fire or smoke.

Root criterion

There are documented fire safety systems which include all the relevant aspects of fire safety, e.g. training, rehearsals, detection and abatement systems, servicing and storage of equipment, escape route signage, storage and handling of flammable materials, etc.

Linked criteria:
1.2.1.4, 1.2.1.5, 1.2.2.4, 1.2.6.1
3.3.2.2
7.1.1.1
10.13.1.4 and related criteria in all clinical SEs
19.6.1.4
20.6.1.6
21.5.1.2, 21.9.1.4

26.3.1.14, 26.10.1.2
29.1.1.5, 29.2.2.2, 29.6.1.4
31.7.1.4
32.9.1.4 and similar criteria in SEs 33 to 38

7.5.1.2 Documented evidence is available from the relevant authority that the facility complies with applicable laws and regulations in relation to fire safety.

Critical criterion

Refer to guideline following intent statement above.

Linked criteria:
7.5.1.1

7.5.1.3 Fire fighting equipment is regularly inspected and serviced at least annually with the date of service recorded on the apparatus.

Abatement systems include all fire safety systems such as fire fighting equipment, fire detection equipment, sprinkler systems, smoke detectors, structural abatement systems such as fire walls and fire doors.

The type of systems to be installed will depend on national requirements and compliance with such stipulations will be reflected in the certification as required in 7.5.1.2.

It is essential that the testing and servicing of all fire safety equipment is up to date, automatic abatement systems are regularly tested, fire and smoke detection systems are tested, and automatic abatement doors are not forced to remain open by means of wedging or putting objects against them.

Documented evidence of inspection, testing and maintenance of fire safety equipment is required. This may include the fixing of service labels onto the equipment itself.

Linked criteria:
1.2.7.3

7.5.1.4 **Flammable materials are clearly labelled and safely stored**.

Critical criterion

Flammable materials are identified by the organisation and stored in accordance with the local fire safety regulations.

The storage precautions are applicable to all areas/services/departments where flammable materials are used. The appropriateness of the storage facility will be determined by the quantity and flashpoint of the materials stored.

Bulk storage requirements and registration will be determined by national regulations. When a fire safety inspection by the relevant authority is conducted, all these storage areas need to be evaluated.

Compliance with such stipulations will be reflected in the certification as required in 7.5.1.2.
Linked criteria:
7.5.1.1

7.5.1.5 Easily recognised and understood signs prohibiting smoking are displayed in areas where flammable materials and combustible gases are stored.

7.5.1.6 A floor plan is displayed, which shows the location of fire fighting equipment, evacuation routes, emergency exits and assembly points.

Linked criteria:
29.2.1.7

7.5.1.7 Annual staff training in fire prevention and evacuation procedures is documented.

A fire safety evacuation plan should be developed by the organisation, with the assistance of fire safety experts (either the local authority or a contracted service provider).Training should be provided and evacuation exercises are held annually. There should be documented evidence that the plan is physically rehearsed in more than one area of the organisation, including patient care areas on an ongoing basis.

If the rehearsal of the evacuation procedure is only a paper exercise this criterion is scored PC.

Linked criteria:
2.4.2.1

7.5.1.8 The organisation has implemented a policy regarding smoking, which applies to patients, families, visitors and staff/volunteers.

Such policy must be in line with national legislation, where applicable and should indicate dedicated smoking areas.

7.6 Emergency Planning

7.6.1 As part of risk management the organisation develops a written plan to respond to emergencies and major incidents.

Standard Intent

Community emergencies, epidemics and major incidents, such as damage to patient care areas as a result of a natural disaster, or flu that affects the staff, may directly involve the organisation. Organisations should also be prepared for bomb threats, fire, flooding, natural disasters, failure of water and electrical supplies, hostage taking, explosions and the consequent loss of vital services.

There may be a time when it is necessary to evacuate patients. This can only be done efficiently and effectively if the members of staff are trained in evacuation procedures.

To respond effectively, the organisation develops a plan and tests it. The plan provides processes for alternate care sites, if needed, and alternate sources of medical supplies, communications equipment, and other materials, such as food and water, if an inpatient unit or day care centre exists on the premises.

7.6.1 Criteria

7.6.1.1 There is a written plan to deal with internal and external emergencies.

Such documented plan is up to date and is available in all departments and services of the organisation.

Linked criteria:
7.1.1.1

7.6.1.2 Documented evidence is available that staff participates in a rehearsal of the plan at least annually.

There should be evidence that the plan is rehearsed in more than one area of the organisation, including patient care areas on an ongoing basis.

This criterion is scored PC if not an actual rehearsal but only a paper-exercise.
The plan needs to be tested annually, evaluated by the relevant experts and the findings documented.

Linked criteria:
2.4.2.1

7.7 Waste Management

7.7.1 *The organisation has documented control systems for the handling, storage and disposal of waste.*

Standard Intent

Household waste, hazardous wastes, such as chemicals, hazardous gases and vapours, pharmaceutical, laboratory and healthcare waste are identified by the organisation and safely controlled according to documented systems.

According to the World Health Organisation (WHO), "healthcare waste (HCW) is a by-product of healthcare that includes sharps, non-sharps, blood, body parts, chemicals, pharmaceuticals, medical devices and radioactive materials. Poor management of HCW exposes healthcare workers, waste handlers and the community to infections, toxic effects and injuries." All healthcare waste is regarded as hazardous or potentially hazardous. The plan is included in the organisation's risk management systems.

7.7.1 Criteria

7.7.1.1 **Waste is managed according to documented systems consistent with legislation, local by-laws and regulations.**

Root criterion

The system needs to include all relevant aspects of waste management, e.g. identification, colour coding, handling, segregation, storage, disposal of, etc with special reference to /healthcare waste, personal protective equipment (PPE), the management of spills and the reporting and investigation of waste related incidents.

All departments and services should be included in the system – including those services that are contracted to external service providers, e.g. laboratories, laundries, cleaning service, etc.

Linked criteria:
1.2.1.4, 1.2.2.4, 1.2.6.1, 1.2.7.3
9.2.1.4
10.13.1.5 and related criteria in all the clinical services
28.4.1.1, 28.7.1.5
31.7.1.5
32.9.1.5 and related criteria in SEs 33 to 38

7.7.1.2 Control systems include safe handling of different types of waste.

Critical criterion

Linked criteria:
7.7.1.1

7.7.1.3 Control systems include safe storage of different types of waste.

7.7.1.4 Control systems include safe disposal of different types of waste.

7.7.1.5 Control systems include the procedures to be adopted if spills occur.

7.7.1.6 Control systems include the use of personal protective equipment when handling waste.

7.7.1.7 There is a colour coding system for bags to be used for the segregation of different types of waste.

SE 8 QUALITY MANAGEMENT AND IMPROVEMENT

OVERVIEW OF QUALITY MANAGEMENT AND IMPROVEMENT

This chapter describes a comprehensive approach to quality management and improvement. The approach includes the following :

- planning for improvement in quality
- monitoring how well work is perfomed through indicator data collection
- analysing the data, and
- implementing and sustaining changes that result in improvement.

These, when performed well, provide the framework for the organisation and its leaders to achieve a commitment to provide quality patient care in a safe, well-managed environment.

This approach is rooted in the daily work of individual healthcare professionals and other staff members. As physicians and nurses assess patient needs and provide care, this chapter can help them understand how to make real improvements to help their patients. Similarly, managers, support staff and others can apply these standards to their daily work to understand how can be made more efficient and resources used more wisely.

The continuous monitoring, analysing and improving of clinical and managerial service must be well organised and have clear leadership to achieve maximum benefit. This organised approach takes into account that most clinical care involve more than one profession. Thus, efforts to improve those must be guided by an overall framework for quality management and improvement activities in the organisation. These National Health Quality standards address the full spectrum of clinical and managerial activities of a healthcare organisation, and include the framework for improving those activities and reducing the risks associated with variation in processes

The framework presented in these standards is suitable for a wide variety of structured processes and less formal approaches to quality improvement. This framework can also incorporate traditional monitoring processess such as those related to unanticipated events (risk management) and resource use (utilisation management).

Over time, organisations that follow this framework will:

- develop greater leadership support for an organisation-wide processes
- train and involve more staff in monitoring and improvement activities
- set clearer priorities for what to monitor and what to improve
- base decisions on indicator data, and
- make improvements based on comparison with other organisations, nationally and internationally.

Standards

8.1 Quality Leadership and Design

8.1.1 There are written organisation-wide quality management and improvement processes.

Standard Intent

If an organisation is to initiate and maintain improvement, leadership and planning are essential.

The governing leaders of the organisation are as important as the managers and clinical care providers in the organisation. Each leader participates in establishing the organisation's commitment, approach to improvement, and processes management and supervision. The leaders, through their vision and support, shape the quality culture of the organisation.

Improvement processess are most effective when they are planned and implemented organisation wide. he framework for these is provided in documents describing the processes, which is inclusive of all services in the organisation, and of all related quality activities such as infection control and risk management activities.

Well-designed or services draw on a variety of information sources. Good process design:

- is consistent with the organisation's mission and plans
- meets the needs of patients, families, the staff and others
- uses current practice guidelines, clinical standards, scientific literature, and other relevant evidence-based information on clinical practice design
- is consistent with sound business practices
- considers relevant risk management information
- uses information from related improvement activities; and
- integrates and connects systems.

A primary responsibility of leaders is to set priorities. Organisations typically find more opportunities for quality monitoring and improvement than they have human and other other resources to accomplish. Therefore, the leaders provide focus for the organisastion's quality monitoring and improvement activities. The leaders prioritise those critical, high-risk or problem prone that most directly relate to the quality of care and the safety of the environment. The leaders use available data and information to identify areas that must be prioritised.

8.1.1 Criteria

8.1.1.1 There is a system for the implementation of quality management and improvement processes.

Root criterion

This is a root criterion for all quality-related criteria in the standards and refers to the existence of organisational structure which support QM&I (quality management and improvement) throughout the entire organisation.This include aspects such as

governance responsibilities, documented systems that refer to QM&I aspects, such as strategic plans, QM&I plans, policy framework, coordinating committee structures, training process, etc.

Such processes may exist in different formats e.g. a detailed single document, or different documented systems, or electronic modules. Whatever format exists, the intention of the standard is that the "processes" should be comprehensive and reflect all components of quality management and improvement in the organisation.

Linked criteria:
1.1.1.8, 1.1.3.8, 1.2.6.1
8.1.1.5, 8.2.2.1

8.1.1.2 Managerial and clinical leaders and relevant stakeholders participate in the implementation of the quality management and improvement processes.

Documented systems on QM&I need to reflect the participation of the relevant leaders, (which include governance, senior management of the organisation, clinical and all other leaders/role players) in the activities listed.The criterion clearly indicates that the organisational QM&I system requires commitment and support from the highest levels of the organisation.

Linked criterion:
1.2.8.1

8.1.1.3 The processes reflect the scope of service delivery in relation to managerial, clinical and support services (including formal educational services where applicable).

The organisational QM&I framework needs to be inclusive of all relevant aspects as listed in the criterion and guided by the intent above.

8.1.1.4 The leaders identify priorities for monitoring activities.

As part of the organisational QM&I framework, the leaders play an active role in collaborating with multi disciplinary teams in the organisation to decide on which organisational activities to include in the formal monitoring for quality improvement purposes. This follows on the identification of the aforementioned relevant standards and indicators.

8.1.1.5 The processes reflect all components and quality activities in relation to standard and indicator development, monitoring, evaluation and remedial action.

Critical criterion

The organisational QM&I framework needs to be guiding staff in the organisation on how to establish quality improvement processes and initiatives with regard to the development of relevant standards for their service, the development of measurable indicators for monitoring purposes and the implementation of remedial actions.

Linked criterion;

8.1.1.1

8.1.1.6 There is a regular reporting system on quality activities to all stakeholders, including governance and the community.

Documented evidence is required of such reporting between departments and the organisational management structures, as well as between organisational management and governance. Such reporting includes feedback from departments on their progress with QM&I processes, results on performance indicator monitoring, problems that may be experienced, etc. These reporting processes support the above and include written reports, newsletters, minutes of meetings, formal presentations, etc.

Linked criteria:
1.1.1.8
8.2.2.4

8.1.2 The leaders coordinate the quality management and improvement processes, and provide technological and other support.

Standard Intent

Available resources are used well when the quality management and improvement activities are centrally co-ordinated. This coordination is achieved through a quality steering group, or a committee, that provides for effective supervision of quality management and improvement activities throughout the organisation. One of the responsibilities of such a group is to communicate information about the quality management and improvement processes to the staff on a regular basis.

The monitoring of clinical and managerial functions in a healthcare organisation results in the accumulation of data and information. An understanding of how well the organisation is doing rests on the analysis of the data and information over time and comparison with other organisations. For large or complex organisations this tracking and comparison may require technology and/or staff members with data management experience. The leaders of an organisation understand the monitoring and improvement priorities in terms of this necessary support. They provide the support consistent with the resources and quality management priorities of the organisation.

Participation in data collection and analysis, and the planning and implementation of quality improvements requires knowledge and skills that most staff members do not have or do not use regularly. Thus, when asked to participate in the processes, the staff receive training consistent with their role in the planned activity. The organisation identifies or provides a knowledgeable trainer for this education

The staff selected to participate in management and improvement processess are those closest to the activities or being monitored, studied or improved. Both managerial and clinical staff participate. Over time, a larger and larger number of staff have the opportunity to be trained and participate.

8.1.2 Criteria

8.1.2.1 There is coordination of the organisation's quality management and improvement processes with all services.

This should be read in conjunction with criteria 8.1.1.1 to 8.1.1.6 in the previous standard.

Such Coordination needs to be reflected in documented systems on QM&I, reporting , minutes of meetings, etc.

8.1.2.2 The leaders provide the required technology and support.

The type of support required will be determined by the design and complexity of the organisational QM&I framework. This may include aspects such as training in quality methodology, aligning work schedules to allow for time to spend on relevant activities, providing assistance with data management (manually or electronically), etc.

Take note of the close link between the QM&I framework and the management of information systems as stated in standard 6.2.1

8.1.2.3 There are relevant training processes to equip staff with the necessary competencies for the design, implementation and evaluation of quality management and improvement processes.

Evidence of compliance could exist in the form of attendance registers at such training sessions, information sharing meetings, availability of training manuals, policies and procedures, analysis of staff attendance, etc.

Linked criterion:
2.4.2.2

8.2 Clinical And Managerial Quality Monitoring

8.2.1 Clinical practice guidelines are used to guide clinical care.

Standard Intent

The goals of healthcare organisations include

- standardising clinical care
- reducing risks within care , particularly those associated with critical decision steps; and
- providing clinical care in a timely, effective manner using available resources efficiently.

Organisations use a variety of tools to reach these and other goals, e.g care providers seek to develop clinical care and make clinical decisions based on the best scientific evidence-based guidelines. Clinical practice guidelines are useful tools in this effort to understand and apply the best science to a particular diagnosis or condition.

In addition, care providers seek to standardise care. Clinical care pathways are useful tools in this effort to ensure effective integration and coordination of care and efficient use of available resources.

Clinical practice guidelines relevant to the organisation's patient population and mission are:

a) selected from among those applicable to the service and patients of the organisaiton (mandatory national guidelines are included in this process, if present)
b) evaluated for their applicability and science
c) focused on high-volume, high-risk, high-cost and problem prone conditions
d) adapted when needed to the technology, drugs and other resources of the organisation or to accepted national professional norms
e) formally approved or adopted by the organisation
f) implemented and monitored for consistent use and effectiveness
g) supported by staff trained to apply the guidelines or pathways and
h) periodically updated.

Each organisation has a process to assess the quality and completeness of patient records. That process is a part of the organisation's performance improvement activities and is carried out regularly. Clinical record review is based on a representative sample (a sample representing the practitioners providing care and of the types of care provided). The medical staff, nursing staff, and other relevant clinical professionals, who are authorised to make entries in the patient record conduct the review process. The focus of the review is on the quality of the record and clinical information available during the care process. Thus, the organisation's record review process includes the review of the records of patients currently receiving care as well as the records of discharged patients.

8.2.1 Criteria

8.2.1.1 The leaders identify key measures to monitor the quality of clinical processes.

Root criterion

Refer to 8.1.1.3
If only statistical data on these aspects, without evidence of their inclusion in formal quality monitoring and improvement processes is found, this will be scored PC.

For example, the provisioning of statistical data on the number of surgical procedures carried out, the number of spinal anaesthetics performed, etc does not qualify as a complete quality improvement process, unless specific trends are identified and there is documented evidence of remedial action implemented with resultant improvements.

Key clinical aspects to monitor need to be reflected in departmental quality improvement processes as indicated in e.g. standard 10.10.1 (as well as similar standards in all clinical service elements).

Linked criteria:
1.2.2.7, 1.2.7.3

22.12.1.2
23.10.1.2
24.12.1.2

8.2.1.2 Leaders use clinical practice guidelines to guide patient care processes.

Please note: the review of these guidelines is dealt with in the individual service element documents.

8.2.1.3 The organisation follows the process described in a) to h) of the intent, by means of clinical audits, to monitor the quality of care provided.

8.2.1.4 Medical, nursing and other clinical leaders use available and relevant clinical practice guidelines in clinical monitoring as part of a structured clinical audit.

Linked criteria:
1.3.2.2
6.3.1.3
8.3.1.1
10.3.1.2 and similar criteria in in-patient services.

8.2.1.5 Patient clinical records are reviewed regularly.

The review period will depend upon established norms within the country and on organisational policy. Some are done monthly, others quarterly.

For this purpose the results ***of patient record audits*** *need to be taken into account. Therefore the score of this criterion needs to reflect the aggregated average score of all linked criteria.*

Linked criteria:
1.3.2.4
3.2.1.4
10.1.2.1, 10.10.1.4 and similar criteria in all in-patient services.
18.5.1.4

8.2.1.6 The review is conducted by medical, nursing and other staff, who are authorised to make entries in patient records or to manage patient information.

8.2.1.7 Records of active and discharged patients are included in the review process.

8.2.1.8 Professional performance is monitored as part of clinical monitoring.

Clinical monitoring, which includes patient record audits, could reveal deficiencies in professional performance. This information should be used to determine the individual's need for training and/or supervision until deemed competent.

This is related to privileging i.e. delineation, for each member of the clinical staff, of the specific surgical or diagnostic procedures that may be performed and the types of illness that may be managed independently or under supervision.

Linked criterion:
2.6.1.4

8.2.2 There are relevant managerial quality monitoring systems.

Standard Intent

Quality management and improvement are data driven. Because most organisations have limited resources, they cannot collect data to monitor everything they want. Thus, each organisation must choose which managerial and support service and outcomes are most important to monitor based on its mission, patient needs and services provided. Monitoring often focuses on those that are high-risk, high volume, or problem prone at organisation and department level.

The leaders of an organisation have the responsibility to make the final selection of the key measures to be included in the organisation's monitoring activities. The measures selected relate to those important areas identified. Important measures to be monitored could include financial issues, stock control, loss control.

For each of these areas leaders decide:

- the process, procedure or outcome to be measured;
- how measurement will be accomplished; and
- the frequency of measurement.

Identification of the process, procedure or outcome to be measured is clearly the most important step. The measure needs to focus on, for example:

- risk points in procedures that frequently present problems or are performed in high volume and
- outcomes that can be clearly defined and are under the control of the organisation.

8.2.2 Criteria

8.2.2.1 Management and all departments identify key measures to monitor quality assurance and improvement processes.

Critical criterion
If only statistical data on these aspects, without evidence of their inclusion in formal quality monitoring and improvement processes is found, this will be scored PC.

Linked criteria:
1.2.2.7, 1.2.7.3, 1.3.1.8
2.6.1.1
8.1.1.1
9.4.1.1
10.10.1.1 and similar criteria in all in-patient services
17.6.1.1
18.5.1.1
19.3.1.1

20.3.1.1
21.6.1.1
22.12.1.1, 22.12.1.2
23.10.1.1, 23.10.1.2
24.12.1.1, 24.12.1.2
25.3.1.1
26.6.1.1
27.4.1.1
28.5.1.1
29.4.1.1
30.4.1.1
31.5.1.1
32.6.1.1 and similar criteria in SEs 33 to 38

8.2.2.2 Data collection is used to study areas targeted for improvement.

Refer to criterion 8.1.1.5
Quality improvement is data driven and this criterion requires evidence that data collected from quality improvement monitoring (results) are in fact used to improve managerial aspects.

8.2.2.3 Data collection is used to monitor and evaluate the effectiveness of improvements.

This implies that there is ongoing monitoring of the improvements achieved in order to ensure these are sustained.

8.2.2.4 The results of monitoring are communicated to the leaders and governance structure of the organisation.

Linked criteria
1.1.1.8,
8.1.1.6.

8.3 Use of Analysed Data

8.3.1 Analysed data is used to improve the quality of managerial and clinical services.

Standard Intent

To reach conclusions and make decisions, data must be aggregated, analysed and transformed into useful information. Data analysis involves individuals with an understanding of information management and skills in data aggregation methods, and in the use of various statistical tools. Data analysis involves the individuals responsible for the process or outcome being measured. These individuals may be representative of clinical, managerial or any other departments and services in the organisation. Thus, data analysis provides continuous feedback of quality management information to help those individuals make decisions and continuously improve clinical and managerial processes.

The organisation determines how often data are aggregated and analysed. The

frequency depends on the activity or area being measured, the frequency of measurement, and the organisation's priorities. For example, clinical data may be analysed weekly to meet local regulations, and patient fall data may be analysed monthly if falls are infrequent. Thus aggregation of data at points in time enables the organisation to judge a particular process's stability or a particular outcome's predictability in relation to expectations.

When an organisation detects or suspects undesirable change from what is expected, it initiates intense analysis to determine where best to focus improvement. In particular, intense analysis is initiated when levels, patterns or trends vary significantly or undesirably from:

- what is expected
- that of other organisations or
- Recognised standards.

Each organisation establishes which events are significant and the process for their intense analysis. When undesirable events can be prevented, the organisation works to carry out preventive changes.

The goal of data analysis is to be able to compare an organisation in four ways:

- with itself over time, such as month to month, or one year to the next
- with other similar organisations, such as through reference databases
- with standards, such as those set by accrediting and professional bodies, or those set by laws or regulations and
- with desirable practices identified in the literature, such as practice guidelines.

These comparisons help the organisation to understand the source and nature of undesirable change and help to focus improvement efforts.

Understanding statistical techniques is helpful in data analysis, especially in interpreting variation and in deciding where improvement needs to occur. Run charts, control charts, histograms and Pareto charts are examples of statistical tools useful in understanding trends and variations in healthcare.

Take note of this standard's link with 6.1.3. in Service Element 6 Management of Information.

8.3.1 Criteria

8.3.1.1 Clinical monitoring data are used to monitor and evaluate the effectiveness of improvements.

Linked criteria: *6.1.1.1, 6.3.1.2* *7.1.1.7, 7.2.6.4* *8.2.1.4*

8.3.1.2 Managerial data are used to monitor and evaluate the effectiveness of improvements.

Linked criteria:

6.1.1.1, 6.3.1.2
7.1.1.7.

8.3.1.3 Comparisons are made over time within the organisation.

8.3.1.4 Comparisons are made with similar organisations, when possible.

Linked criteria:
6.3.2.3

8.3.1.5 Comparisons are made with standards and desirable practices.

8.4 Achieving And Sustaining Quality

8.4.1 Improvement in quality is achieved and sustained.

Standard Intent

The organisation uses the information from data analysis to identify potential improvements or reduce (or prevent) adverse events. Routine monitoring data, as well as data from intensive assessments, contribute to an understanding of where improvement should be planned, and what priority should be given to the improvement. In particular, clinical and managerial leaders plan improvements to those data collection areas requiring priority.

The organisation uses appropriate resources and involves those individuals, disciplines, and departments closest to the activities to be improved. Responsibility for planning and carrying out improvement is assigned to individuals or to a team. Any needed training is provided and information management or other resources are made available.

Once planned, data are collected during a test period to demonstrate that the planned change was actually an improvement. To ensure that the improvement is sustained, monitoring data are then collected for, ongoing analysis. Effective changes are incorporated into standard operating procedures and any necessary staff education is carried out. The organisation documents those improvements achieved and sustained, as part of its quality management and improvement processes.

8.4.1 Criteria

8.4.1.1 The organisation documents the improvements achieved and sustained.

8.4.1.2 This information leads to the development of processes to ensure that quality is sustained.

SE 9 PREVENTION AND CONTROL OF INFECTION

OVERVIEW OF PREVENTION AND CONTROL OF INFECTION

The goal of an organisation's infection surveillance, prevention and control programme is to identify and reduce the risks of acquiring and/or transmitting infections among patients, the staff, contract workers, volunteers, students and visitors.

The infection control programme may differ from organisation to organisation, depending on the organisation's geographic location, patient volume, patient population served, type of clinical activities and number of employees.

Effective programmes have in common identified leaders, appropriate policies and procedures, staff education, and coordination throughout the organisation.

Current scientific information is required to understand and implement effective surveillance and control activities; practice guidelines provide information on preventive practices and infections associated with clinical services and applicable laws and regulations define elements of the basic processes and reporting requirements. Information supports the tracking of risks, rates and trends in nosocomial infections, data analysis, interpretation and presentation of findings. In addition, infection control programme data and information are managed with those of the organisation's quality management and improvement programme.

Standards

9.1 Infection Control Management

9.1.1 The organisation designs and implements co-ordinated processes to reduce the risks of healthcare associated (nosocomial) infections in patients and healthcare workers.

Standard Intent

For infection prevention and control processes to be effective, they must be comprehensive, encompassing both patient care and employee health. The processes are appropriate to the size and geographic location of the organisation, the services offered by the organisation, and the patients seen by the organisation.

Infections can enter the organisation via patients, their families, staff members, volunteers, vectors, visitors, and other individuals such as trade representatives. Thus, all areas of the organisation, where these individuals are found, must be included in the programme of infection surveillance, prevention and control.

One or more individuals, acting on a full-time or part-time basis, direct the processes. Their qualifications depend on the activities they will carry out and may be met through education, training and experience. Their responsibilities include, for example, the setting of criteria for defining nosocomial infections and establishing data collection methods and reporting processes. Coordination involves communication with all parts of the organisation, to ensure that the programme is continuous and proactive.

Whatever the mechanism chosen by the organisation to coordinate the infection control processes medical and nursing staff are represented and engaged in the activities. Others may be included as determined by the size of the organisation and the services offered (for example, epidemiologist, data collection expert, central sterilisation manager, operating theatre supervisor).

The individual, committee, or other mechanism must also monitor those housekeeping and other support service practices, which may lead to the spread of infection, e.g. cleaning, linen supply, laundry services and waste disposal.

Current scientific information is required to understand and implement effective surveillance and control activities; practice guidelines provide information on preventive practices and infections associated with clinical services; and applicable laws and regulations define elements of the basic processes and reporting requirements. Information supports the tracking of risks, rates and trends in nosocomial infections, data analysis, interpretation and presentation of findings. In addition, infection control programme data and information are managed with those of the organisation's quality management and improvement programme.

9.1.1 Criteria

9.1.1.1 There is a process to reduce the risk of healthcare associated (nosocomial) infections to patients and healthcare workers.

Root criterion

for all others in this section as well as for 10.12.1.1 and similar criteria in all other clinical Service Elements.

Formal processes should be followed to identify and assess infection related risks in the organisation (clinical and non-clinical areas), analyse the risks, formulate a risk management plan and continually evaluate the effectiveness of the plan.

These processes refer to all activities/functions that are performed in relation to the prevention and control of infection, which should be performed in accordance with, or guided by, policies, procedures, programmes, plans, etc.

The plan should indicate all risks, preventive measures, policies and procedures, training requirements etc. Such a plan may exist in different formats e.g. a detailed single document, or separate manuals, or various electronic modules, etc.

Linked criteria:
1.2.6.1
7.1.1.1, 7.1.1.7

9.1.1.2 The process is appropriate to the size and geographic location of the organisation, the services offered, and the patients served.

9.1.1.3 Coordination of infection control activities involves medical, nursing and other staff as appropriate to the organisation.

Generally, the coordinator is a professional nurse with training and/or experience in infection prevention and control. He/she needs to be supported by other categories of staff and, depending on the size of the facility and the services provided, should include doctors, nurses, pharmacists, laboratory staff, as well as maintenance, kitchen, laundry and housekeeping staff.

9.1.1.4 All patient, staff and visitor areas of the organisation are included in the infection control processes.

Critical criterion

Linked criteria:
9.1.1.1

9.1.1.5 Responsibility for co-ordinating the processes is assigned to one individual or a committee.

Note guideline for criterion 9.1.1.3
It is advisable for the coordinator to be trained/experienced in infection prevention and control measures.

The responsibilities of the coordinator and committee members must be documented and included in their performance agreements/job descriptions.

Linked criterion:
1.2.8.1

9.1.1.6 The individuals are competent to manage the scope and complexity of the processes.

The qualifications and experience of each committee member should be carefully assessed to ensure that they are able to perform their duties responsibly.

9.1.1.7 The infection control processes are based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

Access to national policies and procedures, guidelines, protocols, laws, regulations and relevant best practice examples related to infection control practices must be available.

9.1.1.8 Information management systems support the infection control processes.

There should be a process whereby all infection control data is collected, verified and outcomes analysed e.g. rates, trends and risks of nosocomial infections and communicable diseases are reported, captured and acted upon.

This can be manual or electronic, depending on the systems available at the facility.

Close co-operation with the information officer/department is therefore essential.

Linked criteria:
6.1.1.1

9.1.2 The organisation designs and implements processes to reduce the risks of healthcare associated (nosocomial) infections in patients and healthcare workers.

Standard Intent

For infection prevention and control measures to be effective, they must be comprehensive, encompassing both patient care and employee health. The processes are guided by a plan that identifies and addresses the infection issues that are epidemiologically important to the organisation. The plan includes systems to monitor infections and investigate outbreaks of infectious diseases. Policies and procedures guide the processes, which include the periodic assessment of risk and setting of risk reduction goals.

Each organisation must establish those epidemiologically important infections, infection sites, and associated devices that will provide the focus of efforts to prevent and reduce the incidence of healthcare associated/nosocomial infections. They consider, as appropriate, infections that involve:

- the respiratory tract – such as the procedures and equipment associated with intubation, mechanical ventilation support and tracheostomy
- the urinary tract – such as the invasive procedures and equipment associated with indwelling urinary catheters, urinary drainage systems, and their care, and so on
- intravascular invasive devices – such as the insertion and care of central

venous catheters, peripheral venous lines
- surgical sites– such as their care and type of dressing and associated aseptic procedures.
- Epidemiologically significant diseases and organisms, multi-drug resistant organisms, highly virulent infections and
- Emerging or re-emerging infections within the community.

9.1.2 Criteria

9.1.2.1 The processes to reduce healthcare associated (nosocomial) infections include systematic and proactive surveillance activities to determine usual (endemic) rates of infection.

Data must be provided of:
- *identification of nosocomial infections according to accepted definitions*
- *reporting systems (from departments and the laboratory)*
- *monitoring mechanisms by the infection control coordinator and committee*

9.1.2.2 The processes include systems to investigate outbreaks of infectious diseases.

This will depend upon the size and location of the organisation and the type and level of services provided.

In public facilities, certain indicators to be monitored and reported upon may have been identified by various levels of government.

9.1.2.3 Epidemiologically significant diseases and organisms are included as appropriate to the organisation and its community.

This will depend upon the size and location of the organisation and the type and level of services provided.

In public facilities, certain indicators to be monitored and reported upon may have been identified by various levels of government.

9.1.2.4 Emerging or re-emerging infections are included as appropriate to the organisation and its community.

Documented evidence of monitoring is required. The indicators may be set by various levels of government or identified by the organisation.
Refer to criterion 9.4.1.2

9.1.2.5 Risk reduction goals and measurable objectives are established and regularly reviewed.

Critical criterion

Information on all infections is to be analysed to identify risks, trends and rates. Documentation needs to be available on how the plans/processes have been redesigned to keep the rates at the lowest possible levels, e.g. changing the type of soap used at hand-wash basins.

Take note of quality management and improvement methodology in standard 8.2.1

Linked criteria:
1.2.2.4

9.2 Infection Control Processes

9.2.1 The organisation identifies the procedures and processes associated with the risk of infection, and implements strategies to reduce infection risk.

Standard Intent

Healthcare organisations assess and care for patients using many simple and complex processes, each associated with a level of infection risk to patients and the staff. It is thus important for an organisation to review those processes and, as appropriate, implement needed policies, procedures, educational and other activities to reduce the risk of infection.

9.2.1 Criteria

9.2.1.1 The organisation has identified those processes associated with infection risk and implemented strategies to reduce such risk.

Root criterion

A formal process should be followed to identify and assess risks in the organisation, analyse the risks, formulate a risk management plan and continually evaluate the effectiveness of the plan.

Evidence of implementation (policies, guidelines, training, protective devices and monitoring of the implementation) must be available.

Linked criteria:
7.1.1.1, 7.1.1.7
10.12.1.1 and similar criteria in all in-patient services i.e. SEs 11 to 16 and 40
17.8.1.1
18.7.1.1
19,5,1,1
20.5.1.1
21.8.1.1
22.14.1.1
23.12.1.1
24.13.1.1
25.4.1.1
26.8.1.1
27.6.1.1
28.6.1.1
29.5.1.1
31.6.1.1
32.8.1.1 and similar criteria in SEs 33 to 38

9.2.1.2 Identified processes include, as appropriate to the services provided by the organisation equipment cleaning, disinfection and sterilisation

This must include all areas where equipment is cleaned, particularly the central sterilising department, healthcare technology workshops and patient care departments.

Guidelines on cleaning materials, chemicals, cleaning methods must be provided to ensure that all areas follow similar protocols. Implementation must be regularly monitored.

9.2.1.3 Identified processes include, as appropriate to the services provided by the organisation laundry and linen management

This must include protection of staff, handling of soiled and infected linen, protection of clean linen from contamination etc.
Guidelines on flow of linen from soiled to clean areas, wearing of protective clothing, searching of linen for sharps, etc. must be available. Implementation must be regularly monitored.

9.2.1.4 Identified processes include, as appropriate to the services provided by the organisation management of healthcare waste

Critical Criterion

Processes must include protection of staff, handling at source, collection, storage and disposal of infectious/healthcare waste.

Linked to standard 7.7.1.1

9.2.1.5 Identified processes include, as appropriate to the services provided by the organisation ensuring that food preparation, handling, storage and distribution are safe and comply with laws, regulations and current acceptable practices.

Guidelines on the effective and hygienically preparation, storage and serving of food must be provided to ensure that all areas follow similar protocols. Infection control guidelines on hand washing protocols and ablution facilities for food handlers must also be provided. Implementation must be regularly monitored.

9.2.1.6 Identified processes include, as appropriate to the services provided by the organisation housekeeping services.

Guidelines on cleaning materials, chemicals and storage there off as well as cleaning methods must be provided to ensure that all areas follow similar protocols. Implementation must be regularly monitored.

Linked criterion:
28.6.1.1

9.2.1.7 Identified processes include, as appropriate to the services provided by the organisation operation of the mortuary area/holding room for the deceased.

Guidelines on identification of infectious/potentially infectious bodies, refrigeration temperatures, use of shrouds and sheets, personal protective equipment, cleaning materials, chemicals and storage thereof, as well as cleaning methods must be provided. Implementation must be regularly monitored.

This criterion will be marked NA where this facility is not provided. For example, in many of the private hospitals arrangements are made with the local undertakers to collect the bodies from the ward/department.

NB This criterion does not apply to forensic mortuaries where autopsies are performed and where more comprehensive, detailed standards are required.

9.2.1.8 Identified processes include, as appropriate to the services provided by the organisation separating patients with communicable diseases from those patients and staff members, who are susceptible to infection due to immuno-suppression or other reasons.

This refers to isolation procedures and reverses barrier nursing procedures, where these are relevant. For example, patients and/or staff, who are receiving chemotherapy, with resultant lowered resistance to infection.

Linked criteria:
1.2.6.1
10.5.2.1 and similar criteria in all in-patient services.

9.2.1.9 Identified processes include, as appropriate to the services provided by the organisation the management of viral haemorrhagic fevers.

Procedures/protocols to be followed are generally provided by the local authorities for both the public and private sector health services. National arrangements, where relevant, will apply.
Evidence of plans to adhere to these guidelines must be provided.

9.2.1.10 Processes associated with risk are described in written documents.

9.2.2 Protective clothing, disinfectants and barrier techniques are available and are used correctly when required.

Standard Intent

Hand washing, barrier techniques and disinfecting agents are fundamental to infection prevention and control. The organisation identifies those situations in which the use of masks and gloves is required and provides training in their correct use. Soap and disinfectants are located in those areas where hand washing and disinfecting procedures are required. Staff are educated in proper hand washing and disinfecting procedures.

9.2.2 Criteria

9.2.2.1 The organisation identifies those situations for which protective clothing is required.

As part of the risk assessment, the organisation will list those areas where protective clothing should be used. These include clinical and non-clinical areas (wards, theatre, CSSD, radiology, kitchen, laundry, maintenance staff, etc.)

Details of the type of protective clothing to be used and under what circumstances must be made known to staff.

Linked criteria:
1.3.1.5
7.3.1.2
9.2.2.1

9.2.2.2 Protective clothing is correctly used in those situations.

Documented evidence of monitoring of the use of protective clothing and other devices in all relevant areas of the hospital must be available. It is recommended that this be included in the monthly workplace inspections.

9.2.2.3 The organisation identifies those areas where hand washing and disinfecting procedures are required.

All hand-wash facilities in all departments must be identified and listed. The provision of hand-washing posters, basins with running water, soap, paper towels and refuse bins must be ensured.

Linked criterion:
1.2.2.3

9.2.2.4 Hand washing and disinfecting procedures are used correctly in those areas.

Evidence of training of all staff in correct hand-washing methods must be provided. In addition, evidence of ongoing monitoring of the implementation of correct methods in all relevant areas of the hospital must be available.

9.3 Obtaining Of Laboratory Cultures

9.3.1 Laboratory cultures are obtained from designated environmental sites in the organisation associated with significant infection risk.

Standard Intent

Infection surveillance procedures rely on specimen collection from those areas of the organisation thought to be associated with a high incidence or risk of infection, such as operating theatres. The infection control programme includes identifying those sites and collecting specimens from those sites. The sites associated with the activities described in 9.2.1 are frequently included in such surveillance activities.

Those individuals who collect specimens are trained in the proper collection and handling of microbiological specimens.

9.3.1 Criteria

9.3.1.1 The organisation identifies those environmental sites from which specimens are to be collected.

This section deals with the collection of environmental specimens. The areas generally considered are the operating theatre, critical care units and kitchens. The areas will depend on the size of the organisation and the services provided.

Because of the costs involved, routine tests are not generally undertaken. However, this section is applicable in all instances, as facilities must have a documented strategy in place to deal with these requirements, stating what specimens will be taken from which sites under what circumstances.
This criterion can, therefore, never be marked NA.

9.3.1.2 The organisation identifies the frequency with which specimens are collected.

9.3.1.3 Policies and procedures, which describe how specimens are taken and sent to the laboratory and action is taken when laboratory reports identify pathogenic organisms, are implemented.

9.4 Infection Control Quality Management

9.4.1 The infection control processes are integrated with the organisation's processes for quality management and improvement.

Standard Intent

The infection control process is designed to lower the risk of infection for patients, the staff and others. To reach this goal, the organisation must proactively monitor and track risks, rates and trends in nosocomial infections. The organisation uses monitoring information to improve infection prevention and control activities and to reduce nosocomial infection rates to the lowest possible levels. An organisation can best use monitoring data and information by understanding similar rates and trends in other similar organisations and contributing data to infection-related databases.

For the purpose of this section, take note of the quality management and improvement methodology as described in Service Element 8.

Also this section contains the root criteria for those listed in all clinical Service Elements such as 10.12.1.1. In other words, the latter cannot be scored compliant unless this section has achieved compliance.

9.4.1 Criteria

9.4.1.1 The organisation uses quality improvement methodology to track infection risks, infection rates, and trend in healthcare associated/nosocomial infections.

Information on all infections is to be analysed to identify risks, trends and rates.

Data must be provided of
- *identification of nosocomial infections according to accepted definitions;*
- *reporting systems (from departments and the laboratory);*
- *monitoring mechanisms by the infection control coordinator and committee.*

Trend = General direction and tendency of events.

Linked criterion:
8.2.2.1

9.4.1.2 Monitoring includes using indicators related to infection issues that are epidemiologically important to the organisation.

This will depend upon the size and location of the organisation and the type and level of services provided. In public facilities, certain indicators to be monitored and reported upon may have been identified by various levels of government.

9.4.1.3 The organisation uses risk, rate and trend information to design or modify processes to reduce healthcare associated/nosocomial infections to the lowest possible levels.

Critical criterion

Information on all infections is to be analysed to identify risks, trends and rates. Documentation needs to be made available on how the plans/process has been redesigned to keep the rates at the lowest level possible.

Linked criteria:
7.1.1.7

9.4.1.4 The organisation compares its infection control rates with other organisations, national and international, through comparative databases.

Documented evidence of comparison with other hospitals at various levels is required. It is important to compare similar facilities in terms of size and services.

Linked criteria:
6.3.2.3

9.4.1.5 The results of infection monitoring in the organisation are regularly communicated to medical and nursing staff and to the management of the organisation.

Minutes of management or other meetings, as well as written reports, where the infection rates were discussed, must be available.
Take note of criterion 8.1.1.6

9.4.1.6 The organisation reports information on infections to appropriate external public health agencies.

Documented evidence of reporting is required. This includes notifiable disease reporting as well as other statistics required according to national legislation.

Linked criteria:
6.3.2.2

9.5 Infection Control Education For The Staff

9.5.1 The organisation provides education on infection control practices to the staff, patients, and, as appropriate, family and other caregivers.

Standard Intent

For an organisation to have effective infection control processes, it must educate staff members about the processes when they begin work in the organisation and regularly thereafter. The education programme includes professional staff, clinical and non-clinical support staff, and even patients and families, if appropriate. The education focuses on the policies, procedures and practices that guide the organisation's infection control processes. The education also includes the findings and trends from the monitoring activities.

9.5.1 Criteria

9.5.1.1 The organisation provides on-going in-service training about infection control to all personnel

Root criterion

The infection control education programme needs to include policies/guidelines as well as relevant issues as they are identified.

All staff should be included in information sharing and training at regular scheduled meetings or other fora.

Documented evidence (e.g. minutes of meetings/attendance records) must be provided.

***All** is still measured in terms of 80% compliance.*

Linked criterion:
2.4.2.1 and 2

9.5.1.2 Personnel are educated in infection control processes, when new policies are implemented and when significant trends are noted in surveillance data.

9.5.1.3 Patients and families are included when appropriate to the patient's needs and condition.

If patients and families are educated, this must be documented in the patient record and must form part of the education programme for patients and visitors.

This is particularly relevant where isolation procedures are implemented for the patient. Another example could be care of wounds at home, etc.